Eesti Haigekassa
Estonian Health Insurance Fund

Estonian Health Insurance Fund Annual Report 2008

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 unforseeable dangers. The Estonian Health Insurance Fund wishes to offer to its insured persons the same protection.

Estonian Health Insurance Fund

Annual Report 2008

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Beginning of financial year	1 January 2008
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Principal activity	Public health insurance
Management Board	Hannes Danilov (Chairman) Mari Mathiesen Kersti Reinsalu
Auditor	KPMG Baltics

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ADDRESS BY CHAIRMAN OF THE MANAGEMENT BOARD

Last May an important health event was organised in Estonia – Tallinn was the venue for a World Health Organisation conference focusing on the role of health systems in a country's performance in general. This theme was chosen due to the ever wider recognition that health systems and their organisation are a critical part of economic success and that a society in ill health can not hope for much as regards economic development: at one point the state of health of people will become a detriment to the progress of the economy.

The conference adopted the Tallinn Charter, which stated the following: "Beyond its intrinsic value, improved health contributes to social well-being through its impact on economic development, competitiveness and productivity. High-performing health systems contribute to economic development and wealth."

The organisation of the conference in Estonia is a sign of recognition of the visible results that we have achieved in developing our health systems during the past 15 years. The presentations made by speakers from Estonia, including those of the Minister of Social Affairs and the Prime Minister were very well received, indicating the high appreciation given by the conference to our health systems.

In 2008 another assessment of the European health systems for patient-friendliness was conducted and, again, Estonia achieved a good result, ranking 11th ahead of such countries of „old Europe" as the UK and Belgium. Sadly this piece of good news was not widely reported by our own media but the British journalists were intrigued. They came to visit our hospitals and family health centres and we got positive coverage in the UK dailies.

The economic downturn in Estonia gives reason to worry. The funding of the health insurance system is going to remain the same and we hope we will be able to maintain our current standards. With the growing awareness of the people the demand for health services increases every year. However, together with the medical institutions we will do our utmost to spare the patients from any inconveniences.

The vision of the Estonian Health Insurance Fund (EHIF) is to create a sense of security in people who have developed health problems. The Health Insurance Fund proceeds from the principles of solidarity and equal treatment in moving towards its vision. I am glad to note that these values have gained in importance across the whole country.

The political forces seem to be slightly confused by the rapidly changing situation of the economy, since the expected gradual and soft landing did not materialise. A fast evolving situation could give rise to hasty and immature decisions. Constant analysis of the situation is therefore called for and if need be, flexible intervention, also through the media, is required in order to ensure smooth operations in every field.

I firmly believe that the process of feverish budget cuts can not lead to demolishing of the health infrastructure – both doctors and hospitals must be protected. Financial reserves must be certainly put into use as well, since the funding of the health system must remain stable.

Difficult times in the economy teach us all to trim down our expectations, which at times tended to be excessive. The goals cannot diverge drastically from the possibilities and they must be such as to guarantee long-term development.

Hannes Danilov

Chairman of the Management Board of the Estonian Health Insurance Fund

MANAGEMENT REPORT 2008

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

Vision: 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.

Core Values:

- Innovation – we target our activities at continuous and sustainable development, relying on competent, loyal, committed and result-oriented employees.
- Consideration – we are reliable, open and friendly. Our decision-making is transparent and considerate of individual needs.
- Cooperation – we create an atmosphere of trust within our organisation and in relations with our partners and clients.

Objectives and Functions

The principal function of the Health Insurance Fund is to organise health insurance, by granting health insurance benefits to the insured and by ensuring the effective and targeted use of the health insurance funds.

In addition the Health Insurance Fund administers and develops the work processes arising from the EU legislation and international agreements, participates in the planning of health care, provides opinions concerning draft legislation and the drafts of international agreements related to the health insurance fund and health insurance and advises on issues related to health insurance.

The Health Insurance Fund Act provides the objective, functions, bases for activities and management of the Estonian Health Insurance Fund.

Table 1. Key indicators 2004–2008

	2004	2005	2006	2007	2008	% of change against 2007
Number of insured persons at year end	1,271,558	1,271,354	1,278,016	1,287,765	1,281,718	0%
Revenue (in EEK thousand)	6,350,129	7,346,892	8,909,947	11,182,824	12,899,863	15%
Health insurance expenditure (in EEK thousand)	6,136,989	6,983,752	7,946,048	10,148,769	12,222,956	20%
EHIF operating expenditure (in EEK thousand)	80,112	89,385	87,044	95,132	116,329	22%
Health insurance expenditure as a percentage of GDP (%)	4.1	4.0	3.8	4.2	4.9	0.7%
Number of insured persons who used specialised medical care	771,513	778,689	796,815	810,834	819,055	1%
Average length of stay (days)	6.6	6.9	6.3	6.4	6.3	–2%
Emergency care as a percentage of costs on specialised medical care (%), incl.						
outpatient	15	15.2	17.3	17.6	17	–0.6%
day care*	–	–	6.9	7.1	6	–1.1%
inpatient	60	64.6	63.2	62.7	63	0.3%
Average cost per case in specialised medical care (EEK), incl.						
outpatient	409	468	447	548	671	23%
day care*	–	–	4,942	6,435	7,324	14%
inpatient	8,701	10,079	10,981	13,629	15,775	16%
Number of prescriptions issued at a discount	4,775,221	5,000,602	5,393,102	5,996,585	6,636,410	11%
Average cost per prescription for EHIF (EEK)	180	173	179	187	193	3%
Number of days of incapacity for work for which benefits were paid	7,321,490	7,685,148	8,195,320	8,888,700	9,182,077	3%
Cost per day of benefit for incapacity for work (EEK)	151	165	184	217	260	20%

* Given the former low proportion of day care the relevant data are available from 2006.

Clients, Partners, Employers

Every person covered by state health insurance is a client of the Health Insurance Fund.

The partners of the Health Insurance Fund are the health care providers: hospitals, medical specialists, family physicians, dentists, pharmacies, professional societies and 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 must pay social tax, and revenues from social tax designated for health insurance constitute the Health Insurance Fund budget. The employers have the obligation to see to it that data concerning the insurance cover of their employees is communicated to the Health Insurance Fund.

Management

The highest body of the Health Insurance Fund is the Supervisory Board, which consists of fifteen members. Five members are representatives of employers' organisations, five stand for the interests of the insured and the remaining five are acting on behalf of the state. The Minister of Social Affairs serves as Chairman of the Supervisory Board in order to ensure that the Ministry of Social Affairs and the Estonian Health Insurance Fund act in harmony and shoulder their political responsibilities. A three-member Management Board is the directing body of the Health Insurance Fund.

Organisation

The Health Insurance Fund has 12 central departments in charge of development activities and four regional departments - Harju, Pärnu, Tartu and Viru – which are dealing with clients, employers and partners. As of 31 December 2008 the Health Insurance Fund had a staff of 225.

Estonian Health Care System: A Brief Overview

The organisation of the current health care system emerged from the health care reform of the 1990s, whose aim was to develop a modern and efficient health care system.

The Ministry of Social Affairs is the steward of the Estonian health care system. The ministry has to develop the relevant regulations and strategies. There are several agencies within the area of administration of the Ministry of Social Affairs; of them the State Agency of Medicines and the Health Care Board are responsible for health care matters. The principal tasks of the State Agency of Medicines include registration of pharmaceuticals, quality control and organisation of trade in pharmaceuticals. The Health Care Board deals with the grant of activity licences to health care providers, registration of health care professionals and funding of emergency medical care.

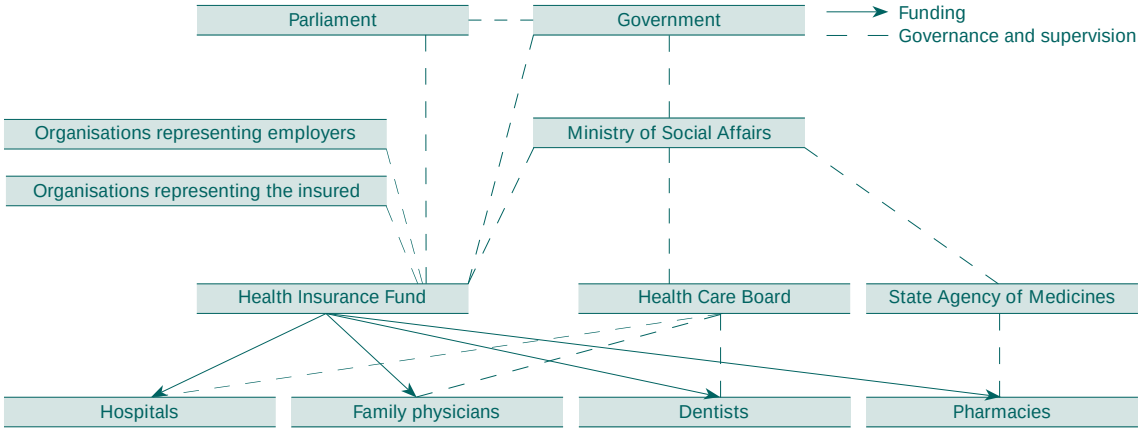


Figure 1. Overview of health care system

The Health Insurance Fund also operates within the area of administration of the Ministry of Social Affairs, however not as its agency but as an independent legal body under public law. The Health Insurance Fund has had its current legal status since 2001, when the system which consisted of the Central Health Insurance Fund and 17 regional health insurance funds was changed. The main duties of the Health Insurance Fund are the following: entry into contracts with health care providers for payment for the provision of care, payment for health services subject to reimbursement, payment for pharmaceuticals included in the list of pharmaceuticals distributed at a discount and payment of benefits for temporary incapacity for work.

The pillars of the Estonian health care system are separation of the provision of health services and funding thereof, the relative independence of health care providers in operational decision-making and the organisation of the health care system around family health centres. Separation of the health care providers and funding is achieved via the independent Health Insurance Fund, which plays no direct role in managing medical institutions (e.g. representatives of the Health Insurance Fund are not represented in the hospitals' supervisory boards). Similarly the service providers are not involved in the management of the Health Insurance Fund (there are no service providers in the Health Insurance Fund Supervisory Board). Such separation of the health care providers and the funders guarantees unbiased funding decisions, aimed only at meeting the treatment needs of the insured and ensuring the use of health insurance moneys for the designated purpose.

Health care providers operate under private law. Despite that hospitals of strategic importance are owned by the public sector. Through their representatives in the hospitals' supervisory boards the owners (state, local government) ensure that public interests are met and operating goals set to serve the public interests are fulfilled by the executives of the hospitals. The organisation of the activities of the service providers in this manner (i.e. combining public ownership and operation under private law) adds to the flexibility and efficiency of their management.

IMPACT OF ECONOMIC ENVIRONMENT ON HEALTH INSURANCE FUND BUDGET

2008 was an exceptional year for the Health Insurance Fund, since the shortfall in the planned social tax revenues caused by a slowdown in wage growth and decreasing employment resulted in the adoption of a negative supplementary budget. Unfortunately the downturn that started in the end of 2008 has continued at an even faster pace in 2009 and has thus had a considerable impact on the revenues of the Health Insurance Fund. Given that ca 64% of the total financing of health care comes from health insurance (85% of the public sector funds), these changes will have a direct impact on the funding of all health care, which has been growing annually by an average 18% on account of health insurance resources during the past six years. Global trends indicate clearly that the economy is not going to turn around any time soon and therefore the forecasts for the coming years should aim at maintaining the current levels.

Once a year the Health Insurance Fund prepares and presents to the Supervisory Board for approval the principles of planning the revenues and expenditures for the next four years[1], and as its annex the four year budget forecast. The Health Insurance Fund revises its forecasts every time that the Ministry of Finance discloses a new economic forecast. In order to ensure transparency in financing the health insurance system the budget is planned four years ahead on an ongoing basis. The result is stability of funding the health care system and the knowledge of all parties involved about the financing principles of the health insurance system and the expected weights of the different types of benefits. A longer planning cycle also facilitates the (preferential) funding of priority areas. The four year planning principles approved by the Supervisory Board serve as a basis for planning the next year's budget.

The expenditures of health services in the Health Insurance Fund budget depend on the services needed by the insured. Even if the revenues from social tax shrink, the availability of services cannot be reduced drastically. This is why the Health Insurance Fund has been accumulating reserves during good times, so as not to cut access to health services during economic recession. In times of economic instability the demand for medical aid and pharmaceuticals could actually increase.

In order to stretch the reserves over a longer period ways should be sought to cut costs as well. Benefits for incapacity for work constitute a large cost item (19% of the costs). These costs depend directly on the share of employees among the insured persons and the current growing number of the unemployed has an immediate impact on the costs. The reduction in employment and the stop in the growth of the average salaries ought to bring about a decrease in costs related to benefits for incapacity for work. On top of that the Estonian Parliament adopted an amendment on 20 February 2009 according to which the Health Insurance Fund starts paying the benefit only as of the ninth sick day.

The cost of adult dental care (from age 19 to pension age) ceases to be reimbursed by the Health Insurance Fund in 2009, thus helping save some costs. While reducing the costs of the Health Insurance Fund this move could have an adverse effect on access to dental care among the insured of working age, given the current economic situation.

During 2005–2008 the Health Insurance Fund saw a 15-25% annual growth in its revenues. The result was an increase in the volume of services provided and in the amounts of benefits. In a situation where revenues are falling choices need to be made and restrictions have to be imposed, with the sole aim of ensuring continued performance of the health care system built over the years and providing health care at the current level. We will be in a position to evaluate the impact of shrinking revenues and reducing the benefits payable to the insured only at the end of 2009.

Kersti Reinsalu,
member of the Management Board
of the Health Insurance Board

[1] http://www.haigekassa.ee/files/est_haigekassa_otsused_2008/otsus%20nr%2011%20eelar%202009%20koost%20n-uded%20ja%20eelarveprognoos.doc

ACHIEVEMENTS IN 2008 AND CHALLENGES FOR 2009

Several new services were included in the list of health services financed from health insurance in 2008, e.g. transplantation of the cornea, surgical ablation treatment of cardiac arrhythmias, capsule endoscopy. The Health Insurance Fund continued its efforts towards ensuring the availability of modern pharmaceuticals for the different disease groups on a more even basis and also took up the funding for pharmaceuticals to treat the rare metabolic disorder, the Fabry disease. The number of users of biological medicines doubled and the choice of pharmaceuticals used to treat oncological patients improved considerably.

The Health Insurance Fund had a busy year, for in addition to its core duty of providing health insurance benefits the employees were involved in several important development activities:

- Commissioned jointly by the WHO Regional Office for Europe and the Estonian Health Insurance Fund, Professor Alan Maynard from the University of York prepared a report, Payment for Performance (P4P): international experience and a cautionary proposal for Estonia. A seminar was organised to discuss the experiences in and the future of performance related funding of health care. Both representatives of professional societies and hospital executives were among the participants. It is important that the ongoing debate on how to evaluate quality and recognise a quality hospital was continued.
- The number of family physicians participating in the voluntary performance pay system increased considerably. The system is being updated on a regular basis in cooperation with the Estonian Society of Family Doctors. In addition to monitoring patients with type 2 diabetes and essential hypertension, from 2009 in-depth monitoring has been extended to patients that are suffering from functional disorders of the thyroid gland and patients that have had myocardial infarction. The performance pay system was first introduced in 2006. The objectives of the system are better monitoring of the patients' state of health, prevention of diseases and monitoring of patients with chronic diseases by family physicians and nurses.
- In cooperation with the representatives of the Estonian Society of Radiology and reference hospitals a new list of radiology services was drafted, enabling the introduction of activity-based prices and modernisation of funding for radiology services in 2009.
- Work on the Digital Prescription Centre was completed by the end of the year. When completely operational, the system will grant the physicians, pharmacists and patients better access to information concerning pharmaceuticals, improve the quality of services as well as the quality of medical treatment. Important work continues in 2009, involving further developments and testing of the system together with the physicians, pharmacists and their IT partners. The purpose of the electronic system is to support the provision of high-quality, accessible health services and contribute towards building a patient-centred health care system.
- A new electronic system was introduced for the payment of benefits for incapacity for work, resulting in more rapid processing of the payments. Transition to the new system constitutes the first stage in developing an electronic certificate of incapacity for work.

