Estonian Health Insurance Fund Annual Report 2010

Eesti Haigekassa
Estonian Health Insurance Fund

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

Why does the turtle symbolize the health insurance (The Estonian Health Insurance Fund)?

In many cultures the turtle represents the creation of the Earth, longevity and constancy to strive to the goals.

Turtles are derided for their slowness but the health insurance itself is a conservative sphere. The progression is calculated and steady symbolizing our Health Insurance Fund and the reliability of the whole system.

The shield is protecting the turtle against unexpected and unforeseeable dangers. The Estonian Health Insurance Fund wishes to offer to its insured persons the same protection.

Estonian Health Insurance Fund Annual Report 2010

Eesti Haigekassa
Estonian Health Insurance Fund

Estonian Health Insurance Fund Annual Report 2010

Name	Estonian Health Insurance Fund
Registration number in the state register of central and local government agencies	74000091
Address	Lembitu 10, Tallinn 10114
Telephone	+372 62 084 30
Fax	+372 62 084 49
E-mail	info@haigekassa.ee
Website	www.haigekassa.ee
Beginning of financial year	January 1st 2010
End of financial year	December 31st 2010
Principal activity	Public health insurance
Management Board	Hannes Danilov (Chairman)
	Mari Mathiesen
	Kersti Reinsalu
Auditor	AS Deloitte Audit Estonia

Table of Contents

Statement by the Chairman of the Management Board

HANNES DANILOV

Chairman of the Management Board

While the year 2009 can be considered a crisis year, then 2010 was a year of careful adaptation. Savings measures did not loosen, but it was not necessary to make additional cuts with regard to the prices and volumes of our services.

However, the results of different savings methods were still remarkable. The length of waiting lists for medical care extended - in outpatient care from 20 days to 45 days, in inpatient care from 30 days to 60 days in average. Salaries of medical staff dropped by 4% in comparison with 2009.

From 2009 to 2010, there was an increase in the share of emergency medical care that is directly related to the extension of waiting lists - it is more difficult to see the doctor in time, mild diseases worsen and patients will then need emergency medical care which is much more expensive than planned medical treatment.

At first sight it may seem that the percentage of wage reduction of medical staff has been small. However, medical staff can always look for better conditions in neighbouring countries and there has been an increase in the number of persons doing so. We are particularly concerned about qualified nursing staff. Proportion of nurses on overall Estonian population is already remarkably smaller than the respective average proportion in the European Union and the number of nurses who will go abroad for employment has a bad impact on our health care system.

Therefore, I am of the opinion that in the course of budgetary procedure of 2012 it is necessary to raise the prices of medical services to the level they were in 2009. It could be a sign to the medical community that the decision-makers care about them and their well-being. Then the intentions to leave will lessen as well.

Availability and quality of services are above all guaranteed by medical staff without whom there would be no point to build modern hospitals, develop new technologies and acquire funds.

Completion of the report "Analysis on sustainable funding of Estonian health care system 2010–2030" in cooperation with the World Health Organization and the Ministry of Social Affairs. After more than a decade, there was completed a new possible action plan setting out different options for securing a sustainable funding of the Estonian health care system. The previous action plan "The Hospital Network Development Plan" gave guidelines for reorganisation of health care system and the completed report discusses the options for future funding of optimised health care system.

During this analysis, different options were compared arising from the core values of European health care systems: solidarity, equal treatment of patients, financial risk protection, transparency in front of the society and efficiency of administration. As a result of the aforementioned work there have been made several proposals to be enforced in the future.

In 2010, the implementation of digital prescription project took a lot of time and energy. After the first obstacles the system was finally put to work within a year under the guidance of the Health Insurance Fund. On the basis of this experience it can be said that neither the contracting entity nor the developers were ready to put into practice such large-scale project involving so many partners, concerning each Estonian resident and demanding so-called translation of a very complicated system for the compensation of medicines into the language of information technology. It explains also the delays in the implementation of other E-health projects.

This annual summary might seem a little distressed, but the main task of the Health Insurance Fund as a public sector organisation is to alleviate and solve our health problems. I am glad that despite all the difficulties faced by our country and health care system the satisfaction with the system has not decreased. It shows that all parties have made their best efforts to survive difficult times and there is still hope for better times in the future.

I would like to thank all the cooperation partners who helped us to fulfil our duties in the previous, very difficult year.

MANAGEMENT REPORT 2010

Principal task of the Estonian Health Insurance Fund is the organisation of health insurance. The Health Insurance Fund Act provides the objectives, functions, bases for activities and management of the Estonian Health Insurance Fund.

The mission of Estonian Health Insurance Fund is to ensure the availability of health insurance benefits to people and the sustainability of health insurance system.

The vision of the Estonian Health Insurance Fund is to create a sense of security in people concerning their potential health problems and resolution thereof.

To fulfil its functions the Health Insurance Fund cooperates with partners and employers. The partners of the Health Insurance Fund are hospitals, medical specialists, family physicians, dentists, pharmacies, professional societies and the associations of health care providers, health promoters, the Ministry of Social Affairs and other state agencies. Hospitals specified in the development plan of the hospital network are strategic partners. Employers pay social tax, and revenues from social tax designated for health insurance constitute a principal amount of the revenue of the Health Insurance Fund.

Organisation and Management

Estonian Health Insurance Fund was created in 2001.

The highest body of the Health Insurance Fund is the Supervisory Board that consists of 15 members. Five members are representatives of employers' organisations, five stand for the interest of the insured and the remaining five are acting on behalf of the state. The Minister of Social Affairs serves as the Chairman of the Supervisory Board.

A three-member Management Board is the directing body of the Health Insurance Fund.

The Health Insurance Fund has an Audit Committee that consists of the members of the Supervisory Board of the Health Insurance Fund. Similarly to the Supervisory, the members of the Audit Committee are also representatives of different interest groups. According to the external quality evaluation of the internal audit function carried out by KPMG Baltics OÜ in 2010, internal auditing of the Health Insurance Fund is in the compliance with the International Standards for the Professional Practice of Internal Auditing.

The Health Insurance Fund has 12 central departments, which in addition to their usual duties are also involved in development work, and 4 regional departments – Harju, Pärnu, Tartu and Viru –, which deal directly with clients, employers and partners. As of 31 December 2010, the Health Insurance Fund had a staff of 216.

Core values of the Health Insurance Fund are:

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

Estonian Health Care System

The Ministry of Social Affairs is the steward of the Estonian health care system. The Health Insurance Fund operates within the area of administration of the Ministry of Social Affairs, being not its agency but an independent legal body under public law.

The pillars of the Estonian health care system are separation of the provision of health services and funding thereof, independency of the providers of health care services in daily decision-making and the organisation of the health care system around family health centres. The Health Insurance Fund is founded for the purpose of separation of health care providers and funding and plays no direct role in managing medical institutions. Such separation of the health care providers and the funders guarantees unbiased funding decisions, aimed above all at meeting treatment needs of the insured and ensuring the use of health insurance resources for the designated purpose (see also Figure 1).

Figure 1. Estonian Health Care System

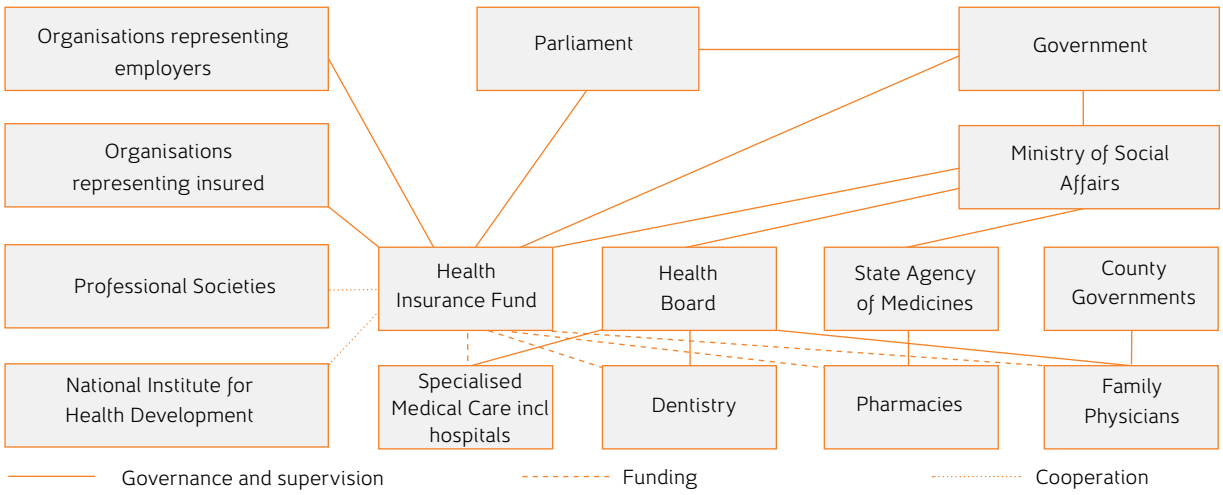


Table 1. Key indicators 2006–2010

	2006	2007	2008	2009	2010	% of change against 2009
Number of insured persons at year end	1,278,016	1,287,765	1,281,718	1,276,366	1,256,240	-2
Revenue (in EEK million)	8,910	11,183	12,900	11,430	10,866	-5
Health Insurance Expenditure (in EEK million)	7,946	10,149	12,223	11,959	10,849	-9
EHIF Operating Expenses (in EEK million)	87	95	116	107	108	1
Health insurance expenditure as a percentage of GDP (%)*	3.8	4.1	4.9	5.5	4.8	-13
Health service indicators						
Number of insured persons who used specialised medical care	796,815	810,834	819,055	800,578	797,048	0
Average length of stay (days)	6.3	6.4	6.3	6.1	6.1	0
Emergency care as a percentage of costs on specialised care (%), incl.						
outpatient care	17	18	17	17	18	1
day care	7	7	6	9	9	0
inpatient	63	63	63	67	67	0
Average cost per case in specialised medical care (EEK), incl. outpatient						
care	447	548	671	687	666	-3
day care	4,942	6,435	7,324	7,030	6,321	-10
inpatient	10,981	13,629	15,775	15,821	15,361	-3
Family physician consultations per 1,000 insured persons	3,789	3,889	4,039	3,895	3,831	-2
Referral to treatment in a foreign country and benefits arising from EU legislation (in EEK million)	27	43	56	68	60	-12
Indicators of the benefits for pharmaceuticals						
Number of prescriptions issued at a discount	5,393,102	5,996,843	6,636,410	6,435,700	6,689,886	4
Number of insured persons who used discount pharmaceuticals	795,677	830,594	840,847	829,748	822,440	-1
Average cost per discount prescription for EHIF (EEK)	179	187	193	215	212	-1
Average cost per discount prescription for a patient (EEK)	109	117	121	126	121	-4
Indicators of benefits for incapacity for work						
Number of days of incapacity for work for which benefits were paid by the Health Insurance Fund	8,195,320	8,888,700	9,182,077	7,379,379	5,453,066	-26
Cost per day of benefit for incapacity for work (EEK)	184	217	260	299	234	-22

* The indicators for 2006-2009 have been revised according to the GDP corrected by the Statistics Estonia.

Active Year Before Euro

KERSTI REINSALU

Member of the
Management Board

As I am responsible for information technology and financial area in the Health Insurance Fund, the title refers rather expressively to the most important activities of the Health Insurance Fund last year. Change of currency is directly related to the financial area and as nowadays the whole accounting depends on computers and software, the main focus was put on changing our information systems. When in the course of planning bigger software developments, there is enough time to describe all nuances in advance and establish reasonable completion deadlines, it was not possible to postpone the arrival of euro and all preparations had to be completed before the turn of the year. The Health Insurance Fund uses different SAP software modules in its information systems which have a vast number of global users and support system that simplifies performance of new solutions and developments. It applies also to the euro developments, when it was possible to share experiences with the other European Union member states who have already survived the transition to euro. Continuing operation of the Health Insurance Fund information systems is important not only for the Health Insurance Fund, but also for our partners who are using electronic channels for data transfer. Now we can also say that all preparations succeeded as planned and there were no hindrances upon the transition.

Besides the operations related to the transition to euro we observed closely the execution of the Health Insurance Fund budget. When during the first months of the year the revenue from the health insurance part of social tax was significantly lower than the forecast, the other half of the year was more stable and closer to the forecast. In total, the budget revenue exceeded the aforementioned revenue by 335 million kroons. At the same time, on the expenditure side the benefits for incapacity for work turned out to be more than 400 million EEK less than initially planned. It became evident that it is more complicated and unforeseeable to forecast that after the amendment to law. Reduction in the benefits for incapacity for work has been caused among other things by the decrease in the number of employed persons and average daily salary in comparison with 2009. Due to the under-execution of some expenditure types, there was no pressure on other liabilities because of the revenue shortfall and it was not necessary to make additional cuts in the course of the year. The Health Insurance Fund fulfilled all other open and contractual obligations.

The year 2010 was also significant because of the investment volumes. Information technology is a constantly developing field and increased requirements for the improvement of operational reliability and efficiency of E-services have created a demand for new investments. In order to achieve the aforementioned goals, we decided to increase the volume of disk arrays and to create a new infrastructure solution at the Health Insurance Fund in 2009. For the purpose of implementation of the aforementioned solution, in 2010 there were made big investments amounting to 10.6 million kroons in total. At the beginning of the year large disk arrays were acquired for the storage of constantly increasing data volumes and at the end of the year new network devices and servers were acquired as well. By the end of 2011, the most critical components of information system of the Health Insurance Fund will to operate as duplicates at two different locations, each application operates as a cluster in two servers and all data are synchronized between two separate control units. All the aforementioned measures are taken with a view to secure maximum operational reliability in case of occurrence of different physical risks.

Considering that 2010 was the year of transition from large deficit to standstill, we expect the next year to be more stable, enabling us to make long-term plans and guarantee assuredness for the insured persons and our partners.

In Addition to Accessibility, the Key Words are Efficiency, Quality and Awareness

MARI MATHIESEN

Member of the
Management Board

Preserving stability after rapid rearrangements that took place after 2009, regardless of continuously complicated economic circumstances, must be considered one of the most essential achievements in 2010. From the viewpoint of insured persons, stability means that the options for medical care and benefits remain reasonably available. Stability means for medical institutions an option to act as planned all the year round. These may seem simple expectations, but because of the economic recession we had to make more than the usual efforts to meet them. Co-functioning is usually put to the test in hardest times and I would like to express my gratitude to our partners for a smooth cooperation.

Efficiency has been one of the key words in the success of Estonian health insurance. However, it would not be very wise for us to rest on laurels. In the analysis of sustainability of health care system that was completed in 2010, experts have highlighted the need to avoid fragmentation of funding. It was pointed out that the Health Insurance Fund should support outpatient and day care upon remuneration of service providers. In addition, the attention was drawn to the fact that upon making funding decisions it becomes increasingly necessary to be guided by comparative assessment of performance and cost-efficiency of the provision of services, i.e. to pay more attention to the assessment of health technologies. These recommendations were taken into account during the preparation of the Health Insurance Fund Development Plan for the period of 2011-2014.

Quality of health care has become a popular topic. We are talking more and more often about the concept of quality, its measurability and competence assessments. It is good that the importance of the content of services was not clouded by economic recession. Quality means also compliance with a standard and it is determined as a result of measurement. Establishment of standard requires prior knowledge about good result and what would be main factors to achieve that and also agreement between parties. In the course of the year, we made one step towards better assessment of quality – we agreed with the Society of Neurologists on the treatment quality indicators of a stroke. As of 2011, we make regular summaries about these indicators and give a relevant feedback. Therefore, a new field which performance needs better assessment was added to the previously agreed indicators of the level of general surgery activities.

Quality is a complex concept and thus the Health Insurance Fund has performed, in addition to regular supervision, several activities that complement each other, in order to encourage the health service providers to systematically monitor and improve their activity level. Regarding reduction of clinical variations, it is important not to underestimate the development and implementation of the evidence-based clinical practice guidelines that are adjusted to the conditions in Estonia. In 2010, we had a good opportunity to use the help of international experts of the World Health Organisation and assess the strengths and opportunities for development of the system that had functioned so far. The Faculty of Medicine of the University of Tartu is an active partner of the Health Insurance Fund in the launched project playing an essential role in development of knowledge of our medical staff. In 2011, we will continue preparation of the manual assisting the development of clinical practice guidelines and testing the manual in practice by developing a new clinical practice guideline.

The importance of peoples' conscious choices and giving information to patients are increasingly important issues. Decisions should be made in a wise manner, thus the Health Insurance Fund should play an increasingly important role in rising public awareness. The social campaign that was launched in 2010 and promoted rational use of medicines received a lot of feedback and brought along discussions of the parties, thus confirming the assessments received in the course of population survey according to which it is important to have sufficient selection of medicines available in pharmacies. The Health Insurance Fund plans to continue communication campaigns, in order to prevent the people who are taking medicines from using excessive patients financial participation.

The year 2010 is of historical importance, as it marks beginning of implementation of digital prescription. Electronic solution cannot be an objective in itself; however, a digital prescription is a tool that has all the aforementioned key words: efficiency, quality and awareness. Rapid information exchange without paper and comprehensive information contained in one system enables to get a clear overview for the person who is using medicines and helps medical staff to make the decisions supporting high-quality treatment. The efforts made for several years in relation to the development of system are justified by the fact that by the end of the year, pharmacies had sold medicines on the basis of more than 4 million digital prescriptions and satisfaction of the users of digital prescriptions amounted to 91%. The project of digital prescription achieved predominantly the first place in the e-services competition organized by the Ministry of Economic Affairs and Communications and the project will be put forward for World Summit Award competition.

The importance of our achievements encourages us to further development in the future.

HEALTH INSURANCE FUND: 2010 STRATEGIC GOALS AND ATTAINMENT THEREOF

Scorecard 2010

Objective	Weight %	Performance indicator	Unit	Comments	2009 performance	2010 Objective	2010 performance	Performance %
	6.0	Satisfaction of the insured with the health system	%	Satisfaction of the insured with the health system as determined in the course of a general survey conducted among the insured	61	64	63	**5.9**
1. Ensure access to health services, pharmaceuticals and financial benefits	**28.5**							**27.5**
	7.5	Satisfaction with accessibility to medical care	%	A part of the general survey	54	63	55	87.3
• Ensure uniform access	7.5	Involve the insured in activities leading to improved monitoring of their health status	%	The ratio of the number of the involved insured to the total number of the insured	85	85	90	100
	7.5	Maximum waiting time for cataract operations	time	Maximum waiting time for cataract operations cannot be more than 1.5 yrs	1.5	1.5	1.5	100
	6.0	Maximum waiting times for endoprosthetic replacement	time	Maximum waiting time for endoprosthetic replacement cannot be more than 2.5 yrs	2.5	2.5	2.5	100
2. Develop the quality of the health care system	**20.0**							**19.8**
	6.0	Satisfaction with the quality of medical care	%	A part of the general survey	74	77	74	96.1
• Improve assessment and control of the quality of health services	4.0	Number of clinical audits	Number	Number of clinical audits	5	5	5	100
	4.0	Conformity of the documents pertaining to the provision of health services with relevant legislation	Number	Number of cases audited	13,698	12,000	12,673	100
• Develop feedback to partners and disclose results	4.0	Satisfaction of the partners with cooperation with EHIF	%	Survey results	95.4	95	95	100
3. Shape the awareness and health behaviour of people	**19**							**16.2**
	7.0	Visibility of social campaigns	%	Determined in the course of a general survey conducted among the insured	79	75	43	57.3

• Increase the awareness of people about health system and health factors	6.0	Awareness of the insured of their rights	%	% of the responding insured persons who knew their rights in the following fields % of the responding insured persons who knew their rights in the following fields at least at the level of "good": primary health care. specialised medical care. benefits for incapacity for work. pharmaceuticals distributed at a discount. health insurance coverage	71.9	73	74	100
• Ensure implementation of health promotion and disease prevention project as planned	6.0	Coverage of cancer screening	%	Coverage is measured on the basis of the health insurance database, as a percentage of persons invited, who have had mammography or PAP test during last 3 years (%)	breast cancer 69% cervical cancer 71%	breast cancer 65% cervical cancer 55%	breast cancer 66% cervical cancer 62%	100
4. Ensure efficient use of health insurance resources and sustainable development of health insurance system	**16.0**							**16.0**
• Support sustainable development of health insurance system	7.0	A four-year agreement with professional associations concerning the needs of the insured for their services	Num-ber	Number of analysis-based agreements	1	1	1	100
• Increase the efficiency of using health insurance resources	9.0	Average cost per case	%	Structural increase of the average cost of a case in specialised medical care in comparison with the previous period. %	–	1	−0.1	100
5. Improve the operation of the organisation	**10.5**							**10.5**
• We value employees of the Health Insurance Fund and develop their competencies	5.5	Satisfaction of the employees with the management and organisation of work of EHIF	%	Aggregate satisfaction indicator derived from the results of the employees' survey concerning the organisation of work of EHIF	95	90	93	100
• Apply standard and highly functional information systems	5.0	Availability	%	Availability of information systems	96	100	100	100
Total	**100.0**							**95.9**

Attainment of Goals in 2010

Objective	Performance indicator	Attainment of Goals
	Satisfaction of the insured with the health system	
1. Ensure access to health services, pharmaceuticals and financial benefits		
	Satisfaction with accessibility to medical care	55% of Estonian people said that the availability of medical care was good or rather good, while 42% said it was poor or rather poor. Compared with previous years, there have not been significant changes. Satisfaction levels with accessibility to medical care are above the average among younger people (15-19 year olds) who are Estonians and have better health and higher income (monthly income per one family member is more than 5,000 kroons). In terms of regions, the highest satisfaction levels with accessibility to medical care are the respondents living in Central Estonia (72% consider it "good"), the lowest satisfaction levels are among the respondents living in Northern Estonia (46% consider it "good").
• Ensure uniform access to health insurance benefit	Involve the insured in activities leading to improved monitoring of the status of their health	In 2010, 90% of family physicians have joined the system based on their quality fees (90% in Harju region, 88% in Tartu region, 94% in Pärnu region and 87% in Viru region). People on the list of family physicians who have joined the quality fee system are more involved in preventive activities and systematic observation of chronic illnesses.
	Waiting list for cataract operations	Waiting list for cataract operations falls into the limits of waiting time approved by the Supervisory Board of the EHIF (length of waiting time 1.5 years).
	Maximum waiting list for endoprosthetic replacement	Waiting list for cataract operations falls into the limits of waiting time approved by the Supervisory Board of the EHIF (length of waiting time 2.5 years).
2. Develop the quality of the health care system		
	Satisfaction with the quality of medical care	Three-quarters (74%) of Estonians considered the quality of medical care to be "good" in Estonia. In comparison to the previous years, it appears that while the share of positive opinions increased during the period from 2005 to 2008, this indicator has remained stable in recent years.
• Improve assessment and supervision of the quality	Number of clinical audits	5 clinical audits were organised: • "Quality of rectal cancer treatment", auditor: working group of the Estonian Society of Oncologists; • "Quality of diagnostics and treatment of acute abdomen", auditor: dr Marko Murruste, Tartu University Hospital; • "Quality of outpatient psychiatric treatment", auditor: working group of the Estonian Psychiatric Association; • "Quality of diagnostics and treatment of type 2 diabetes", auditors: working groups of the Estonian Association of Family Doctors and the Estonian Endocrine Society; • "II Part of Use of the Fund for Examinations and Tests Meant for Family Physicians", auditor: working group of the Estonian Society of Family Doctors.
	We verify the conformity of the documents pertaining to the provision of health services with relevant legislation.	In 2010, there was planned the inspection of 12,000 health insurance benefits. In total, 12,673 documents proving health insurance benefit were checked.
• Develop feedback to partners and disclose results	Satisfaction of the partners with cooperation with the EHIF	Satisfaction of the contractual partners is measured once a year by making a survey "Satisfaction of the EHIF partners". In 2010, overall satisfaction of the contractual partners with cooperation with the EHIF was 95%.

3. Shape the awareness and health behaviour of people		
	Visibility of social campaigns	Campaign for the prevention of injuries was started at the end of August. In October 2010, average visibility of the campaign "One thoughtless act can change your life. Forever." was 46%, but the visibility in the campaign target group (aged 15–29 years) was 53%. The campaign concerning the use of medical products "The difference is in the price of the medical product" was launched at the end of September and in October 2010 the average visibility of this campaign was 39% and 41% in the target group (40-59 years). The visibility was measured as an interim result within the framework of satisfaction survey of people that was conducted in October; both campaigns were not completed by that time and will continue also in 2011. Objective 75% was set as an end goal that can be measured in 2012.
• Increase the awareness of people about health system and health factors	Awareness of the insured of their rights	74% of Estonian citizens are aware of their rights and obligations. The awareness has been increasing gradually each year, but the knowledge level is uneven and depends on different demographic and socio-economic factors (place of residence, native language, age, area of activity, etc).
• Ensure implementation of health promotion and disease prevention projects as planned	Coverage of cancer prevention screening	Coverage of breast cancer screening of the women invited to screening was 66% (the goal was set to 65%), coverage of cervical cancer screening of the women invited to screening was 62% (the goal was set to 55% coverage). The coverage did not include dead and uninsured women and the women to whom it was not possible to send the invitation because of incomplete address.
4. Ensure efficient use of health insurance resources and sustainable development of health insurance system		
• Support sustainable development of health insurance system	A four-year agreement with professional associations concerning the needs of the insured for their services	A document concerning the use of the field of psychiatry is drawn up with regard to the period 2005–2009. In cooperation with the professional society the need for the next 4 years has been ascertained and the relevant agreement has been completed.
• Increase the efficiency of using health insurance resources	Average cost per case	Structural increase of the average cost of a case in specialised medical care in comparison with the previous period was –0.1%.
5. Improve the operation of the organisation		
• We value employees of the Health Insurance Fund and develop their competencies	Satisfaction of the employees with the management and organisation of work of EHIF	Aggregate satisfaction indicator derived from the results of the employees' survey concerning the management and organisation of work of the EHIF was 93%.
• Apply standard and highly functional information systems	Availability	Availability of information systems means securing the availability of information and information services, arising from the demands of users and mutual agreements. In 2010, the availability level was 100%.