The main challenge for the Health Insurance Fund in 2009 is ensuring the availability of medical care despite the constraints caused by the economic crisis. Year by year the choice of services and pharmaceuticals distributed at a discount has become wider, and the frequency of visits to doctors and the number of cases has grown. The principal task is to continue the provision of health services and pharmaceuticals distributed at a discount at the current level; the expected revenues do not permit the introduction of innovative ways of treatment or reduction of the waiting lists. However, due to careful rearrangement of resources it is possible, from 1 July:

- to use new efficient active ingredients for treating certain types of cancer and thus increase the survival rate of such patients;
- to use certain new life-saving services, for which no alternatives existed before (e.g. bone anchored hearing aids and cardiac pacemakers).

The modification of existing services and introduction of new services have led to a more efficient use of the health insurance funds without any extra cost.

Smooth operation of the system of family physicians is of paramount importance for overcoming the difficulties in 2009.

A study will be launched in the spring of 2009 upon the initiative of the Health Insurance Fund and in cooperation with the Estonian Association of Traumatology and Orthopaedics, the Estonian Orthopaedic Nurses' Society and hospitals to evaluate the changes in the quality of life of patients that have undergone endoprosthetic replacement of the knee or hip joint. Quality continues to be the highest priority for the Health Insurance Fund.

Mari Mathiesen,
member of the Management Board
of the Health Insurance Board

HEALTH INSURANCE FUND: 2008 STRATEGIC GOALS AND ATTAINMENT THEREOF

The Health Insurance Fund uses the balanced scorecard model for performance management and development of the organisation's strategy. The model helps channel the knowledge, skills and competences of the employees into achieving the long-term goals of the organisation in line with its mission and vision.

The Health Insurance Fund strategy is client-oriented, geared to improving the quality of services provided to the insured and developing the working processes. By measuring the activities listed in the scorecard the Health Insurance Fund gives feedback to the insured about how it has been fulfilling its pledge to achieve the established objectives and about the efficiency of using the taxpayers' money and the provision of services.

SCORECARD 2008

Objective	Weight	Performance indicator	Unit	Comments	2007 performance	2008 objective	2008 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 a general survey conducted among the insured	60	63	61	5.8%
1. Ensure access to health services, pharmaceuticals and financial benefits	28.50%							27.2%
	7.5%	Satisfaction with accessibility to medical care	%	A part of the general survey	60	63	53	84
• Ensure uniform access	7.5%	Involve 60% of the insured in activities leading to improved monitoring of the status of their health	%	The ratio of the number of the involved insured to the total number of the insured	44	60	78	100
	7.5%	Timely access of the insured to consultation by a medical specialist	%	The insured who were seen by a medical specialist at a planned consultation within the established time limits (100% less the percentage of the insured who could not be seen due to limited capacity or lack of funds)	-	99	99.9	100
• Develop relations with partners and ensure performance of contractual commitments	6.0%	Satisfaction of the partners with cooperation with EHIF	%	Survey results	81	85	84	99
2. Develop the quality of the health system and its services	12.0%							12%
	4.0%	Satisfaction with the quality of medical care	%	A part of the general survey	69	72	73	100

• Enhance the quality of health services	4.0%	Clinical practice guidelines prepared in cooperation with EHIF and professional associations	Number	Number of jointly prepared clinical practice guidelines	5	5	6	100
• Improve assessment and control of the quality of health services	4.0%	Number of clinical audits	Number	Number of clinical audits conducted	5	5	5	100
3. Shape the health behaviour of people through health promotion and disease prevention activities	17.5%							17.1%
	6.5%	Visibility of social campaigns	%	Measured in the course of specific health promotion projects		75	75	100
• Ensure implementation of health promotion and disease prevention projects as planned	5.0%	Coverage of cancer screening	%	Coverage is measured on the basis of the health insurance database, as a percentage of persons participating in screening of those invited		Breast cancer 65% and cervical cancer 45%	Breast cancer 61% and cervical cancer 57%	97
• Ensure the awareness of the clients and partners of their rights and obligations	6.0%	Awareness of the insured of their rights	%	% 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	69	73	70	96
4. Ensure financial sustainability of the health insurance system via targeted and efficient planning and use of health insurance resources	18.0%							17.3%
	6%	Satisfaction with the range of services funded by health insurance	%	A part of the general survey	50	52	46	88.5
• Improve the needs assessment and planning of health insurance benefits, balancing the needs and budgetary resources	6.0%	A four-year agreement with professional associations concerning the needs of the insured for their services	Number	The number of analysis-based agreements	2	1	1	100

• Increase the efficiency of using health insurance resources	6.0%	Average cost per case	%	Structural increase (volume inflation) of the average cost of an inpatient treated case in comparison with the previous period, %	6	4	1,8	100
5.Improve the operation of the organisation	18.0%							17.7%
• Develop the competences and motivation of the employees	6.0%	Satisfaction of the employees with the management and organisation of work of EHIF	Score	Aggregate satisfaction indicator derived from the results of the employees' survey concerning the organisation of work of EHIF, on a 4-point scale	3.4	3.5	3.6	100
• Apply standard and highly functional information systems	6.0%	Availability	%	Availability of information systems	92.6	100	95	95
• Improve processes	6.0%	The share of electronic entries in the register of insured persons	%		79	80	87	100
Total	100%							97,1%

ATTAINMENT OF GOALS IN 2008

Objective	Perfomance indicator	Results achieved in 2008
	Satisfaction of the insured with the health system	Every year EHIF conducts a patient satisfaction survey in order to measure their satisfaction and changes thereof.
1. Ensure access to health services, pharmaceuticals and financial benefits		
	Satisfaction with accessibility to medical care	Access to medical care influences general satisfaction with the health system. Improving access is one of the key objectives in the EHIF development plan and scorecard. The survey conducted in 2008 showed that in the age group 15–74 53% of the people considered access to medical care as "rather good" or "very good", which is 7% less than last year. 41% (32% in 2007) of the respondents saw shortcomings as regards access to medical care. Increased expectations can be regarded as one of the reasons for decreasing satisfaction.
• Ensure uniform access	Involve 60% of the insured in activities leading to improved monitoring of the status of their health	Disease prevention and monitoring patients with chronic diseases by family physicians are activities leading to improved monitoring of the status of persons' health. In 2008 78% of the insured persons were covered with such activities: 77% in Harju region, 69% in Tartu region, 88% in Pärnu region and 85% in Viru region.
	Timely access of the insured to consultation by a medical specialist	In 2008 99.7% of the insured could gain timely access to an outpatient consultation by a medical specialist (Harju 99.5%; Pärnu 99.8%; Tartu 99.8 and Viru 99.9%) and the relevant figure for inpatient consultations was 100%.

• Develop relations with partners and ensure performance of contractual commitments	Satisfaction of the partners with cooperation with EHIF	Smooth cooperation between EHIF and its contractual partners is key to the access to health services and their quality. An independent company measures the satisfaction of the partners concerning cooperation once every year[2]. In comparison with 2007 the general satisfaction of the partners has increased by 3% in 2008; 84% of the partners regarded cooperation as “very good” or “rather good”, and the share of those who regarded cooperation “very good” had grown. Among the various groups of partners the opinions of representatives of specialised medical care, nursing care and pharmacists had improved by several percentage points against the 2007 results. Family physicians and dentists had not changed their views. The opinions of the respondents about the different areas of cooperation stayed pretty much the same as in 2007, the number of partners with a negative opinion decreased. As regards the regions, Pärnu’s results changed most for the better compared with 2007 (7%) (based on the number of those who thought cooperation was “very good” or “rather good”).
2. Develop the quality of the health system and its services		
	Satisfaction with the quality of medical care	Several health care providers measure on a regular basis the satisfaction of patients with the quality of medical care, taking the results into account in their activities. The survey commissioned jointly by EHIF and the Ministry of Social Affairs to measure the satisfaction of the insured[3], reflects the attitudes of the society at large concerning the quality of medical care. It transpires from this survey that the opinion of the people about the quality of medical care has generally improved over the last three years. At the same time there has been a decrease in the number of respondents who think that the quality of medical care is “rather bad” (2008 - 14%; 2007 - 18%) or “bad” (2008 - 3%; 2007 - 4%). In 2008 19% of the respondents considered the quality of medical care “good” (2007 - 23%) and 54% “rather good” (2007 - 46%). The people of Southern Estonia were of a slightly better opinion about the quality of medical care.
• Enhance the quality of health services	Clinical practice guidelines prepared in cooperation with EHIF and professional associations	The purpose of clinical practice guidelines is to harmonise the methods of diagnostics and treatment, to avoid regional differences in dealing with patients. In addition to helping provide quality services the use of guidelines contributes to the use of more cost-effective methods. Aiming to improve the quality of health services EHIF supports the preparation of clinical practice guidelines by professional associations. EHIF also conducts health economics analyses of the clinical practice guidelines. EHIF monitors the implementation of the clinical practice guidelines it has approved through clinical audits and control of medical files. Six clinical practice guidelines were subjected to analysis: • Estonian Clinical Practice Guidelines for Parkinson’s Disease (prepared by the Ludvig Puusepp Society of Neurologists & Neurosurgeons); • Clinical Practice Guidelines for Developmental Treatment of Cerebral Palsy (PCI) (prepared by the Estonian Association of Physicians in Rehabilitation); • Guidelines for Follow-up Care of High-Risk Infants through the First and Second Year of Life (prepared by the Estonian Perinatal Society); • Clinical Practice Guidelines for Acute Abdominal Pain (prepared by the Estonian Surgical Association) • Estonian Clinical Practice Guidelines for Type 2 Diabetes (prepared by the Estonian Society of Family Doctors and the Estonian Endocrine Society); • Clinical Practice Guidelines for Bipolar Disorder (prepared by the Estonian Psychiatric Association) The first five sets of guidelines specified above were also recognised in memoranda signed by EHIF.

[2] http://www.haigekassa.ee/uploads/userfiles/HKaruanne2008(2).pdf

[3] http://www.haigekassa.ee/uploads/userfiles/Patsientide%20rahulolu%202008.pdf

• Improve assessment and control of the quality of health services	Number of clinical audits	Five clinical audits were conducted in 2008: • Justification and quality of inpatient medical rehabilitation (health service code 8026), conducted by dr Meeli Mumma, Kaja Elstein, Reet Tanne and Katrin Pürg, recommended by Estonian Association of Physicians in Rehabilitation • Evaluation of the quality of perinatal care in maternity departments of Estonian hospitals, conducted by a working group of the Estonian Gynaecologists` Society • The quality of vascular surgery in the vascular surgery departments of the North Estonia Medical Centre (SA PERH), Tartu University Hospital (SA TÜK), the surgery clinic of East Tallinn Central Hospital (AS Ida-Tallinna Keskhaigla) and in Reconstructive Surgery Clinic (AS Taastava Kirurgia Kliinik), conducted by dr Urmas Lepner and Tiit Vaasna, recommended by the Estonian Surgical Association • The quality of providing speech therapy services (health service codes 3014 and 7611), conducted by the Estonian Logopedists' Union • Quality of conducting psychological assessments (code 7610), conducted by Union of Estonian Psychologists
3. Shape the health behaviour of people through health promotion and disease prevention activities		
	Visibility of social campaigns.	• The trauma prevention campaign under the slogan "Older children also need the wisdom of parents to prevent injuries. Keep your child in one piece" pointed to the high injury mortality of Estonian children.The campaign was mostly targeted at parents, who play an important role in accident prevention. According to goal-attainment studies the visibility of the campaign was over 80%. • The anti-alcohol campaign under the slogan "Alcohol destroys your brain and your life" focussed on changingthe positive image derived from alcohol advertisements. The campaign was targeted at young adults, aiming to make them aware of damage caused by alcohol. The visibility of the campaign was estimated as 70%.
• Ensure implementation of health promotion and disease prevention projects as planned	Coverage of cancer screening.	In 2008 55,645 women were called to participate in screening for breast cancer. The coverage of women who underwent mammography was measured at 61 % (54% in 2007). 34,525 women were invited to screening for cervical cancer. The activities of 2008 resulted in 57% coverage of women who took the PAP test, the result exceeds considerably the 41% coverage achieved in 2007.
• Ensure the awareness of the clients and partners of their rights and obligations	Awareness of the insured of their rights	EHIF, in cooperation with the Ministry of Social Affairs assesses the awareness of the insured once a year in a survey"Evaluation of Health and Medical Care by Patients[4]". 1,500 inhabitants of Estonia participate in the survey. A survey of this kind has been conducted since 2001. The purpose of the survey is to establish: • how often people go to a doctor and how satisfied they are with medical care received; • how people rate their status of health and their lifestyles; • how people rate the quality of medical care; • how well aware the people are about their rights and the EHIF possibilities; • from which sources people derive their information and which would be their preferred sources of information, etc. It emerged from the 2008 survey that 70% of the people knew their rights and obligations. From 2005 the awareness levels have remained mostly unchanged.

4. Ensure financial sustainability of the health insurance system via targeted and efficient planning and use of health insurance resources		
	Satisfaction with the range of services funded by health insurance	
• Improve the needs assessment and planning of health insurance benefits, balancing the needs and budgetary reaources	A four-year agreement with professional associations concerning the needs of the insured for their services	In 2008 an agreement was concluded with the Estonian Endocrine Society concerning the medical care and pharmaceuticals needs for 2009–2012.
• Increase the efficiency of using health insurance resources	Average cost per case	The structural increase (volume inflation) of the average cost of an inpatient treated case in 2008 in comparsion with 2007 was 1.8%.
5. Improve the operation of the organisation		
• Develop the competences and motivation of the employees	Satisfaction of the employees with the management and organisation of work of EHIF	At the end of every year an internal survey is conducted in order to establish the satisfaction of the employees with the management and organisation of work of EHIF. 79% of the employees participated in the 2008 survey. The target was to achieve 3.5 points as the level of satisfaction on a 4-point scale. The actual level was 3.57.
• Apply standard and highly functional information systems	Availability	Availability of information means access to information and information services (the provision of information and information services) upon the request of the users and subject to their mutual agreement. Ensuring availability means activities related to the provision of conditions for avialability, monitoring and analysing availability and organising reporting, as agreed upon in the service levels agreement. The aim is to achieve availability at the agreed levels and subject to the agreed conditions. In 2008 performance was achieved at the level of 95%, i.e. not every problem could be eliminated during the agreed time limit.
• Improve processes	The share of electronic entries in the register of insured persons	Electronic entries are the various entries related to the commencement and termination of insurance cover, performed by employers or contractual partners for data exchange (Social Insurance Board, Ministry of Education, Estonian Unemployment Insurance Fund etc) The aim for 2008 was to make 80% of all entries by electronic means. Actually a total of 1.5 million health insurance related entries were made in the EHIF health insurance database, 87% of these entries were electronic entries.

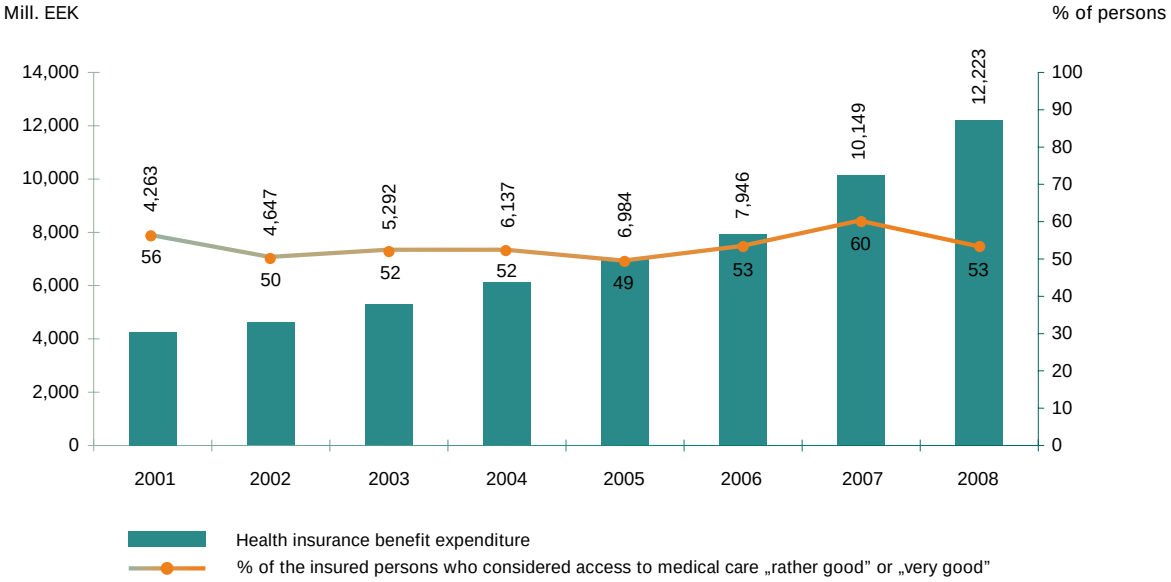
[4] http://www.haigekassa.ee/uploads/userfiles/Patsientide%20rahulolu%202008.pdf

ACCESS TO HEALTH SERVICES

Timely and accessible medical care is a precondition for achieving high-quality results in treatment. Therefore one of the key priorities for EHIF is to ensure timely access to health services i.e. access, in the neighbourhood of the patient, to consultations by family physicians and medical specialists.

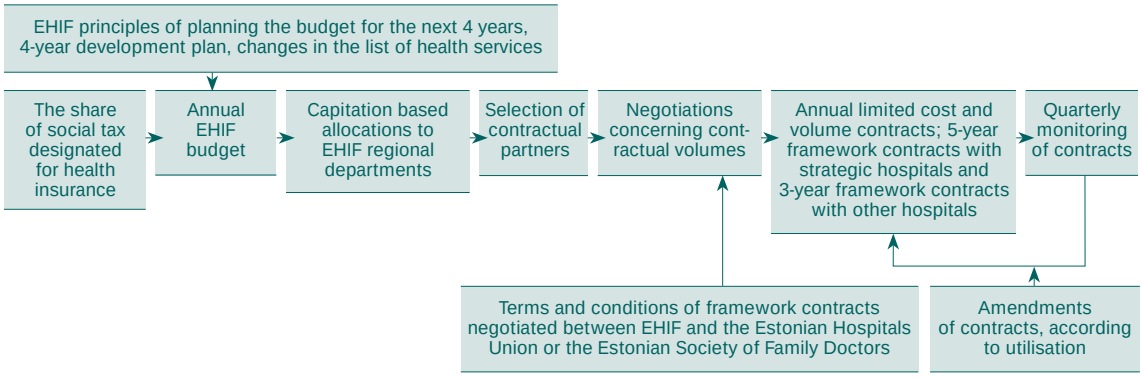
Access to medical care is of critical importance for the people, and as such, a subjective opinion about accessibility has a major impact on general satisfaction with the health system. Improving access is one of the most important goals set out in the EHIF development plan. Based on the satisfaction survey conducted in 2008 53% of the people in the 15-74 age group were of the opinion that access to medical care was “rather good” or “very good”; the figure is down by 7% in comparison with 2007 (see figure 2). The reason for the decreasing satisfaction lies in the fact that people’s expectations outpace the possibilities.

Figure 2. Satisfaction of the insured persons with access to medical care and costs of health insurance benefits 2001–2008



The costs of health service benefits are managed by contracts concluded between EHIF and the health care providers. To fund health services EHIF concludes yearly contracts for the provision of health services with medical institutions.

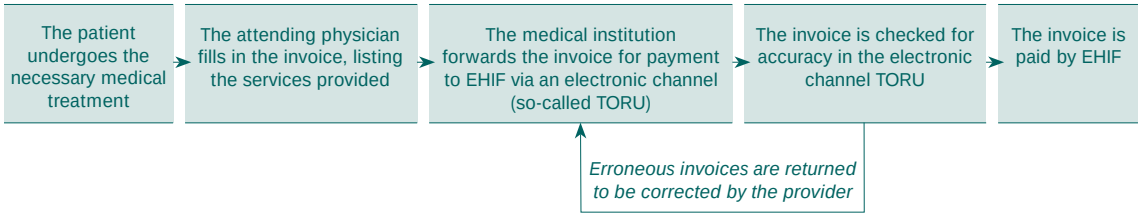
Figure 3. The process of funding medical treatment



LIST OF HEALTH SERVICES

The Estonian Health Insurance Fund and health care providers enter into contracts for funding, agreeing about numbers of cases and financial amounts. For each patient treated the health care provider issues an invoice to EHIF for the reimbursement of expenses of medical treatment. For years such invoices have been issued in a paperless environment, via electronic channels to EHIF.

Figure 4. Steps of issuing invoices for medical treatment to EHIF



In the invoice for medical treatment the medical institution lists the health services provided for the patient. The health services subject to reimbursement by EHIF are contained in the List of Health Services approved by the Government. The list currently includes more than 2000 health services[5].

The health services' list is updated every year in order to meet the current needs. In general proposals for amendments (e.g. a request to add a new service) come from the relevant professional associations. The proposals are processed by following the procedure prescribed by law. Specialists in the relevant field assess consistency of the proposed services with the principles of evidence-based medicine; experts on health economics evaluate the cost effectiveness thereof. In addition EHIF calculates the impact of the new service on the health insurance budget and establishes whether sufficient funds exist to reimburse the costs of providing the service. The Ministry of Social Affairs assesses all proposals from the health policy angle. Usually the processes of negotiating with the author of the proposal and gathering all the various opinions take about six months. Then the EHIF Management Board takes the proposal to amend the List of Health Services to the Supervisory Board, which is to give its own opinion before the Minister of Social Affairs can present the renewed list to the Government of the Republic for final approval.

The prices of health services constitute an important element of the List of Health Services. EHIF purchases health services from a variety of health care providers, whose actual costs may differ for the same health services. For example the hospitals may pay a different price for acquiring one and the same medical device. As a result the hospital "own cost per service" sometimes is not the same as the price paid by EHIF.

The Health Insurance Fund wishes to achieve full transparency, for all parties concerned, of the price formation of health services. The prices should be sufficient to cover the optimal costs needed for the provision of the services. EHIF uses the activity-based method for price formation, i.e. the activities and resources needed for the provision of each health service must be described.

[5] https://www.riigiteataja.ee/ert/act.jsp?id=13154310

Table 2 below lists the costs contained in a consultation by a medical specialist.

Table 2. Price formation of a consultation by a medical specialist

	Type of cost	Price, EEK
Physician (20 min)	Personnel costs: labour, training, office, working clothes and management costs	95
Nurse (20 min)	Personnel costs: labour, training, office, working clothes and management costs	50
Consultation room (20 min)	Premises-related costs: furnishings, repair, maintenance and public utilities costs, plus depreciation	6
Lab tests	Costs of less sophisticated lab tests	20
Patient management	Costs related to registration of the patient and management of the patient's data	13
Total		184

In its price formation EHIF works closely with specialists and providers in order for the prices of health services to reflect the actual costs as closely as possible. In cooperation with the Estonian Society of Radiology EHIF developed prices for radiology in 2008.

INNOVATIVE AND VERSATILE DIGITAL PRESCRIPTION

It is a well-known fact that pharmaceuticals can be purchased in pharmacies today by presenting a prescription issued in paper format by the physician.

On 1 September 2009 the period of transition to the digital prescription will be completed. This has been the highest priority and most innovative project of the Health Insurance Fund in 2008. The doctor writes the prescription in the computer and sends it to the electronic database of the Digital Prescription Centre by using the secure data exchange layer X-Road. The pharmacist connects with the Prescription Centre and finds the prescription by using the patient's personal identification code.

The new development opens up a variety of options for patients. For example a patient with a well controlled chronic disease, taking the same medicine according to the same scheme over a long period of time, can, with the consent of the doctor and after a telephone consultation, purchase the medicine in any pharmacy without the need to fetch the prescription from the doctor first, since the latter has already sent the prescription digitally to the Prescription Centre. The use of a computer is not necessarily needed in order to be able to use the possibilities of the digital prescription. The prescribed medicinal product can be purchased by presenting an identity document. The ID card and knowledge about its various uses open up new possibilities, e.g. to view one's digital prescriptions, to monitor the viewing of one's digital prescriptions by physicians and pharmacists, and to monitor their reasons for doing so; to determine and change the names of persons who have the right to purchase the prescribed medicinal product in the pharmacy.

Thanks to the introduction of the digital prescription physicians can obtain information about whether the patient has actually purchased the medicines prescribed previously for the patient, thus allowing more ways to improve the quality of pharmacotherapy. With an online database at their disposal, the physicians can make inquiries about all prescriptions issued to the patient. Based on this information a better evaluation can be made about the way the patient is following the doctor's recommendations and also how the pharmaceuticals prescribed to the patient by different doctors could interact together. Such information also allows detecting possible abuse of medicines. However, the physicians can issue paper-based prescriptions in exceptional cases, e.g. when making home visits.

The digital prescription facilitates the work of pharmacists as well. Under the current system they have to key in the data concerning the medicinal product, the patient and the physician, the new system only requires data about the medicinal product, since the prescription contains all the other information already.

DISEASE PREVENTION AND PERFORMANCE PAY OF FAMILY PHYSICIANS

Prevention

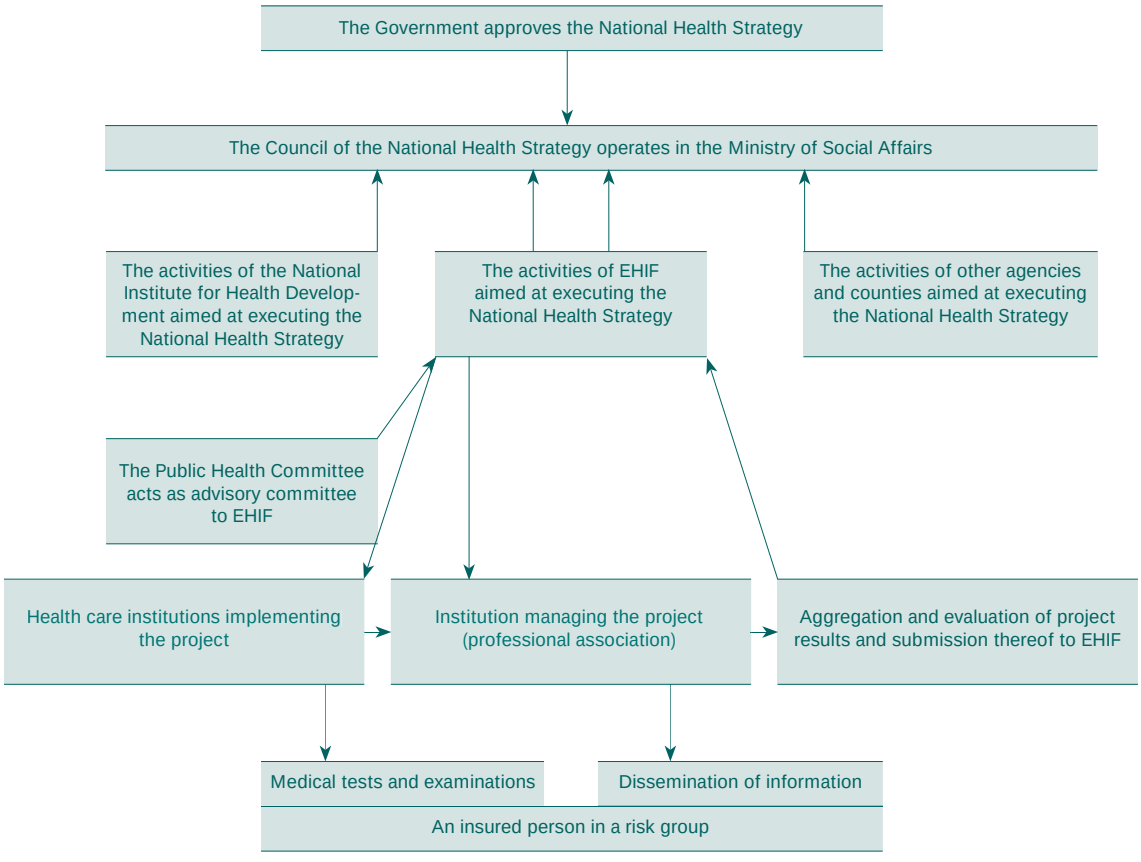
Health promotion and disease prevention are important priorities for the Health Insurance Fund. Through health promotion (social campaigns, dissemination of health information, counselling etc) people are encouraged to pursue healthy lifestyles. The ultimate goal is to improve the status of health and quality of life of the people.

Disease prevention (health checks and medical examinations) creates the possibilities for risk groups for early detection of health problems, timely intervention, if necessary; and eventually preservation of their health. Any preventive medical examination must be acceptable and easy to undertake for the patient and produce evidence-based information. Timely detection of a disease through the examination must result in treatment leading to recovery. These conditions are met in the case of preventive activities funded by EHIF.

The need and frequency of many preventive examinations or health checks are often specified in the clinical practice guidelines[6] (e.g. those to be undertaken during pregnancy, dental checks etc).

The disease prevention projects financed by EHIF constitute a part of the activities in the relevant field to be undertaken in the framework of the National Health Strategy.

Figure 5. Planning and implementation of disease prevention projects



[6] Clinical practice guidelines are systematically developed opinions to help health care professionals and patients in making clinical decisions concerning appropriate treatment and/or course action to resolve a specific clinical situation.

AMOR Youth Counselling Centres

According to both EHIF and foreign experts the activities of the AMOR Youth Counselling Centres were among the best performing prevention projects. These activities are aimed at achieving a good reproductive health status in the young. In addition to lectures and online information the centres are providing youth-friendly, reliable and accessible sexual health services, e.g. testing for sexually transmitted diseases, counselling concerning sex life and contraceptives, and, if necessary, also psychological aid.

The Estonian Sexual Health Association is managing the project. Their website, www.amor.ee contains information about the counselling centres, but also materials for reading up on the subject; it is also possible to get anonymous counselling by e-mail. Almost all the employees of the AMOR Youth Counselling Centres have been visiting schools in order to promote the centres and encourage young people to seek assistance.

Girls make up most of the customers of the counselling centres. The young men have been less involved, mostly due to the limited number of specialists dealing with male sexual health issues. As a more general trend men are less prone to visiting doctors altogether.

The feedback given by the young people is proof of the excellent work done by the counselling centres. On a 4-point scale satisfaction with the services was rated at 3.8 in 2008.

From the beginning of the project in 2002 almost 10 000 visits have been paid to the Youth Counselling Centres. The knowledge of senior students in basic schools concerning sexual life has improved and the use of contraceptives has grown among the youth.

The sexual health indicators of young people show that the incidence of sexually transmitted diseases has decreased by almost one half in comparison with the early years of the project.

According to Estonia's health statistics of the year 2000 young women of up 19 years of age underwent abortions in 1651 cases and gave birth in 1307 instances, in 2006 the figures were 1318 and 1110 respectively. Thus there has been a change for the better, with the number of abortions decreasing by a third.

Performance Pay of Family Physicians

A quality related bonus system, i.e. performance pay system has been introduced for family physicians in cooperation with the Estonian Society of Family Doctors. The system consists of three parts:

- Prevention (vaccination and examination of children and prevention of cardio-vascular diseases in adults);
- Monitoring patients with chronic diseases (type 2 diabetes, essential hypertension, myocardial infarction, hypothyroidism);
- Activities requiring additional professional competence in a physician (monitoring pregnancies, minor surgical procedures and manipulations) and teamwork (professional in-service training of family physicians and nurses).

By the end of 2008 78% of the family physicians had joined the performance pay system. The coverage differs by region: 77% in Harju region, 69% in Tartu region, 88% in Pärnu region and 85% in Viru region, reflecting the differences in the coverage of people with preventive activities by region.

The family physicians' performance pay system evolves constantly. In cooperation with the Estonian Society of Family Doctors and EHIF every now and then new diseases or conditions to be monitored are added to the system. At the beginning the activities of family physicians were only assessed on the basis of patients suffering from two chronic diseases (type 2 diabetes and essential hypertension), whereas now patients with hypothyroidism and those who have had an infarction are included as well.

In 2008 EHIF studied whether the performance pay system really did make the family physicians undertake activities ensuring better health for their patients. The survey compared coverage of a specific target group (in this example diabetic patients) in 2005 (when the performance pay system was not yet operational) with 2006 and 2007.

Table 3. Coverage of patients with type 2 diabetes with monitoring activities by physicians participating in the performance pay system, 2005–2007

	Average coverage		
Patients with type 2 diabetes	2005	2006	2007
Fundus examination	28%	33%	51%
Measurement of glycohemoglobin in blood serum	22%	34%	46%
Measurement of creatinine in blood serum	24%	38%	49%
Measurement of total cholesterol in blood serum	34%	45%	54%
Measurement of cholesterol fractions in blood serum, once every three years	8%	28%	54%
Urine test	23%	35%	42%
Measurement of albumin in urine (microalbuminuria)	8%	22%	29%
Advice given by family nurse concerning diet and healthy lifestyles	-	-	39%

The health status of patients of physicians participating in the performance pay system is better than the results of those who are not. This is true for both preventive activities aimed at children and adults and for monitoring chronic diseases.