Sustainable Financing of Estonian Health Care System

TRIIN HABICHT

Head of the Department of Health Care Economics

At the beginning of 2009, the Minister of Social Affairs assigned to the Management Board of the Health Insurance Fund a task of forming a working group of sustainable financing of health care system, in order to analyse the health care financing system in Estonia and to offer final solutions for ensuring sustainability of the system in final report of the analysis. The report is the result of a year-long process of stakeholder consultations and ekspert analysis initiated by the Ministry of Social Affairs in 2009 in partnership with EHIF and the WHO Regional Office for Europe. The report was completed by early spring 2010 and it was introduced to the public on 5 March at the conference "Responding to the challenge of financial sustainability in Estonia's health system". The summaries of the report and round-table discussions http://www.haigekassa.ee/eng/health-insurance-in-estonia/sustainablity-of-estonian-heal.

The working group assessed the performance of Estonian health care system and its sustainable financing; the group also analysed whether the current financing system is vital for a long-term perspective (until 2030); and offered the opportunities for making the financing policy more efficient. Upon the assessment of health care, the forecasts for both revenues and expenses of health sector and a broader macro-economic environment and the opinions of interest groups were taken into consideration.

Strengths and weaknesses of financing of Estonian Health Care System set out in the report

Estonian Health Care System is financed primarily through targeted social tax payable on wages. Approximately two-thirds of aggregate health care expenses are covered from social tax, approximately one tenth of the expenses are covered from the other sources of the state budget and a little less than a quarter of the expenses are covered from patients out of pocket payments.

According to the assessment of external experts, the strength of funding of the Estonian Health Care System lies in its stability which has been achieved mainly thanks to targeted social tax and prudent management of resources by the Health Insurance Fund. Single payer system has fully justified itself, securing a transparent and efficient activities and low administrative costs. The fact that health insurance is separate from the rest of social insurance (e.g. pensions and unemployment insurance) can also be considered an advantage. This principle should be kept in mind, in order to secure the accountability and transparency of social sector and a clear division of responsibility areas.

The weakness of funding system of Estonian health care lies in the fact that health care expenses constitute only a small share of the Estonian Gross Domestic Product (GDP) which is caused mainly by a scarce funding by public sector. Low costs of public sector are accompanied by an increase in the patients cost sharing in health care financing, making it more difficult for elderly people and people with smaller incomes to cope and getting treatment may depend more on one's ability to pay than on actual need.

Revenue and expenditure forecasts until 2030

This report analyses, on the basis of different scenarios, the impact of demographic, macro-economic factors and the factors related to labour market and health care system. All scenarios indicate that the state must contribute more and more resources to the health care in future. According to the forecasts, there will be a significant difference between revenues and expenses in public sector health costs that will constitute 0.4–1.4% of GDP by 2030 (se Figure 2). It is also important to keep in mind that the decisions made in the nearest future regarding the prices of health care services will have an impact on future expenditure and thus there may be even bigger difference between revenues and costs.

Recommendations for improvement of financing policy of health care system

These recommendations have been prepared keeping mind that they should correspond to the interests of most interest groups, be politically feasible and increase the system's ability to achieve its goals.

First recommendation: to increase revenue base of public sector. As the current system is working properly, then it is not necessary to change its main elements: targeted contribution for health insurance, central management of health insurance money and single payer system. At the same time, it is also necessary to increase the revenue base of public sector by the means of taxes other than the ones based on employment (e.g. capital and consumption taxes), paying health insurance tax from other revenues of state budget on behalf of the pensioners and imposing a social tax also on the dividends receivable from capital investments. It is important to note that the principles for increase of revenue base should be transparent and stable.

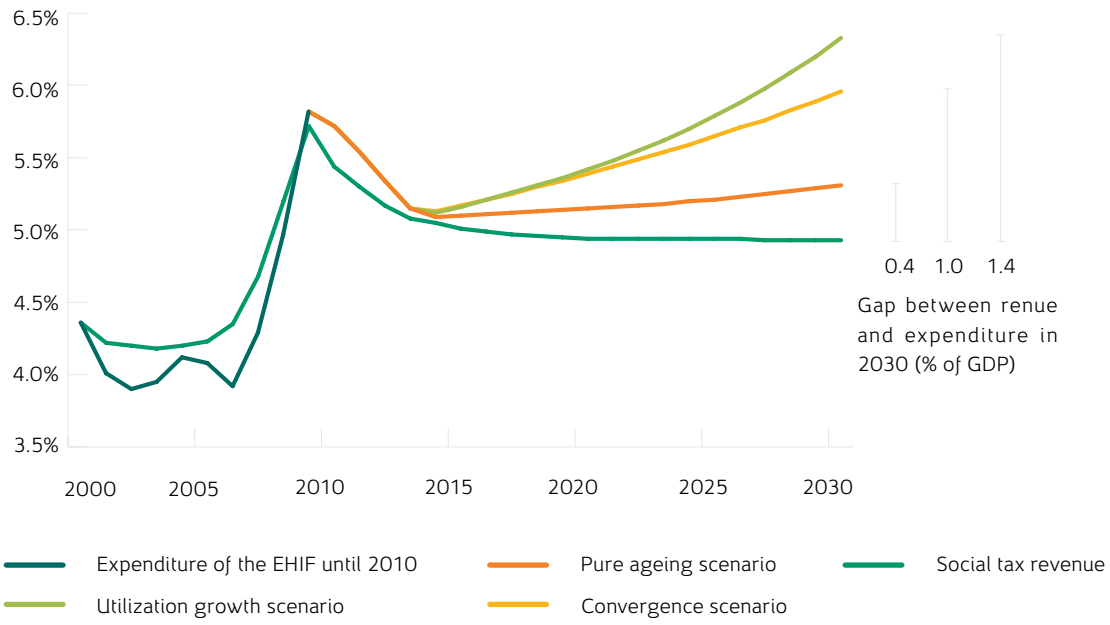
Second recommendation: To improve financial protection by curbing out of pocket payments. For that purpose, it is

necessary to promote rational use of medicines and increase the prescription of [1]generic medicines. At the same time, it is also necessary to make the policy of patients cost sharing simpler and more targeted, in order to make it easier above all for the people with smaller incomes and using vast amount of services. It is also necessary to consider adding adult dental care again to the package of recoverable services of sickness insurance.

Third recommendation: to Continue to improve health system performance through better resource allocation and purchasing. In general terms, the Estonian health care system functions well and the Health insurance Fund is internationally recognized for its achievements.. However, there are several opportunities for increasing the efficiency of the system: capacity of excess hospital network must be continuously decreased and the development plan of hospital network must be implemented; it is necessary to strengthen the role of family physicians as gatekeepers and coordinators; equipping them with the means to steer patients through the health system, improving their governance and accountability and keeping primary care free at the point of use for the whole population (not just those entitled to EHIF benefits).

Fourth recommendation: to maintain the strong governance of the health care system. It is important to pay more attention than before to monitoring and evaluation of the activities of service providers, in particular to monitoring and evaluation of clinical performance indicators. Investments into E-health system can be useful in order to raise clinical quality, because information exchange will improve and duplication of analyses and surveys will decrease. It must be kept in mind that Estonian single payer system is a well-functioning system and it should not be weakened or replaced by some competition-based model. Government should make its best efforts, in order to avoid a further fragmentation in the flow of resources that will create inefficiencies and contrary incentives.

Figure 2. Forecasts of the revenues and expenditures of the Health Insurance Fund as a percentage of GDP according to different scenarios, 2000–2030 (including the costs of benefits for temporary incapacity for work)



[1]Generic medicine (sometimes also called as a copy medicine and analogue medicine) is the drug that contains the same active ingredient as original medicine and is meant for the treatment of the same medical condition and is as efficient, safe and has the same quality as original medicine. Generic medicine arrives in the market after termination of patent proctection of original medicine, but the other manufacturers of medicines are also allowed to manufacture the medicine with the same active ingredient.

Campaign "The Difference is in Medicine Price"

KRISTA MERESMAA

Chief Medicine Specialist

In September 2010, the Health Insurance Fund started a info campaign "The Difference is in Medicine Price", in order to decrease the amount of the patients who are making uneconomic choices because of the lack of awareness.

Analysis of the use of medicines among Estonian patients reveals that expensive medicines are purchased more frequently, although the cheaper medicines are also on sale in the pharmacies. For example, the most economical medicines for the treatment of hypertension purchased in 2010 constituted less than 15% of sold medicines. In case of some active ingredients, the cheapest medicine was chosen among the medicines with the same active ingredient even in less than 5% of the relevant cases.

Similarly to other countries, there has been established a reference price in Estonia for active ingredient in case of equal choices upon compensation of medicines for the purpose of avoiding unreasonable expenses for health insurance. Pharmacies are obliged to stock up pharmaceuticals under or equal to reference price and offer the best alternative to the patient. If patient prefers to buy a pharmaceutical the price of which exceeds the reference price, then he must pay the price difference. Therefore, patients, who will not use the opportunity to purchase medicines for reference price or for even smaller price, will spend more money for pharmaceuticals than is actually needed for their treatment.

Diseases are treated by an active ingredient which is inside the pharmaceutical and not by a trade name (so-called trade mark) meant for marketing. There are several countries in Europe, including United Kingdom and Germany, where the share of the use of generics exceeds 60%. In Estonia, the relevant indicator has been about half of this so far. Are we talking about conscious choices? This question is answered by survey "Assessments of residents regarding health and medical care" that is organised annually by the Health Insurance Fund in cooperation with the Ministry of Social Affairs. According to the survey results of 2010, 81% of the respondents consider it important to be able to choose themselves a pharmaceutical for the most convenient price when purchasing prescription medicines. According to the same survey, only 38% of the respondents have actually had the opportunity to make the aforementioned choice.

Selection of medicines of by a person is affected by several external circumstances, for example, whether a doctor gives a prescription based on active ingredient or writes a trade mark of the medicine on the prescription; what kind of medicines are available in the pharmacy where a person is going; and which medicine will be offered to the patient by a pharmacist among the equivalent ones. Patient shouldn't be only a passive bystander in the process. On the contrary, a patient should have a right to make a conscious choice in cooperation with the doctor and pharmacist, expressing a wish to get necessary medicine at most economical price. Or otherwise he makes an informed choice for more expensive alternative.

By the info campaign, the Health Insurance Fund reminded the patients of their rights and encouraged them to be more active than before. The Estonian Society of Family Doctors, State Agency of Medicines and the Ministry of Social Affairs contributed to this campaign as well. We gave also information about the differences between generic and original medicines, why can the prices of equivalent medicines turn out to be different and which should be the procedure for prescription of medicines by a doctor and issuance of medicines by a pharmacy. We notified that a part of patients financial share can be fully avoided in the situation where there are available equivalent alternatives with more economic price.

In case of a successful campaign, the Health Insurance Fund does not presume a direct reduction of expenses for pharmaceuticals , because the current reference price system offers protection to health insurance for unreasonable costs occurring in case of uneconomic choices. However, the growth of the awareness enables people who are using medicines to save money. Rational use of medicines is useful for the whole society - sustainability of a person's treatment will generally improve, if he or she spends a reasonable amount of money to medicines, the disease is thus better controlled, there are fewer complications and less need for inpatient care, a person is more productive and the society is healthier.

Campaign for Injury Prevention "One Thoughtless Act Can Change Your Life. Forever."

SIRJE VAASK

Chief Health Care Specialist

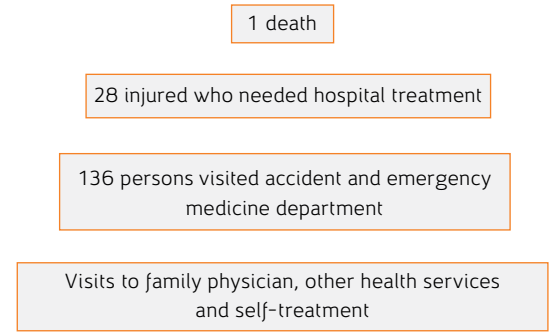
In Estonia, indicators of deaths of 19-year-olds occurring as a result of injuries are among the highest in Europe. Deaths of young people are caused mainly by injuries and poisonings.

Every year, more than 100 young people aged 15–24 years, mostly young men, die because of injuries. Deaths are caused above all by traffic injuries, followed by drownings, fire accidents and fallings, but it is really just a top of iceberg. Relation of deaths caused by injuries to the deaths that are not caused by injuries is described by injury pyramid [2] (See Figure 3).

In 2010, the expenses made for injury treatment amounted to 445 million kroons, 165,000 people needed treatment. The number of people who needed treatment was nearly by 150,000 smaller in 2009, medical treatment costs were 400 million kroons.

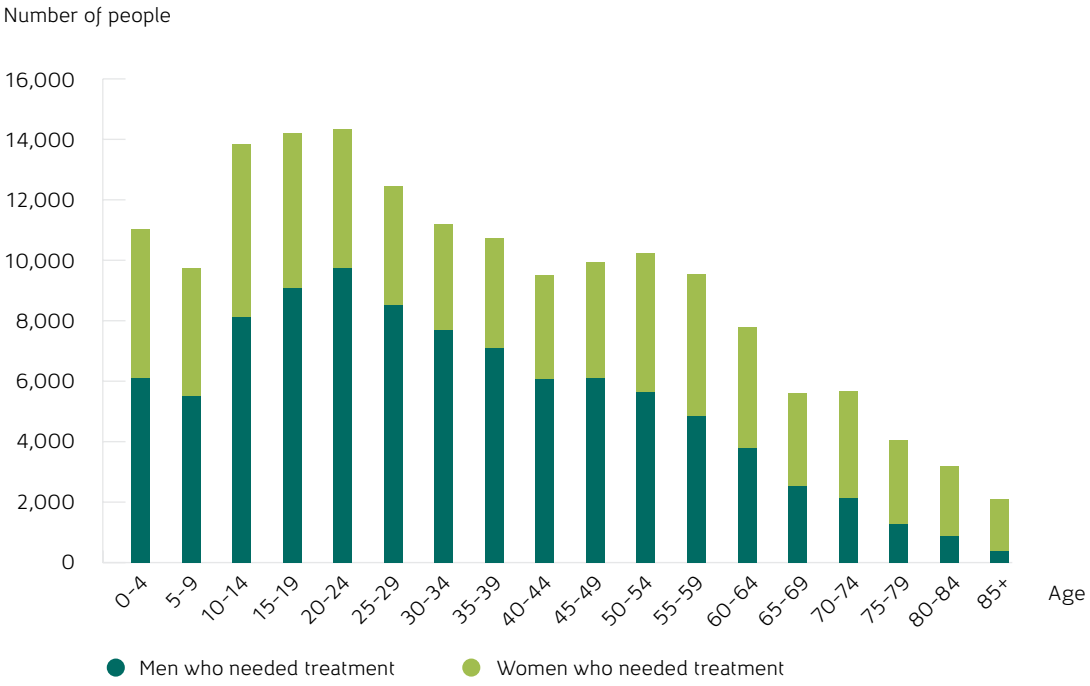
Rate of incidents caused by injuries increases from the age of 10 and is the highest among young people aged 15–24 years (see Figure 4). Half of the injuries to young people are caused by falling: statistics show that every day a full class-size of young people and every month more than 1000 young people need medical care because of injuries caused by falling.

Figure 3. Injury pyramid



[2] Source: Injuries in the European Union. 2009-Report. European Comission, 2009.

Figure 4. Number of persons who needed treatment because of injuries by gender and age groups in 2010 (source: database of health insurance)



Injuries usually occur when a particular situation and conditions coincide. In most cases, alcohol consumption is a contributing factor making it harder to assess risks properly.

In order to avoid injuries, the following measures should be taken:

- to reduce the need for taking risks;
- to create safer physical environment;
- to design products that are safer for consumer;
- to reorganise job practices towards safety;
- to change social attitude, i.e. group norms.

Most recent measure was the campaign "One thoughtless act can change your life. Forever. What is the formula for your life?" that was launched in August 2010 for the purpose of drawing attention of young people to risk and life-threatening behaviour. In addition to personal problems, a life of an injured person means essential treatment and rehabilitation expenses and imposes a burden on the people closest to the injured person and whole society. This campaign encourages young people to intervene more actively if they notice risk behaviour.

Tallinn Charter recognizes rights and responsibilities of people for their health. According to the Health Insurance Fund Development Plan, shaping health awareness and behaviour of citizens is one of the most important activity areas. Injury prevention is considered to be one of the most efficient options to promote above all men's health and prolong their lifetime. The Health Insurance Fund plans to continue the communication campaign, in order to reduce the amount of injuries to the level equivalent to the developed European countries which is an important prerequisite for increase of lifetime and economic development.

Updating the System of Development of Clinical Practice Guidelines

KATRIN MAISTE

Health Care Specialist

The Health Insurance Fund considers the improvement of quality of health care system, because better quality ensures a better treatment outcome for a patient and enhances overall performance of the system through optimal use of resources. The Health Insurance Fund is convinced that the current health care system enables to improve quality within the limits of existing budget, supporting the use of quality and cost-effective treatment methods. In order to ensure continuous high-level performance, the Health Insurance Fund supports the development of clinical practice guidelines contributing to the use of evidence-based treatment methods.

In Estonia, clinical practice guidelines have been developed systematically for approximately ten years. During this time, we have gained experience of developing the guidelines corresponding to local conditions; meanwhile, global practices have been advanced which has not been fully implemented yet in Estonia. Therefore, we became more and more convinced that the process for development of clinical practice guidelines and "Manual for Development of Clinical Practice and Activity Guidelines" need to be reviewed. Considering the importance of this topic, it was reflected in the cooperation agreement concluded between the World Health Organisation and Estonia and at the beginning of 2010, the Management Board of the Health Insurance Fund approved Development Project of Clinical Practice Guidelines.

Purpose of this Project is to update the process of development and implementation of evidence-based, cost-efficient clinical practice guidelines which have been adjusted for local conditions, in order to support development of treatment quality and reduce variations in clinical treatment. The Project includes development activities that will last until the end of 2011 and during these activities strengths and weaknesses of Estonian practice up to this time will be analysed and the experiences of other countries regarding development of clinical practice guidelines will be examined. As a result, a new "Manual for development of Estonian clinical practice guidelines" will be prepared and it will be tested beforehand upon development of one clinical practice guideline.

In the 1st half of 2010, different parties assessed the system so far. In order to get as comprehensive overview as possible, independent assessments were given by WHO, Estonian experts and the Health Insurance Fund. In addition, there was ordered an analysis assessing the hindrances to implementation of clinical practice guidelines. In addition to the previous agenda, within the framework of project it was also necessary not only to deal with the processing of clinical practice guidelines to be financed by the Health Insurance Fund, but also to develop the system for preparation of clinical practice guidelines all over Estonia.

As a result of these assessments there were made several proposals, for example, recommendations to determine more specifically the roles of different parties in preparation of the guidelines, to increase the role of the Advisory Committee on Clinical Practice Guidelines advising the Health Insurance Fund both in selection of topics and approval of guidelines, to include more representatives of patients, to develop assessment of the evidence-based approach and economic impact and giving recommendations arising therefrom, to pay more attention to the implementation of completed guidelines, to assess regularly the impact of the clinical practice guidelines on clinical practice and treatment outcome. In the summer of 2010, one started to prepare a new manual for clinical practice guidelines based on the aforementioned recommendations. The Faculty of Medicine of the University of Tartu is also participating as a partner in preparation of this manual and WHO experts are giving advice based on international practice.

Clinical treatment of an adult patient with hypertension on the primary care level was chosen for testing of new manual. In October, the Estonian Association of Hypertension Association and the Estonian Association of Family Doctors appointed their representatives to the working group of sample clinical guidelines and there was formed secretariat. In November, the first joint meeting took place with the participation of WHO and thereafter started substantive activities: working group developed a precise framework for the clinical guideline and secretariat started to assess the found evidence-based source materials.

This is a large project involving several parties and among other things it is also important to improve the competency of the parties. In 2010, several trainings were conducted and further trainings will be offered to health care professionals in the future as well.

Development of Day Surgery

KRISTIINA KAHUR

Chief Specialist of Health Care Economics

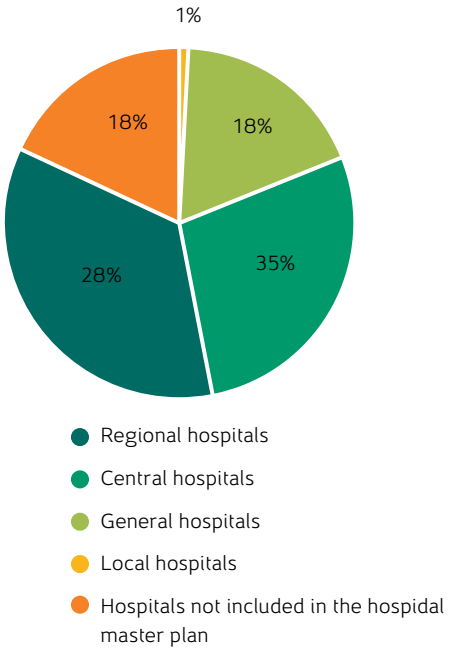
The Health Insurance Fund considers the provision and further development of day care (incl. day surgery) services very important and has planned separate funds for that purpose both in its budget as well as in the contracts with health care providers. Provision of services in day care setting enables to spend health insurance funds in a more efficient manner and is more convenient for patients in comparison with longer hospitalisation. Approximately 70% of day care cases are related to day surgery, when a patient arrives at hospital the morning of the planned surgery and leaves hospital on the same day after the surgery.

Over the years, there has been a continuous increase in the volume of the services provided in day care setting. Over the last seven years, the number of surgeries has almost doubled (83%). However, it should be noted that this share increased until 2007 and it has not exceeded 30% of total surgeries in last four years. This share is lower compared to several countries of the European Union, for example, in Great Britain, where day surgery is most advanced; more than a half of the surgical procedures are made as day surgery.[3]

In order to assess development potential, we made an analysis on the content of day surgery in Estonia in 2010. Day surgery is prevalent for treatment of orthopaedic and gynaecological, general surgery, otorhinolaryngologic and ophthalmology patients. Day surgery activities are most advanced in ophthalmology, where most cataract operations are performed in day care setting. As regards the aforementioned indicator, our ophtalmologists are at the same level as the most forward-looking countries.[4]

The Health Insurance Fund data revealed that day surgery has not been implemented very often in other specialties so far and its implementation varies according to the preference of a specific service provider. Day surgery option has been used most often by central hospitals (35% of all day surgery cases) and approximately one half of day surgery cases are related to cataract operations in these hospitals (see figure 5). 28% of all day surgeries are done in regional hospitals and 18% of services are provided in general hospitals and hospitals not belonging to the hospital master plan.

Figure 5. Division of the number of day surgery cases by hospitals



Share of the same surgeries performed as day surgery varies by hospitals. For example, in the average 20% of hernia surgeries are performed as day surgery in Estonia, at the same time this share varies between 0 and 100% in different hospitals. The relevant indicator in Nordic countries is between 45 and 75% and more than 80% in the USA. Thus, it can be concluded that capacity of hospitals to provide day surgery services has been different so far.

Therefore, we can also draw the conclusion that in Estonia there is still room to transfer the surgeries that have been performed in inpatient setting up to now to day care setting. Similarly to the practice of more advanced countries, it is possible to increase the share of procedures in day care setting, for example, the share of foot varicose vein operations (the share of operations performed in day surgery was 50% in 2010), the share of surgeries of benign diseases of rectum (25%), the share of laparoscopic cholecystectomies (2%) and the share of several orthopaedic and gynaecological surgeries.

Naturally, transfer to broader implementation of day surgery cannot happen overnight. In order to achieve this purpose, it is necessary to make changes in work organisation and infrastructure (use of rooms and equipment) of health care providers, as well as in attitudes and opinions of people.

[3] Thomson S, et al. Responding to the challenge of financial sustainability in Estonia's health system. WHO Regional Office for Europe, 2010. (http://www.euro.who.int/__data/assets/pdf_file/0003/107877/E93542.pdf)

[4] Castoro C, et al. Day Surgery: making it happen. WHO Regional Office for Europe on behalf of the European Observatory on Health Systems and Policies, 2007. (http://www.euro.who.int/__data/assets/pdf_file/0011/108965/E90295.pdf)

Secondly, the prerequisites for promotion of day surgery are the selection of suitable patients, preparation for surgery and awareness of patients - adherence to recommendations for post-operative treatment, in order to ensure proper recovery.

In order to promote day surgery, the Health Insurance Fund should also set goals through financing and encourage the provision of care in the form of day surgery. For this purpose it is necessary to implement appropriate payment methods and create favourable conditions also in the contracts. Upon financing of day-surgery activities, DRG and fee-for-service payment are combined[5] similarly to hospital treatment. Until the end of 2010, DRG-based financing made no difference between in-patient and day surgery case. In the course of 2010, the Health Insurance Fund made preparations for the transition to a new DRG-version, in order to implement the updates since the beginning of 2011. By the means of new version, it is possible to make a distinction between day-surgery and in-patient case, thus broadening the options for analysing, planning and targeted financing of day-surgery activities.

[5]DRG (diagnoses related groups) is the system of case based financing where the patients, who are similar clinically and are expected to use the same level of hospital resources, are classified to the same group.

Medicine Prescriptions in Digital Format

ERKI LAIDMÄE

Chief Medicine Specialist

The year 2010 is of historical importance, because then Estonia started to use digital prescriptions, i.e. an electronic prescribing system. Doctors can now prescribe pharmaceuticals in their information system and the prescriptions will thereafter be forwarded to a national database – Prescription Centre (see Figure 6). The dispensing chemists and pharmacists working in pharmacy have an access to digital prescriptions via their information system. The medicines are issued to the customers visiting pharmacy on the basis of an identity document. Therefore, when visiting a pharmacy, you do not have to worry any more about forgetting the prescription on paper at home.

In addition to patients, doctors and pharmacists, tens of different information systems and registries were included in the development of digital prescription. It was not an easy task to implement such innovation involving so many parties – on the one hand, it was necessary to change working habits and processes of people and on the other hand, to reduce many technical risks. Technical problems that occurred on the first half of 2010 pointed quickly to the weak points of new technical system in different parts of whole chain. We managed to solve widely discussed problem of load bearing capacity by more efficient administration, special attention was paid to software optimization as well.

The efforts have been worthwhile, as many people benefit from digital prescription. By the means of the system, patients can get necessary medicines in a more convenient manner than before; at the same time, it is easy to keep track of your medicines in a computer.