LEGISLATIVE WORK

The Estonian Health Insurance Fund monitors the legislative process and participates actively therein on a daily basis. All the activities of EHIF, including its development activities should be set in a proper legal framework. Legal clarity lays the foundation for stable relations with partners and clients, which are based on mutual understanding.

In 2008 EHIF was called to provide opinions concerning 15 draft laws and 37 draft regulations. The opinions are based on economic analysis and forecasts concerning the activity, as well as on legal arguments. EHIF has initiated the process of drafting legislation in matters concerning health insurance and the fund, and has actively participated in the legislative work.

The List of Health Services, established by regulation of the Government of the Republic on the basis of subsection 30(1) of the Health Insurance Act is among the most important instruments. The regulation enumerates the health services in the case of which the Health Insurance Fund assumes the obligation of an insured person to pay for the services. In addition to the list proper, the regulation sets forth the terms and conditions of providing the services and the limits for the payment.

Drafting the legal framework for the operation of the Digital Prescription Centre was a labour intensive project, undertaken jointly with the Ministry of Social Affairs.

EHIF was also actively involved in preparing legislation for the Health Information System.

Proposals to amend the Health Insurance Act so as to improve the possibilities of paying medical devices benefits to the insured were sent to the Ministry of Social Affairs.

In 2008 EHIF participated in the EU legislative work as well, providing opinions and making proposals concerning the following:

- Proposal for a Regulation of the European Parliament and of the Council laying down the procedure for implementing Regulation (EC) No 883/2004, which, once it enters into force, will regulate a system of electronic data exchange between the Member States, the provision of health services in another Member State and the rules of payment for these services;
- Proposal for a directive of the European Parliament and of the Council on the application of patients' rights in cross-border healthcare, which will regulate quality matters arising with respect to the provision of health services in another Member State and liability in cases of obtaining health services in another Member State, as well as rules of payment for the health services received in another Member State;
- Proposal for a directive of the European Parliament and of the Council on standards of quality and safety of human organs intended for transplantation, which will also establish the procedure for paying for transplantation services;
- Proposal for a directive of the European Parliament and of the Council amending Council Directive 92/85/EEC on the introduction of measures to encourage improvements in the safety and health at work of pregnant workers and workers who have recently given birth or are breastfeeding. The introduction of the legislation will not result in major changes in the legal protection of the persons insured by EHIF in comparison with currently applicable law;
- Proposal for a directive of the European Parliament and of the Council on the application of the principle of equal treatment between men and women engaged in an activity in a self-employed capacity. The objective of the directive is to provide social protection for the spouses of self-employed persons, who participate in economic activities, including the granting of maternity/paternity leave for them.

COOPERATION WITH INSURED PERSONS, PARTNERS AND EMPLOYERS

Information

An important part of the daily activities of EHIF is taken up by informing the insured persons, partners and employers of their rights and obligations, as well as other aspects pertaining to the health system. The Health Insurance Fund has created a wide variety of ways for informing the stakeholders.

- The EHIF website www.haigekassa.ee is an important information channel, which contains a lot of useful materials for the insured, partners and employees. The insured persons can get an overview of all benefits available under health insurance and the principles of calculating the benefits; there is also advice on how to apply for health insurance and information about medical care in the EU. Employers can find information about how to forward insurance data and certificates of incapacity for work, they can learn about the Portal for Enterprises and how to use it. Partners can use the website to get information about clinical practice guidelines and health services. In addition the website contains statistics (about pharmaceuticals distributed at a discount and waiting lists), the budgets and annual reports of the Health Insurance Fund. All possible forms required for communicating with EHIF are also posted on the website. Questions can be sent to the Health Insurance Fund via the website and by e-mail info@haigekassa.ee. In 2008 more than 2000 queries were made through the website and another 2000 questions were received by e-mail. The biggest number of inquiries concerned benefits for temporary incapacity for work.
- Haigekassa Teataja is the journal of the Health Insurance Fund, which is published once a year in both Estonian and Russian. The 2008 issue discussed the health insurance system in Estonia, prices of health services, waiting lists, visit fees, certificates of incapacity for work, benefits, examinations for early detection of cancer, rehabilitation and nursing care, medical care in the EU.
- Cooperation with daily and local newspapers and professional media is important in order to explain the health insurance system to all stakeholders. Some of the themes covered by the various articles were the following: the European health insurance card, pharmaceuticals distributed at a discount, the procedure for paying benefits for dentures, the system of family physicians, visit fees etc. The more active partners among the local newspapers in 2008 were the following: Põhjarannik, Narvskaja Gazeta and Sillamjaeski Vestnik, Linnaleht, Koit, Vooremaa, Valgamaalane; and the national farmers' weekly Maaleht. The medical newspaper Meditsiiniuudised has also become a good partner.
- The following brochures were commissioned and distributed in 2008: "Benefits and Support for Pregnant Women and for Parents", „Is Childlessness Inevitable?", „Health Insurance for the Self-Employed", „Medical Care by Family Physicians", „Benefits for Temporary Incapacity for Work". The brochures are free and can be picked up at the customer service bureaux, hospitals, women's outpatient clinics, family health centres and other health institutions.
- The EHIF hotline 16,363 provides advice and help for target groups. The insured persons can call if they have any question concerning health insurance, benefits for temporary incapacity for work etc. Employers can get advice on how to use the X-Road system and partners on how to upload data to the database.

Over the years ever more people have started calling the hotline. In 2008 179,346 calls were taken, with the daily average of 712 calls and in the month of May the daily average was even as high as 976 calls.

Table 4. Calls made to the hotline, broken down by year

	2005	2006	2007	2008
Number of calls	116,916	138,550	170,726	179,346

- The purpose of meetings and information days is to communicate directly, without the media, with the target groups. Such meetings were organised for both the insured and the partners in 2008. Special mention should be made of lectures to school children on health insurance during travel in the EU and studies abroad. Some schools have considered awareness among their students about health insurance of such importance that they have set up a link to the EHIF website on the school homepage. The meetings with partners were mostly devoted to random selection, clinical practice guidelines, dentures and dental care benefits.

ELECTRONIC HEALTH INSURANCE FUND

The Health Insurance Fund has gradually replaced its IT solutions that had become obsolete and started to use the SAP software. This electronic document management software saves the insured, employers and medical institutions from the need to submit paper documents.

One of the activities to have been placed on the SAP platform is processing health insurance cover. The transition has proven really useful and in 2008 87% of all insurance entries were made electronically.

In 2008 the processing of benefits for incapacity for work was also transferred into the SAP system. As a result the speed of processing the benefits accelerated considerably. This is a step towards introducing an electronic certificate of incapacity for work in a few years.

During 2009 the remaining cash benefits (benefit for dental care and supplementary benefit for pharmaceuticals) will enter the SAP system. The combination of the health insurance data and processing of cash benefits in one system ensures efficient, transparent and reliable operation of the processes.

SATISFACTION SURVEYS

The Health Insurance Fund receives feedback about its activities through annual satisfaction surveys (http://www.haigekassa.ee/haigekassa/uuringud).

- In the satisfaction survey of the insured "Patient Evaluation of Health and Health Care" the respondents expressed their opinion as regards access to medical care and its quality, the financing of health care, the procedures of prescribing and purchasing pharmaceuticals, the work of EHIF etc. The survey reflects the opinion of the patients about the state of their health and lifestyles.
- The survey „Satisfaction of the EHIF Contractual Partners" measured the satisfaction of the contractual partners. The survey results were broken down by types of contractual partners (family physicians, medical specialists, dentists, pharmacists, providers of nursing care). The issues surveyed included cooperation with EHIF, contracts for funding medical care, organisation of electronic data exchange. Most of the partners were of a high opinion as regards cooperation with EHIF: more than one-third thought that cooperation was "very good".
- The employers responded to the survey "Satisfaction of the Employers with EHIF". In addition to expressing their level of satisfaction the employers replied to questions about their preferred channels for forwarding documents and obtaining information, and about their satisfaction with the EHIF customer services. It emerged that employers continued to be well satisfied with the customer services of the Health Insurance Fund and that in comparison with the previous years forwarding documents by post has grown considerably in popularity.

EHIF ORGANISATION AND EMPLOYEES

At the end of 2008 EHIF employed a staff of 225, 87% women and 13% men.

Figure 6. Years of Service

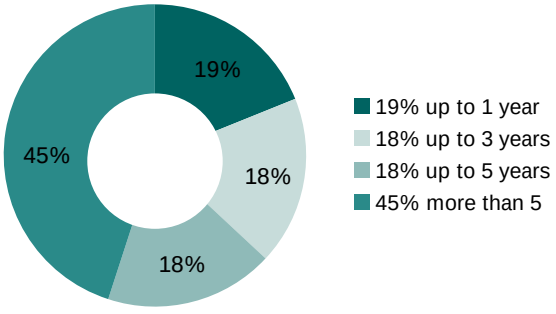
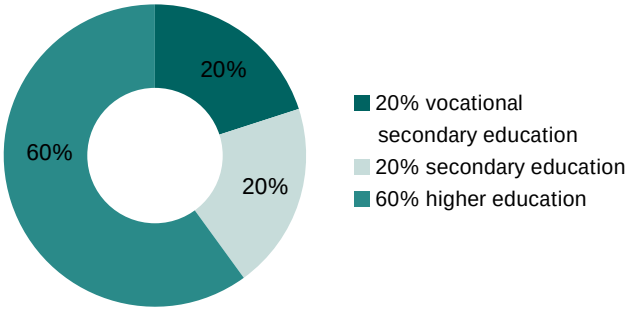


Figure 7. Education



Communicating the Values to Employees

The strategic goals of the Estonian Health Insurance Fund derive from its core values, which also serve as a basis for organisation of work in EHIF.

When we first formulated our values, the objectives were centred on our clients and partners. In 2007 a discussion was launched with the employees in order to establish how the declared values tied in with the values of our employees and whether there were other values that had a significant impact on our daily work. The results of the discussion led to the idea of creating a film devoted to the EHIF values, which would take examples from real life situations in order to best convey the EHIF values. The film was ready in summer 2008.

A Day of Values was organised in September, aiming at improving cooperation and attaining the strategic goals. It emerged that the employees of EHIF regard the following as important values:

- A supportive working environment: a committed and supportive team engaged in interesting work;
- Consideration: trust of the team, recognition, feedback on work done;
- Development: professionalism, innovation, desire to study.

The most important value was usefulness for the society – to work in EHIF for the benefit of the people.

Development of Training Strategy

Training needs are assessed within a four year context in order to establish the knowledge and skills to be developed for the various areas of activity, as well as determine the groups of employees that need training due to changes in legislation, the introduction of new IT applications or modifications in the organisation of work.

The training strategy is developed for targeted training of the employees. The strategy sets out the following for the next four years: general trends to be followed in training, priority areas and target groups. The strategy takes into account the development trends in the areas of activity of the organization, changes in the organisation of work and IT systems, as well as feedback concerning the usefulness of the trainings conducted during the previous period.

Communicating the Strategy to Employees

In the course of preparing the annual EHIF development plan and scorecard, annual scorecards are also established for its departments, setting out the necessary performance indicators, objectives and development activities. The employees' scorecards derive from the general EHIF scorecard and those of the departments.

Evaluation of attainment of objectives is performed as follows: the performance period of an employee commences and ends with a performance interview, dedicated to evaluating the results achieved during the previous period and planning the objectives, performance indicators and/or activities for the next performance period. The Supervisory Board evaluates the performance of the Health Insurance Fund.

Satisfaction of Employees with EHIF Management and Organisation of Work

A strong team is built by recruiting competent employees who meet the values of the organisation. It is important to inform the employees of what is expected of them and involve the employees in decision-making. A team whose every member is ready to perform at his or her best to jointly attain the established goals, can experience the feeling of success and get recognition from colleagues, partners and clients for good performance. A sense of success in its turn contributes to commitment. Successful attainment of the goals is an indication of a responsible organisation and improves its image in the society at large. The satisfaction of the employees is guaranteed by involving and developing the employees and by giving them recognition for work well performed. This is key to the success of the organisation.

2008 BUDGET EXECUTION REPORT

Table 5. Budget (in EEK thousand)

	2007 actual	2008 budget	2008 actual	Budget execution %	% of change against 2007
REVENUE					
Share of social tax designated for health insurance	11,000,420	12,495,963	12,502,365	100.1%	13.7%
Revenue from contracts for persons considered equal to insured persons	34,071	32,000	40,244	125.8%	18.1%
Amounts due from other persons	9,356	11,000	14,208	129.2%	51.9%
Financial income	97,104	94,000	165,844	176.4%	70.8%
Other income	41,873	182,100	177,202	97.3%	323.2%
Total budget revenue	11,182,824	12,815,063	12,899,863	100.7%	15.4%
HEALTH INSURANCE EXPENDITURE					
Health service expenses	6,825,468	8,361,533	8,252,477	98.7%	20.9%
Disease prevention expenses	90,148	119,000	109,095	91.7%	21.0%
Expenses on primary health care	886,076	1,086,608	1,047,224	96.4%	18.2%
Expenses on specialised medical care	5,419,985	6,611,226	6,558,922	99.2%	21.0%
Nursing care expenses	189,267	238,599	237,972	99.7%	25.7%
Dental care expenses	239,992	306,100	299,264	97.8%	24.7%
Health promotion expenses	12,688	14,000	13,970	99.8%	10.1%
Expenses on pharmaceuticals reimbursed to the insured	1,120,559	1,324,000	1,281,486	96.8%	14.4%
Expenses on benefits for temporary incapacity for work	1,926,851	2,415,554	2,387,453	98.8%	23.9%
Other cash benefits expenses	184,665	258,162	201,678	78.1%	9.2%
Other expenses	78,538	111,000	85,892	77.4%	9.4%
Health service benefits arising from international agreements	34,200	26,565	32,470	122.2%	–5.1%
Benefits for medical devices	44,338	84,435	53,422	63.3%	20.5%
Total health insurance expenditure	10,148,769	12,484,249	12,222,956	97.9%	20.4%
EHIF OPERATING EXPENDITURE					
Personnel and management expenses	60,030	73,077	72,543	99.3%	20.8%
Wages and salaries	45,038	54,826	54,428	99.3%	20.8%
incl remuneration paid to management board members	2,109	2,302	3,056	132.8%	44.9%
Unemployment insurance	129	158	154	97.5%	19.4%
Social tax	14,863	18,093	17,961	99.3%	20.8%
Administrative expenses	18,621	21,097	20,110	95.3%	8.0%
IT expenses	8,023	10,401	10,283	98.9%	28.2%
Development expenses	3,738	4,521	3,309	73.2%	–11.5%
Training	1,527	1,791	1,481	82.7%	–3.0%
Consultations	2,211	2,730	1,828	67.0%	–17.3%
Financial expenses	90	100	132	132.0%	46.7%
Other operating expenses	4,630	5,618	9,952	177.1%	114.9%
Pre-printed forms and publications	948	932	974	104.5%	2.7%
Supervision of the health insurance system	1,033	1,285	983	76.5%	–4.8%
Public relations/communication	1,101	1,147	1,311	114.3%	19.1%
Other expenses	1,548	2,254	6,684	296.5%	331.8%
Total EHIF operating expenditure	95,132	114,814	116,329	101.3%	22.3%
Total budget expenditure	10,243,901	12,599,063	12,339,285	97.9%	20.5%
Total changes in reserves	938,923	216,000	560,578	x	x
Transfer to legal reserve	122,000	162,000	196,907	x	x
Transfer to risk reserve	41,000	54,000	65,636	x	x
Retained earnings	775,923	0	298,035	x	x
Total	11,182 824	12,815,063	12,899,863	100.7%	15.4%

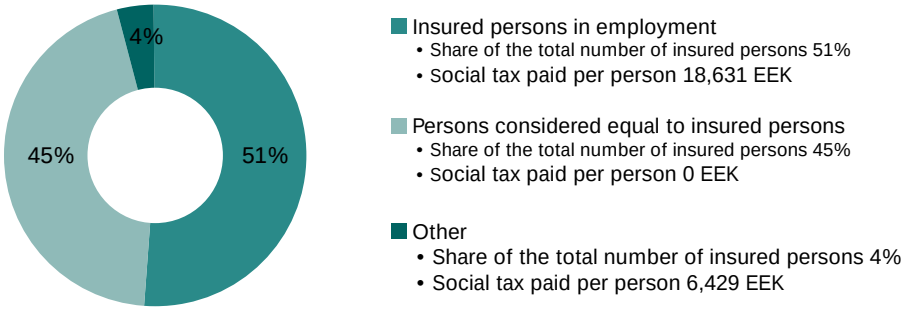
Table 6. Number of insured persons

Persons	31.12.2007	31.12.2008	Change 2008/2007 %
Insured persons in employment	672,706	658,079	–2.2%
Persons insured by the state	31,942	40,477	26.7%
Persons considered equal to insured persons	579,698	579,752	0.0%
Persons insured under international agreements	3,419	3,410	–0.3%
Total	1,287,765	1,281,718	–0.5%

Table 7. Average expenses per one insured person in 2008

Age of insured persons	Number of insured persons as of 31.12.2008	Expenses on primary health care, EEK	Expenses on specialised medical care, EEK	Expenses on pharmaceuticals, EEK	Total expenses, EEK
0–9	139,887	796	3,869	325	4,990
10–19	153,470	693	3,358	290	4,341
20–29	177,209	738	3,576	474	4,788
30–39	171,520	808	3,720	584	5,112
40–49	167,548	788	4,135	773	5,696
50–59	168,027	867	6,411	1,304	8,582
60–69	138,129	962	9,118	2,153	12,233
70–79	112,737	932	11,969	2,669	15,570
80–89	47,780	858	11,322	2,249	14,429
90–99	5,302	774	9,575	1,221	11,570
100–109	109	735	9,035	–	9,770

Figure 8 . Breakdown of insured persons by type and their respective social tax contributions



REVENUE

Table 8. Revenue (in EEK thousand)

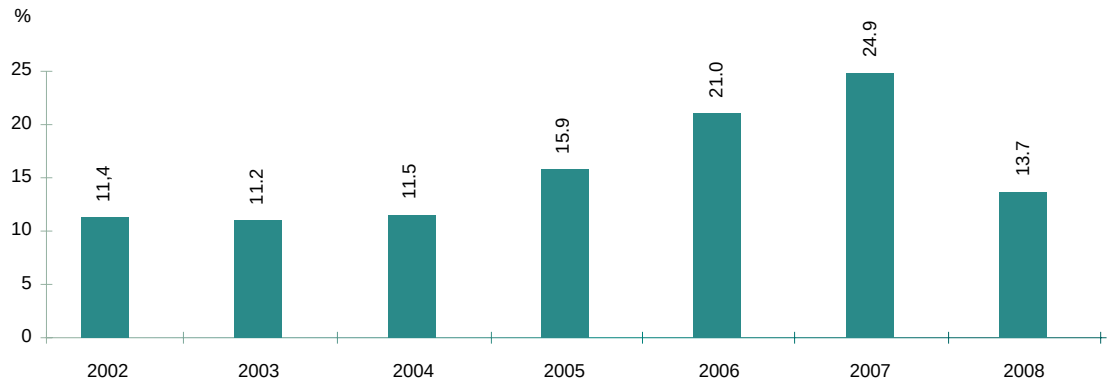
	2007 actual	2008 budget	2008 actual	Budget execution %	% of change against 2007
Share of social tax designated for health insurance	11,000,420	12,495,963	12,502,365	100%	14%
Revenue from contracts for persons considered equal to insured persons	34,071	32,000	40,244	126%	18%
Amounts due from other persons	9,356	11,000	14,208	129%	52%
Financial income	97,104	94,000	165,844	176%	71%
Other income	41,873	182,100	177,202	97%	323%
Total	11,182,824	12,815,063	12,899,863	101%	15%

Share of social tax designated for health insurance

The social tax revenues designated for health insurance constitute the biggest part of the EHIF revenue; 96.9% in the 2008 fiscal year.

The budget was prepared on the basis of the Ministry of Finance forecast for social tax revenues. In line with the 2008 spring forecast the EHIF Supervisory Board approved a supplementary budget in autumn 2008, cutting the revenues by 538 million EEK (The total budget as approved at the beginning of 2008 had been 13,034 million EEK). Even if the social tax revenues designated for health insurance did not grow at a pace comparable with the previous years, the total for 2008 amounted to 12.5 billion EEK, a 13.7% increase in comparison with 2007.

Figure 9. Increase in social tax revenues (by year)



Revenue from contracts for persons considered equal to insured persons

Insurance on the basis of voluntary insurance contracts yielded 4.3 million EEK and insurance on the basis of the Health Insurance Agreement concerning Non-working Pensioners of the Armed Forces of the Russian Federation residing in Estonia produced 35.9 million EEK.

Amounts due from other persons

13.6 million EEK worth of unjustified payments were recovered in 2008 from health care providers, insured persons and employers. The actions by the Prison Board produced 0.6 million EEK. These cases mostly involved recovery of expenses on medical treatment, pharmaceuticals distributed at a discount and sickness benefits from the offender in cases of causing bodily injury.

Financial income

The EHIF finances are being managed by the Government Payments Office of the Ministry of Finance. Financial income was budgeted on the basis of the volume of reserves and average balance of funds, plus the rate of return forecast by the Ministry of Finance. Given that the balance and the rate of return both exceeded the planned levels the budget execution rate was 176%.

Table 9. EHIF key investment indicators as of 31.12.2008

	Investments of risk reserve and earnings	Investments of legal reserve
Volume of fund at cost, in EEK thousand	2,938,251	467,002
Volume of fund at market value, in EEK thousand	2,971,558	483,884
Realised gains from the beginning of the year, in EEK thousand	134,201	13,534
Revaluation gain, in EEK thousand	33,307	16,882
Profitability from the beginning of the year (on a yearly basis)	5.07%	5.69%
Average duration of investments in days (on a yearly basis)	0.17	1.21

Other income (incl government grants)

- 38 million EEK earmarked for covering the costs of infertility treatment and 125.1 million EEK for compensating the depreciation costs of buildings of health care providers were allocated from the state budget (see p 38 for costs incurred on account of government grants). The depreciation costs were reimbursed to the Health Insurance Fund from the state budget on the basis of the volume of health services indicated in the invoices for medical treatment and the reference prices applicable at the time of providing the services[7], to which the share of the depreciation of buildings contained in the reference price was applied.
- 12.7 million EEK was received for services provided to the insured persons of other EU member states. The Health Insurance Fund pays for medical care afforded in Estonia to the insured persons of other member states on an equal footing with the Estonian insured persons. The competent authority of the relevant member state shall later reimburse the costs to EHIF.
- 1.4 million EEK was earned from the sale of prescription forms and for processing invoices for medical treatment during the period under review.

[7] Reference price – the price on the basis of which the Health Insurance Fund assumes the obligation to pay for health services (the price paid by the Health Insurance Fund to the service provider). A reference price of health services covers all expenses necessary for the provision of the health service.

EXPENDITURE

The Health Insurance Fund expenditure consists of health insurance expenditure and operating expenditure.

HEALTH INSURANCE EXPENDITURE

1. Health Services

The Health Insurance Fund based the planning of the 2008 budget for health services on the following objectives:

- To guarantee access to health services at least at the level of 2007;
- To increase the number of cases in areas where an increased need can be expected (oncology, cardiology, infectious diseases) and where a need for funding new cases arises as a result of adding new health services to the List of Health Services;
- To harmonise the waiting lists for specialised medical care, by cutting the waiting times by at least six months for endoprosthetic replacement and cataract operations;
- To increase the volume of compensating the costs of biological medicines, first undertaken in 2007, in order to ensure continuation of treatment for those who benefited from the possibility and to enable such treatment for new patients;
- To increase the choice of pharmaceuticals that can be used to treat oncological diseases.

In 2008 EHIF assumed the obligation to pay for 8.3 billion EEK worth of health services, exceeding the 2007 amount by more than 1.4 billion EEK.

Table 10. Health service benefits (in EEK thousand)

Health service benefits	2007 actual	2008 budget	2008 actual	Budget execution %	% of change against 2007
Disease prevention	90,148	119,000	109,095	92%	21%
Health services of primary health care	886,076	1,086,608	1,047,224	96%	18%
Specialised medical care	5,419,985	6,611,226	6,558,922	99%	21%
Nursing care	189,267	238,599	237,972	100%	26%
Dental care benefits	239,992	306,100	299,264	98%	25%
Total	6,825,468	8,361,533	8,252,477	99%	21%

Health services constitute the largest part of all health insurance expenses (see figure 10). The biggest cost item among health services is specialised medical care (see figure 11).

Figure 10. Distribution of health insurance expenditure, 2008

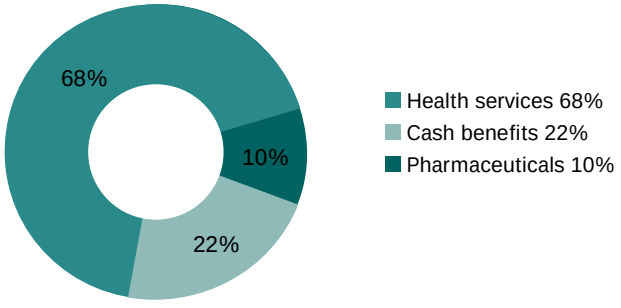
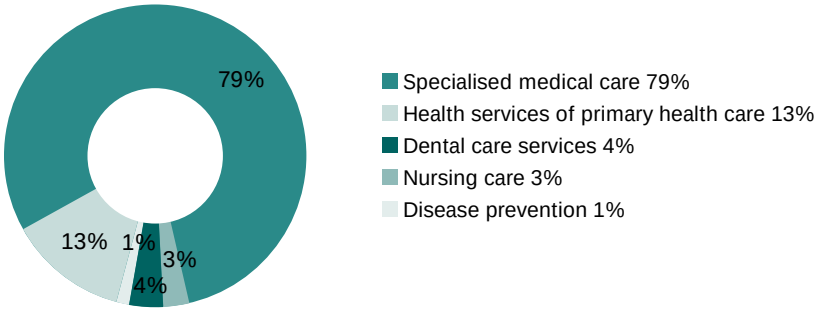


Figure 11. Distribution of health service expenses, 2008



Depreciation costs of buildings reimbursed to health care providers

The Health Insurance Fund reimbursed health care providers 168.6 million EEK of depreciation costs of buildings, embedded in reference prices. 125.1 million EEK in the form of a government grant came from the state budget to compensate to the Health Insurance Fund the share of the depreciation of buildings contained in the reference price (see p 36 for government grants).

Table 11. Depreciation costs of buildings, embedded in health service reference prices (in EEK thousand)

	Depreciation of buildings
Specialised medical care	124,997
Prevention	1,298
Dental care	5,583
Nursing care	9,319
Family physicians	27,378
Total	168,575

1.1. Disease Prevention

The objective of disease prevention is to detect a predisease condition in a patient as early as possible and to take measures to avoid illness. 109 million EEK was spent on disease prevention in 2008.

Table 12. Disease prevention (in EEK thousand)

Preventive activity	2007 actual	2008 budget	2008 actual	Budget execution %	% of change against 2007
School health	46,343	61,484	58,933	96%	27%
Youth reproductive health project	10,022	13,000	13,138	101%	31%
Early detection of breast cancer	11,750	13,664	12,760	93%	9%
Early detection of cervical cancer	2,553	4,720	2,307	49%	–10%
Projects aimed at preventing heart diseases	2,310	2,564	2,565	100%	11%
Early detection of osteoporosis	1,050	1,430	1,216	85%	16%
Phenylketonuria and hypothyroidism screening	2,807	3,280	3,155	96%	12%
Prenatal diagnostics for hereditary diseases	10,198	12,996	10,373	80%	2%
Newborn hearing screening	3,089	5,040	4,191	83%	36%
Immunisation against hepatitis B	26	238	18	8%	–31%
Other preventive activities (evaluation of projects)	0	584	439	75%	–
Total	90,148	119,000	109,095	92%	21%

Table 13. Results of disease prevention projects

Preventive activity	Actual number of participants 2007	Planned number of participants 2008	Actual number of participants 2008	Actual 2008/ planned 2008	Results
School health	175,537	174,671	167,422	96%	As of the end of 2008 only ten schools (ca 1 200 pupils) did not have a school health contract. 34% of schools have established health councils in their schools
Youth reproductive health project (number of visits)	28,395	30,000	32,077	107%	Sexually transmitted diseases were detected in 652 cases (incl 9 with HIV). Of the young women of up 19 years of age who visited the counselling centres 147 were given referrals to register their pregnancies and 177 to undergo abortion.
Projecst aimed at early detection of breast cancer*	26,467	32,000	30,177	94%	762 women or 2.5% of the screened women were referred to undergo further examinations. 134 of these women were referred to consultations by breast specialists, resulting in detection of 120 cases of cancer. 83% of these cases were early stage breast cancers.
Early detection of cervical cancer*	11,659	20,000	12,063	60%	700 women (ca 6%) of the screened women were discovered to have precancer or cancer.
Projects aimed at preventing heart diseases	5,055	4,250	4,979	117%	39% of the project participants started work with their risk factors. In the course of the project the general heart disease risk went down in 6% of those examined, incl a drop in systolic pressure by more than 6 mm Hg in persons with hypertension and a 0.9 mmol/l decrease in average cholesterol levels in persons with higher cholesterol levels. 5% of the smoking participants stopped using tobacco during the project.
Early detection of osteoporosis	1,357	1,300	1,188	91%	Osteoporosis was detected in 34% of the persons examined and osteopenia (a pre-osteoporosis state) in 38%. 50% of the persons who were examined for the first time were taking Calcium supplements and vitamin D, wereas the figure was 85% among those who underwent a repeat examination.
Phenylketonuria and hypothyroidism screening	15,692	16,000	16,224	101%	100% of the newborns were screened, resulting in timely detection of 2 cases of phenylketonuria and 5 cases of hypothyroidism.
Prenatal diagnostics for hereditary diseases	2,150	2,200	2,100	95%	39% of the examinations were undertaken because of age risk. Fetal chromosomal anomaly was detected in 73 cases (3%), including 26 instances of Down syndrome.
Newborn hearing screening	11,536	14,000	13,301	95%	98% of the newborns were screened in the participating health care institutions. 16 babies were diagnosed with hearing loss. In 2008 four children, whose hearing loss was detected through screening received cochlear implants.
Immunisation against hepatitis B	231	1,000	152	15%	The immunisation was mostly limited to students of the Faculty of Medicine.

* All persons falling into risk groups constitute the target for prevention projects, however for the purposes of planning the budget for a project the number of cases is estimated by taking into account the numbers of participants that can realistically be expected to join the project.

In most prevention projects the budget execution figures have been lower than originally budgeted, since additional examinations are carried out on a selective basis and their need is no longer that significant.

Mostly young women visited the Youth Counselling Centres, with only 5% being young male visitors. 20% of the cases were primary visits to the centre, and, as a positive development, every tenth new visitor was an adolescent. 36% of the visits resulted in testing for sexually transmitted diseases and 64% of the visits were devoted to sexual counselling. Every fifth visitor came for a repeat visit during the year.

In 2008 94% of the planned activities was achieved in screening for early detection of breast cancer. The result can be deemed positive.

However, screening for cervical cancer resulted in only 60% of the planned activities. Given that preventive PAP tests are also carried out in the course of regular visits to gynaecologists, some of the invitees could have preferred to see their own specialist for this purpose.

The population survey conducted every year by EHIF contains a question for women aged 15-74 about their awareness of and readiness to participate in cancer screening. 806 women gave an answer to the question and they were surprisingly well informed and ready to participate, especially women belonging to the screening target groups (aged 35-64). On the average the women's awareness levels of screening reached 90% and a similar number of women said that they were ready to undergo the health check when invited by the Health Insurance Fund. Consequently, low awareness levels cannot be the reason why the participation rate continues to be low among the women. The Health Insurance Fund makes every effort to ensure that the information and invitations reach the target group. From 2009 the mammography bus travels to all counties so as to facilitate access to the service.

Screening of all women was aimed at diagnosing hereditary diseases prenatally and reducing the need for invasive procedures. In 2007 invasive examinations were conducted in 51% of cases involving age risk, in 2008 the figure dropped to 39%. The reduction in invasive procedures also helped reduce the project costs.

Immunisation against hepatitis B was mostly limited to students of the Faculty of Medicine of the University of Tartu. The actual coverage in comparison with the planned immunisation levels turned out to be considerably lower, given that many students had been given the vaccine at the age of 13 and re-immunisation was not required.