Doctors place the most value on the system's capability to find the right rate of reimbursement discount for a prescription. In the past, it was more complicated resulting in several errors. Doctors also like the option to get an overview of the medicines that have been prescribed by other doctors to patient and to get information about purchase of a medicine. In the future, automatic processing of this information would result in the assessment of co-effects of pharmaceuticals prescribed by different doctors, patient compliance, etc. that will jointly offer an opportunity to improve treatment quality. Updating and development of information system will continue, in order to enhance its functionality.

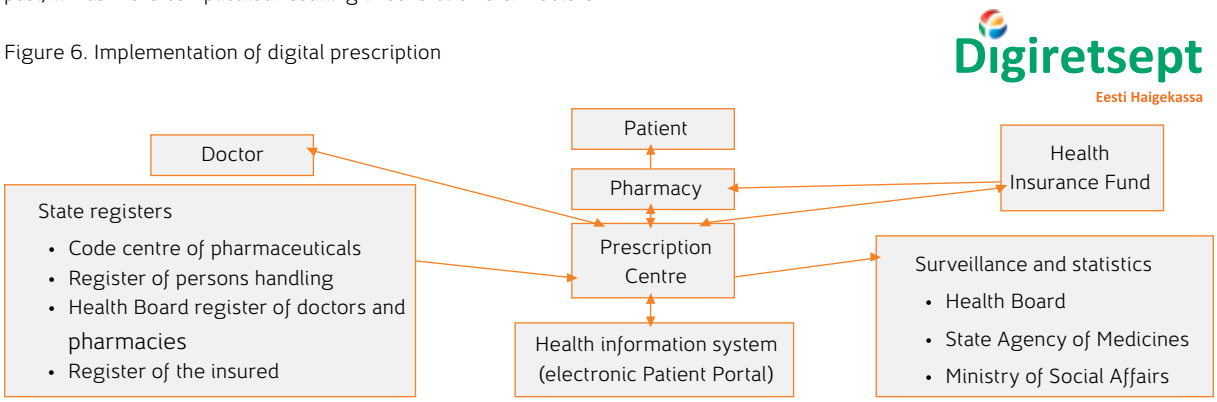
The life of pharmacists is also made easier by the fact that a majority of prescription data are already available electronically and all they do not have to enter the data manually from paper. In addition, settlement with the Health Insurance Fund is much easier.

The state institutions will have an opportunity to get better control over the activities in the field of medicines. Even though statistics concerning pharmaceuticals were available in different databases earlier, the information was not as readily usable as it will be from now. Persons exercising supervision will have much broader opportunities to receive quickly up-to-date data and better data quality enables .health care planners to make more precise analyses and forecasts.

Digital prescription system has created preconditions for better interaction between different levels of health care systems; better data exchange contributes to the improvement of quality, thus promoting national health.

The highest acknowledgement for new system is expressed by statistical data on the use thereof and the opinion of Estonian people. By the end of the first year of activity, almost all the pharmacies had joined the system and doctors have written approximately ¾ of the prescriptions in a digital format. In 2010, people purchased medicines from pharmacies on the basis of 4.1 million digital prescriptions in total. Results of the national survey organised in October 2010[6] show that 41% of all respondents think that digital prescription makes it easier to prescribe and purchase prescription pharmaceuticals. Satisfaction among the people, who had already had personal experience with digital prescription, amounted to 91%.

Figure 6. Implementation of digital prescription



[6]Assessments of residents regarding health and medical care in 2010. See http://www.haigekassa.ee/uploads/userfiles/Hinnangud_arstiabile_2010(1).pdf

Satisfaction with Health Care Administration and the Health Insurance Fund

Every autumn, the Health Insurance Fund organises in cooperation with the Ministry of Social affairs a national survey to get an overview of the assessments of Estonian people of their health and medical treatment offered in Estonia and examine satisfaction with availability and quality of health care services. During the survey, 1524 people aged 15-24 years were interviewed.

EVELIN KOPPEL

Head of the Public Relations Department

Half of Estonians consider their health status to be good

Similarly to previous years, a half of the respondents considered their health status to be very good or rather good. 38% of the respondents consider their health status to be average, 11% consider their health status to be rather bad or very bad. As expected, younger respondents consider their health to be better than older respondents.

According to the survey, one third of the respondents have some long-term or chronic illness or health problem. 89% of the respondents think that this health problem affects their daily activities.

Use of medical care remains large

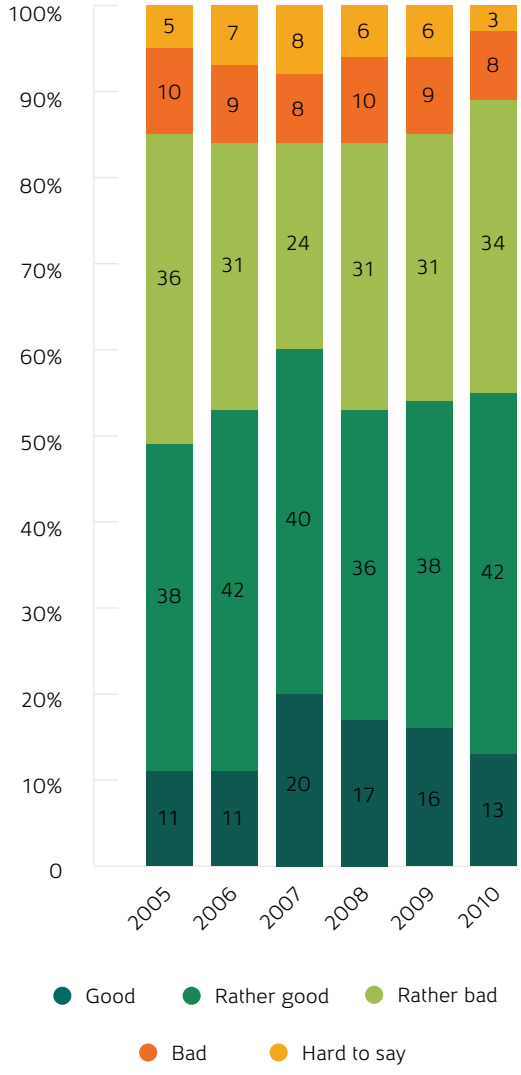
In 2010, 74% of Estonians aged 15–74 years visited doctors because of health problems. During this time, 64% of the respondents have visited family physician, 45% medical specialist, 38% dentist, 18% family nurse, 12% have been in the hospital for examination or treatment and 8% have used emergency care. In comparison with previous years, there has been a decrease in the share of people who have visited dentist, family nurse and medical specialist.

All health care services have been more frequently used by women in comparison with men. Elderly people have visited doctors most often; however, dentists were visited most often by younger people.

2/3 of Estonians consider health care organisation to be good

63% of Estonian people said that the health care administration was good, while 32% said it was bad. Respondents think that long waiting lists are among the most disturbing factors of the current health care administration. The other disturbing factors were the prices for services and careless attitude of medical staff. 74% of the respondents consider the quality of medical care to be good. Availability of medical care was considered to be good by 55% of the respondents (see Figure 7).

Figure 7. Assessments of availability of medical care (%)



People's readiness to pay for treatment

Most respondents (59%) would prefer the health services to be financed from health insurance, regardless of the fact that waiting lists may be sometimes very long. However, 30% of the respondents would prefer that only a limited amount of health services are financed from health insurance and there are almost no waiting lists or the lists are very short. Figure 8 gives an overview of the amounts people are ready to pay, in order to get treatment outside waiting list.

A little more than a half of the respondents are ready to pay themselves for nursing care and rehabilitation. 41% of the respondents agree to pay themselves for dental care, 36% agree to pay for outpatient specialised medical care or consultation of medical specialist, 27% agree to pay for hospital treatment, 18% for examinations and analyses and 8% agree to pay for family physician care. There is an increase in the readiness to pay for rehabilitation and nursing care, but increasingly less people are ready to pay for family physician care.

The system of discount medicines is generally considered to be good

Three-quarters of Estonian residents consider the current order for drug prescription and redemption to be good as a whole. About one fifth of them have experienced problems in connection with prescribing medicines at the doctor's as well as in purchasing the prescribed medicines at the chemist's.

81% of the people consider it important to have the opportunity to choose a medicine with a suitable price themselves when purchasing a prescribed medicine, however, only 27% of the questioned persons who had recently bought a medicine were offered to choose a medicine with a suitable price themselves.

Satisfaction with the Health Insurance Fund is continuously high

16% of Estonians aged 15-74 years have had personal contacts with the Health insurance Fund within last 12 months, mostly in customer service office and in relation to certificate of incapacity for work, benefit for incapacity for work, dental care benefit, additional benefit of medicines or European health insurance card. 82% of the respondents who have had contacts with the Health Insurance Fund have been content with the communication with the Health Insurance Fund (see Figure 9).

In last 5 years, there has been a decrease in the on-the-spot communication with customer service person and sending a letter through regular mail; however, there has been an increase in the communication by e-mail and there has been created an opportunity to use a citizens' portal.

Figure 8. The amounts people are ready to pay, in order to get treatment more quickly

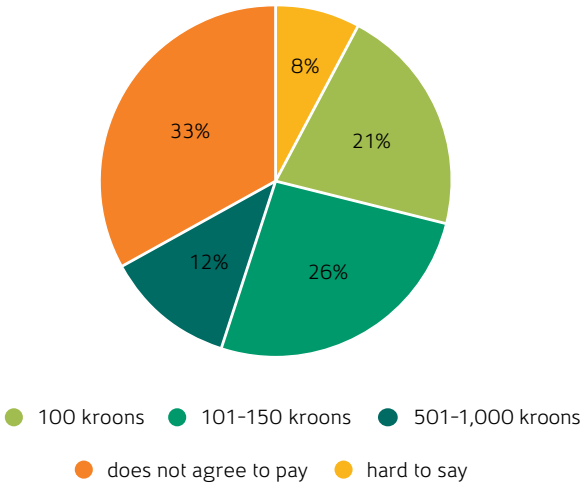
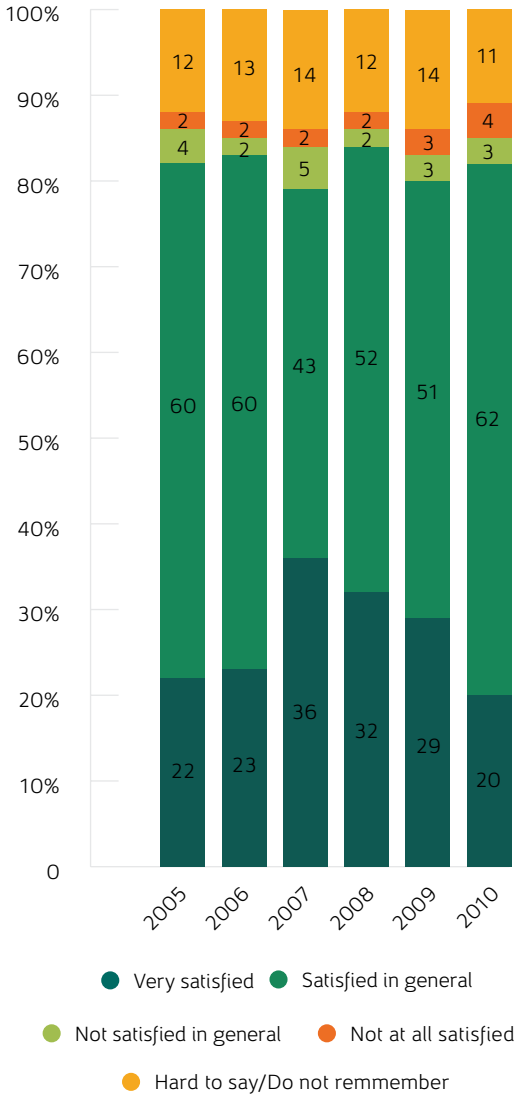


Figure 9. Satisfaction with communication with the Health Insurance Fund



2010 BUDGET EXECUTION REPORT

Table 2. Budget (in thousand kroons)

	2009 actual	2010 budget	2010 actual	Budget execution %	% of change from 2009
EHIF REVENUE					
Revenue from the health insurance part of social tax	11,234,307	11,066,925	10,731,725	97.0	-4.4
Revenue from contracts for persons considered equal to insured persons	47,841	40,000	49,324	123.3	3.1
Amounts due from other persons	14,110	10,000	11,049	110.5	-21.7
Financial income	105,131	65,000	38,268	58.9	-63.6
Other revenue received	28,475	33,900	35,236	103.9	23.7
Total budget revenue	**11,429,864**	**11,215,825**	**10,865,602**	**96.9**	**-4.9**
EXPENDITURE ON HEALTH INSURANCE					
Health service expenses	8,049,487	7,875,327	7,838,189	99.5	-2.6
Disease prevention expenses	114,118	110,000	108,561	98.7	-4.9
Expenses on primary health care	1,056,204	1,035,067	1,009,317	97.5	-4.4
Expenses on specialised medical care	6,354,972	6,219,880	6,218,733	100.0	-2.1
Expenses on nursing care	237,013	227,306	223,040	98.1	-5.9
Expenses on dental care	287,180	283,074	278,538	98.4	-3.0
Health promotion expenses	13,150	13,000	12,292	94.6	-6.5
Expenses on pharmaceuticals reimbursed to insured persons	1,383,331	1,452,150	1,419,720	97.8	2.6
Expenses on Benefits for Temporary Incapacity for Work	2,204,104	1,687,955	1,274,202	75.4	-42.2
Expenses on other cash benefits	160,622	200,144	140,259	70.1	-12.7
Other expenses	148,563	192,603	164,314	85.3	10.6
Expenses financed from the state budget	18,330	20,900	17,775	85.0	-3.0
Other expenses on health insurance benefits	130,233	171,703	146,539	85.3	12.5
Total expenditure on health insurance	**11,959,257**	**11,421,179**	**10,848,976**	**95.0**	**-9.3**
EHIF OPERATING EXPENSES					
Personnel and administrative expenditure	69,970	70,961	67,955	95.8	-2.9
Wages and salaries	52,215	52,821	50,614	95.8	-3.1
including remuneration of the members of the Management Board	2,193	2,156	2,082	96.6	-5.1
Unemployment insurance premium	533	709	677	95.5	27.0
Social tax	17,222	17,431	16,664	95.6	-3.2
Administrative expenses	20,314	16,816	16,465	97.9	-18.9
Information technology expenses	9,995	12,502	10,229	81.8	2.3
Development costs	2,525	2,682	1,992	74.3	-21.1
Training	1,151	1,301	997	76.6	-13.4
Consultations	1,374	1,381	995	72.0	-27.6
Financial expenses	322	1,100	1,427	129.7	343.2
Other operating expenses	3,927	9,725	9,726	100.0	147.7
Supervision of the health insurance system	1,436	1,457	1,444	99.1	0.6
Public relations/communication	1,167	1,077	753	69.9	-35.4
Other expenses	1,324	7,191	7,529	104.7	468.7
Total EHIF operating expenditure	**107,053**	**113,786**	**107,794**	**94.7**	**0.7**
TOTAL BUDGET EXPENDITURE	**12,066,310**	**11,534,965**	**10,956,770**	**95.0**	**-9.2**
Total changes in reserves	**-636,446**	**-319,140**	**-91,168**	**-**	**-**
Transfer to legal reserve	0	0	0	-	-
Transfer to risk reserve	-58,773	-27,922	22,404	-	-
Retained earnings	-577,673	-291,218	-113,572	-	-
TOTAL	**11,429,864**	**11,215,825**	**10,865,602**	**96.9**	**-4.9**

Table 3. Number of insured persons

Persons	31.12.2008	31.12.2009	31.12.2010	% of change from 2009	Changes from 31.12.2010 to 31.12.2009 (persons)
Persons considered as equal to insured persons	579,752	599,966	609,467	1.6	9,501
Employed insured persons	658,079	587,254	565,933	-3.6	-21,321
Persons insured by the state	40,477	85,609	77,254	-9.8	-8,355
Persons insured under international agreements	3,410	3,537	3,586	1.4	49
Total	**1,281,718**	**1,276,366**	**1,256,240**	**-1.6**	**-20,126**

The socio-economic changes are also reflected in the structure of health insurance: rising employment has slowed down the reduction in the number of employed insured persons and the number of persons insured by the state that was doubled in 2009 is starting to reduce gradually, due to the return of unemployed persons to the labour market (see Table 3). Demographic situation has also an impact on the group of employed insured persons, wherefrom the women who started parental leave and the persons who became old-age pensioners move to the group of persons considered as equal to insured persons. The slight decrease in the total number of insured persons was caused by addition of long-term unemployed persons and by increase in the number of persons who left the country.

The shares of insured persons among the total number of insured persons and the contribution of the insured persons to the payment of the health insurance part of the social tax are presented on Figure 10.

An overview of average expenses per insured person by age groups is provided in Table 4.

Figure 10. Shares of insured persons among the total number of insured persons and their social tax contributions

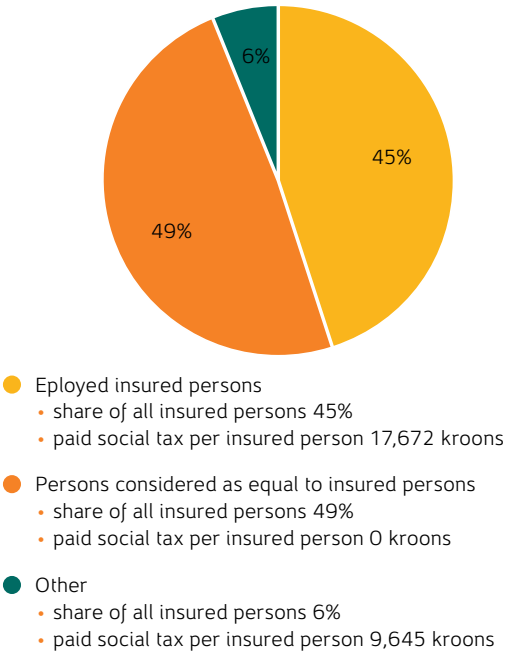


Table 4. Average expenses per one insured person

Age of insured persons	Number of insured persons as of 31.12.2010	Expenses on primary health care, EEK	Expenses on specialised medical care, EEK	Expenses on pharmaceuticals, EEK	Total health insurance expenses, EEK
0-9	145,914	861	3,552	422	4,835
10-19	137,050	704	3,254	344	4,302
20-29	169,751	720	3,458	516	4,694
30-39	163,132	735	3,677	642	5,054
40-49	160,643	782	3,802	845	5,429
50-59	167,400	829	5,867	1,471	8,167
60-69	139,920	861	8,668	2,331	11,860
70-79	114,022	970	11,281	3,004	15,255
80-89	52,574	892	11,391	2,441	14,724
90-99	5,676	798	9,544	1,283	11,625
100-109	158	735	8,152	250	9,137

Revenue

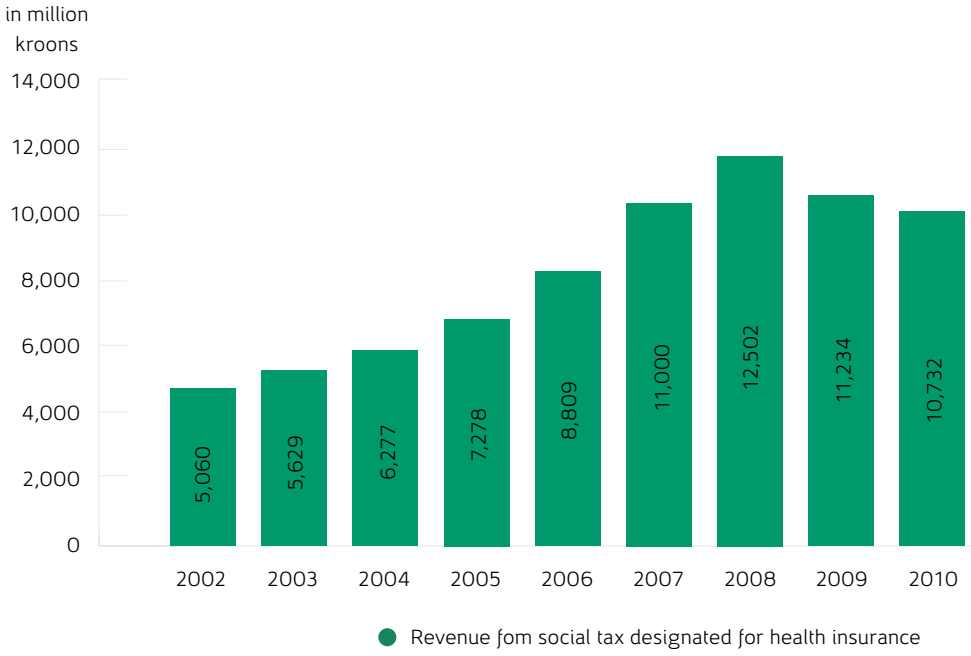
Table 5. Revenue (in thousand kroons)

	2009 actual	2010 budget	2010 actual	Budget execution %	% of change from 2009
Revenue from the health insurance part of social tax	11,234,307	11,066,925	10,731,725	97	-4
Revenue from contracts for persons considered equal to insured persons	47,841	40,000	49,324	123	3
Amounts due from other persons	14,110	10,000	11,049	110	-22
Financial income	105,131	65,000	38,268	59	-64
Other revenue received	28,475	33,900	35,236	104	24
Total	**11,429,864**	**11,215,825**	**10,865,602**	**97**	**-5**

Share of Social Tax Designated for Health Insurance

The share of social tax designated for health insurance constitutes major part of the revenue of the Health Insurance Fund, amounting to 98.8% in 2010. In 2010, actual revenue to the budget was 335.2 million EEK less than planned. Overview of the revenue by years is given on Figure 11.

Figure 11. Revenue from the health insurance segment of the social tax in 2002-2010



Revenue from contracts for persons considered equal to insured persons

Pursuant to the Health Insurance Act, a person without an insurance cover may obtain the insurance independently by signing a contract with the Health Insurance Fund and making monthly insurance payments.

Revenue from the voluntary contracts amounted to 4.2 million EEK during the accounting period. The revenue from contracts for considering persons as equal to insured persons also includes the revenue from the insurance of non-working pensioners of the armed forces of the Russian Federation. This revenue amounted to 45.1 million EEK in 2010.

Amounts due from other persons

11 million EEK worth of claims for recovery of unjustified payments were submitted to health care providers, insured persons and employers. In comparison with 2009, there have been changes in the shares of types of some claims. In relation to the transition to digital prescription, there has been a reduction in the numbers and amounts of the claims submitted against health care providers and pharmacies. In 2010, the number of claims submitted against health care providers because of incorrect prescription of medicine reduced by 903 claims, the number of claims submitted against pharmacies reduced by 48 claims.

In 2010, there was a slight increase in the claims submitted to the insurance companies, but the amount of claims decreased, due to the reduction in the rate of benefits for temporary incapacity for work arising from the amendment of the Health Insurance Act. Rate of sickness benefits decreased from 80% to 70%, due to changes in the calculation of average revenue in a calendar day.

In 2010, the number of other claims (including the extrajudicial proposals made for voluntary compensation of damages arising from criminal cases) increased by 139 claims. Precept allowed by court judgements and law have been submitted to bailiff for execution in the amount of EEK 1.6 million.

Financial income

Financial income is the income received from allocation of the reserves and available funds of the Health Insurance Fund. Financial resources of the Health Insurance Fund are managed by the Ministry of Finance.

Upon allocation of funds, the Ministry of Finance adheres to established investment restrictions and benchmark portfolios. Annual rate of return depends above all on benchmark portfolios, the events that have had impact on price variations in bond market and interest rates of short-term deposit. Reserve funds are mainly invested to the bonds of the governments of the European Union countries, bonds of companies with small credit risk and deposits. Duration of investments depends on the duration of benchmark portfolio and vision of portfolio manager of the events on bond market.

Table 6 gives an overview of the investments made in 2010.

Table 6. Investments by EHIF

	Investments in risk reserve and earnings		Investments in reserve capital	
	As of 31.12.2009	As of 31.12.2010	As of 31.12.2009	As of 31.12.2010
Volume of fund at acquisition cost (in EEK thousand)	2,292,621	2,138,013	812,333	831,612
Volume of fund at market value (in EEK thousand)	2,297,589	2,142,112	825,852	838,071
Realised gains from the beginning of the year (in EEK thousand)	113,889	30,710	19,932	19,411
Revaluation gain (in EEK thousand)	4,968	4,099	13,519	6,459
Profitability from the beginning of the year (on annual basis),(%)	3.37	1.16	3.82	1.53
Average duration of investments in days (on annual basis)	0.25	0.19	0.93	1.18

Other Income

During the accounting period, 18.5 million EEK were allocated for coverage of infertility treatment from the state budget, 16.2 million EEK were received for services provided to the nationals of other EU member states, and revenue from economic activities amounted to 531 thousand EEK. Revenue from economic activities is the revenue received from processing invoices for medical treatment of non-insured persons.

Expenditure

The expenditure of the Health Insurance Fund is divided between insurance expenditure and operating expenditure.

Health Insurance Expenditure

1. Health Services

Table 7. Health service expenditure (in EEK thousand)

	2009 actual	2010 budget	2010 actual	Budget execution %	% of change from 2009
Disease prevention expenses	114,118	110,000	108,561	99	-5
Expenses on primary health care	1,056,204	1,035,067	1,009,317	98	-4
Expenses on specialised medical care	6,354,972	6,219,880	6,218,733	100	-2
Expenses on nursing care	237,013	227,306	223,040	98	-6
Expenses on dental care benefits	287,180	283,074	278,538	98	-3
Total	**8,049,487**	**7,875,327**	**7,838,189**	**100**	**-3**

The budget of 2010 was executed as planned.

With regard to execution of the 2010 budget of health services, the Health Insurance Fund deems important the level of budget execution in disease prevention and nursing care as well as 100% budget execution in specialised medical care. The number of cases funded was 1% higher than budgeted, i.e. 3% more cases[7] (TC) were financed than in 2009.

Compared to 2009, health insurance expenditure on health services decreased in 2010, because as of November 15 2009, the reference prices of all health services were subjected to the coefficient of 0.94. Application of the coefficient also impacted on the average cost of a treated case[8] (ACTC) and the cost of pharmaceuticals in the budget of specialised medical care.

1.1. Disease Prevention

The objective of disease prevention is to detect a pre-disease condition in a person as early as possible and to take measures to avoid illness. The budget of disease prevention and execution thereof is provided in Table 8 below.