In 2008 external evaluation of the impact and efficiency of the Youth Reproductive Health Project and Prenatal Diagnostics for Hereditary Diseases Project was completed. Based on the results of the evaluation the youth counselling centres project can be deemed as one of the most successful prevention projects as regards the structure and organisation of the activities undertaken. The prenatal diagnostics project was also carried out as planned, but here more emphasis is needed on prior coverage by primary screening. From 2009 the age of the pregnant woman is not considered as the sole indicator for invasive examinations, the results of a prior screening and hereditary risks also have to be taken into account.

1.2. Primary Health Care

The organisation of Estonian health care is family medicine centred: the family physician is the first point of entry for a patient, the family physician makes the decision concerning treatment or refers the patient to the relevant medical specialist.

In 2008 one billion EEK was spent on primary health care.

Table 14. Health services of primary health care (in EEK thousand)

	2007 actual	2008 budget	2008 actual	Budget execution %	% of change against 2007
Basic allowance	115,046	121,080	119,135	98%	4%
Distance allowance	5,325	5,366	5,205	97%	–2%
Qualification allowance*	4,760	0	0	0%	–100%
Capitation fee (under age 2)	28,551	35,991	35,295	98%	24%
Capitation fee (aged 2–70)	495,110	587,384	584,120	99%	18%
Capitation fee (over age 70)	86,419	104,716	105,096	100%	22%
Fund for examinations and tests (fee for service)	140,391	206,690	178,927	87%	27%
Family physician's performance pay **	3,435	14,954	11,574	77%	237%
Family doctor hotline	7,039	8,427	7,872	93%	12%
Primary health care reserve ***	0	2,000	0	0%	–
Total	886,076	1,086,608	1,047,224	96%	18%

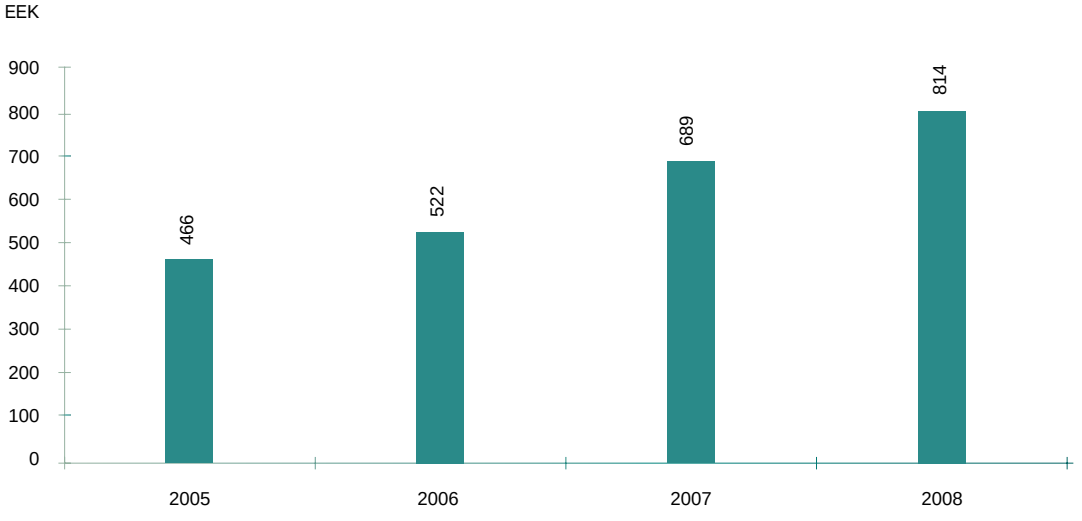
* Qualification allowances were paid until the end of June 2007, thereafter payments started to be made under the performance pay system.

** In the first half year of 2008 performance pay was effected in monthly instalments, based on the 2006 results and in the second half year performance pay was paid as one single amount, based on the 2007 result.

*** The amounts budgeted in the reserve for monitoring pregnancies and for autopsies are included in expenses in the line for the fund for examinations and tests.

Primary health care expenses grew by 18% (161 million EEK) in comparison with 2007. The increase in reference prices for capitation fees and basic allowances for health services and a larger fund for examinations and tests accounts mainly for the increase in expenses. The total increase in the above costs is also reflected in the primary health care expenses per insured person.

Figure 12. Primary health care expenses per insured person (2005–2008)



Performance pay system. In 2008 the activities of family physicians were evaluated for the second time under the performance pay system and family physicians received performance pay, i.e. additional pay for their quality performance in disease prevention and monitoring of patients with chronic diseases. The original monthly performance payments were stopped and the total amount was paid out at once, as this was considered a better incentive financially.

In 2006 nine family physicians received performance pay with a coefficient of 1.0 and 21 family physicians with a coefficient of 0.8. In 2007 performance pay was given to 175 family physicians – almost a six-fold increase.

In the long run the performance pay system will be increasing the efficiency of the activities of the family physicians in preventing diseases and monitoring chronic diseases of the persons belonging to the practice list of the family physician.

Fund for examinations and tests. In 2008 27% of the capitation fee; and from the second quarter of 2008, 32% of the capitation fee of family physicians participating in the performance pay system was scheduled for conducting examinations and tests. Of the planned amount only 87% was actually used up in 2008, which shows that the size of the fund is sufficient for the proper examination of patients.

Capitation fee. The number of persons in the age group of younger than two and that of older than 70 has grown by 3%. The EHIF expected an even higher birth rate in its budget planning, thus only 98% of the money budgeted for this age group was spent.

The reserve budget included funds required for monitoring pregnancies and conducting autopsies. In the annual report the actual costs for these activities are included in the expenses incurred from the fund for examinations and tests. Of the budgeted amounts designated for the primary health care reserve 251 thousand kroons was spent on monitoring pregnancies and 445 thousand kroons on autopsies, in total 696 thousand kroons.

Table 15. Number of practice lists of family physicians and number of insured persons in these lists

Number of lists and persons	2007 actual	2008 actual	% of change against 2007
Number of practice lists			
Number of practice lists	800	801	0%
Distance allowance	196	193	–2%
Qualification allowance	794	0	–100%
Average practice list	1,607	1,606	0%
Number of persons*			
Number of persons under 2, for whom capitation fee is paid	26,629	27,488	3%
Number of persons aged 2–70 for whom capitation fee is paid	1,100,233	1,096,321	0%
Number of persons over 70 for whom capitation fee is paid	158,790	162,788	3%
Total number of persons for whom capitation fee is paid	1,285,652	1,286,597	0%

* The number of persons for whom capitation fee is paid and the number of insured persons found in the EHIF statistics is not exactly the same, since capitation fee was calculated on the basis of the numbers as of 15.12. 2008 and statistics as of 31.12. 2008. In addition a family physician in whose service area the number of permanent residents is under 1,200, will be paid additional capitation fees to cover for the difference between the actual numbers and 1,200.

At the end of 2008 67 practice lists were smaller than the standard number of persons on a practice list (1,200–2,000 persons[8] per list) and 177 practice lists were larger than the standard; whereas among the 177 lists there were 48 practice lists containing more than 2,300 persons. 15 family physicians service areas with less than 1,200 permanent residents. These family physicians still received capitation fees for 1,200 persons from the Health Insurance Fund. A basic allowance at a coefficient of 1.5 was paid to the 59 family physicians who provide services at several locations due to the special nature of the region.

[8] Persons– include both insured and non-insured persons

Table 16. Consultations of family physicians

	2007 actual*		2008 actual		% of change against 2007	
	Consultations	Persons	Consultations	Persons	Consultations	Persons
Primary consultation	1,659,622	786,848	1,665,688	784,488	0%	0%
Subsequent consultation	2,337,228	694,073	2,382,556	698,294	2%	1%
Prophylactic consultation	401,153	229,828	450,309	231,071	12%	1%
Home visit	112,060	75,461	93,507	62,829	–17%	–17%
Independent consultation of family nurse	281,283	152,649	353,066	199,084	26%	30%
Planned consultation for non-insured persons	11,933	7,475	10,277	6,771	–14%	–9%
Home visit by family nurse	18,574	9,799	17,787	9,697	–4%	–1%
Telephone contacts	178,459	114,694	216,640	134,507	21%	17%

* The 2007 data has been adjusted to take into account the modifications carried out in the EHIF database, arising from the zero-amount invoices issued by family physicians (thus the difference here in comparison with the 2007 Annual Report).

The number of prophylactic consultations has grown. Another increase has occurred in the number of consultations by family nurses (26%) and the number of persons seen independently by family nurses (30%). This is a positive development that has resulted in more prophylactic efforts undertaken within the framework of the performance pay system for family physicians. The higher number of telephone contacts is in correlation with the reduction in home visits. The number of primary and subsequent consultations by family physicians and the number of persons seen during these consultations has not changed in comparison with 2007.

The national family doctor hotline took a total of 174,031 calls in 12 months (in 2007 – 154,467 calls), the daily average being 477. This is an increase of almost 13% against 2007. Most of the people called about their health problems, about 1% needed advice about the organisation of health care.

1.3. Specialised Medical Care

Expenses on specialised medical care in 2008 totalled 6.6 billion EEK, incl. 188.2 million EEK spent on the purchase of centrally contracted health services.

1.3.1. Health Services of Specialised Medical Care (Except Centrally Contracted Services)

In 2008 expenses on specialised medical care amounted to 6.4 billion EEK, an increase of 20% in comparison with 2007. The costs went up as a result of the following factors: a rise in reference prices of health services in early 2008; volume inflation (i.e. due to the provision of more expensive services); increase in the number of cases and new services added into the List of Health Services.

The share of outpatient and day care costs grew as well, for ever more examinations were conducted and health services were provided in the form of outpatient care or day care. 36% of the expenses incurred on specialised medical care were used to pay for outpatient and day care services and 64% for inpatient services (the respective figures in 2007 were 34% and 66%; in 2006 - 32% and 68% respectively).

3.1 million cases were financed from the budget, of these 92% were treated as outpatient or day care cases. The higher than planned volume of outpatient and day care cases has ensured access to specialised medical care to more patients. Tables 17 and 18 illustrate the distribution of resources and cases by specialties and by types of care.

Table 17. Expenses of specialised medical care (in EEK thousand)

	2007 actual	2008 budget	2008 actual	Budget execution %	% of change against 2007
Surgery	1,055,556	1,245,774	1,209,721	97%	15%
outpatient care	174,425	202,854	210,164	104%	20%
day care	39,301	44,532	43,018	97%	9%
inpatient care	841,830	998,388	956,539	96%	14%
Otorhinolaryngology	162,367	188,409	187,407	99%	15%
outpatient care	64,422	77,651	82,461	106%	28%
day care	32,670	37,537	32,279	86%	–1%
inpatient care	65,275	73,221	72,667	99%	11%
Neurology	171,594	205,949	205,999	100%	20%
outpatient care	75,165	87,159	93,099	107%	24%
inpatient care	96,429	118,790	112,900	95%	17%
Ophthalmology	212,714	249,855	251,535	101%	18%
outpatient care	105,816	129,643	129,206	100%	22%
day care	93,042	104,173	106,503	102%	14%
inpatient care	13,856	16,039	15,826	99%	14%
Orthopaedics	442,935	519,053	519,769	100%	17%
outpatient care	94,439	109,933	113,009	103%	20%
day care	29,890	34,426	33,163	96%	11%
inpatient care	318,606	374,694	373,597	100%	17%
Oncology	390,639	553,476	552,967	100%	42%
outpatient care	177,641	276,672	276,959	100%	56%
day care	2,729	13,371	38,628		–
inpatient care	210,269	263,433	237,380	90%	13%
Obstetrics and gynaecology	552,652*	634,516	626,704	99%	13%
outpatient care	229,670	260,162	269,439	104%	17%
day care	33,267	33,766	31,337	93%	–6%
inpatient care	289,715	340,588	325,928	96%	12%
Pulmonology	155,986	190,847	199,939	105%	28%
ambulatoorne	65,393	74,842	91,310	122%	40%
statsionaarne	90,593	116,005	108,629	94%	20%

Dermatovenereology	62,388	75,090	74,595	99%	20%
outpatient care	50,407	59,625	61,073	102%	21%
day care	720	968	1,471	152%	104%
inpatient care	11,261	14,497	12,051	83%	7%
Paediatrics	241,613	277,511	279,164	101%	16%
outpatient care	50,714	55,890	62,957	113%	24%
day care	6,485	7,599	6,196	82%	–4%
inpatient care	184,414	214,022	210,011	98%	14%
Psychiatry	248,273	297,859	290,092	97%	17%
outpatient care	61,818	75,861	75,428	99%	22%
day care	847	982	1,023	104%	21%
inpatient care	185,608	221,016	213,641	97%	15%
Infectious diseases	76,540	83,172	88,934	107%	16%
outpatient care	18,906	21,566	26,158	121%	38%
inpatient care	57,634	61,606	62,776	102%	9%
Internal diseases	1,281,387	1,540,894	1,553,589	101%	21%
outpatient care	236,714	283,800	299,729	106%	27%
day care	102,483	109,821	115,599	105%	13%
inpatient care	942,190	1,147,273	1,138,261	99%	21%
Follow-up care	16,929	20,661	22,184	107%	31%
inpatient care	16,929	20,661	22,184	107%	31%
Rehabilitation	113,412	145,083	144,658	100%	28%
outpatient care	48,261	64,817	66,658	103%	38%
inpatient care	65,151	80,266	78,000	97%	20%
Unspecified specialities	11,317	15,213	13,335	88%	18%
outpatient care	11,317	15,213	13,335	88%	18%
Total specialised medical care	5,196,302	6,243,362	6,220,592	100%	20%
Total outpatient care	1,465,108	1,795,689	1,870,985	104%	28%
Total day care	341,434	387,175	409,217	106%	20%
Total inpatient care	3,389,760	4,060,498	3,940,390	97%	16%
On-call duty fee[9]	97,626	150,487	150,095	100%	54%
Kokku	5,293,928*	6,393,849	6,370,687	100%	20%

* In order to ensure comparability the 2007 costs of obstetrics and gynaecology have been adjusted to take into account the cost of infertility treatment, covered from a government grant in the amount of 16.8 million EEK. In the 2007 Annual Report the government amounts earmarked for infertility treatment were included under “Other cash benefits”, whereas in the 2008 report they appear under the costs of obstetrics and gynaecology.

Table 18. Specialised medical care cases

	2007 actual,	2008 budget	2008 actual	Budget execution %	% of change against 2007
Surgery	368,518	375,757	380,201	101%	3%
outpatient care	310,980	317,290	323,534	102%	4%
day care	8,953	9,195	8,839	96%	–1%
inpatient care	48,585	49,272	47,828	97%	–2%
Otorhinolaryngology	206,292	211,832	210,239	99%	2%
outpatient care	187,440	192,488	191,138	99%	2%
day care	6,378	6,719	5,890	88%	–8%
inpatient care	12,474	12,625	13,211	105%	6%
Neurology	129,989	132,820	137,270	103%	6%
outpatient care	123,001	125,756	129,931	103%	6%
inpatient care	6,988	7,064	7,339	104%	5%
Ophthalmology	350,052	363,984	363,742	100%	4%
outpatient care	337,630	350,767	350,104	100%	4%
day care	10,808	11,510	11,916	104%	10%
inpatient care	1,614	1,707	1,722	101%	7%

[9] Ensuring round the clock preparedness per quarter per a medical specialty (medical specialists of certain specialties are on call in the hospital 24 hours a day).