Table 8. Disease prevention (in EEK thousand)

	2009 actual	2010 budget	2010 actual	Budget execution %	% of change from 2009
School health	56,175	52,941	52,309	99	-7
Early detection of breast cancer	13,024	13,342	13,467	101	3
Youth reproductive health project	13,815	12,372	12,601	102	-9
Prenatal diagnostics of hereditary diseases	8,894	8,665	8,942	103	1
Health examination of young athletes	8,539	7,503	7,620	102	-11
Newborn hearing screening	4,429	4,333	4,372	101	-1
Early detection of cervical cancer	2,778	3,980	3,129	79	13
Phenylketonuria and hypothyroidism screening	3,038	3,105	2,880	93	-5
Prevention of cardiac diseases	1,985	2,140	1,904	89	-4
Early detection of osteoporosis	1,108	1,197	1,029	86	-7
Other preventive activities (evaluation of projects)	326	408	308	75	-6
Immunisation against hepatitis B	7	14	0	0	-
Total	**114,118**	**110,000**	**108,561**	**99**	**-5**

[7] Treatment case – Invoice for treatment that reflects all medical examinations and services provided to one insured person within one case.
[8] Average cost of treatment case – the average amount of an invoice for treatment that is calculated by dividing the sum by the number of mdeical cases.

In 2010, disease prevention activities were executed as planned with the exception that in some cases the need of preventive services proved to be greater than planned (see Table 9).

Table 9. Results of disease prevention projects

	Actual number of participants 2009	Planned number of participants 2010	Actual number or participants 2010	2010 actual/ 2010 planned%	Results
School health	160,358	160,000	158,091	99	21% of students participated in activities related to health education, 12% of students received first aid training. Preventive medical examinations carried out in the framework of school health services revealed that 16% of students had posture problems, 19% of students suffered from decreased vision. 10% of students were overweight, 3% were underweight, and 3% of students had increased blood pressure. The school health boards have been established in 36% of the schools.
Early detection of breast cancer	30,576	33,000	33,419	101	3.3% (1,059 women) of all women examined were referred to undergo further examination. 183 of women were referred to consultations by a specialist on mammology, with 142 discovered cases of cancer, of which 101 were in an early stage.
Youth reproductive health project (number of cases)	33,759	32,000	33,165	104	22% of the visitors visited the youth centre for the first time, 5% of all visitors were young men (12.7% of first-time visitors were young men). Sexually transmitted diseases were detected in 640 cases, incl. 5 cases of HIV. 97 of young women of up to 19 years of age who visited the counselling centres were given referrals to register their pregnancies and 131 to undergo abortion.
Prenatal diagnostics for hereditary diseases	1,776	1,750	2,064	118	66% of the examinations were undertaken on the basis of the results of serum screening and 7% because of age risk. A foetal chromosomal anomaly was detected in 59 cases (4%), incl. 26 instances of Down syndrome.
Health examination for young athletes	9,682	9,500	8,806	93	14% of the examined young athletes required further examination and treatment. 32% of the examined young athletes had health problems diagnosed for the first time. The main pathologies discovered were associated with cardiovascular system (34%) or the skeletal and muscular system (43%). Anaemia was discovered in 1.5% of the young athletes with first-diagnosed health problems.
Newborn hearing screening	13,951	14,600	14,534	100	96.1% of newborns were screened in the participating health care institutions. 26 children were diagnosed with a loss of hearing. Four children whose loss of hearing was discovered during the screening received cochlear implants in 2010.
Early detection of cervical cancer	13,887	16,000	12,541	78	A pre-cancer condition or cancer was discovered in ~7% of the women examined.
Phenylketonuria and hypothyroidism screening	15,595	16,600	15,648	94	99.6% of newborns were screened. 39 parents refused the test. The tests resulted in the discovery of 2 children with phenylketonuria and 3 children with hypothyroidism.
Prevention of cardiac diseases	3,400	4,000	3,429	86	Non-pharmaceutical management of risk factors was initiated for 40% and pharmaceutical treatment was prescribed for 8% of the project participants. Apparent hypertension affected 13% of the persons; 22% had serious hyperlipidemia and 22% had apparent hyperglycemia. Pathology was discovered during ECG in 2% of the participants. 43% of the participants in the project were men.
Early detection of osteoporosis	1,098	1,300	1,114	86	Osteoporosis was detected in 19% of the persons examined and osteopenia (a pre-osteoporosis state) in 46%. 48% of the patients with discovered osteoporosis or osteopenia used calcium supplements and vitamin D, while the Figure was 60% on average among those who underwent a repeated examination. Osteoporosis was treated in 70% of patients with osteoporosis and in 30% of osteopenia patients.
Immunisation against hepatitis B	52	60	0	0	Was not conducted due to a lack of need thereof since the immunisation against hepatitis B is a part of the national immunisation plan.

The volume of **screening for cervical cancer** has not increased compared to 2009. This is mainly due to the women's preference to undertake the screening with their gynaecologist. In 2011, the code of practice for cervical cancer screening will be revised in order to include those addressees who turn to their gynaecologist, thereby making the screening more systematic.

The projects for prevention of cardiovascular diseases and osteoporosis only target adults with high risk levels. The need to refer these patients to further examination has been lower and this has impacted on the level of execution of these projects.

Phenylketonuria and hypothyroidism screening comprised over 99% of newborns.

The need for **prenatal diagnostics of hereditary diseases** has indeed increased, but since the principles for establishing a need for examination (invasive examination is not only based on a woman's age) have been specified, the activities are more cost-effective, and compared to the growing number of women participating in the project, budgetary increase thereof has been markedly lower.

In 2010, health examination of young athletes mostly concerned those who trained more than 8 hours per week, which also resulted in the need for further examinations. This in turn increased the average cost of a treated case (ACTC), wherefore the number of young athletes examined was lower than planned.

The students of the Faculty of Medicine did not require immunisation against **hepatitis B** in 2010, because they had already been vaccinated at the age of 13 within the national immunisation plan. Starting from 2011, expenditure on immunisation of the students of the Faculty of Medicine is no longer included in the budget.

In 2010, **the audit to assess the impact and efficiency** of screening for phenylketonuria and hypothyroidism was completed. On the basis of the audit, the attainment of the project objective can be deemed very good, for almost all children with phenylketonuria and congenital hypothyroidism have been discovered.

Furthermore, it was assessed in 20 schools whether the provision of school health services was in agreement with the established guidelines. As a result of this assessment, the guidelines of school health services were revised. The assessment revealed that in small schools, where school health services are not provided, the school itself is active in health promotion, first aid training and provision thereof, but those schools mostly do not organise health interviews and surveillance of children belonging to risk groups. In the future, more attention should be given to cooperation with dentists, dental nurses and family physicians, because it would enable to consistently monitor the development and health of pupils.

33,419

women screened for breast cancer

1.2. Primary Health Care

Expenditure on primary health care has decreased compared to 2009. This change in expenditure is also due to coefficient of 0.94 applied all the reference prices and a drop in the total number of the insured.

Capitation fee constituted the largest portion of the total expenditure with 67%, the fund for examinations and tests accounted for 19% and basic allowance for 11% (see Table 10).

Table 10. Health services of primary health care (in EEK thousand)

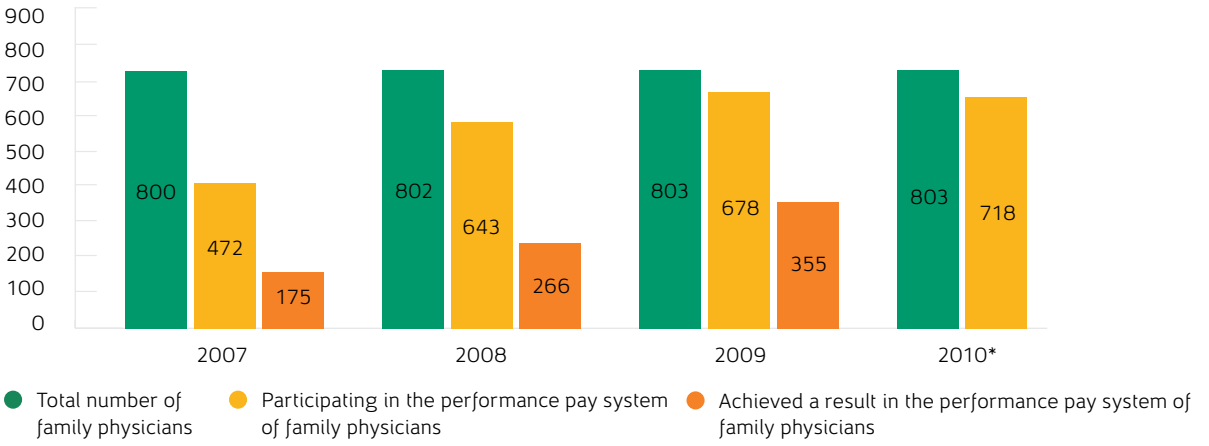
	2009 actual	2010 budget	2010 actual	Budget execution %	% of change from 2009
Basic allowance	118,279	112,265	111,912	100	-5
Distance allowance	5,099	4,847	4,736	98	-7
Capitation fee on insured persons of up to 2 years of age	36,539	35,055	34,947	100	-4
Capitation fee on insured persons aged 2 to 70	575,292	544,129	539,148	99	-6
Capitation fee on insured persons over 70	107,209	103,083	104,050	101	-3
Fund for examinations and tests	192,138	207,532	190,109	92	-1
Family physician's performance pay*	12,276	17,202	15,517	90	26
Family doctor hotline	9,372	8,954	8,898	99	-5
Primary health care reserve**	0	2,000	0	-	-
Total	**1,056,204**	**1,035,067**	**1,009,317**	**98**	**-4**

* Performance pay is budgeted 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 under the primary health care reserve, but the corresponding expenses, if incurred, are shown on the line of the fund for examinations and tests.

In 2010, there were 803 practice lists of family physicians in Estonia. A basic allowance at a coefficient of 1.5 was paid to 57 family physicians that provided services at several locations.

Compared to 2009, the use of the fund for examinations and tests increased (in 2009, family physicians used only 89% of the fund by the end of the year), for the volume of the fund is 5% greater for those family physicians who participate in the performance pay system (see Figure 12).

Figure 12. Performance pay system of family physicians



* The 2010 results of the performance monitoring of family physicians will be determined by July 1, 2011.

In 2010, already 90% of family physicians participated in the performance pay system. The family physicians in Harju region constituted 90% (83% in 2009), those in Tartu region 88% (81%), Pärnu region 94% (93%) and Viru region 87% (86%) of all family physicians. The insured persons on the practice lists of family physicians, who participate in the performance pay system, are therefore better covered by preventive activities and systematic monitoring of chronic illnesses.

In 2010, the Health Insurance Fund remunerated family physicians for their quality performance in 2009. In 2009, 678 family physicians (85% of all family physicians) applied for performance pay. Additional remuneration for high-quality work in disease prevention and monitoring of patients with chronic diseases with a coefficient of 1.0 was paid to 231 family physicians and with a coefficient of 0.8 to 124 family physicians – in total 355 family physicians (266 in the previous year), from among whom 194 family physicians received allowance for additional professional qualifications.

Table 11. Number of practice lists of family physicians and the number of insured persons on the lists

	2009 actual	2010 actual	% of change from 2009
Number of practice lists			
Number of practice lists	803	803	0
Distance allowance	191	187	-2
Average practice list	1,595	1,583	-1
Number of persons			
Number of persons aged up to 2 years, for whom capitation fee was paid	28,700	28,900	1
Number of persons aged 2-70, for whom capitation fee was paid	1,084,648	1,071,678	-1
Number of persons aged over 70, for whom capitation fee was paid	167,447	170,504	2
Total number of persons for whom capitation fee was paid	**1,280,795**	**1,271,082**	**-1**

The total number of practice lists has not changed, but the number of insured persons on the lists has decreased somewhat, whereas the number of persons aged 0–2 and those over 70 has increased (see Table 11).

As of the end of 2010, 63 (67 in 2009) practice lists were smaller than the standard size (1,200 persons) and 189 (186 in 2009) lists were larger than the standard size (2,000 persons), including 47 (50 in 2009) lists with more than 2,300 persons. There were 14 small practice lists with the service area of less than 1,200 permanent residents, which received additional capitation fees for 1,200 insured persons.

Of the budgeted amounts designated for the primary health care reserve, 174.5 thousand EEK was spent on monitoring normal pregnancies and 722 thousand EEK on conducting autopsies. In the annual report, the respective costs are included in the expenses of the fund for examinations and tests.

Table 12. Consultations of family physicians

	2009 actual		2010 actual		% of change from 2009	
	Consultations	Persons	Consultations	Persons	Consultations	Persons
Primary consultation	1,606,570	769,112	1,501,403	735,283	-7	-4
Subsequent (repeated) consultation	2,222,541	679,663	2,036,258	630,591	-8	-7
Prophylactic consultation	387,782	213,962	394,360	223,327	2	4
Home visit	85,925	58,911	67,690	45,691	-21	-22
Independent consultation of family nurse	401,786	224,142	463,195	255,621	15	14
Planned consultation for uninsured persons	9,233	6,222	10,398	6,996	13	12
Home visits by family nurse	16,519	9,521	17,074	9,992	3	5
Telephone contacts	258,092	158,337	378,585	208,347	47	32
Total	**4,988,448**	**973,129**	**4,868,963**	**957,090**	**-2**	**-2**

Albeit the share of the insured persons who had a consultation with their family physician has remained almost the same within the last three years, both the number of consultations and the total number of persons consulted reveal a falling trend (see Tables 12 and 13).

The number of home visits has dropped the most: 1.6 visits are paid per one practice list in a week on average. At the same time, telephone consultations of insured persons have become markedly more frequent.

Table 13. Number of consultations of family physicians 2008–2010

	2008 actual	2009 actual	2010 actual
Consultations	5,189,830	4,988,448	4,868,963
Persons consulted	983,466	973,129	957,090
Number of persons on practice lists	1,286,597	1,280,795	1,271,082
Share of persons consulted by family physicians of persons included in the practice lists (%)	76	76	75

The general practitioner advisory phone line 1220 took a total of 213,739 calls (213,596 calls in 2009, 174,031 calls in 2008) in 12 months, with an average of 586 calls per day. The majority of the callers required consultation on a health problem, 1% needed advice on the organisation of health care.

1.3. Specialised Medical Care

Total expenditure on specialised medical care in 2010 amounted to 6.2 billion EEK.

1.3.1. Specialised Medical Care, Except Centrally Contracted Services

The 2010 budget was executed as planned. The availability of specialised medical care has been kept at the same level as in 2009.

The Health Insurance Fund uses the information on waiting lists received from its partners to analyse the availability of health insurance benefits.

When monitoring the waiting lists, the EHIF sees that the insured persons would receive planned care on time (see Table 14). Care is provided as planned if the maximum length of a permitted waiting period established by the Council is not exceeded, waiting times may be longer in the case of follow-up monitoring or when the patient wishes to choose a doctor.

Table 14. Waiting list for specialised medical care by causes (number of persons on the list)

	As of 01.01.2009	As of 01.01.2010	As of 01.01.2011
Persons receiving care within the permitted waiting period	116,815	116,273	122,820
Persons on the waiting list:			
Patients' reasons	46,635	40,692	46,080
Follow-up monitoring	26,486	34,770	43,389
Other reason	2,375	1,691	3,477
Lack of capacity	1,549	1,553	1,827
Lack of financial resources	98	2,975	969
Total	**193,958**	**197,954**	**218,562**

Table 15 presents an overview of waiting lists with the highest number of patients waiting for care by specialities.

Table 15. Persons on the waiting lists for specialised medical care per 1,000 insured persons

	01.01.2007	01.01.2008	01.01.2009	01.01.2010	01.01.2011
Obstetrics and gynaecology	25	29	29	30	30
Ophthalmology	20	26	24	23	27
Internal diseases	21	23	22	24	25
Surgery	15	15	16	17	18
Psychiatry	8	6	9	10	12
Otorhinolaryngology	12	10	12	9	11
Dermatovenereology	6	6	7	9	10
Neurology	6	7	6	7	9
Orthopaedics	6	7	7	7	9
Oncology	5	5	5	7	8

Tables 16 and 17 present the distribution of resources and cases by specialities and care types in specialised medical care.

3,671,655

out-patient visits

797,048

persons who used specialise medical care

Tabel 16. Expenses on specialised medical care (in EEK thousand)

	2009 actual	2010 budget	2010 actual	Budget execution %	% of change from 2009
Internal diseases	1,500,966	1,459,585	1,477,669	101	-2
outpatient care	288,512	286,924	291,342	102	1
day care	105,215	93,637	94,655	101	-10
inpatient care	1,107,239	1,079,024	1,091,672	101	-1
Surgery	1,149,539	1,116,233	1,113,058	100	-3
outpatient care	204,253	204,129	203,337	100	0
day care	44,878	49,137	48,664	99	8
inpatient care	900,408	862,967	861,057	100	-4
Obstetrics and gynaecology	629,157	611,942	615,314	101	-2
outpatient care	282,025	276,547	281,596	102	0
day care	33,179	33,823	34,491	102	4
inpatient care	313,953	301,572	299,227	99	-5
Oncology	569,816	579,556	556,218	96	-2
outpatient care	295,391	305,343	298,784	98	1
day care	33,357	35,089	17,601	50	-47
inpatient care	241,068	239,124	239,833	100	-1
Orthopaedics	501,320	496,471	497,690	100	-1
outpatient care	110,747	110,787	112,090	101	1
day care	27,371	28,792	29,300	102	7
inpatient care	363,202	356,892	356,300	100	-2
Psychiatry	286,712	286,815	291,172	102	2
outpatient care	79,065	79,115	79,101	100	0
day care	1,262	1,232	1,557	126	23
inpatient care	206,385	206,468	210,514	102	2
Paediatrics	276,658	259,959	267,423	103	-3
outpatient care	64,452	63,668	63,731	100	-1
day care	6,318	5,959	5,964	100	-6
inpatient care	205,888	190,332	197,728	104	-4
Ophthalmology	246,457	244,198	243,942	100	-1
outpatient care	124,188	124,605	125,932	101	1
day care	108,170	105,983	105,152	99	-3
inpatient care	14,099	13,610	12,858	94	-9
Neurology	198,086	196,741	200,854	102	1
outpatient care	88,428	89,912	92,234	103	4
day care	270	285	445	156	65
inpatient care	109,388	106,544	108,175	102	-1
Pulmonology	196,748	194,734	185,857	95	-6
outpatient care	89,634	87,960	88,085	100	-2
inpatient care	107,114	106,774	97,772	92	-9
Otorhinolaryngology	170,434	162,695	159,371	98	-6
outpatient care	79,811	77,866	75,551	97	-5
day care	25,934	27,980	27,095	97	4
inpatient care	64,689	56,849	56,725	100	-12
Rehabilitation	143,257	137,704	138,453	101	-3
outpatient care	71,055	68,343	68,336	100	-4
inpatient care	72,202	69,361	70,117	101	-3

Infectious diseases	91,314	87,703	87,219	99	-4
outpatient care	28,060	28,283	28,141	99	0
inpatient care	63,254	59,420	59,078	99	-7
Dermatovenereology	72,896	69,358	71,084	102	-2
outpatient care	61,086	58,341	59,671	102	-2
day care	1,225	1,270	1,173	92	-4
inpatient care	10,585	9,747	10,240	105	-3
Follow-up care	21,041	21,882	21,570	99	3
inpatient care	21,041	21,882	21,570	99	3
Total	**6,054,401**	**5,925,576**	**5,926,894**	**100**	**-2**
Total outpatient care	1,866,707	1,861,823	1,867,931	100	0
Total day care	387,179	383,187	366,097	96	-5
Total inpatient care	3,800,515	3,680,566	3,692,866	100	-3
On-call duty fee	**154,485**	**130,404**	**130,404**	**100**	**-16**
Total	**6,208,886**	**6,055,980**	**6,057,298**	**100%**	**-2**

Table 17. Specialised medical care cases

	2009 actual	2010 budget	2010 actual	Budget execution %	% of change from 2009
Internal diseases	415,561	420,629	425,654	101	2
outpatient care	358,061	363,879	368,111	101	3
day care	4,214	3,985	4,047	102	-4
inpatient care	53,286	52,765	53,496	101	0
Surgery	361,888	366,190	371,219	101	3
outpatient care	308,676	312,053	316,944	102	3
day care	8,826	9,835	9,796	100	11
inpatient care	44,386	44,302	44,479	100	0
Obstetrics and gynaecology	520,754	518,015	527,447	102	1
outpatient care	471,233	468,090	477,916	102	1
day care	16,177	16,762	16,196	97	0
inpatient care	33,344	33,163	33,335	101	0
Oncology	93,009	98,362	93,633	95	1
outpatient care	81,164	85,676	82,054	96	1
day care	2,574	3,160	1,789	57	-30
inpatient care	9,271	9,526	9,790	103	6
Orthopaedics	254,414	259,099	261,633	101	3
outpatient care	237,286	241,128	243,841	101	3
day care	3,573	3,861	3,933	102	10
inpatient care	13,555	14,110	13,859	98	2
Psychiatry	220,233	224,236	231,950	103	5
outpatient care	208,715	212,612	220,729	104	6
day care	224	230	269	117	20
inpatient care	11,294	11,394	10,952	96	-3
Paediatrics	142,431	142,587	146,702	103	3
outpatient care	110,975	111,588	114,476	103	3
day care	1,518	1,426	1,725	121	14
inpatient care	29,938	29,573	30,501	103	2

Ophthalmology	337,879	351,787	364,498	104	8
outpatient care	323,853	336,582	348,971	104	8
day care	12,496	13,563	13,973	103	12
inpatient care	1,530	1,642	1,554	95	2
Neurology	130,272	137,451	135,929	99	4
outpatient care	122,881	130,250	128,447	99	5
day care	63	69	77	112	22
inpatient care	7,328	7,132	7,405	104	1
Pulmonology	64,750	65,908	68,686	104	6
outpatient care	61,177	62,315	65,204	105	7
inpatient care	3,573	3,593	3,482	97	-3
Otorhinolaryngology	199,117	203,297	195,557	96	-2
outpatient care	182,206	186,214	179,279	96	-2
day care	4,937	5,646	5,641	100	14
inpatient care	11,974	11,437	10,637	93	-11
Rehabilitation	65,330	63,758	67,514	106	3
outpatient care	58,617	57,240	60,962	107	4
inpatient care	6,713	6,518	6,552	101	-2
Infectious diseases	33,812	34,741	34,373	99	2
outpatient care	23,011	22,609	23,491	104	2
inpatient care	10,801	12,132	10,882	90	1
Dermatovenereology	171,701	171,252	174,869	102	2
outpatient care	169,916	169,456	173,027	102	2
day care	472	506	473	93	0
inpatient care	1,313	1,290	1,369	106	4
Follow-up care	1,921	1,968	2,118	108	10
outpatient care	1,921	1,968	2,118	108	10
Total	**3,013,072**	**3,059,280**	**3,101,782**	**101**	**3**
Total outpatient care	2,717,771	2,759,692	2,803,452	102	3
Total day care	55,074	59,043	57,919	98	5
Total inpatient care	240,227	240,545	240,411	100	0
Payment on-call duty fee	**203**	**380**	**380**	**100**	**87**
Total	**3,013,275**	**3,059,660**	**3,102,162**	**101**	**3**

Oncology: the budget was under-executed in terms of both expenses and the cases, which was mainly due to the fact that Northern Estonian Regional Hospital (SA Põhja-Eesti Regionaalhaigla) provided services in a volume lower than contracted in the first half of the year, namely in terms of outpatient care. This under-execution decreased, however, by the end of the year.

Psychiatry: growth in the number of cases in recent years indicates an increasing need for psychiatric services. Although an increase in the number of psychiatric cases was planned for the year 2010, the amounts budgeted for cases were further exceeded. However, the number of persons who received outpatient care has not markedly increased, but the number of outpatient cases per person treated has grown. The EHIF opinions that the increased number of consultations may also be caused by the difficult economic situation.

Paediatrics: cases across all care types in paediatrics exceeded the budget. An increase in the number of cases has resulted from the growing share of children aged up to 5 years of all children. Compared to the previous year, the expenses in the speciality have decreased but not in the extent planned.

Neurology: expenses of any care types in the speciality exceeded the budget. According to the EHIF, such growth in expenditure in neurology is due to changes in the list of radiology services and references prices for services.

Follow-up care: the number of referrals to follow-up care after hospitalisation has been on the increase. This has enabled to make a more efficient use of the means, for the more specialised and high-tech resources of regional and central hospitals are made available for the active treatment of subsequent patients. Thus, the increase in the number of cases in follow-up care could be deemed a positive indicator.

Structural Changes in Average Cost of a Treated Case

Changes in the structure of a case of treatment are brought about by the development of diagnostics and treatment opportunities, as well as changes in the organisation of health care and in the legal framework, leading to changes in the average structural cost of a case of treatment (str_ACTC). The estimations of str_ACTC exclude the impact of changes in the reference prices of health services, and the prices of individual services for different periods are equalised. The calculations use the coefficient of 1.0 on the reference prices.

Compared to 2009, the change in str_ACTC in specialised medical care was −0.1% in specialised medical care, indicating a certain structural depreciation. Changes in str_ACTC by treatment types (see Table 18) are varied: both outpatient and inpatient services have undergone structural rise, at the same time, str_ACTC underwent a fall of 7.2% in day care. The latter resulted in particular from changes in the conditions for use and application of erythropoietin therapy included in the List of Health Services leading to a situation, where the cost of this pharmaceutical was not recorded in the treatment invoices in day care in 2010. The rise in inpatient str_ACTC is mostly caused by the shift of relatively cheaper and less severe cases from inpatient care to day care or outpatient care. More severe cases have required more active treatment in inpatient care and resulted in the increase of str_ACTC. For example, this is evident in structural increase in the expenditure on bed days, blood and blood products, transports, test and procedures. Outpatient str_ACTC has risen mainly on the account of operations, tests, procedures and laboratory tests.

Table 18. Average structural cost of a treated case (str_ACTC) by care types

Care type	Str_ACTC 2009 EEK	Str_ACTC 2010 EEK	% of change in str_ACTC from 2009
Outpatient care	708	718	1.4
Day care	6,772	6,282	-7.2
Inpatient care	16,108	16,481	2.3
Total	**2,046**	**2,044**	**-0.1**

Endoprosthetic Replacements, Cataract Operations, Cardiac Surgery and Deliveries

For the purposes of budget planning and monitoring, demands for the following four specialised services are considered separately: deliveries, cardiac surgery, endoprosthetic replacements and cataract operations. Given that deliveries and emergency cardiac surgery cannot be forecast in precise terms and given the long waiting lists for endoprosthetic replacements and cataract operations, it is the aim of the EHIF to ensure access to these services for the insured persons and to keep these cases under separate monitoring. Tables 19 and 20 provide an overview of the care needs and expenses of these services.

Table 19. Cost of endoprosthetic replacements, cataract operations, cardiac surgery and deliveries (in EEK thousand)

	Cost					% of change			
	2006	2007	2008	2009	2010	2007/ 2006	2008/ 2007	2009/ 2008	2010/ 2009
Endoprosthetic replacements	128,824	149,243	166,904	160,587	161,026	16	12	-4	0
Cataract operations	78,967	91,362	102,995	100,987	99,238	16	13	-2	-2
Cardiac surgery	127,433	145,210	163,335	148,313	145,717	14	12	-9	-2
Deliveries	126,782	169,283	197,398	192,203	184,756	34	17	-3	-4
Total	**462,006**	**555,098**	**630,632**	**602,090**	**590,737**	**20**	**14**	**-5**	**-2**

Table 20. Number of endoprosthetic replacements, cataract operations, cardiac surgeries and deliveries

	Number of cases, actual					% of change			
	2006	2007	2008	2009	2010	2007/ 2006	2008/ 2007	2009/ 2008	2010/ 2009
Endoprosthetic replacements	2,643	2,743	2,870	2,734	2,851	4	5	-5	4
Cataract operations	9,102	10,236	11,211	11,320	12,867	12	10	1	14
Cardiac surgery	1,062	1,081	1,115	995	993	2	3	-11	0
Deliveries	14,573	15,439	15,627	15,338	15,503	6	1	-2	1

The number of deliveries has stabilised in recent years with the annual average of 15,500 in the last four years. The share of Caesarean sections has also stabilised, constituting 21% of all deliveries.

The amounts budgeted for cases of endoprosthetic replacements and cataract operations were executed as planned. The number of insured persons on the waiting lists for endoprosthetic replacement has been stable in recent years.

The number of patients waiting for cataract operations has undergone a remarkable increase within a year. In relation to the changes in the List of Health Services, the cost of cataract operations has decreased and certain service providers are no longer interested in expanding their contractual commitments. However, East Tallinn Central Hospital has expanded the volume of its operations to keep the waiting lists within the permitted limits.

12,867

cataract surgeries

In conclusion, considering the operations planned in the 2010 budget and the average waiting times, the waiting lists for endoprosthetic replacements and cataract operations were kept within the permitted lengths in 2010.

1.3.2. Centrally Contracted Health Services

Centrally contracted health services are high-cost medical services for treatment of severe and relatively rare cases.

Treatment need of such cases cannot be planned in precise terms by years: in 2010, the actual demand was lower than planned in the budget (see Tables 21 and 22).

Table 21. Centrally contracted health services (in EEK thousand)

	2009 actual	2010 budget	2010 actual	Budget execution %	% of change from 2009
Centrally contracted pharmaceuticals	72,954	91,351	92,301	101	27
Peritoneal dialysis	25,384	25,722	22,855	89	-10
Haematological treatment	20,618	21,338	21,476	101	4
Bone marrow transplants	17,887	15,905	16,033	101	-10
Cochlear implants	4,925	4,646	4,646	100	-6
Emergency transport of the insured	2,549	2,453	2,349	96	-8
Pathoanatomical autopsies	722	1,500	879	59	22
Artificial urinary sphincters	848	797	708	89	-17
Antidotes, serums	199	188	188	100	-6
Total	**146,086**	**163,900**	**161,435**	**98**	**11**

Table 22. Cases and average cost of centrally contracted health services

	2009 actual		2010 actual		% of change from 2009	
	Cases	ACTC	Cases	ACTC	Cases	ACTC
Centrally contracted pharmaceuticals	2,801	26,046	3,943	23,409	41	-10
Peritoneal dialysis	947	26,805	888	25,738	-6	-4
Haematological treatment	304	67,822	336	63,917	11	-6
Bone marrow transplants	85	210,435	97	165,289	14	-21
Cochlear implants	20	246,250	20	232,300	0	-6
Emergency transport of the insured	91	28,011	91	25,813	0	-8
Pathoanatomical autopsies	451	1,601	368	2,389	-18	49
Artificial urinary sphincters	10	84,800	8	88,500	-20	4
Antidotes, serums	2	99,500	2	94,000	0	-6

Budget of Centrally Contracted Health Services

The amounts budgeted for **bone marrow transplants, haematological treatment and centrally contracted pharmaceuticals** were exceeded. There were more patients who needed bone marrow transplants and haematological treatment than planned. The money designated for one of the highest cost items – **centrally contracted pharmaceuticals** – was used to pay for the biological treatment of rheumatic and gastroenterological diseases, enzyme therapy for type 1 of Gaucher's disease, risperidone depot injections for treating psychiatric cases, treatment of Fabry disease, acromegaly, hormone treatment of neuroendocrine tumours and inpatient erythropoietin therapy. The budgeted amounts for the largest treatment group – biological treatment – were exceeded and these costs were covered on the account of unused resources set aside for other centrally contracted health services. The increased use of biological treatment was caused by the fact that more than a half of the patients planned to be treated in the year started their treatment already in the beginning of the year, whereas the budget was based on the use of resources in previous years, when new patients arrived proportionally over the course of the year. Treatment need was also higher than expected with regard to acromegaly and neuroendocrine tumours.

In emergency transport of the insured: the costs were lower than estimated. The cost of emergency air transport depends on the duration of flight and the type of transportation used. The hourly rate of a plane is cheaper than the hourly rate of a helicopter. The budget lines for **peritoneal dialysis and Pathoanatomical autopsies** were also under-executed because these services were required less than anticipated. **Artificial urinary sphincters** were planned for 9 patients, whereas actual operations were performed on 8 patients.

Cases of Centrally Contracted Health Services and the Average Cost of a Case Thereof

In comparison to 2009, the number of patients treated increased with regard to **bone marrow transplants, haematological treatment and centrally contracted pharmaceuticals.** The latter budget line saw the largest addition of cases, where the number of patients receiving biological treatment grew almost by one fifth and the number of cases in acromegaly and neuroendocrine treatment almost by a half. The average cost of a treated case decreased in the service of bone marrow transplants because post-operational complications were fewer than in 2009. The average cost of autopsies rose. In 2010, the Estonian Forensic Science Institute started to perform more autopsies that use more expensive studies.

232,300

EEK: the average cost of the most expensive service, hearing implantation

1.3.3. Comparison of Main Usage Indicators in Specialised Medical Care

Table 23 provides an overview of the main usage indicators in specialised medical care.

Table 23. Main usage indicators of inpatient and outpatient specialised medical care

	2009 actual	2010 actual	% of change from 2009
Average cost of a case of treatment, EEK			
outpatient care	687	666	-3
day care	7,030	6,321	-10
Inpatient care	15,821	15,361	-3
Number of inpatient bed days	1,449,960	1,458,555	1
Average length of stay in inpatient care (days)	6.1	6.1	0
Number of outpatient consultations	3,647,303	3,671,655	1
outpatient care	3,573,286	3,609,613	1
day care	74,017	62,042	-16
Number of outpatient consultations per case of treatment	1.32	1.18	-11
outpatient care	1.31	1.29	-2
day care	1.34	1.07	-20
Number of persons using specialised medical care services	800,578	797,048	0
outpatient care	777,144	774,589	0
day care	44,474	47,063	6
inpatient care	163,911	162,514	-1
Number of cases of treatment per person	3.76	3.89	3
outpatient care	3.50	3.62	3
day care	1.24	1.23	-1
inpatient care	1.47	1.48	1
Share of emergency care in treatment costs (%)			
outpatient care	17	18	1
day care	9	9	0
inpatient care	67	67	0
Share of emergency care in treated cases (%)			
outpatient care	17	17	0
day care	15	12	-3
inpatient care	61	62	1
Number of operations	155,010	160,403	3
outpatient care	20,302	21,154	4
day care	42,620	46,911	10
inpatient care	92,088	92,338	0

The overall average cost of a case of treatment (ACTC) decreased across all care types. **The number of bed days** has gone up due to longer stays in inpatient care. Every day, some patients with less serious health problems receive day care instead of inpatient care, which in turn increases the average length of stay in inpatient care. The number of bed days is also impacted by population ageing and application of new treatment methods for more severe cases.

Number of persons using specialised medical care services has slightly decreased across all care types. The usage indicator has been positively impacted by a decrease in the number of insured persons in comparison with the previous period. A positive indicator is the growing number of persons treated in day care.

3.89

cases of specialised medical care per person

Share of emergency care in a total number of treated cases has stayed at the same level, which is a good result. The share of emergency care in treatment costs increased, indicating that cases in emergency care prove to be more expensive.

Operations. The total number of operations increased in 2010 and namely in operations performed in the more efficient care type, i.e. day care and outpatient care.

Usage of cases of treatment per 1,000 insured persons is illustrated in Table 24. In budget planning the EHIF has already increased the number of cases in specialities with a growing demand for services (obstetrics and gynaecology, ophthalmology) to improve the availability of such services. Demand estimation also considers information about waiting lists (waiting times for consultations by a medical specialist, number of persons on the waiting list).

Owing to population ageing, the number of cases in sub-specialities of internal diseases is on the increase.

Table 24. Cases of treatment in specialised medical care per 1,000 insured persons

	2006 actual	2007 actual	2008 actual	2009 actual	2010 actual
Obstetrics and gynaecology	383	397	408	408	420
Internal diseases	294	307	325	326	339
Surgery	277	286	297	284	296
Ophthalmology	254	272	284	265	290
Orthopaedics	195	201	206	199	208
Psychiatry	154	158	166	173	185
Otorhinolaryngology	157	160	164	156	156
Dermatovenereology	125	128	133	135	139

1.3.4. Cost of Pharmaceuticals in the Budget of Specialised Medical Care

The Health Insurance Fund compensates for pharmaceuticals included in the List of Health Services but not included in the bed day reference price. The cost of pharmaceuticals paid from the budget of specialised medical care has been on a steady growth; introducing treatment schemes and increased use of centrally contracted biological treatment (see Figure 13).

Figure 13. Cost of pharmaceuticals in specialised medical care, 2006–2010

thousand kroons

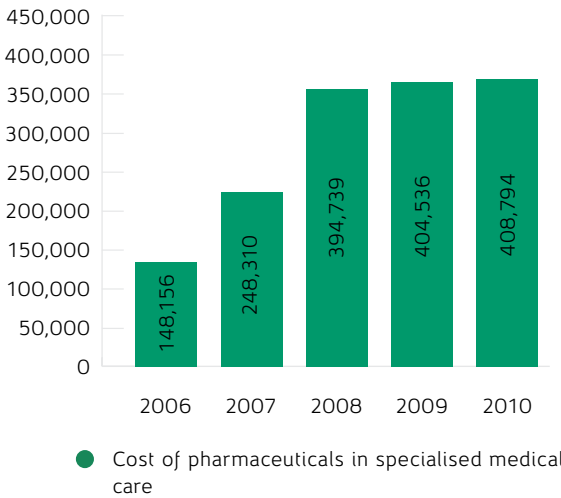
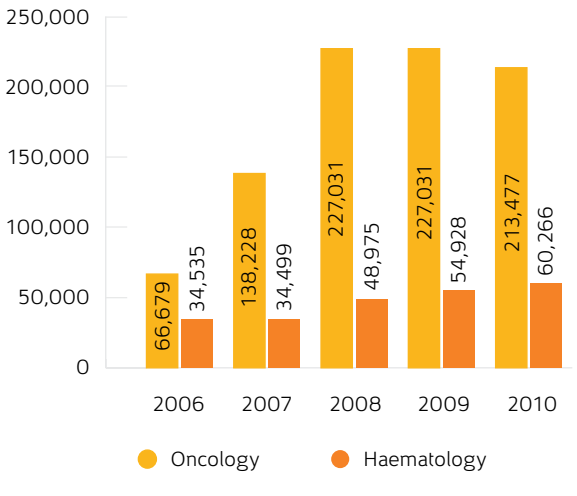


Figure 14. Specialities with the highest cost of pharmaceuticals, 2006–2010

thousand kroons



Oncology has been a speciality with highest expenditure on pharmaceuticals in specialised medical care in recent years (see Figure 14), accounting for 52% of the total expenditure on pharmaceuticals in specialised medical care in 2010. The cost of pharmaceuticals in oncology constituted *ca* 38% of the total expenditure in the speciality.

The speciality with the second highest expenditure on pharmaceuticals is haematology, the cost of pharmaceuticals in which constituted *ca* 15% of the total expenditure on pharmaceuticals in specialised medical care.

1.4. Nursing Care

The Health Insurance Fund seeks to improve access to nursing care by affording preferential treatment to outpatient services. Table 25 provides an overview of the nursing care budget and execution thereof.

Table 25. Expenses on nursing care (in thousand kroons)

	2009 actual	2010 budget	2010 actual	Budget execution %	% of change from 2009
Inpatient nursing care	197,916	184,545	178,498	97	-10
Outpatient nursing care, including	39,097	42,761	44,542	104	14
home nursing	32,855	36,279	38,104	105	16
home care for cancer patients	5,155	5,370	5,204	97	1
geriatric assessment	1,087	1,112	1,234	111	14
Total	**237,013**	**227,306**	**223,040**	**98**	**-6**

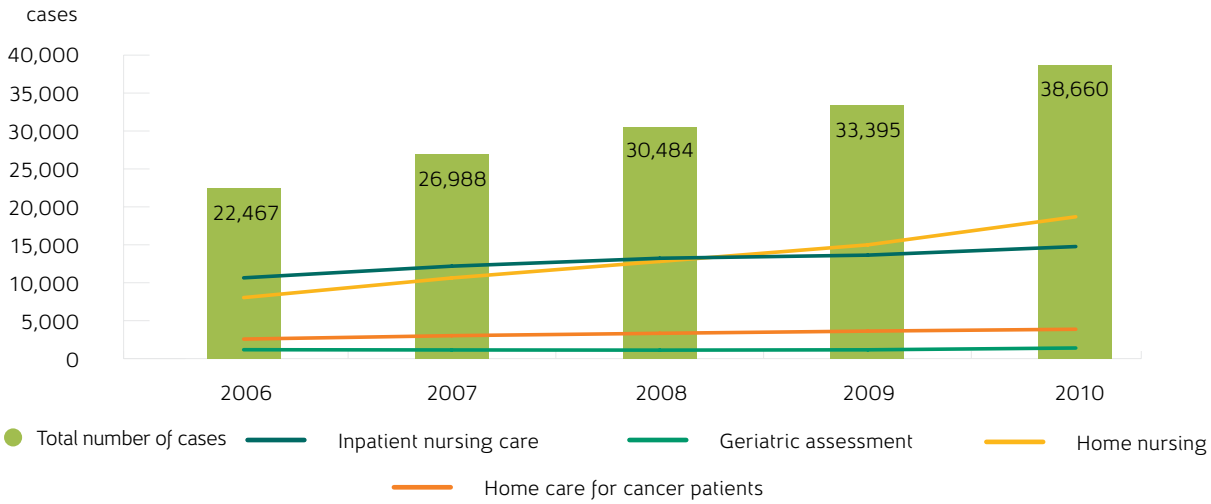
Introducing a 15% patient's financial participation in inpatient care has resulted in increased number of cases of outpatient nursing care (especially in home nursing) compared to 2009 (see Table 26 and Figure 15).

The implementation of patient's financial participation has decreased the average case cost, making it possible to increase also the number of cases in inpatient nursing care.

Table 26. Cases of nursing care and average cost thereof

	2009 actual		2010 actual		% of change from 2009	
	TC	ACTC	TC	ACTC	TC	ACTC
Inpatient nursing care	13,631	14,520	14,753	12,099	8	-17
Outpatient nursing care, including	19,764	1,978	23,907	1,863	21	-6
home nursing	14,987	2,192	18,677	2,040	25	-7
home care for cancer patients	3,612	1,427	3,851	1,351	7	-5
geriatric assessment	1,165	933	1,379	895	18	-4
Total	**33,395**	**7,097**	**38,660**	**5,769**	**16**	**-19**

Figure 15. Nursing care cases, 2006–2010



The ACTC has decreased while the number of visits of outpatient nursing care (home nursing service) and persons visited has increased, which can be considered a positive trend (see Table 27).

The over-execution of geriatric assessment was caused by the fact that in addition to the existing partners, the hospitals of Valga, Põlva and Jõgeva also started using the service.

The number home care visits of cancer patients and persons receiving the service decreased in comparison to the same period of the previous year because the service is being provided by a larger number of home nursing providers. In both cases, the service lies in the facilitation of coping skills at home for patients with chronic medical condition, sometimes with several simultaneous medical conditions.

Table 27. Outpatient nursing care visits

	2009		2010		% of change from 2009	
	Visits	Persons	Visits	Persons	Visits	Persons
Home nursing	123,065	3,971	149,991	4,753	22	20
Home care for cancer patients	14,459	927	14,356	890	-1	-4

4,753

persons who received home nursing service

1.5. Dental Care

Pursuant to the Health Insurance Act, the EHIF shall pay for the dental care services for insured persons of up to 19 years of age. In the case of dental care services for adults, the EHIF shall only pay for services provided as part of emergency care.

In 2010 the dental care expenditure section was under-executed (see Table 28). The largest fall was detected in the preventive dental care for children and in the emergency dental care for adults.

Table 28. Expenses on dental care (in thousand kroons)

	2009 actual	2010 budget	2010 actual	Budget execution %	% of change from 2009
Dental care for children	226,500	222,517	216,958	98	-4
Orthodontics	43,081	42,419	45,941	108	7
Emergency dental care for adults	11,208	11,740	10,178	87	-9
Preventive dental care	6,391	6,398	5,461	85	-15
Total	**287,180**	**283,074**	**278,538**	**98**	**-3**

Table 29. Cases of dental care

	2009 actual	2010 budget	2010 actual	Budget execution %	% of change from 2009
Dental care for children	299,081	298,983	306,100	102	2
Orthodontics	36,409	36,963	39,877	108	10
Emergency dental care for adults	17,260	18,465	17,530	95	2
Preventive dental care	28,109	28,711	25,147	88	-11
Total	**380,859**	**383,122**	**388,654**	**101**	**2**

The number of cases was smaller than planned only in the preventive dental care section (see Table 29). The decrease of the preventive dental care expenses and cases was caused by a smaller number of persons in the target group that participated in the prevention.

The number of orthodontics cases exceeded the budget. The situation where there was lack of service providers in some regions (Ida-Virumaa) but the need for orthodontics services existed, has been resolved.

In comparison to 2009 the emergency dental care for adults expenditure has decreased but the number of cases has increased. One of the reasons for this decrease is stricter supervision by the EHIF, according to the EHIF's opinion. The ACTC in dental care has decreased the most on the emergency dental care for adults section.

278.5

mln EEK of dental expenses

306,100

children's dental cases

2. Health Promotion

The Health Insurance Fund is engaged in health promotion through health promotion projects based on the priorities approved by the Supervisory Board of the EHIF and in coordination with the Ministry of Social Affairs. Health promotion activities of the EHIF are a part of the national health strategies. The slight under-execution of the budget was caused by the fact that a third of the project implementers executed their planned activities in a more cost-efficient manner than initially planned in the budget (see Table 30).

Table 30. Health promotion expenses (in thousand kroons)

	2009 actual	2010 budget	2010 actual	Budget execution %	% of change from 2009
Prevention of domestic and leisure time injuries	4,423	4,700	4,490	96	2
Health promotion activities for children	3,360	3,200	3,630	113	8
Activities aimed at multiple priority areas	3,067	2,800	3,000	107	-2
Prevention of cardiovascular diseases	463	800	240	30	-48
Prevention of alcohol-induced health damage	1,000	800	812	102	-19
Early detection of cancer	837	700	120	17	-86
Total	**13,150**	**13,000**	**12,292**	**95**	**-7**

The number of persons reached through health promotion projects has increased each year. The number of persons who received individual counselling and the total print run of publications also increased (see also Table 31).

Table 31. Quantitative indicators of project activities

	2006 actual	2007 actual	2008 actual	2009 actual	2010 actual
Total print run of publications	346,500	354,700	362,600	415,512	702,450
The number of participants in training, sports and other events aimed at the general population	25,100	39,300	53,890	60,250	70,400
Number of persons who received individual counselling	4,470	8,240	8,967	11,051	12,687
Number of participants in training events for teachers	3,300	2,310	1,227	2,136	1,961
Number of participants in training events for other stakeholders (social workers, managers, task forces)	2,440	2,181	1,605	1354	1,368
Number of participants in training events for health care professionals	600	1,830	427	193	229
Number of various printed publications	24	24	18	18	25
Number of radio and TV programmes/clips	19	11	8	15	8

Development of Infrastructures and Activities Aimed at Stakeholders

A total of 16 nurses/counsellors have been trained through the project "Children's dental health". Nurses provided dental hygiene training in 20 nursery schools and to 550 children and 150 parents through various family health centres. In addition, data from 452 parents on their awareness on oral hygiene were collected. Educational materials include acquired training materials, preparation of an information brochure and poster, a training film for children and a website have been developed.

132 nursery school and 146 school employees participated in health promotion trainings under the leadership of the National Institute for Health Development (NIHD). Local coordinators provided counselling to 300 nursery schools and 227 schools.

A national health promotion conference "Messages on health in the era of information abundance" took place in Tallinn on 4 June and had 380 participants on the specialised field. The role of media in transmitting health information was discussed.

Media Communications

Social campaigns on injury prevention and rational use of medicinal products were launched in the third quarter of 2010. The aim of the campaign **"One thoughtless act can change your life. Forever."** that was launched in August was to draw the public's attention to the topic of injuries, analyse the possible health risks associated to careless behaviour, and make young people care about their health and lives and those of their friends. In relation to the national campaign, first aid training was enhanced in schools, which was approved by the Minister of Social Affairs Regulation No. 54 of 13.08.2010 as part of health services in schools. Schools received campaign materials and publications (including "Life-saving first aid for injuries") for educational purposes. Through the support of the EHIF, all counties have injury prevention working groups.

A campaign **"The difference is in the price of the medical product"** was launched in September, focusing on informing the public on the active ingredient based selection and of the possibility to reduce patient's financial participation when buying medicinal products through the use of generic medical products.

Both campaigns are planned to continue in 2011 and the outcomes of these campaigns will be measured by a public satisfaction survey in 2011.

Injury prevention projects were carried out in all 15 counties and in the two major cities: Tartu and Tallinn. The 2010 project included the preparation of local injury profiles which will serve as a basis for setting objectives for the next years. Safety camps "Protect yourself and help others" were carried out for 6th grade students in all counties. In order to involve young people and to draw their attention to the issue they were shown a play called "The head of Simo Karl is the main thing" or an interactive forum theatre event was carried out. Also, round-table meetings were carried out where young people could offer their own solutions. Trainings were organised for specialists and events for the general public, stressing their own role in injury and hazard prevention.

Individual health counselling was provided in 12,687 cases **through projects for stakeholders**, with the most active coverage in web-based counselling on sexual health for youth (a total of 4,734 questions were answered). There were 1,535 cases of first-time pregnancy crisis counselling and a total of 4,289 cases of counselling. 3550 answers were provided through the online forum of Perekool.ee. Children from 40 families that have lost a family member participated in a therapeutic grief camp.

9 new **patient guidelines** were published and 9 re-published in 2010. The newly published materials included guidelines on chronic renal disease and premature newborns, health diary for the observation of children from the age of 0 to 7, and a grief brochure for people who have lost a family member. Reprints of health publications were published: children's nutrition and weight, balanced nutrition, physical exercise and early detection of breast cancer and cervical cancer. The total print run of these publications was 400,000, which were distributed to family health centres.

3. Expenses on Pharmaceuticals Reimbursed to the Insured

The expenditure on reimbursing the cost of pharmaceuticals to insured persons is an open commitment for the Health Insurance Fund. The EHIF is obliged to pay compensation to pharmacies for the cost of pharmaceuticals to the extent prescribed by law and based on the needs of the person.

Development and enforcement of measures to control the expenditure is organised by the Ministry of Social Affairs and the Government of the Republic.

1.4 billion kroons worth of expenses on pharmaceuticals were reimbursed to the insured persons in 2010. 98% of the planned budget was executed in 2010 (see Table 32).

Table 32. Pharmaceuticals reimbursed to the insured (in thousand kroons)

	2009 actual	2010 budget	2010 actual	Budget execution %	Share of expenses by type of reimbursement %	
					2009	2010
Reimbursement of 100% of cost	644,276	654,627	675,323	103	47	48
Reimbursement of 90% of cost	384,187	401,810	416,520	104	28	29
Reimbursement of 75% of cost	85,040	95,308	84,733	89	6	6
Reimbursement of 50% of cost	269,710	300,280	243,139	81	19	17
Pharmaceuticals reimbursed in special cases	118	125	5	4	0	0
Total	**1,383,331**	**1,452,150**	**1,419,720**	**98**	**100**	**100**

Despite the difficult economic situation, the year 2010 was characterised by a general increase in the consumption of discount pharmaceuticals.

The use of pharmaceuticals in December 2010 differed markedly from the remaining months. One of the reasons for this may lie in the anticipation regarding the changeover to the euro from January 2011 among patients, doctors and pharmacists.

While the average amount of reimbursement per one insured person was 1,084 kroons in 2009, it rose to 1,130 kroons in 2010 (see Figure 16). Another reason is clearly a wider selection of medicines, which included 18 new active ingredients that were reimbursed with the highest rate (75%, 100%) in 2010. For example, medicine ranges was expanded in the treatment of the following diseases: hypertension, osteoporoses, chronic renal insufficiency, brain tumour, glaucoma, thrombosis, neuropathic pain, epilepsy and schizophrenia.

The list of diagnoses was also expanded in 2010 in order to ensure better availability of discount pharmaceuticals to the insured persons. This change resulted in the availability of several pharmaceuticals to be used for the treatment of fungal infections in patients with primary or acquired immunodeficiency, disturbances of activity and attention, urea cycle disorder and Wilson's disease.