Orthopaedics	259,000	267,461	263,959	99%	2%
outpatient care	241,724	249,344	245,812	99%	2%
day care	4,324	4,597	4,293	93%	–1%
inpatient care	12,952	13,520	13,854	102%	7%
Oncology	83,598	88,503	95,186	108%	14%
outpatient care	73,186	77,211	82,942	107%	13%
day care	202	876	2,735	–	–
inpatient care	10,210	10,416	9,509	91%	–7%
Obstetrics and gynaecology	511,407	517,452	522,729	101%	2%
outpatient care	459,482	464,610	471,334	101%	3%
day care	16,081	16,221	15,912	98%	–1%
inpatient care	35,844	36,621	35,483	97%	–1%
Pulmonology	61,334	62,713	67,130	107%	9%
outpatient care	57,521	58,624	63,671	109%	11%
inpatient care	3,813	4,089	3,459	85%	–9%
Dermatovenereology	164,535	166,640	169,788	102%	3%
outpatient care	162,676	164,733	167,785	102%	3%
day care	327	326	484	148%	48%
inpatient care	1,532	1,581	1,519	96%	–1%
Paediatrics	140,111	133,969	142,373	106%	2%
outpatient care	110,174	103,797	111,632	108%	1%
day care	1,924	1,859	1,583	85%	–18%
inpatient care	28,013	28,313	29,158	103%	4%
Psychiatry	203,927	205,327	212,774	104%	4%
outpatient care	192,030	193,440	201,410	104%	5%
day care	172	173	176	102%	2%
inpatient care	11,725	11,714	11,188	96%	–5%
Infectious diseases	26,999	27,533	29,030	105%	8%
outpatient care	17,242	17,800	19,456	109%	13%
inpatient care	9,757	9,733	9,574	98%	–2%
Internal diseases	395,390	403,542	416,492	103%	5%
outpatient care	334,924	342,385	355,736	104%	6%
day care	3,891	3,934	4,048	103%	4%
inpatient care	56,575	57,223	56,708	99%	0%
Primary follow-up care	1,750	1,821	1,939	106%	11%
inpatient care	1,750	1,821	1,939	106%	11%
Rehabilitation	55,892	57,862	61,115	106%	9%
outpatient care	49,013	50,993	53,822	106%	10%
inpatient care	6,879	6,869	7,293	106%	6%
Unspecified specialities	18,340	18,260	18,172	100%	–1%
outpatient care	18,340	18,260	18,172	100%	–1%
Total specialised medical care	2,977,134	3,035,476	3,092,139	102%	4%
Total outpatient care	2,675,363	2,727,498	2,786,479	102%	4%
Total day care	53,060	55,410	55,876	101%	5%
Total inpatient care	248,711	252,568	249,784	99%	0%
On-call duty fee	129	266	126	47%	–2%
Total	2,977,263*	3,035,742	3,092,265	102%	4%

* In order to ensure comparability the 2007 cases of obstetrics and gynaecology have been adjusted to take into account the cases of infertility treatment, covered from a government grant.

The principal changes by specialty were the following:

- Oncology: the expenses have grown on account of new services added to the List of Health Services, adjustment in reference prices for cytostatic treatment and an increase in providing chemotherapy as outpatient or day care, rather than inpatient care, as was the case earlier. The transition of chemotherapy services from inpatient care to outpatient and day care has eliminated the waiting list, caused by the limited capacity of medical institutions. The total number of oncology cases went up by 14% on account of outpatient cases, at the same time the number of inpatient cases dropped by 7%.
- Pulmonology: the treatment costs increased by 28% in total (36% in 2007), with the growth of outpatient costs twice outpacing (40%) that of inpatient costs (20%). The reasons lie in the growing number of patients receiving oxygen treatment and the growing number of treatments given to such patients, and in detecting more frequent cases of tuberculosis among persons with HIV. A larger share of the treatment has been provided in outpatient clinics (the total number of outpatient cases grew by 11%).
- Infectious diseases: like in oncology and pulmonology, the number of outpatient cases has been growing and that of inpatient cases has been going down. The treatment costs increased by 16% (outpatient costs went up by 38%). The rising costs result from more HIV and AIDS cases.
- Neurology: the total costs went up by 20% in 2008 and the average cost per case grew by 14% (in 2007 both increased by 36%). The introduction of modern radiological examination methods in hospitals is behind the increase.
- Internal diseases: the increasing use of invasive methods in cardiology continues to put the biggest pressure on the growth of costs. The total expenses went up by 21%, the increase was the same for all types of treatment.
- On-call duty fees: the expenses grew by 54%, due to changes in the principles of financing on-call duty fees from the second quarter of 2008.
- Follow-up care: the increase in cases and costs resulted from the growing number of persons referred from regional and central hospitals to general hospitals for follow-up, caused by the reduction of allowed acute care bed days per one case in 2008.
- Rehabilitation: the increase in costs and cases results from the ageing of the population and a larger number of primary traumas. A higher demand for primary follow-up care and rehabilitation has led to more cases and increased costs in these fields. The growing demand for follow-up care has been caused by the increase in the number of persons referred from regional and central hospitals to general hospitals for follow-up care. This in its turn was caused by the reduction of allowed acute care bed days per one case in 2008. The growing need for rehabilitation results from the ageing population and a larger number of primary traumas. In comparison with 2007 the number of insured persons who required specialised medical care services grew by 1% in 2008. In the case of outpatient and day care services this has been accompanied by the funding of additional cases. In the case of inpatient services the number of cases and the number of persons who received treatment have remained the same over the last three years (2006–2008).

Volume Inflation

In 2008 the average cost of a treated case (ACTC) in inpatient settings increased by 1.8% due to volume inflation. In comparison with 2007 the volume inflation has been slower, caused mainly by the reduction of the maximum number of higher priced bed days per specialty from 2008.

A moderate volume inflation of ACTC[10] over time is a natural phenomenon, accompanying the development of medical technology and the introduction of new methods of diagnostics and treatment. However, a rapid increase in ACTC requires additional financial resources and could endanger access to health services.

[10] ACTC – average cost of a treated case, i.e. the average invoiced amount, which is the quotient of the total invoiced amount and the number of cases.

Table 19. Average structural cost of a treated case in specialized medical care

Types of care	ASCTC 2007, EEK	ASCTC 2008, EEK	% of change against 2007
Outpatient care	632	673	6.5%
Day care	6,716	7,321	9.0%
Inpatient care	15,538	15,811	1.8%
Total*	1,986	2,017	1.5%

* The total ASCTC is lower than the average for individual types of care. This is because the average is calculated by adding up a large number of relatively cheap outpatient and day care cases and a smaller number of considerably more expensive inpatient cases.

Endoprosthetic Replacements, Cataract Operations, Cardiac Surgery and Deliveries

The treatment needs for the following services of specialised medical care are kept under special monitoring for the purposes of budget planning and execution: deliveries, cardiac surgery, endoprosthetic replacements and cataract operations. Given that deliveries and emergency cardiac surgery cannot be forecast in very precise terms and given the long waiting lists for endoprosthetic replacements and cataract operations, it is the aim of the Health Insurance Fund to ensure access to these services for the insured persons and thus EHIF keeps separate account of these cases. The number and costs of the each of these special cases have grown during 2005–2008.

Table 20. Cost of endoprosthetic replacements, cataract operations, cardiac surgery and deliveries

In EEK thousand	Cost				% of change		
Special case	2005	2006	2007	2008	2006/ 2005	2007/ 2006	2008/ 2007
Endoprosthetic replacements	121,211	128,824	149,243	166,904	6%	16%	12%
Cataract operations	68,308	78,967	91,362	102,995	16%	16%	13%
Cardiac surgery	113,078	127,433	145,210	163,335	13%	14%	12%
Deliveries	100,047	126,782	169,283	197,755	27%	34%	17%
Total	402,644	462,006	555,098	630,989	15%	20%	14%

Table 21. Number of endoprosthetic replacements, cataract operations, cardiac operations and deliveries

	Number of cases, actual				% of change		
Special case	2005	2006	2007	2008	2006/ 2005	2007/ 2006	2008/ 2007
Endoprosthetic replacements	2,600	2,643	2,743	2,870	2%	4%	5%
Cataract operations	7,820	9,102	10,236	11,211	16%	12%	10%
Cardiac surgery	982	1,062	1,081	1,115	8%	2%	3%
Deliveries	13,813	14,573	15,439	15,628	6%	6%	1%
incl by caesarean section	2,536	2,805	3,128	3,171	11%	12%	1%
Share of caesarean sections	18%	19%	20%	20%	–	–	–

Endoprosthetic replacements and cataract operations. The aim of EHIF was to cut the maximum waiting time by at least six months for endoprosthetic replacement and cataract operations in 2008 (in 2008 the waiting lists were up to 2.5 and 1.5 years respectively). In order to achieve the aim the number of endoprosthetic replacements grew by 5% (with costs going up by 12%) and the number of cataract operations went up by 10% (and costs by 13%).

Cardiac surgery. 3% more cardiac operations were performed in 2008 in comparison with 2007. The increase was mainly due to meeting the growing needs of children aged five and younger.

Deliveries. The total number grew by 1% in comparison with 2007. Caesarean sections constitute 20% of the total and the number has been stable.

1.3.2. Centrally Contracted Health Services

Centrally contracted health services are low frequency, high cost specialised medical care services. The Health Insurance Fund keeps separate account of the costs of these services in order to eliminate the impact of the centrally contracted services to the general performance indicators of specialised medical care.

The needs for centrally contracted services differ by region. In order to ensure equal access, the provision of the centrally contracted services is planned across Estonia (i.e. not by region) on the basis of a common waiting list.

The costs of centrally contracted health services have gone up in 2008 in comparison with 2007. The increase was caused by changes in reference prices, the inclusion of two new pharmaceuticals and increased use of some of the centrally contracted health services.

Table 22. Centrally contracted health services (in EEK thousand)

Centrally contracted health services	2007 actual	2008 budget	2008 actual	Budget execution %	% of change against 2007
Bone marrow transplants	12,954	15,464	14,473	94%	12%
Planned treatment abroad	8,740	18,500	23,122	125%	165%
Peritoneal dialysis	29,684	33,764	26,598	79%	–10%
Emergency transport of the insured (by plane, helicopter)	1,830	3,400	2,102	62%	15%
Health checks of young athletes	6,364	8,603	8,189	95%	29%
Haematological treatment	12,482	16,000	17,505	109%	40%
Antidotes and serums	200	200	200	100%	0%
Artificial urinary sphincters	620	660	754	114%	22%
Cochlear implants	2,916	3,499	3,499	100%	20%
Patoanatomical autopsies	1,023	1,700	935	55%	–9%
Centrally contracted pharmaceuticals	19,695	65,587	52,467	80%	166%
Infertility treatment	29,549	50,000	38,391	77%	30%
Total	126,057	217,377	188,235	87%	49%

Table 23. Cases of centrally contracted health services

	2007 actual		2008 actual		% of change against 2007	
Centrally contracted health services	Cases	ACTC	Cases	ACTC	Cases	ACTC
Bone marrow transplants	85	152,400	94	153,968	11%	1%
Planned treatment abroad	75	116,532	105	220,208	40%	89%
Peritoneal dialysis	1,096	27,084	972	27,364	–11%	1%
Emergency transport of the insured	84	21,786	80	26,275	–5%	21%
Health checks of young athletes	9,428	675	10,449	784	11%	16%
Haematological treatment	282	44,262	294	59,541	4%	35%
Antidotes and serums	2	100,000	2	100,000	0%	0%
Artificial urinary sphincters	7	88,571	8	94,250	14%	6%
Cochlear implants	10	291,600	12	291,583	20%	0%
Patoanatomical autopsies	622	1,645	596	1,569	–4%	–5%
Centrally contracted pharmaceuticals	718	27,430	1,828	28,702	155%	5%
Infertility treatment	1,737	17,012	1,960	19,587	13%	15%

The number of cases of centrally contracted health services differs by year. The distribution between the more serious and less serious cases does not remain the same every year either.

The average cost of a treated case for bone marrow transplants and health checks of young athletes was lower than forecast for 2008. The higher than budgeted costs in haematological treatment resulted from the increased use of blood coagulation factors required for severe traumas and major surgery, causing the average cost of a treated case to go up by 11% in comparison with the forecast.

The money designated for centrally contracted pharmaceuticals is used to pay for the biological treatment of rheumatic and gastro-enterological diseases, enzyme replacement therapy of type 1 of Gaucher disease, risperidone depot injections for treating psychiatric cases and from 2008 also for the treatment of Fabry disease, acromegaly and neuroendocrine tumours. The needs for these pharmaceuticals were determined in cooperation with professional associations.

The actual use of the two new pharmaceuticals and of the pharmaceuticals for psychiatric diseases was lower than planned for 2008 by almost a half, as a result not all the budgeted funds for centrally contracted pharmaceuticals were spent. A part of the money left over was used to cover the extra costs for services where the needs were larger than planned, e.g. haematological treatment and artificial urinary sphincters.

People are referred to planned treatment abroad, taking into account the terms and conditions of the Health Insurance Act, the possibilities for free movement of the insured persons within the EU, and the agreement between EHIF and the Finnish Red Cross concerning non-related donors for bone marrow transplants.

In most cases an insured person is referred to planned treatment in a foreign state, in case the health service applied for or alternatives to such health service are not provided in Estonia; the provision of the health service applied for the insured person is therapeutically justified; the medical efficacy of the health service applied for has been proved; and the average probability of the aim of the health service applied for being achieved is at least 50%.

A considerably higher number of people were sent for examination or treatment abroad in 2008. The average cost of a treated case has increased as well. Among the reasons for such developments are a wider media coverage of the possibilities for treatment abroad, increased interest in and awareness of the society at large of these possibilities. The Health Insurance Fund has also informed health care providers about the possibilities for referring patients to planned treatment abroad.

The costs of examination or treatment abroad include the costs of searching non-related donors for bone marrow transplants, transplant costs, examinations concerning genetic diseases etc.

The 2008 funding of infertility treatment came from the state budget as a government grant. 3000 cases were scheduled to be undertaken during the period under review and the average cost of a treated case was planned at 33,330 EEK. The actual demand for infertility treatment was lower by a third and given that in many cases the treatment commenced in 2008 continues in 2009 the average cost of a treated case was also lower than originally expected.

26.3 million EEK was spent on infertility treatment services and 12.1 million EEK on pharmaceuticals used for treatment.

1.3.3. Comparison of Main Indicators of Specialised Medical Care

Table 24. Main indicators of using inpatient and outpatient specialised medical care

Criterion	2007 actual	2008 actual	% of change against 2007
Average cost of a treated case, EEK			
outpatient care	548	671	22%
day care	6,435	7,324	14%
inpatient care	13,629	15,775	16%
Number of inpatient bed days	1,590,749	1,560,768	–2%
Average length of stay	6.4	6.3	–2%
Number of outpatient consultations	3,695,585	3,797,861	3%
outpatient care	3,624,744	3,722,259	3%
day care	70,841	75,602	7%
Number of outpatient consultations per a treated case	1.35	1.34	–1%
outpatient care	1.35	1.34	–1%
day care	1.33	1.35	2%
Number of persons using specialised medical care services*	810,834	819,055	1%
outpatient care	786,178	795,791	1%
day care	45,612	45,911	1%
inpatient care	168,912	169,755	0%
Number of treated cases per person	3.67	3.78	3%
outpatient care	3.41	3.50	3%
day care	1.16	1.22	5%
inpatient care	1.47	1.47	0%
Share of emergency care in treatment costs			
outpatient care	17.6%	17.0%	–0.6%
day care	7.1%	6.0%	–1.1%
inpatient care	62.7%	63.0%	0.3%
Share of emergency care in treated cases			
outpatient care	17.1%	16.0%	–1.1%
day care	16.5%	13.0%	–3.5%
inpatient care	56.6%	57.0%	0.4%
Number of operations, incl	167,027	170,457	2%
outpatient care	20,359	22,682	11%
day care	48,394	48,304	0%
inpatient care	98,274	99,471	1%
Deliveries	15,439	15,638	1%

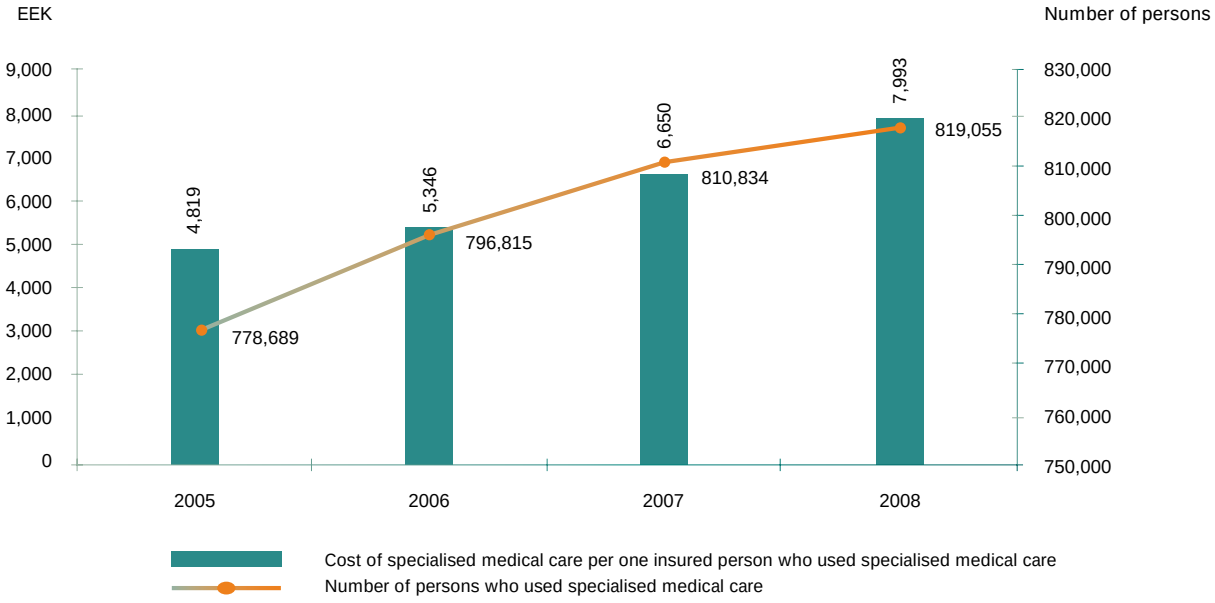
* The number of persons using specialised medical care, as broken down by types of treatment, is larger than the total number of persons who used specialised medical care, since one person could have used each: outpatient care, day care and inpatient care services.