Figure 16. Total expenditure on reimbursement of pharmaceuticals and expenditure per patient

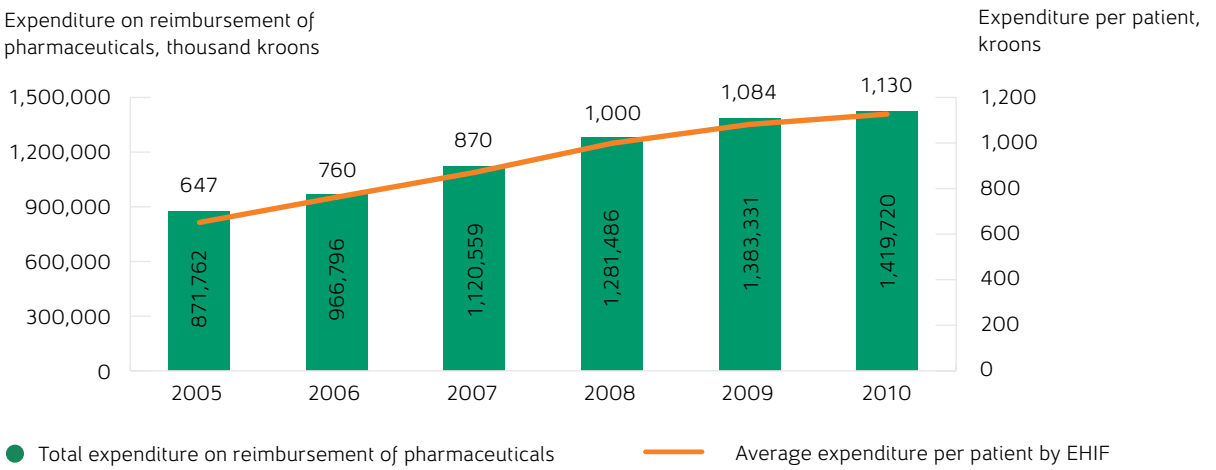


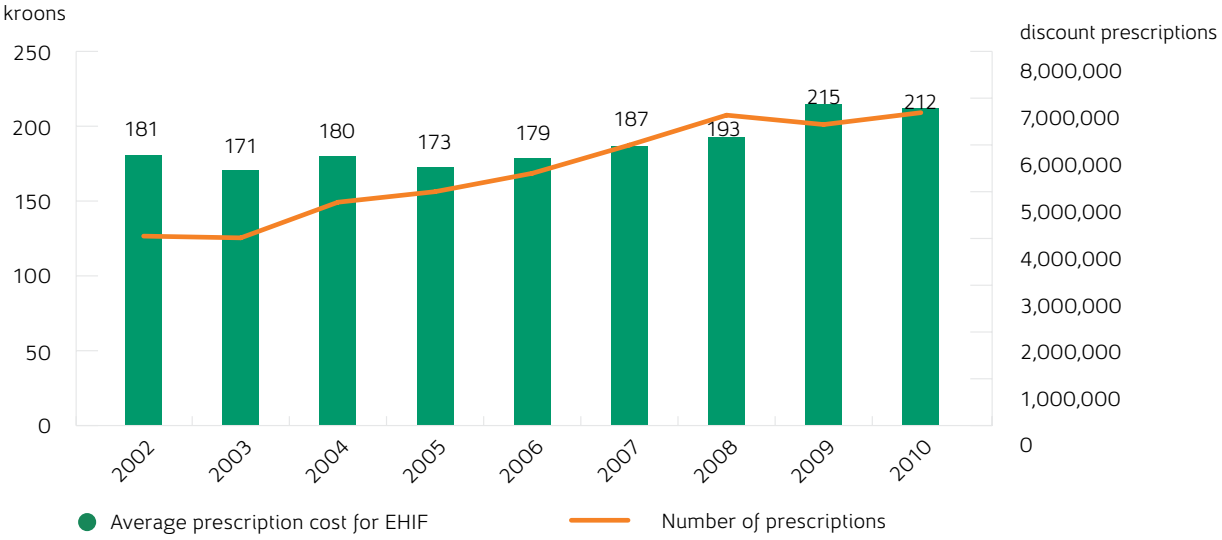
Table 33. Number of discount prescriptions (DP) and average cost in kroons

	2009		2010		2009/2010	
	Number of DPs	Average cost of DP for EHIF	Number of DPs	Average cost of DP for EHIF	Number of DPs %	Average cost of DP for EHIF %
100% reimbursement	703,877	915	744,866	907	6	-1
90% reimbursement	2,077,851	185	2,319,683	180	12	-3
75% reimbursement	486,978	175	498,772	170	2	-3
50% reimbursement	3,166,994	85	3,126,565	78	-1	-8
Total	**6,435,700**	**215**	**6,689,886**	**212**	**4**	**-1**

The number of reimbursed prescriptions has increased by 4% compared to 2009 and has reached the level of 2008 again. The largest increase took place in the purchase of pharmaceuticals subject to 90% reimbursement.

The average cost of prescriptions for the EHIF has decreased among all reimbursement levels with the largest drop in the pharmaceuticals subject to 50% reimbursement. This is probably caused by the fact that reference prices were set for most pharmaceuticals subject to 50% reimbursement and price agreements with marketing authorisation holders were concluded by the Ministry of Social Affairs in the financial year.

Figure 17. Changes in the number of discount prescriptions and average cost



There were no significant differences between the changes in the increase in the number of discount prescriptions and benefits for pharmaceuticals when compared to previous periods.

Compared to 2009, the average sum paid per prescription by the EHIF has decreased by 2.7 kroons and the patient's financial participation increased by 5 kroons, for the first time in years. The fall of average cost per prescription for patients was especially evident in the 4th quarter of 2010. The requirement of recommending the cheapest medicine by pharmacies and the EHIF's information campaign on rational use of medicines are showing the first signs of success.

6,689,886

discount prescriptions issued from pharmacies

5

EEK paid less for a discount medication in 2010 than in 2009 by an insurable person

Table 34. Financial participation by insured persons (%)

	2009 actual	2010 actual	% of change from 2009
100% reimbursement	3.2	3.4	0.2
90% reimbursement	32.7	33.3	0.6
75% reimbursement	42.0	42.0	0.0
50% reimbursement	66.6	67.9	1.3
Average financial participation by insured persons	36.9	36.2	-0.7
including prescriptions subject to 75%, 90% and 100% reimbursement	19.5	19.9	0.4

New medicine users were added to the diagnosis groups with large **reimbursement costs on medicines.**

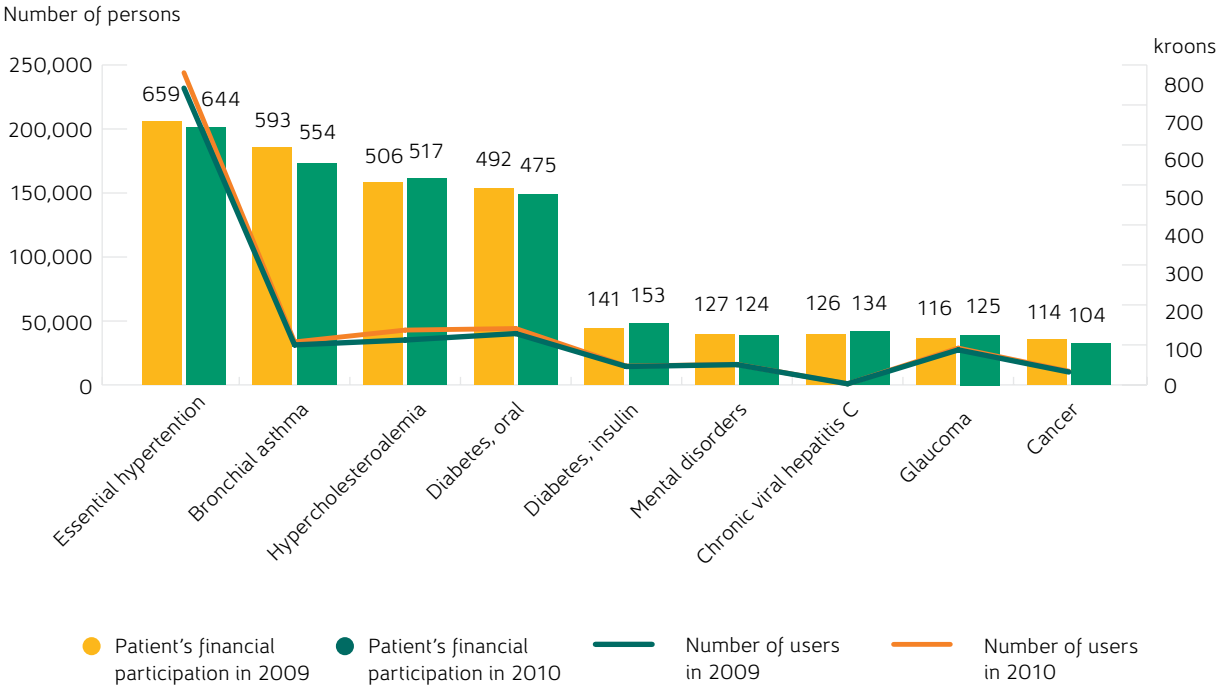
The most expensive diagnosis per person receiving medicines is currently chronic hepatitis C where annual treatment per patient costs 139,000 kroons, and the cheapest one is hypertension with 1,480 kroons paid for the treatment of a patient.

Table 35. Diagnoses with the highest expenditure on benefits for medicines (in thousand kroons)

	2009 actual		2010 budget		2010 actual	
	Reimbursed by EHIF	% of total cost of benefits for medicinal products	Reimbursed by EHIF	% of total cost of benefits for medicinal products	Reimbursed by EHIF	% of total cost of benefits for medicinal products
Hypertension	203,167	15	229,154	16	204,275	14
Total diabetes, including	205,477	15	192,665	13	205,663	14
insulin	160,016	12	157,117	11	152,763	11
orally administrated products	45,461	3	35,548	2	52,900	4
Cancer	128,619	9	126,337	9	145,733	10
Bronchial asthma	83,240	6	90,571	6	84,499	6
Glaucoma	71,565	5	68,774	5	64,644	5
Mental disorders	47,078	3	54,277	4	47,673	3
Hypercholesterolemia	57,102	4	46,698	3	50,075	4
Chronic hepatitis C	35,228	3	35,212	2	33,693	2
Total	**831,476**	**60**	**843,688**	**58**	**836,255**	**59**

Compared to 2009, the addition of new generic preparations has continued, enabling the EHIF to treat a larger number of people without a significant cost increase while decreasing the patient's financial participation through the reduced prices of medicines (e.g. the diagnosis of hypertension) (see Figure 18). The patient's financial participation ranges from 104 kroons (cancer) to 644 kroons (hypertension) per year, or 9–54 kroons per month, with respect to these diagnoses. Hypercholesterolemia is a converse example, where despite the addition of cheaper medicines people continue to prefer products that cost more than the established reference price. Hence, the EHIF's costs are under control, but the expenditure of patients buying the medicine has grown.

Figure 18. Financial participation by insured persons



A patient spent an average of 980 kroons on pharmaceuticals subject to reimbursement in 2010, an equivalent to approximately 1.9% of the annual net income of a pensioner who receives average pension or to 2.1% of the net income of a person who receives the minimum wage.

With the expected shrinking of the revenue base for health insurance and on the assumption that the availability of health services is not reduced, finding additional funds in order to make new medicines available will prove to be a challenging task. The EHIF considers it essential to systematically review the list of reimbursed pharmaceuticals in order to exclude any medicines that are no longer beneficial and for which cost-effective alternatives exist.

Overall, an analysis of the 2010 cost of the benefits for medicines shows a rise in the use of medicines: the use of pharmaceuticals subject to 100% and 90% reimbursement has witnessed a particularly noticeable rise. Although the number of persons who have purchased pharmaceuticals subject to reimbursement has fallen by 1% compared to 2009, this number still constitutes 65% of the total number of insured persons, similarly to the previous three years.

822,440

ensurable persons using discount medications

4. Expenditure on Benefits for Temporary Incapacity for Work

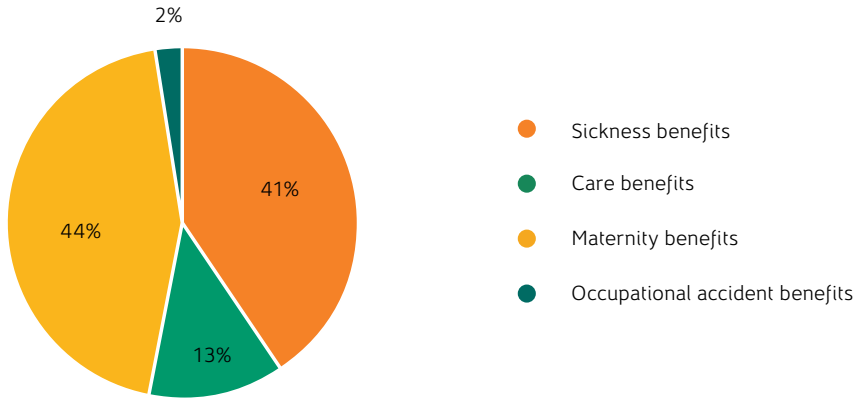
The expenses on benefits for temporary incapacity for work in 2010 amounted to 1.3 billion kroons, which is nearly one billion less than in the previous year (see Table 36).

Table 36. Expenses on benefits for temporary incapacity for work (in thousand kroons)

	2009 actual	2010 budget	2010 actual	Budget execution %	% of change from 2009
Sickness benefits	1,192,085	892,530	519,075	58	-56
Maternity benefits	661,232	528,451	565,120	107	-15
Care benefits	318,444	237,659	160,380	67	-50
Occupational accident benefits	32,343	29,315	29,627	101	-8
Total	**2,204,104**	**1,687,955**	**1,274,202**	**75**	**-42**

Figure 19 provides an overview of the distribution of expenditure on the benefits for temporary incapacity for work and Table 37 provides a comparison to the respective expenses of the previous years. Compared to 2009, the share of expenses on sickness benefits has fallen by 13%, leaving maternity benefits the largest expenditure category now. There has been no significant change in the shares of care benefits and occupational accident benefits when compared to 2009.

Figure 19. Distribution of benefits for temporary incapacity for work by types of benefits in 2010



1,274,202

thousand EEK to benefits for incapacity for work

5,453,066

days of incapacity for work compensated by the health insurance fund

Table 37. Comparison of expenses on benefits for temporary incapacity for work

	2008 actual	2009 actual	2010 actual	% of change from 2009
Sickness benefits				
Number of certificates paid for by EHIF	470,950	305,476	169,391	-45
Total number of certificates issued to insured persons*	-	339,740	246,737	-27
Number of days paid for by EHIF	6,354,414	4,708,595	3,185,903	-32
Total number of sickness days*	-	4,884,728	3,603,095	-26
Average duration of leave paid for by EHIF	13.5	15.4	18.8	22
Total average duration of leave paid for by EHIF*	-	14.4	14.6	1
Amount of benefit paid for by EHIF (thousand kroons)	1,474,551	1,192,085	519,075	-56
Average daily income (kroons)	232	253	163	-36
Maternity benefits				
Number of certificates	13,229	12,456	11,007	-12
Number of days	1,742,868	1,676,535	1,533,010	-9
Average duration of leave	131.7	134.6	139.3	3
Benefit amount (thousand kroons)	586,209	661,232	565,120	-15
Average daily income (kroons)	336	394	369	-6
Care benefits				
Number of certificates	111,299	103,883	76,141	-27
Number of days	949,676	902,775	643,276	-29
Average duration of leave	8.5	8.7	8.4	-3
Benefit amount (thousand kroons)	287,795	318,444	160,380	-50
Average daily income (kroons)	303	353	249	-29
Occupational accident benefits				
Number of certificates	6,173	4,191	4,154	-1
Number of days	135,119	91,474	90,877	-1
Average duration of leave	21.9	21.8	21.9	0
Benefit amount (thousand kroons)	38,898	32,343	29,627	-8
Average daily income (kroons)	288	354	326	-8
Total benefits				
Number of certificates paid for by EHIF	601,651	426,006	260,693	-39
Number of days paid for by EHIF	9,182,077	7,379,379	5,453,066	-26
Average duration of leave paid for by EHIF	15.3	17.3	20.9	21
Benefits paid for by EHIF (thousand kroons)	2,387,453	2,204,104	1,274,202	-42
Average daily income (kroons)	260	299	234	-22

* All certificates and leave days issued for the leave period are included (including the financial participation of insured persons, employers and the EHIF).

The EHIF also pays benefits for temporary incapacity for work if medical conditions have developed abroad based on certificates from foreign doctors. In 2010 approximately 716,000 kroons of benefits were paid based on 282 certificates. 1.7 million kroons based on 378 certificates were paid in the previous year. Similarly to 2009, the majority of the certificates were issued in Latvia (31%), Finland (21%) and the reasons for leave included: sickness (76%), occupational accident (10%), caring for a child under 12 years of age (5%), domestic injury (5%), traffic injury (2%), pregnancy and maternity leave (1%). There were no significant changes in the reasons for leave certificates abroad.

The fall in expenditure on the benefits for temporary incapacity for work was caused by:

- change in legal regulations pertaining the payment of benefits for temporary incapacity for work;
- decrease in the number of insured persons in employment;
- decrease of the income subject to social tax.

Change in the legal regulations pertaining the payment of benefits for temporary incapacity for work

Until 1 July 2009 the payment of benefit for temporary incapacity for work was covered exclusively from the EHIF budget as a solidarity health insurance. After the approval of a negative state budget in 2009, one of the biggest changes in the sphere of responsibility of the Ministry of Social Affairs was the reduction of expenditure on the benefits for temporary incapacity for work from the EHIF health insurance budget. This reduction was achieved through an increase in the financial participation of insured persons, employers' obligation to partially cover the sickness benefit costs and the procedure for reimbursement was changed as follows:

- sickness benefit will be paid from the 4th day of the illness, compared to the previous 2nd day limit;
- employers will pay the sickness benefit from the 4th to the 8th day;
- the EHIF will pay the sickness benefit from the 9th day onwards;
- the sickness benefit was reduced from 80% to 70% of the insured person's income subject to social tax in the previous calendar year;
- the benefit for caring for a child under 12 years of age was reduced from 100% to 80% of the insured person's income subject to social tax in the previous calendar year;
- the maximum duration of the maternity leave was reduced from 154 days to 140 days.

An analysis of the effect of these changes on the EHIF's expenditure on the benefits for temporary incapacity for work show that the costs were cut even more than planned: the benefit for temporary incapacity for work budget was executed by 75% in 2010. However, it is not possible to assess based on the data available to the EHIF whether the introduction of employer's financial participation has met the expectation of leading employers to consider more the health promotion needs of their employees stated in the explanatory memorandum to the amendment of the Occupational Health and Safety Act.

Decrease in the number of insured persons in employment

As a result of an increase in the number of unemployed persons[9] the number of insured persons in employment was decreased by 7% in 2010 compared to 2008 (see table 38). As a result of both the reduction of the number of insured persons in employment and the payment of benefits for incapacity for work, the number of certificates of incapacity for work decreased by 25% in 2010 and the number of certificates per insured person in employment decreased by 20%.

Table 38. Number of insured persons, use of certificates of incapacity for work

	2009 actual	2010 actual	% of change from 2009
Number of insured persons (average of the period)	1,278,911	1,264,624	-1
Number of insured persons in employment (average of the period)	613,332	570,506	-7
Share of insured persons in employment from all insured persons (%)	48	45	-6
Number of certificates of incapacity for work	464,174	346,803	-25
Number of certificates of incapacity for work per insured person	0.76	0.61	-20

Change in the income subject to social tax

In 2010, the average payment per certificate of incapacity for work was 3,064 kroons for sickness benefits, 2,106 kroons for care benefits, 51,342 for maternity benefits and 7,132 for occupational accident benefits. In addition to the duration of the incapacity for work, the amount of benefit for incapacity for work depends most directly on the amount of income subject to social tax of the insured persons. The EHIF calculates the benefit for incapacity for work from the income of the insured person based on social tax calculated or paid in the calendar year preceding to the commencement date of the leave indicated on the certificate of incapacity for work. If the insured person had no income in the previous year (the majority of these include persons returning from maternity leave or employed after long-term employment), the EHIF shall calculate the benefit based in the minimum monthly wage laid down by the Government of the Republic. Compared to 2008, the average gross salary decreased by 5% in 2009 and the average cost per certificate of incapacity for work day decreased by 22% in 2010 compared to 2009.

[9] According to Statistics Estonia, the number of unemployed persons increased by 26% when comparing three quarters between 2009 and 2010.

Sickness benefits

Based on the certificates for sick leave, the reasons for leave are distributed as follows: illness 84%, domestic injury 12%, transfer to an easier job 3%, other causes (quarantine, occupational disease, etc.) 1%. Compared to 2009 the share of illness has decreased by 3%. However, the share of domestic injuries has increased by 2% and the share of certificates for sick leave due to transfer to an easier job increased by 1%. An analysis of certificates for sick leaves by treatment types shows that in 2010, 87% of certificates for sick leave were issued after out-patient care and 12% after in-patient care. 1% of all certificates for sick leave were issued after out-patient or in-patient medical rehabilitation. There were no significant changes with respect to the types of treatment compared to 2009.

The number of sick leave days reimbursed by the EHIF decreased by 32% and the number of certificates for sick leave by 45% in 2010. Sick leave days not reimbursed by the EHIF (days 1–3 of the patient's financial contribution or days 4–8 reimbursed by employers) made up only 31% of the total amount of the certificates for sick leave in 2010. Sick leave days that were not subject to patient's financial contribution constituted 1% of the total sick leave days and the number of sick leave days solely reimbursed by employers (days 4–8) constituted 11% of the total sick leave days. In terms of the overall period of sick leave, not just the sick leave days reimbursed by the EHIF, the average duration of a certificate for sick leave was approximately 15 days, a growth by 1.1 days in the period between 2008 and 2010.

Table 39. Number of certificates for sick leave and sick leave days

	Number of certificates			Number of days			
	Certificates issued for days 1–8 (financial contribution by insured persons and employers)	Certificates subject to reimbursement by EHIF	Total	1–3 days (insured person's financial contribution)	4–8 days (employer's financial contribution)	Days subject to reimbursement by EHIF	Total
2010	77,346	169,391	**246,737**	37,208	379,984	3,185,903	**3,603,095**
2009	34,264	305,476	**339,740**	17,544	158,589	4,708,595	**4,884,728**

Care benefits

The number of certificates for care leave decreased by 27% and the number of care leave days reimbursed decreased by 29% in 2010. The average duration of certificates for care leave did not have a significant decrease. Certificates for caring for a child under 12 years of age constituted 98% of all certificates for care leave, certificates for caring for a child under 3 years of age or for a disabled child under 16 years of age constituted 1% and certificates for caring for a sick family member constituted 1% of all certificates for care leave. Compared to the previous periods there were no significant changes n the reasons for leave in the cases of certificates for care leave. 26% of all certificates for care leave were issued for men, which is 2% less than in 2009. Certificates issued for caring for children between the ages of 2 and 6 constituted 78% of total certificates for care leave issued for caring for children under the age of 12.

Maternity benefits

The number of days of incapacity for work under maternity benefits decreased by 9% and the number of certificates for maternity leave decreased by 12% in 2010. This decrease in the number of days has been affected by the reduction of the maximum days of maternity leave from 154 to 140 days from 1 July 2009. The average cost per day decreased by 7%. These changed reduced the EHIF's expenditure on maternity benefits by 15%. The average age of persons receiving maternity benefits was 29.6 and the share of women over 30 among the persons receiving maternity benefits was 48%, which is a 3% increase from 2009.

An average of 20 certificates for adoption leave are issued annually to the EHIF, the costs of which are recorded in the maternity benefit expenditure. Expenditure on the adoption of a child under the age of 10 constituted 0.1% of the total maternity benefit expenditure in 2010.

Occupational accident benefits

The number of leave days and certificates for sick leave due to occupational accidents in 2010 remained nearly at the 2009 level, decreasing only by 1%.

Looking at the certificates for sick leave due to occupational accidents, the reasons for leave are distributed as follows: occupational accidents 94%, complications arising from occupational accidents 3%, and traffic-related occupational injury 3%. There were no significant changes with respect to the reasons of occupational accidents compared to 2009.

5. Other Cash Benefits

5.1. Dental Care Cash Benefits

The expenditure on dental care benefits for adults in 2010 was 133.6 million kroons, which was 70.3% of the annual budget (see Table 40).

The EHIF reimburses from the dental care service expenditure to groups of insured persons as follows: 450 kroons to pregnant women; 450 kroons to persons with an increased need for dental care; 450 kroons to mothers of children under 1 year of age; and 300 kroons to insured persons over 63 years of age and to persons eligible for a pension for incapacity for work or an old-age pension.

Insured persons over 63 years of age and persons eligible for a pension for incapacity for work or an old-age pension are reimbursed up to 4000 kroons for dentures within 3 years.

The expenditure on dental care services has decreased compared to the previous year with the largest drop in denture benefit expenditure. This decrease in the denture benefit expenditure was not expected and it probably arose from the general situation where patients consider dental care too expensive.

Table 40. Dental care benefits (in thousand kroons)

	2009 actual	2010 budget	2010 actual	Budget execution %	% of change from 2009
Benefits for dentures	121,918	156,695	105,344	67	-14
Dental care benefits	31,950	33,305	28,283	85	-11
Total	**153,868**	**190,000**	**133,627**	**70**	**-13**

The decrease in the number of dental care benefit cases also exceeded the expected rate (see Table 41). The decrease in the number of applications can be explained by the EHIF and Ministry of Social Affairs survey in 2010 on the public's assessment of their health and medical care, which shows a trend of people visiting a dentist after a longer period of time and for fewer times. Compared to 2009, the number of people who say that they do not visit a dentist because of financial reasons has increased by 15% and 13% of all respondents are disturbed by the high price of medical services.[10]

Table 41. Dental care benefits

	2009 actual	2010 budget	2010 actual	Budget execution %	% of change from 2009
Benefits for dentures	47,073	60,500	40,674	67	-14
Dental care benefits	107,653	105,456	91,366	87	-15
Total	**154,726**	**165,956**	**132,040**	**80**	**-15**

An analysis of the applicants of dental care service benefits by application type shows that the majority of persons applying for the 300 and 450 kroon benefits were persons over 63 years of age and persons eligible for a pension for incapacity for work or an old-age pension, making up 86% of the total number of applicants. Both pregnant women and mothers of children under 1 year of age equally made up 7% of the total number of applicants. Applicants over 19 years of age who were reimbursed for services provided before 2009 made up a marginal share of 1% and the number of persons with an increased need for dental care made up even a smaller share, 0.1%.

[10] See http://www.haigekassa.ee/uploads/userfiles/Hinnangud_arstiabile_2010.pdf

5.2. Supplementary Benefit for Medicinal Products

Supplementary benefit for medicinal products is a financial benefit granted to insured persons whose expenditure on medicinal products in the EHIF's list of medicinal products exceed 6,000 kroons in a calendar year.

In 2010 both the number of insured persons and the expenditure amount on benefits was smaller than planned and to the execution of the 2009 budget (see Table 42). The reason for this may lie in the raised awareness of insured persons when purchasing medicinal products in pharmacies: people are more likely to ask for and prefer cheaper products.

Table 42. Supplementary Benefit for Medicinal Products

	2009 actual	2010 budget	2010 actual	Budget execution %	% of change from 2009
Benefit amount (thousand kroons)	6,754	10,144	6,632	65	-2
Number of persons receiving the benefit	1,830	2,428	1,774	73	-3
Average amount paid per person (kroons)	3,691	-	3,738	-	1

6. Other Expenses on Health Insurance Benefits

6.1. Benefits Paid on the Basis of EU Legislation and Referral to Planned Treatment in a Foreign Country

6.1.1. Referral to Treatment in a Foreign Country

Referral of patients to planned treatment in a foreign country is subject to the provisions of the Health Insurance Act, EU regulations pertaining the free movement of insured persons within the European Union, and the agreement between the EHIF and the Finnish Red Cross for finding unrelated bone marrow donors.

An insured person is referred to planned treatment in a foreign country if the health service in question and any alternatives to that service are not provided in Estonia, provision of the health service is indicated for the insured person, the medical effectiveness of the health service is confirmed by evidence, and the average probability of achieving the desired outcome is at least 50%.

Compared to 2009 the number of invoices received for the treatment or examination of persons in a foreign country increased by 25 invoices in 2010. A total of 129 invoices were received in 2010, 34 of which concerned the treatment of insured persons, 59 of which the examination of insured persons and 36 of which the expenses for finding bone marrow donors (see Tables 43 and 44).

Table 43. Planned treatment abroad (in thousand kroons)

	2007 actual	2008 actual	2009 actual	2010 budget	2010 actual	Budget execution %	% of change from 2009
Planned treatment abroad	8,740	23,122	20,686	21,000	15,198	72	-27

Table 44. Number of cases of planned treatment and average cost of a treated case (kroons)

	2009 actual		2010 actual		% of change from 2009	
	TC	ACTC	TC	ACTC	TC	ACTC
Planned treatment abroad	104	198,904	129	117,814	24	-41

From 2006 the largest number of patients referred to foreign countries has been for health services concerning cardiac surgery, followed by oral and maxillofacial surgery and oncological surgery. Insured persons of Estonia have been referred to planned treatment or examination into 20 countries, mostly to Finland, the Netherlands, Germany, Belgium and Sweden.

6.1.2. Expenses on Health Services on the Basis of Regulations of the Council of the European Union

The EHIF reimburses benefits for health services arising from the EU regulations coordinating social security systems.

Persons insured with the EHIF, while staying in another Member State, have the right to:

- the necessary health care when their stay in another Member State is temporary;
- any type of health care when they reside in another Member State.

The costs of this health care are covered by the EHIF.

Persons insured in other EU Member States, while staying in Estonia, have the right to:

- the necessary health care when their stay here is temporary;
- any type of health care when they reside in Estonia.

129

persons directed abroad for planned care

The health care costs related to persons insured in other EU Member States are first reimbursed to health care providers by the EHIF, which then submits the invoices for payment to the competent authorities of the other EU Member States. Thus the final body covering the health care costs of insured persons in an EU Member State will be the insuring country.

Compared to 2009 the benefits paid to other Member States by the EHIF for health services and subsidised pharmaceuticals received in another Member States by persons insured with the EHIF decreased by 13% in 2010 (see Table 45). At the same time, the benefit for health services and subsidised pharmaceuticals provided in Estonia to persons from other Member States increased by 18%. (These costs are initially paid by the EHIF to the providers of health care services and pharmacies and are then referred to the respective Member State for reimbursement). These reimbursements are recorded in the overview of received income section of the annual report.

Table 45. Expenses on health services on the basis of the Regulations of the Council of the EU (in thousand kroons)

	2007 actual	2008 actual	2009 actual	2010 budget	2010 actual	Budget execution %	% of change from 2009
Payments for health services provided in other Member States to persons insured with the EHIF	25,259	22,119	37,093	36,038	32,228	89	-13
Payments for health services provided in Estonia to persons insured in other Member States	8,941	10,351	10,312	11,343	12,196	108	18
Total	**34,200**	**32,470**	**47,405**	**47,381**	**44,424**	**94**	**-6**

The treatment costs of pensioners of other EU Member States who reside in Estonia and of the family members of persons employed in another EU Member State and residing in Estonia are reimbursed by the insuring country on the basis of the average cost of treatment. The implementing regulation of the EC specifies the rules for calculating the average cost of treatment (the average cost of treatment does not include the cost of benefits for incapacity for work). Estonia calculates the average cost of treatment for two age groups: 0–62 and from 63 years of age (see Tables 46 and 47). As changes in regulations enable the submission of actual costs for each group of insured persons, the average cost of treatment is not calculated in Estonia from 2010.

Table 46. Average cost of treatment in the age group 0–62, 2004–2009

	2004 actual	2005 actual	2006 actual	2007 actual	2008 actual	2009 actual
Cost of health services of the age group (in thousand kroons)	3,233,647	3,638,577	4,121,144	5,313,659	6,351,075	6,135,092
Number of insured persons (0–62)	1,012,604	1,010,444	1,022,413	1,030,389	1,024,249	1,016,394
Average cost per person per year (kroons)	3,193	3,601	4,031	5,157	6,201	6,036
Average cost per person per year (kroons)*	213	240	269	344	413	402
Change from previous year (%)	-	13	12	28	20	-3

*reduced by 20% according to the requirement of the implementing regulation 574/72

Table 47. Average cost of treatment in the age group 63+, 2004–2009

	2004 actual	2005 actual	2006 actual	2007 actual	2008 actual	2009 actual
Cost of health services of the age group (in thousand kroons)	1,991,151	2,280,408	2,555,575,	3,271,392	3,854,332,	3,984,139
Number of insured persons (63+)	258,954	260,910	255,603	257,376	257,469	259,972
Average cost per person per year (kroons)	7,689	8,740	9,998	12,711	14,970	15,325
Average cost per person per year (kroons)*	513	583	667	847	998	1,022
Change from previous year (%)	-	14	14	27	18	2

* reduced by 20% according to the requirement of the implementing regulation 574/72

6.2. Benefits for Medical Devices

The benefit for medical devices is an open commitment for the EHIF like the reimbursement of the cost of pharmaceuticals to insured persons. 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.

Table 48. Benefits for medical devices (in thousand kroons)

	2009 actual	2010 budget	2010 actual	Budget execution %	% of change from 2009
Glucometer test strips	33,053	42,000	37,088	88	12
Primary prostheses and orthoses	14,861	17,600	17,507	99	18
Stoma appliances	11,908	13,000	13,192	101	11
Insulin pumps	1,720	2,000	2,166	108	26
Other medical devices	600	800	561	70	-7
Total	**62,142**	**75,400**	**70,514**	**94**	**13**

Table 49. Treatment cases of benefits for medical devices

	2009 actual		2010 actual		% of change from 2009	
	TC	ACTC	TC	ACTC	TC	ACTC
Glucometer test strips	22,982	1,438	26,711	1,388	16	-3
Primary prostheses and orthoses	7,669	1,938	8,937	1,959	17	1
Stoma appliances	1,521	7,829	1,551	8,505	2	9
Insulin pumps	66	26,061	91	23,802	38	-9
Other medical devices	215	2,791	220	2,550	2	-9
Total	**32,453**	**1,915**	**37,510**	**1,880**	**16**	**-2**

Compared to 2009 the use of medical devices has increased (except for other medical devices). However, the actual use of medical devices planned for 2010 remained lower than expected (see Tables 48 and 49).

The lowest rate of budget execution was witnessed in the **other medical devices** section: intermediate containers for administration of asthma medication, disposable urinary catheters, pressure garments for burn patients and therapeutic contact lenses. The actual need for pressure garments for burn patients and disposable urinary catheters was half of the planned amount.

Nearly 2/3 of the users of medical devices are diabetics who use glucometric test strips necessary for self-testing and insulin pump treatment. The use of **glucometric test strips** was smaller than planned. As the number of diabetics treated with pills, who purchase less test strips than those one insulin injection treatment, increases the amount of benefit per person has decreased. Although according to the estimation of endocrinologists there are nearly 70,000 diabetics in Estonia, only about half of them used the possibility of self-testing. The reason for the low usage rate may lie in the low awareness of the necessity of self-testing among persons with type 2 diabetes. The number of users of insulin pumps and insulin pump accessories reimbursed to persons under the age of 19 increased by nearly 1/3 compared to the planned amount. More children exchanged injection treatment for insulin pump treatment because technically more advanced insulin pumps and insulin pump accessories were added to the list of medical devices from 1 July. The average cost of benefit per user was decreased as the reference price of the new devices is lower.

The planned expenses for the year were also slightly smaller in the **primary prostheses and orthoses** section. The amount of prostheses used after amputation purchased decreased. The number of persons receiving post-traumatic and post-operative orthoses has increased on an annual basis. The increase in the number of orthoses benefits is a result of higher awareness of the available options among the insured persons and improving the availability of orthoses in different regions.

More **stoma appliances** were purchased than planned. Maximum unit limits have been laid down for stoma appliances, as for other medical devices. The usage of stoma appliances has increased on an annual basis, but it has not reached the maximum amount yet. The needs of stoma patients can vary to a great degree but the needs of more socially active insured persons (those who study or work) were considered when laying down the maximum limits as they use these appliances more than average users.

6.3. Expenses Covered from Targeted Financing from the State Budget

Infertility treatment is funded from the state budget through targeted financing. A total of 17.8 million kroons were paid for infertility treatment during the reporting period.

6.4. Expenses from the Risk Reserve

The Supervisory Board Decision No. 2 of 15.01.2010 prescribed the use of up to 27.9 million kroons from the risk reserve for covering the costs related to vaccination of the pandemic influenza A/H1N1.

The Ministry of Social Affairs was paid 14.5 million kroons for the vaccine and physicians were paid a total of 1.9 million kroons for vaccination.

EHIF Operating Expenses

Table 50. EHIF operating expenses (in thousand kroons)

	2009 actual	2010 budget	2010 actual	Budget execution %	% of change from 2009
Total personnel and management expenses	69,970	70,961	67,955	96	-3
Wages and salaries	52,215	52,821	50,614	96	-3
including remuneration of the members of the Management Board	2,193	2,156	2,082	97	-5
remuneration of the members of the Supervisory Board	3	3	3	100	0
Unemployment insurance premium	533	709	677	95	27
Social tax	17,222	17,431	16,664	96	-3
Administrative expenses	20,314	16,816	16,465	98	-19
Information technology expenses	9,995	12,502	10,229	82	2
Development costs	2,525	2,682	1,992	74	-21
incl. training	1,151	1,301	997	77	-13
consultations	1,374	1,381	995	72	-28
Financial expenses	322	1,100	1,427	130	343
Other operating expenses	3,927	9,725	9,726	100	148
incl. supervision of the health insurance system	1,436	1,457	1,444	99	1
public relations/communication	1,167	1,077	753	70	-35
other expenses	1,324	7,191	7,529	105	469
Total EHIF operating expenditure	**107,053**	**113,786**	**107,794**	**95**	**1**

The operating expenditure budget was used as planned (see Table 50). The budget was exceeded only in the section of financial expenses because the increase of the reserve administration was agreed after the approval of the annual budget.

Compared to the previous year IT expenses, financial expenses and other operating expenses were increased.

- IT expenses increased because the EHIF information systems have to be very reliable and have top quality.
- Financial expenses increased as a result of the increased expenses on reserve administration (futher information on the investments related to the legal reserve and risk reserve can be found in the section "Financial income", page 35).
- Other expenses increased as a result of changes in the principles of recording the VAT expenditure. From 2010, VAT expenditure is recorded as a separate expenditure (previously it was recorded with the corresponding budget expenses or in the cost of non-current assets). In order to improve the comparability of the expenditures of the EHIF and other institutions/organisations the EHIF's financial calculation principles were changed and the VAT is now recorded under other expenses. These changes have resulted in larger other expenses and lower administrative and development costs.

Legal Reserve

The legal reserve is a reserve formed, pursuant to the Estonian Health Insurance Fund Act, of the budget funds of the EHIF with the objective of reducing the risks arising from potential macroeconomic changes to the health insurance system. The legal reserve constitutes 6% of the budget.

As of 31 December 2010, the legal reserve of the EHIF amounted to 800.3 million kroons. The amount of the mandatory legal reserve in 2011 is 698 million kroons.

Risk Reserve

The risk reserve of the EHIF is a reserve formed of the budget funds of the EHIF for the reduction of risks arising from the obligations assumed for the health insurance system. The risk reserve constitutes 2% of the health insurance budget of the EHIF and its use is subject to a decision of the Supervisory Board of the EHIF.

27,922,000 kroons were used from the risk reserve based on the Supervisory Board's decision for covering the costs related to vaccination for the pandemic influenza A/H1N1 in 2010.

The amount of the mandatory legal reserve in 2011 is 230.4 million kroons. In order to comply with this legal requirement, an additional 50.3 million kroons were transferred to the risk reserve in 2010.

As of the end of the financial year, the risk reserve of the EHIF included 230.4 million kroons.

Retained Earnings

As of 31 December 2010, the Health Insurance Fund had 2.4 billion kroons in retained earnings.

ANNUAL FINANCIAL STATEMENTS 2010

Declaration of the Management Board

The Management Board declares its responsibility for the accuracy of the Estonian Health Insurance Fund's annual financial statements set out on pages 71 to 86 and confirms, to the best of its knowledge, that:

- the accounting principles used in preparing the annual financial statements correspond with the generally accepted accounting principles;
- the annual financial statements present a true and fair view of the financial position, the results of operations and the cash flows of the Estonian Insurance Fund;
- all relevant circumstances, which have occurred before the completion of the report on 30 March 2011, have been duly recognised and presented in the annual financial statements;
- The Estonian Health Insurance Fund is continuously operating.

	Date	Signature
Hannes Danilov Chairman of Management Board	30.03.2011	
Mari Mathiesen Member of Management Board	30.03.2011	
Kersti Reinsalu Member of Management Board	30.03.2011	

Balance Sheet

Assets			
In thousand kroons	31.12.2010	31.12.2009	Note
Current assets			
Cash and cash equivalents	1,071,205	1,337,960	2
Bonds and other securities	1,586,073	1,424,337	3
Receivables and prepayments	1,150,907	1,137,392	4
Inventories	80	88	5
Total current assets	3,808,265	3,899,777	
Non-current assets			
Long-term financial investments	332,011	371,859	6
Property, plant and equipment	14,637	9,153	7
Intangible assets	581	1,422	7
Total non-current assets	347,229	382,434	
Total assets	**4,155,494**	**4,282,211**	

Liabilities and equity			
Liabilities			
Current liabilities			
Loans and prepayments	718,501	754,049	9
Total current liabilities	718,501	754,049	
Total liabilities	718,501	754,049	
Net assets			
Reserves	1,030,686	1,008,282	
Surplus of the previous periods	2,497,475	3,156,326	
Surplus for the financial year	-91,168	-636,446	
Total net assets	3,436,993	3,528,162	
Total liabilities and equity	**4,155,494**	**4,282,211**	

Statement of Financial Performance

In thousand kroons	2010	2009	Note
Revenue from the health insurance part of social tax and claims collected from other persons	10,742,774	11,248,417	10
Income from government grants	18,466	18,350	14
Expenses related to government grants	-32,272	-18,330	14
Expenditure on health insurance	-10,816,704	-11,940,927	11
Gross surplus	**-87,736**	**-692,490**	
Administrative expenditure	-96,641	-102,804	12
Other operational revenue	66,094	57,966	
Other operating expenditure	-9,726	-3,927	
Operating surplus	**-128,009**	**-741,255**	
Financial income and expenses			
Interest and financial income	38,268	105,131	
Financial expenses	-1,427	-322	
Total financial income and expenses	36,841	104,809	
Net surplus for the period	**-91,168**	**-636,446**	

Cash Flow Statement

In thousand kroons	2010	2009
Cash flows from operating activities		
Social tax received	10,722,824	11,643,871
Payments to suppliers	-10,905,763	-12,108,926
Personnel expenses paid	-56,082	-53,452
Payroll expenses paid	-20,392	-18,145
Other revenue received	105,189	156,217
Net cash flows from operating activities	**-154,224**	**-380,435**
Cash flows from investing activities		
Purchase of fixed assets	-9,887	-1,629
Proceeds from disposal of financial assets	2,185,267	3,705,496
Purchase of financial assets	-2,287,911	-2,975,553
Net cash flows from investing activities	**-112,531**	**728,314**
Net increase/decrease in cash and cash equivalents	**-266,755**	**347,879**
Cash and cash equivalents at the beginning of the period	1,337,960	990,081
Change in cash and cash equivalents	-266,755	347,879
Cash and cash equivalents at the end of the period	1,071,205	1,337,960
including short-term deposits	959,096	1,235,233

Statement of Changes in Net Assets

In thousand kroons	2010	2009
Reserves		
Reserves at the beginning of the year	**1,008,282**	**1,067,055**
Increase in reserves	50,326	0
Decrease in reserves	-27,922	-58,773
Reserves at the end of the year	**1,030,686**	**1,008,282**
Surplus of the previous periods		
At the beginning of the year	**2,519,879**	**3,097,553**
Decrease in reserves	27,922	58,773
Increase in reserves	-50,326	0
Surplus for the financial year	-91,168	-636,446
At the end of the year	**2,406,307**	**2,519,880**
Net assets at the beginning of the year	**3,528,162**	**4,164,608**
Net assets at the end of the year	**3,436,993**	**3,528,162**

Notes to the Annual Financial Statements

Note 1. Calculation principles used for preparing the annual financial statements

General principles

The EHIF annual financial statements for 2009 have been prepared in accordance with the generally accepted accounting principles in Estonia. The generally accepted accounting principles of Estonia are internationally accepted accounting and reporting principles, the main requirements of which have been stipulated in the Accounting Act of the Republic of Estonia, and supplemented by the guidelines issued by the Accounting Board of the Republic of Estonia. The general rules for state accounting have also been taken into account when preparing these annual financial statements.

The financial year began on 1 January 2010 and ended on 31 December 2010. The annual financial statements are shown in thousands of Estonian kroons.

Financial statement formats

For the purpose of the revenue and expenditure account, layout no 2 of the profit and loss account set out in the Accounting Act is used, whereas the structure of the entries thereof is adjusted pursuant to the specific feature of the activities of the EHIF.

Financial assets and liabilities

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

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

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

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

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

Cash and cash equivalents

Cash and cash equivalents are cash in the bank, deposits at call and short-term bank deposits (with the redemption term of less than 3 months) which do not have an essential risk of changes in the market value. Cash flow statement is prepared using the direct method.

Recording of foreign currency transactions

Transactions denominated in foreign currency are recorded on the basis of the foreign currency exchange rates of the Bank of Estonia officially valid on the transaction date. Monetary and non-monetary financial assets and liabilities denominated in foreign currencies that are recorded at fair value are retranslated into the Estonian kroons at the exchange rate quoted by the Bank of Estonia ruling at the balance sheet date. Gains and losses from foreign currency transactions are recorded in the income statement as income and expense for the period.

Financial investment accounts

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

Long-term financial investments are securities which are most probably not resold during the financial year and securities with a fixed redemption date which is later than year after the balance sheet date.

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

Profits and losses arising from the changes in value are recorded in the statement of financial performance on the financial year. Securities the fair value of which can not be reliably assessed are recorded in the balance sheet in their acquisition cost less any possible write-downs.

Receivables accounts

Trade receivables contain receivables for goods sold and services provided and claims for payment regarding health insurance benefit the due date of which will be in the next accounting year. Receivables with a due date longer than one year, including postponed tax claims against the Tax and Customs Board, are recorded as long-term receivables.

Receivables for goods sold and services provided contain receivables for prescription forms sold to medical institutions and family physicians, claims to the Ministry of Social Affairs for the service of processing invoices for medical treatment and claims to be submitted to competent authorities of EU Member States for health services provided.

The probability of collecting receivables is assessed once a year at the balance sheet date. Receivables and loans are assessed individually and reflected on the balance sheet on a conservative basis in view of the amounts collectible. Doubtful receivables are recorded under expenses. Previous receivables put to expenses but have been accrued in the reporting period are reflected as a reduction of the uncollectible claims.

Receivables and loans which do not justify any recovery measures for a practical or economic reason are deemed irrecoverable and are written off.

Inventories

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

Property, plant and equipment

Property, plant and equipment are assets having an expected useful life of more than one year and an acquisition cost of more than 30,000 kroons. Assets that have a shorter expected useful life and a smaller acquisition cost are put to expenses at the time of acquisition. Pursuant to amendments to the general rules for state accounting entered into force on 21.10.2010, the EHIF has written off all tangible and intangible assets that were acquired before 01.05.2005 and the acquisition cost of which was less than 30,000 kroons from the balance sheet of 2010. The residual value of these assets is recorded as depreciation costs.

Tangible assets are recognised at their acquisition cost and depreciated on a straight-line basis in accordance with their expected useful life. Land is not subject to depreciation.

The following depreciation time limits periods (in years) are applied:

- buildings 10-20
- inventories 2-4
- machinery and equipment 3-5

Intangible fixed assets

Intangible assets are identifiable non-monetary assets that have no physical substance, have an expected useful life of more than one year, are used for own activities and have an acquisition cost of more than 30,000 kroons.

Intangible assets are recognised at their acquisition cost and depreciated on a straight-line basis during 2 to 5 years.

Expenditure on tangible and intangible assets incurred after acquisition are, as a rule, put to expenses for the period. Additional expenditure are added to the cost of intangible assets, if it is likely that this expenditure allows the asset to generate more economic benefits in the future than expected and if this expenditure can be reliably assessed and related to the asset.

Government grants

Government grants are the grants which are targeted, given or received on certain conditions and in the case of which the provider of the targeted financing will check the targeted use of the grant. Government grants are not shown as revenue or expenditure before there is sufficient evidence that the grant recipient meets the requirements set for government grants and the government grants are actually paid.

Government grants are recorded based on the gross price method. Government grants are recorded as income in the periods when expenses for the compensation of which the government grants were meant incurred.

Revenue and expenditure accounts

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

From 2010, VAT expenditure is recorded as a separate expenditure (previously it was recorded with the corresponding budget expenses or in the cost of non-current assets).

Operating and financial lease accounts

A lease is deemed to be financial lease, if all the main risks and benefits related to the ownership of the assets are transferred to the lessee. In the opposite case the lease is deemed to be an operating lease. When classifying leases into operating and financial leases, public sector units also regard cases described in paragraph 15 of IPSAS 13 (Leases) standard where leased assets cannot be easily replaced by another asset as financial lease.

The property leased by way of financial lease is recognised on the balance sheet as assets and liabilities, according to the just value of the leased property. The lease payments are divided into finance costs and downward adjustment of liabilities. Finance costs are recognised during the lease period.

Operating lease payments are recognised as expenses during the lease period, using the linear method.

Provisions and Contingent Liabilities

The EHIF shall set up provisions for the liabilities which have uncertain timing or amount. Setting up provisions or the timing of provisions is based on the opinion of management or other experts.

A provision shall be recognised in the balance sheet if the EHIF has a liability arisen as a result of legal or functional activity, the probability of provisions settlement is greater than 50% and amount of provision can be prescribed with sufficient reliability.

Risk Reserve

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

- The risk reserve of the EHIF is a reserve formed of the budget funds of the EHIF for the reduction of risks arising from the obligations assumed for the health insurance system.
- The legal reserve constitutes 2% of the EHIF health insurance budget.
- The risk reserve's use is subject to a decision of the Supervisory Board of the EHIF.

The EHIF has the obligation to establish a risk reserve as of 1 October 2002 with regard to the entry into force of the new Health Insurance Act. The said Act amended the Estonian Health Insurance Act by adding § 39¹ to it.

Provisions are formed into the risk reserve based on a decision of the Supervisory Board after the approval of the audited annual report.

Legal Reserve

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

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

Provisions are formed into the legal reserve based on a decision of the Supervisory Board after the approval of the audited annual report.

Events following the balance sheet date

The Annual financial statements include significant circumstances affecting the assessment of assets and liabilities, which were identified between the date of 31 December 2010, the date of the balance sheet, and the date when the report was prepared, but are related to the transactions carried out in the accounting period or previous periods.

Events following the balance sheet date that were not taken into account in the assessment of assets and liabilities but significantly affect the result of the next financial year, are published in the notes to Annual financial statements.

Note 2. Cash and cash equivalents

In thousand kroons	31.12.2010	31.12.2009
Deposits at call	25,914	7,982
Fixed term deposits	1,045,291	1,329,978
Total cash and cash equivalents	**1,071,205**	**1,337,960**
Fixed term deposits:		
Due within 1 month	556,401	887,622
Due within 1 to 3 months	488,890	442,356
Total	**1,045,291**	**1,329,978**
Interest income cash and cash equivalents	16,092	54,820

Note 3. Bonds and other securities

	Risk reserve and investment of surplus		Legal Reserve	
In thousand kroons	**31.12.2010**	**31.12.2009**	**31.12.2010**	**31.12.2009**
Volume of fund at cost	1,153,004	1,049,406	427,640	370,136
Volume of fund at market value	1,156,510	1,050,231	429,563	374,106

Bonds of 2010

In thousand kroon						
Bond	**Date of acquisition**	**Maturity date**	**Underlying currency**	**Acquisition cost**	**Fair value**	**Rate of return %**
The Government of France	14.01.2010	13.01.2011	EUR	23,301	23,468	0.72
The Government of Italy	30.11.2010	14.01.2011	EUR	46,888	46,934	0.88
The Government of Italy	15.01.2010	14.01.2011	EUR	96,231	96,996	0.80
The Government of Belgium	18.02.2010	17.02.2011	EUR	46,649	46,915	0.61
The Government of Ireland	12.07.2010	14.03.2011	EUR	61,989	62,380	1.90
The Government of Italy	16.07.2010	15.03.2011	EUR	125,820	126,484	1.08
The Government of Belgium	24.11.2010	14.04.2011	EUR	162,828	163,073	0.82
Lloyds TSB Bank	15.09.2010	15.06.2011	EUR	77,513	77,795	1.23
Land Nordrhein-Westfalen	15.09.2010	04.07.2011	EUR	56,636	57,344	0.93
Bank Nederlandse Gemeenten	20.09.2010	04.07.2011	EUR	113,305	114,653	0.82
The Government of Spain	11.05.2010	30.07.2011	EUR	48,727	48,698	2.18
The Government of Spain	04.05.2010	30.04.2012	EUR	47,747	47,527	1.86
General Electric	10.05.2004	04.05.2011	EUR	15,603	15,676	1.17
BNP Bank	14.10.2010	14.10.2011	EUR	78,233	78,447	1.08
Rabobank	08.10.2010	08.10.2012	EUR	18,768	18,825	1.14
Svenska Handelsbanken	29.01.2010	14.01.2013	EUR	78,147	78,591	1.38
Nordea Bank AB	17.06.2010	17.06.2013	EUR	31,246	31,521	1.73
Barclays Bank	23.11.2005	23.11.2015	EUR	7,796	7,520	1.57
General Electric	17.01.2007	17.05.2021	EUR	15,577	13,663	1.27
Bank Nederlandse Gemeenten	27.01.2009	27.01.2011	EUR	13,268	13,657	2.87
Danske Bank A/S Estonia Branch	30.04.2008	28.01.2011	EEK	19,978	21,345	6.88
The Government of Spain	19.02.2010	18.02.2011	EUR	77,556	78,100	0.86
The Government of Finland	25.01.2008	23.02.2011	EUR	15,417	15,294	3.48
The Government of Belgium	09.02.2009	28.03.2011	EUR	19,539	19,641	2.15

The Government of France	13.08.2008	25.04.2011	EUR	15,735	15,799	4.15
The Government of Italy	30.06.2010	15.06.2011	EUR	81,947	82,331	1.23
The Government of Spain	15.07.2010	17.06.2011	EUR	19,971	20,108	1.98
Berger	20.09.2010	04.07.2011	EUR	36,103	36,338	0.88
Lander	20.09.2010	07.09.2011	EUR	51,100	51,308	0.92
The Government of Belgium	13.08.2009	28.09.2011	EUR	61,402	59,889	1.79
NRW Bank	16.11.2009	16.11.2011	EUR	15,624	15,753	1.70
Total				**1, 580, 644**	**1, 586, 073**	

Short-term investments are bonds maturing in 2011 and bonds acquired for the purpose of contributing to the risk reserve which, in the opinion of the EHIF, shall probably be redeemed in 2011. The revenue and expenditure of the revaluation are reflected in the statement of financial performance as financial income.

Bonds of 2009

In thousand kroons						
Bond	**Date of acquisition**	**Maturity date**	**Underlying currency**	**Acquisition cost**	**Fair value**	**Rate of return %**
The Government of France	16.01.2009	12.01.2010	EUR	22,231	22,556	1.47
The Government of the Netherlands	12.01.2009	15.01.2010	EUR	63,374	64,435	1.73
The Government of Austria	15.01.2009	15.01.2010	EUR	34,156	34,642	1.49
The Government of Germany	15.07.2009	27.01.2010	EUR	81,147	81,353	0.49
The Government of France	13.08.2009	28.01.2010	EUR	46,831	46,929	0.50
The Government of Italy	31.07.2009	29.01.2010	EUR	62,397	62,575	0.60
The Government of Italy	30.11.2009	31.05.2010	EUR	46,779	46,833	0.68
The Government of the Netherlands	04.11.2009	31.05.2010	EUR	62,370	62,482	0.60
The Government of France	17.09.2009	03.06.2010	EUR	62,349	62,469	0.53
The Government of Germany	12.02.2009	11.06.2010	EUR	49,066	49,044	1.28
The Government of Finland	30.01.2009	15.09.2010	EUR	47,663	47,985	1.78
The Government of Finland	15.07.2009	15.09.2010	EUR	31,978	31,990	0.86
Swedish Export Credit Bank	29.10.2009	20.09.2010	EUR	112,693	113,382	1.37
The Government of France	15.10.2009	23.09.2010	EUR	66,020	66,189	0.76
The Government of the Netherlands	18.11.2009	30.09.2010	EUR	108,857	108,993	0.70
The Government of Belgium	15.10.2009	14.10.2010	EUR	65,961	66,132	0.81
The Government of France	17.12.2009	16.12.2010	EUR	46,558	46,583	0.81
General Electric	10.05.2004	04.05.2011	EUR	15,603	15,539	0.85
Barclays Bank	23.11.2005	23.11.2015	EUR	7,796	7,000	2.92
General Electric	17.01.2007	17.05.2021	EUR	15,577	13,120	4.14
The Government of Italy	27.02.2009	15.02.2010	EUR	20,797	21,036	1.22
The Government of France	10.09.2009	25.02.2010	EUR	27,331	27,368	0.39
The Government of Germany	12.03.2009	12.03.2010	EUR	20,746	20,932	0.99
The Government of Germany	12.11.2008	09.04.2010	EUR	15,828	16,134	2.39
The Government of Italy	02.07.2009	14.05.2010	EUR	7,295	7,339	0.92
Swedish Export Credit Bank	18.01.2008	07.06.2010	EUR	20,528	21,161	4.08
Land Nordrhein-Westfalen	25.06.2007	30.06.2010	EUR	15,050	16,088	4.63
The Government of France	30.07.2009	12.07.2010	EUR	79,550	79,981	0.71
The Government of the Netherlands	08.09.2008	15.07.2010	EUR	16,021	16,452	4.12
The Government of the Netherlands	30.07.2009	15.07.2010	EUR	65,400	65,809	0.78
The Government of Finland	16.12.2008	15.09.2010	EUR	15,751	15,995	2.35
The Government of Germany	30.06.2009	10.12.2010	EUR	27,041	26,992	1.08
The Government of France	17.12.2009	16.12.2010	EUR	38,798	38,819	0.81
Total				**1,419,542**	**1,424,337**	

Note 4. Receivables and prepayments

In thousand kroons	31.12.2010	31.12.2009
Accounts receivable	15,943	12,046
Claims for government grants *	625	851
Claims for reimbursement of maintenance costs	63	66
Contractual claims against insured persons	255	275
Allowance for doubtful receivables	-24	-6
Interest receivables	677	4,443
Social tax receivable	1,132,669	1,118,434
Prepaid expenses	699	1,283
Total	**1,150,907**	**1,137,392**

* Claim to the Ministry of Social Affairs for the financing of external in vitro fertilisation.

Social tax receivable in the amount of 1,133 million kroons comprises a short-term claim to the Tax and Customs Board for the health insurance part of social tax.

Note 5. Inventories

As of 31.12.2010, the EHIF has unused prescription forms worth 80 thousand kroons (as of 31.12.2098, 88 thousand kroons). Inventories belonging to the EHIF are deposited into storage with liability with other persons with the balance sheet value of 19 thousand kroons (as of 31.12.2009, 45 thousand kroons).

Note 6. Long-term financial investments

6.1. The EHIF has acquired shares with the following nominal value

Shares of AS Viimsi Haigla (at cost)

In thousand kroons	31.12.2010	31.12.2009
Balance at the beginning of the year	90	90
Balance at the end of the year	90	90

The EHIF owns 900 shares of AS Viimsi Haigla, 10.2% of share capital.

6.2. The EHIF has acquired long maturity bonds as follows

Legal Reserve	
In thousand kroons	**31.12.2010**	**31.12.2009**
Volume of fund at cost	317,777	347,451
Volume of fund at market value	322,229	356,701

Bonds of 2010

In thousand kroons						
Bond	**Date of acquisition**	**Maturity date**	**Underlying currency**	**Acquisition cost**	**Fair value**	**Rate of return %**
The Government of the Netherlands	30.06.2009	15.01.2012	EUR	19,745	20,232	1.78
The Government of Belgium	30.06.2009	28.03.2012	EUR	15,586	15,960	2.15
The Government of Austria	17.06.2009	15.07.2012	EUR	7,121	7,215	2.57
Svenska Handelsbanken	20.08.2009	20.08.2012	EUR	31,240	32,337	3.06
The Government of Finland	18.05.2009	15.09.2012	EUR	14,705	14,741	2.11
Rabobank	08.10.2010	08.10.2012	EUR	28,153	28,237	1.14

The Government of Belgium	02.08.2010	28.03.2013	EUR	26,595	26,609	1.33
Dexia Bank	21.01.2010	21.01.2014	EUR	46,834	48,656	2.69
Bancaja Cavale Bank	27.10.2009	27.10.2014	EUR	31,193	29,534	3.07
Rabobank	16.02.2010	16.02.2015	EUR	15,634	16,275	3.02
The Government of Slovenia	17.03.2010	17.03.2015	EUR	31,122	31,659	2.87
KIG	25.01.2010	25.01.2017	EUR	7,750	8,229	3.78
General Electric	30.07.2009	22.02.2016	EUR	13,792	14,816	1.19
European Investment Bank	06.06.2005	24.03.2020	EUR	12,340	11,659	1.94
The Government of France	17.12.2010	25.10.2020	EUR	15,967	16,070	3.38
Total				**317,777**	**322,229**	

The coupon rates of long-term financial investments are recorded in the fair value of the securities.

Bonds of 2009

In thousand kroons						
Bond	**Date of acquisition**	**Maturity date**	**Underlying currency**	**Acquisition cost**	**Fair value**	**Rate of return %**
BNG Bank	27.01.2009	27.01.2011	EUR	13,268	13,861	2.87
Danske Bank A/S Estonia Branch	30.04.2008	28.01.2011	EEK	19,978	21,961	6.88
The Government of Finland	25.01.2008	23.02.2011	EUR	15,417	15,973	3.48
The Government of Belgium	09.02.2009	28.03.2011	EUR	19,539	20,067	2.15
The Government of France	13.08.2008	25.04.2011	EUR	24,844	26,195	4.15
The Government of the Netherlands	09.07.2008	15.07.2011	EUR	31,657	33,848	4.58
The Government of Belgium	13.08.2009	28.09.2011	EUR	61,402	61,896	1.79
NRW Bank	16.11.2009	16.11.2011	EUR	15,624	15,657	1.70
The Government of the Netherlands	30.06.2009	15.01.2012	EUR	19,745	20,296	1.78
The Government of Belgium	30.06.2009	28.03.2012	EUR	15,586	15,954	2.15
The Government of Austria	17.06.2009	15.07.2012	EUR	7,121	7,333	2.57
Svenska Handelsbanken AB	20.08.2009	20.08.2012	EUR	31,240	32,004	3.06
The Government of Finland	18.05.2009	15.09.2012	EUR	14,705	14,850	2.11
Bancaja Cavale Bank	27.10.2009	27.10.2014	EUR	31,193	31,163	3.07
General Electric	30.07.2009	22.02.2016	EUR	13,792	14,550	3.06
European Investment Bank	06.06.2005	24.03.2020	EUR	12,340	11,093	3.14
Total				**347,451**	**356,701**	

6.3 Other long-term receivables

In thousand kroons	31.12.2010	31.12.2009
Long-term part of the amount paid to the Social Insurance Board for renovating the premises of the Pärnu Department and Rapla OfficePostponed long-term tax claim against the Tax and Customs Board.Total	4,084	9,419
Long-term part of the amount paid to the Social Insurance Board for renovating the premises of the Pärnu Department and Rapla Office	5,608	5,649
Total	**9,692**	**15,068**

Note 7. Non-current assets

7.1. Property, plant and equipment

In thousand kroons			
Acquisition cost	**Land and buildings**	**Other inventories**	**Total**
31.12.2008	5,537	30,852	36,389
Purchase of fixed assets	472	621	1,093
Written off	0	-8,274	-8,274
31.12.2009	6,009	23,199	29,208
Purchase of fixed assets	0	10,510	10,510
Written off	0	-4,685	-4,685
31.12.2010	6,009	29,024	35,033
Accumulated depreciation			
31.12.2008	2,781	21,789	24,570
Calculated depreciation	292	3,467	3,759
Written off		-8,274	-8,274
31.12.2009	3,073	16,982	20,055
Calculated depreciation	322	4,703	5,025
Written off	0	-4,684	-4,684
31.12.2010	3,395	17,001	20,396
Residual value			
31.12.2009	2,936	6,217	9,153
31.12.2010	2,614	12,023	14,637

7.2. Intangible fixed assets

In thousand kroons	
Acquisition cost	**Purchased licenses**
31.12.2008	6,682
Purchase of fixed assets	0
Written off	0
31.12.2009	6,682
Purchase of fixed assets	0
Written off	-481
31.12.2010	6,201
Accumulated depreciation	
31.12.2008	4,408
Calculated depreciation	852
Written off	0
31.12.2009	5,260
Calculated depreciation	841
Written off	-481
31.12.2010	5,620
Residual value	
31.12.2009	1,422
31.12.2010	581

Note 8. Leased assets

Operating lease

The Statements of financial performance of 2010 include operating lease payments in the amount of 5,154 thousand kroons 485 thousand kroons of which was paid for the lease of means of transport and 4,669 thousand kroons pursuant to commercial lease contracts of premises.

In 2009 the operating lease payments were 6,109 thousand kroons 447 thousand kroons of which was paid for the lease of means of transport and 5,662 thousand kroons pursuant to commercial lease contracts of premises.

The minimum lease payment obligations under non-cancellable lease agreements are divided as follows:

In thousand kroons	
Less than 1 year	2,210
1–5 years	1,758
More than 5 years	506
Total minimum lease payments	4,474

9.2. Debts and prepayments

9.1. Supplier payables

In thousand kroons	31.12.2010	31.12.2009
Accounts payable for medical care services	562,991	523,923
Accounts payable for medicinal products subject to discount	101,092	117,961
Supplier payables for health insurance benefits	33,715	56,947
Other supplier payables	5,614	2,680
Total	**703,412**	**701,511**

9.2. Tax liabilities

In thousand kroons	31.12.2010	31.12.2009
Personal income tax	5,675	32,360
Social tax	2,064	4,831
Income tax from fringe benefits	0	34
Unemployment insurance premium	79	367
Mandatory funded pension premium	0	20
VAT	106	47
Total	**7,924**	**37,659**

The personal income tax liability includes personal income tax (31,018 thousand kroons as of 31.12.2009) deducted from the benefits for incapacity for work paid by the EHIF to the insured persons.

The social tax liability includes social tax in the amount of 810 thousand kroons (889 thousand kroons as of 31.12.2009) calculated from the holiday pay not disbursed to the employees.

9.3. Other debts

In thousand kroons	31.12.2010	31.12.2009
Payables to employees	6,265	9,618
Other debts	900	934
Prepayments received	0	4,327
Total	**7,165**	**14,879**

Note 10. Revenue from operating activity

In thousand kroons	2010	2009
Revenue from the health insurance part of social tax	10,731,725	11,234,307
Amounts due from other persons	11,049	14,110
Total	**10,742,774**	**11,248,417**

Note 11. Expenditure on health insurance

In thousand kroons	2010	2009
Health service benefits, including	7,838,189	8,049,487
disease prevention	108,561	114,118
general medical care	1,009,317	1,056,204
specialised medical care	6,218,733	6,354,972
nursing care	223,040	237,013
dental care	278,538	287,180
Health promotion activities	12,292	13,150
Expenditure on benefits of medicinal products, including	1,419,720	1,383,331
pharmaceuticals reimbursed in special cases	5	118
Expenses on Benefits for Temporary Incapacity for Work	1,274,202	2,204,104
Other Cash Benefits	140,259	160,622
Other expenditure on health insurance benefits, including *	132,042	130,233
health service benefits arising from international agreements	59,621	68,091
Benefit for medical devices	70,514	62,142
Benefits to doctors for vaccination	1,907	0
Total expenditure on health insurance	**10,816,704**	**11,940,927**

*The expenditure of 2010 differs from the expenditure on the budget implementation sheet by 32,272 thousand kroons, government grants (see Note 14). In 2009, the difference in expenditure was 18,330 thousand kroons.

Note 12. Administrative expenditure

In thousand kroons	2010	2009
Personnel and administrative expenditure	67,955	69,970
Remuneration	50,614	52,215
including remuneration of the members of the Management Board	2,082	2,193
including remuneration of the members of the Supervisory Board	3	3
Unemployment insurance premium	677	533
Social tax	16,664	17,222
Management costs	16,465	20,314
Information technology costs	10,229	9,995
Development costs	1,992	2,525
Total administrative expenditure	**96,641**	**102,804**

Remuneration of the members of the Management Board in 2009 includes performance pay in the amount of 308 thousand kroons which was not disbursed in 2010. The performance pay of 2010 includes 246 thousand kroons, which will be disbursed after a decision of the Supervisory Board in 2011, as estimated by the Management Board.

Number of employees of the EHIF

	2010	2009
Members of the Management Board	3	3
Managers	18	18
Professionals	33	34
Associate professionals	157	164
Auxiliary staff	5	5
Total number of employees calculated in full-time equivalents	216	224

Note 13. Transactions with related parties

Related parties are the members of the Management Board and Supervisory Board and enterprises connected with them.

The highest body of the Health Insurance Fund is the Supervisory Board that consists of 15 members. 5 members are representatives of employers' organisations, 5 stand for the interest of the insured and the remaining 5 are acting on behalf of the state. The Minister of Social Affairs serves as the Chairman of the Supervisory Board. A three-member Management Board is the directing body of the Health Insurance Fund.

Transactions with related parties during the financial year include the following related parties: AS Helmes (transactions in the amount of 905 thousand kroons), Eesti E-Tervise SA (26 thousand kroons), SA Põhja-Eesti Regionaalhaigla (1,5 billion kroons) and OÜ Eesti Diabeedikeskus (279 thousand kroons).

Upon termination of a contract with members of the Management Board, they will be paid a three-month remuneration.

Remuneration paid to the members of the Management Board and Supervisory Board in 2008 is indicated in Note 12.

Note 14. Government grants

Government grants are made by the Ministry of Social Affairs pursuant to subsection 5 of § 35¹ of Artificial Insemination and Embryo Protection Act reimbursing the expenditure on the medicinal products in external in vitro fertilisation and paying to the insured person for the infertility treatment based on the agreements with the providers of the services.

Expenses related to government grants:

In thousand kroons	2010	2009
Reimbursing the expenditure on the medicinal products in external in vitro fertilisation	10,622	11,933
Reimbursement of the infertility treatment pursuant to health services	7,153	6,397
Influenza vaccine Pandermix	14,497	0
Total	**32,272**	**18,330**

Revenue from government grants

In thousand kroons	2010	2009
Reimbursing the expenditure on the medicinal products in external in vitro fertilisation	10,622	11,933
Reimbursement of the infertility treatment pursuant to health services	7,153	6,397
Cost of land in Jõhvi	0	20
Instruments of the national cancer prevention strategy	451	0
Funding of the changeover to the euro project	240	0
Total	**18,466**	**18,350**

Expenses related to government grants on the instruments of the national cancer prevention strategy are recorded under health promotion activities and the changeover to the euro expenses are recorded in the EHIF operational expenses.

The Ministry of Social Affairs was reimbursed for the influenza vaccine and the vaccine was distributed to family physicians for the prevention of influenza.

Note 15. Events after the balance sheet date

As of 1 January 2011 Estonia joined the eurozone and the Estonian kroon (EEK) was replaced with the euro (EUR). Pursuant to the changeover, the EHIF converted its accounting into euros as of that date, and the financial statements from 2011 will be prepared in euros.

All reference data will be converted using the changeover exchange rate of 15.6466 EEK/EUR.

Signatures to the Annual Report

The Management Board of the Estonian Health Insurance Fund has prepared the 2010 Annual Report.

The Annual Report consists of the management report, annual accounts and auditor's report.

The Supervisory Board of the Health Insurance Fund has reviewed and approved the 2010 Annual Report.

The Management Board

Chairman of Management BoardHannes Danilov

Member of Management Board Mari Mathiesen

Member of Management Board Kersti Reinsalu

The Supervisory Board

Chairman of Supervisory Board Hanno Pevkur

Members of Supervisory Board

Jürgen Ligi

Ivi Normet

Ene Tomberg

Aare Kitsing

Ulvi Tammer-Jäätes

Kaia Vask

Merle Smutov

Tõnis Allik

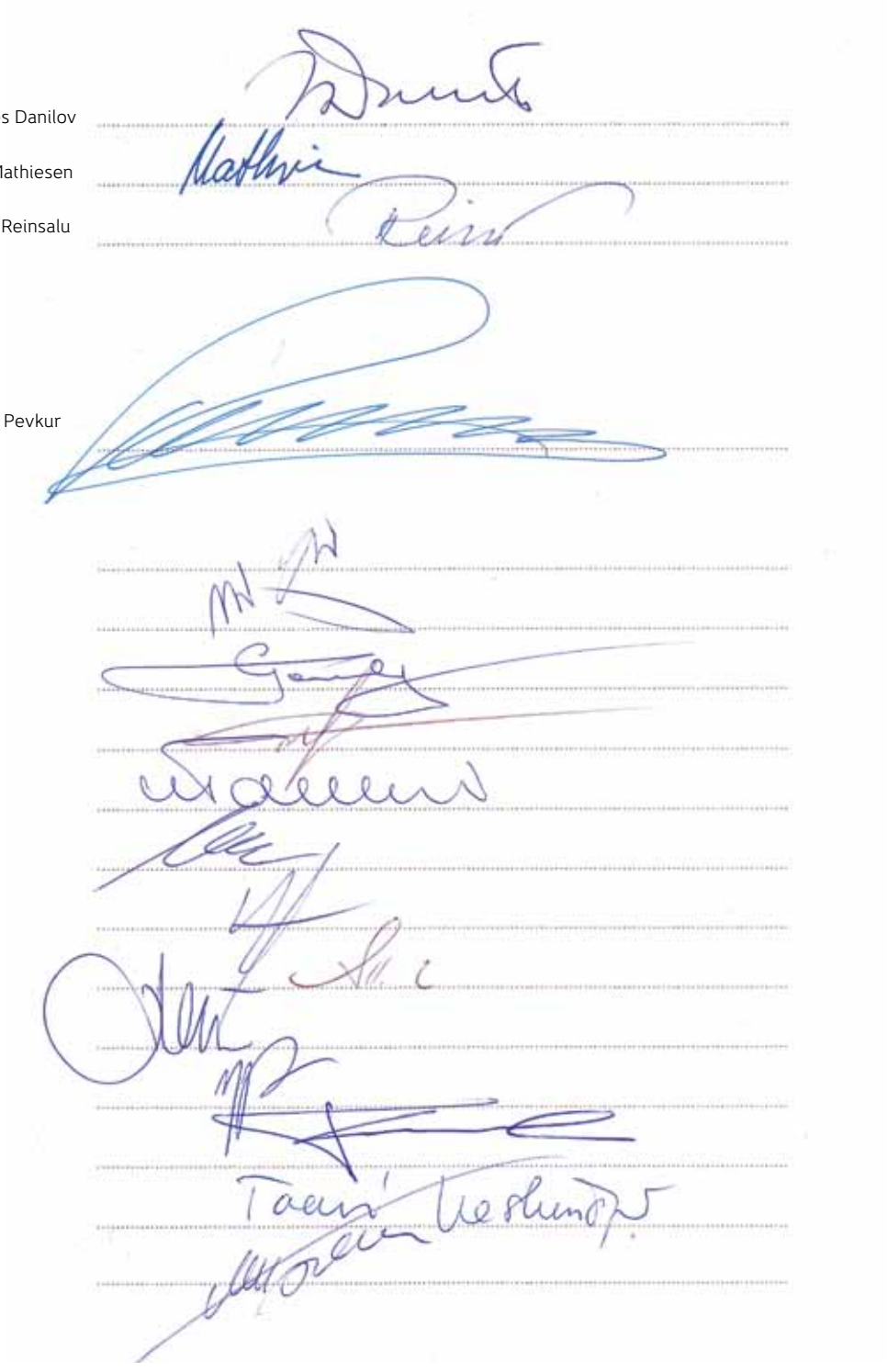
Tarmo Kriis

Jaan Pillesaar

Tiit Kuuli

Taavi Veskimägi

Margus Tsahkna



AS Deloitte Audit Eesti
Roosikrantsi 2
10119 Tallinn
Estonia

Tel: +372 640 6500
Fax: +372 640 6503
www.deloitte.ee

Reg.no. 10687819

INDEPENDENT SWORN AUDITOR'S REPORT

To the Management Board and Supervisory Board of Eesti Haigekassa (Estonian Health Insurance Fund):

We have audited the accompanying annual accounts (pages 71 to 86) of Eesti Haigekassa, which comprise the balance sheet as at 31 December 2010, and the income statement, statement of changes in net assets and statement of cash flows for the year then ended, and a summary of significant accounting policies and other explanatory notes.

Management Board's Responsibility for the Annual Accounts

Management Board is responsible for the preparation and fair presentation of these annual accounts in accordance with Estonian Accounting Act, State Accounting Principles and the guidelines issued by the Estonian Accounting Standards Board, and for such internal control as the Management Board determines is necessary to enable the preparation of annual account that are free from material misstatement, whether due to fraud or error.

Sworn Auditor's Responsibility

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

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the annual accounts. The procedures selected depend on the sworn auditor's judgment, including the assessment of the risks of material misstatement of the annual accounts, whether due to fraud or error. In making those risk assessments, the sworn auditor considers internal control relevant to the entity's preparation and fair presentation of the annual accounts 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 the Management Board, as well as evaluating the overall presentation of the annual accounts.

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 annual accounts present fairly, in all material respects, the financial position of Eesti Haigekassa as at 31 December 2010, and its financial performance and its cash flows for the year then ended in accordance with Estonian Accounting Act, State Accounting Principles and the guidelines issued by the Estonian Accounting Standards Board.

30 March 2011

Monika Peetson
Sworn auditor No 555

Veiko Hintsov
Sworn auditor No 328
AS Deloitte Audit Eesti
License No 27