Average cost of a treated case (ACTC). ACTC has grown for all types of treatment in specialised medical care – outpatient care, day care and inpatient care, resulting from new reference prices for health services, applicable from 2008.

The number of bed days has gone down by 2%, since the average length of stay has dropped to 6.3 days (6.4 days was the average in 2007). In 2008 the maximum numbers of hospital bed days was cut in the List of Health Services.

The number of persons who used specialised medical care services in 2008 grew by 1% against 2007. In the case of outpatient and day care services this has been accompanied by the funding of additional cases.

Figure 13. Costs of specialised medical care per person and the number of persons who used specialised medical care



Share of emergency care. The Health Insurance Fund has been constantly monitoring the share of emergency care in the number of treated cases and in costs, since an increase in the share of emergency care could be an indication of the fact that insured persons do not have timely access to medical specialists. Emergency care is also more expensive than planned treatment. In 2008 the share of both emergency care cases and costs in outpatient and day care decreased. The share of emergency care cases and costs in the most expensive form of care, i.e. inpatient care, did not change in comparison with 2007.

Operations. The total number of operations undertaken in 2008 grew by 2%, whereas outpatient surgical services increased by 11%. The number of surgical abortions decreased by 9% in comparison with 2007, this is partly due to the inclusion of a new health service (medicinal product-induced abortion, a non-surgical service) in the List of Health Services at the beginning of 2008.

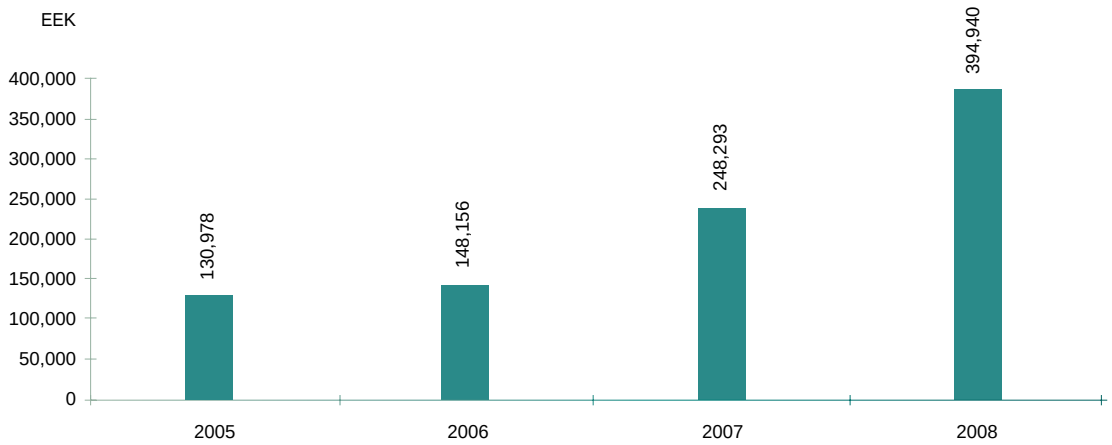
Most of the operations still continue to be performed under inpatient care, but their share in the total number of operations is shrinking. In recent years the number of operations carried out in outpatient and day care settings has been on a steady uprise: 37% in 2006, 41% in 2007 and 42% in 2008.

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

During 2008 the Health Insurance Fund paid 394.9 million EEK for pharmaceuticals used upon the provision of specialised medical care services (i.e. the pharmaceuticals included in the List of Health Services, but are not included in the bed day reference price). In comparison with 2007 the costs of pharmaceuticals increased by ca 52.2%.

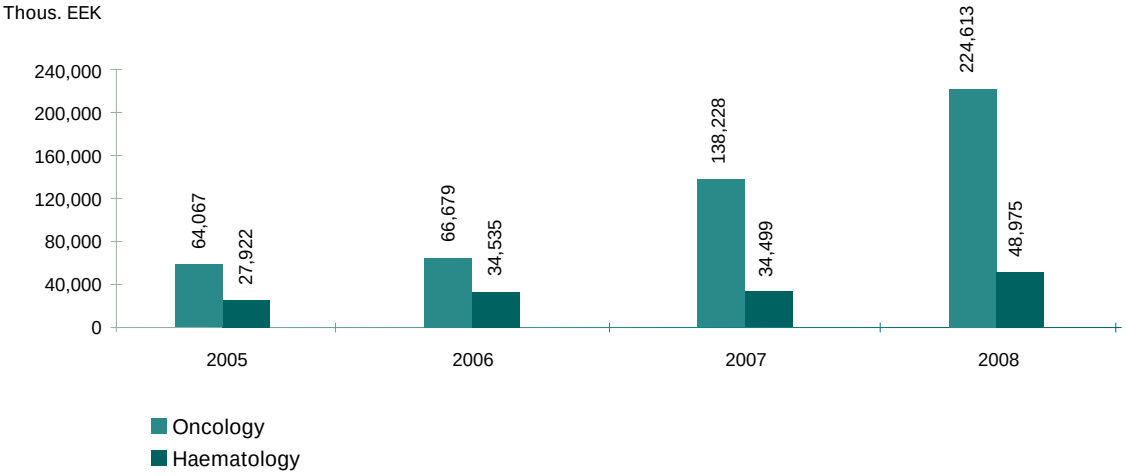
In 2008 the List of Health Services contained 27 different treatments with pharmaceuticals. The Health Insurance Fund wishes to ensure more uniform access to pharmaceuticals to patients in the different disease groups. Therefore the following changes were made in the List of Health Services in 2008: treatment for Fabry disease was added, biphosphonates were made available for oncology patients to alleviate bone damage resulting from chemotherapy, antifungal pharmaceuticals were made available for treating invasive fungal infections, access to somatostatin generics was improved for patients with acromegaly and neuroendocrine tumours, cytostatic treatments of lung cancer were modernised and TNF-alpha inhibitors were introduced for biological treatment. The above has contributed to a general increase in the cost of pharmaceuticals used upon the provision of specialised medical care services.

Figure 14. Cost of pharmaceuticals in specialised medical care services, 2005–2008



The costs of pharmaceuticals have been the highest in oncology and haematology. Oncology has seen the biggest augmentation of costs in recent years (see figure 15), here the cost of pharmaceuticals constituted ca 41% of the total of 553 million EEK in 2008.

Figure 15. Specialties where costs of pharmaceuticals were the highest, 2005-2008



1.4. Nursing Care

The Health Insurance Fund seeks to improve access to nursing care, by affording preferential treatment to outpatient services, so that the insured in need of nursing care would cope as long as possible in their home environment. In 2008 EHIF paid 238 million EEK for nursing care.

Table 25. Cost of nursing care (in EEK thousand)

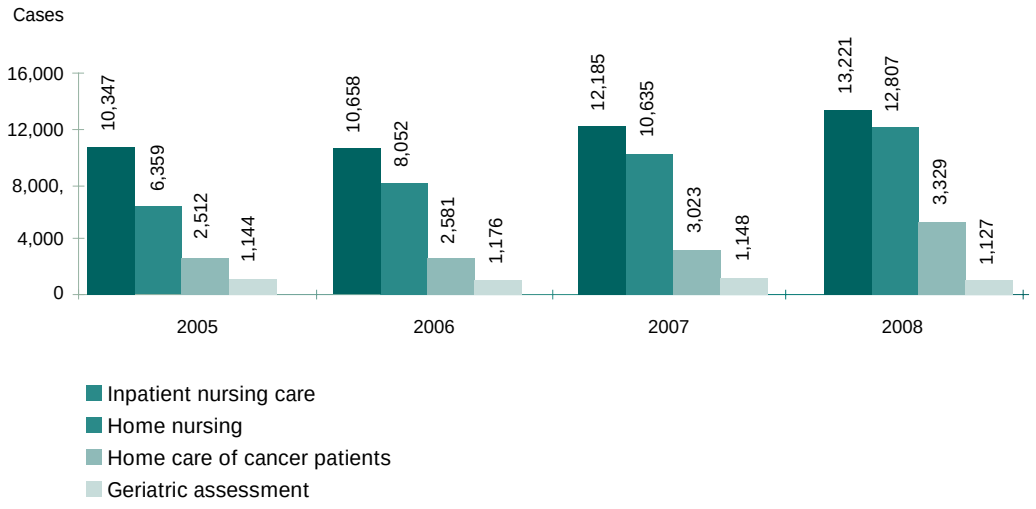
	2007 actual	2008 budget	2008 actual	Budget execution %	% of change against 2007
Inpatient nursing care	160,583	199,582	198,835	100%	24%
Outpatient nursing care, incl	28,684	39,017	39,137	100%	36%
home nursing	23,792	33,071	32,996	100%	39%
home care of cancer patients	4,043	4,859	5,095	105%	26%
geriatric assessment	849	1,087	1,046	96%	23%
Total	189,267	238,599	237,972	100%	26%

The reasons for increased nursing care costs in 2008 derive from new health service reference prices applicable from the beginning of the year and the growth in treated cases. The new reference prices contributed to the increase in both inpatient and outpatient nursing care costs and also the average cost of a treated case in nursing care.

Table 26. Cases of nursing care

	2007 actual		2008 actual		% of change against 2007	
	Cases	ACTC, EEK	Cases	ACTC, EEK	Cases	ACTC
Inpatient nursing care	12,185	13,179	13,221	15,039	9%	14%
Outpatient nursing care, incl	14,806	1,937	17,263	2,267	17%	17%
home nursing	10,635	2,237	12,807	2,576	20%	15%
home care of cancer patients	3,023	1,337	3,329	1,530	10%	14%
geriatric assessment	1,148	740	1,127	928	–2%	25%
Total	26,991	7,012	30,484	7,806	13%	11%

Figure 16. Cases of nursing care, 2005–2008



1.5. Dental Care

In 2008 the Health Insurance Fund 299.3 million EEK for dental care services provided to insured persons.

Table 27. Cost of dental care (in EEK thousand)

	2007 actual	2008 budget	2008 actual	Budget execution %	% of change against 2007
Dental care for children	185,522	237,231	231,151	97%	25%
Orthodontics	35,435	45,620	43,658	96%	23%
Preventive dental care	9,180	11,136	10,545	95%	15%
Emergency dental care for adults	9,855	12,113	13,910	115%	41%
Total	239,992	306,100	299,264	98%	25%

Dental care costs went up by a quarter, this on account of increased health service reference prices in 2008 and a larger number of dental cases (3%). The cases in dental care for children grew the most in number (4%). Budget execution in the case of orthodontics was 90%, since there was no one to provide these services in the Viru region.

Table 28. Cases of dental care

	2007 actual	2008 budget	2008 actual	Budget execution %	% of change against 2007
Dental care for children	290,220	297,920	300,889	101%	4%
Orthodontics	38,143	41,958	37,719	90%	–1%
Preventive dental care	48,423	48,191	45,738	95%	–6%
Emergency dental care for adults	18,248	17,588	20,617	117%	13%
Total	395,034	405,657	404,963	100%	3%

2. Health Promotion Expenses

Health promotion activities form a part of activities undertaken on the basis of national strategies, they are following the priorities established by the EHIF Supervisory Board and are approved by the Ministry of Social Affairs. In 2008 14 million EEK was spent on health promotion. 38 projects were completed in 2008 and contracts were concluded for implementing a further 30 health promotion projects.

Table 29. Health promotion expenses (in EEK thousand)

Priority area	2007 actual	2008 budget	2008 actual	Budget execution %	% of change against 2007
Health promotion activities targeted at children	2,914	3,000	3,226	108%	11%
Prevention of cardio-vascular diseases	1,254	700	711	102%	–43%
Early detection of malignant tumours	433	500	582	116%	34%
Prevention of domestic and leisure injuries and intoxication	3,442	4,000	4,153	104%	21%
Prevention of alcohol-induced health damage	1,521	2,500	2,064	83%	36%
Activities aimed at multiple priority areas	3,124	3,300	3,234	98%	4%
Total	12,688	14,000	13,970	100%	10%

In 2008 the promotion activities of EHIF were focussed on the prevention of injuries, prevention of alcohol-induced health damage and early detection of cancer.

Table 30. Quantitative indicators of project activities, 2008

Health promotion activity	2005	2006	2007	2008
Number of participants in training, sports and other events aimed at the population at large	5,250	25,100	39,300	53,890
Number of persons given individual counselling	6,680	4,470	8,240	8,967
Number of participants in training events organised for health care professionals	1,000	600	1,830	427
Number of participants in training events organised for teachers	1,950	3,300	2,310	1,227
Number of participants in training events organised for other stakeholders (social workers, managers, task forces)	1,780	2,440	2,181	1,605
Number of various publications*	23	24	24	18*
Total run of publications*	277,000	346,500	354,700	362,600
Number of radio and TV programmes/clips	81	19	11	8

* except health pages published in national dailies and weeklies

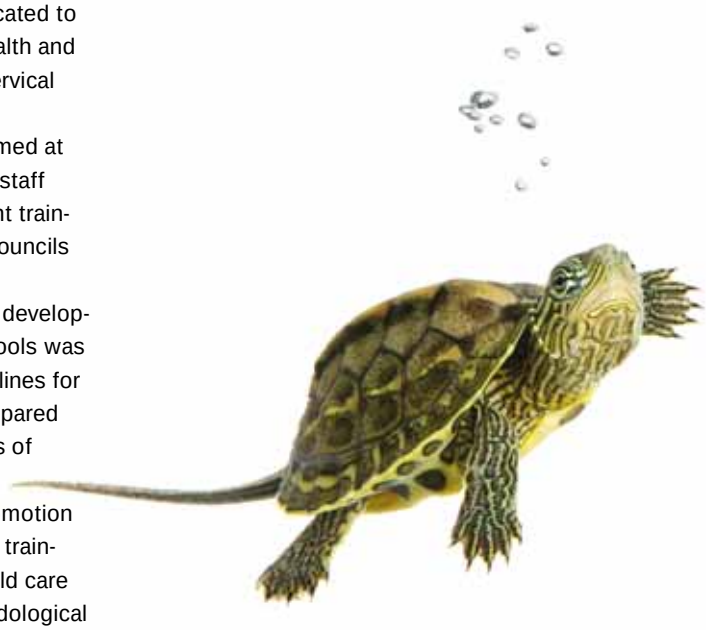
Thanks to county injury prevention projects the activities have come closer the people. The number of people who received individual counselling has grown.

The number of health publications decreased but their total run was still larger than in 2007. The reason for the reduction in individual publications lay primarily in the fact that the counties started publishing information in county and municipal newspapers instead of individual publications.

Main health promotion activities in 2008:

- The trauma prevention campaign under the slogan "Older children also need the wisdom of parents to prevent injuries. Keep your child in one piece" pointed to the high injury mortality of Estonian children. The visibility of the campaign was over 80%.
- The anti-alcohol campaign under the slogan "Alcohol destroys your brain and your life" focussed on changing the positive image derived from alcohol advertisements by using evidence-based information. The visibility of the campaign was measured at 70%.
- Guidelines were prepared for patients about rheumatoid arthritis and glaucoma; a study film, “Our Deaf Children” and accompanying materials were developed for the parents of children with hearing implants.
- Family physicians and nurses disseminated 275 thousand health publications dedicated to cardio-vascular diseases, children’s health and early detection of breast cancer and cervical cancer.
- Within the framework of the project aimed at developing health councils at schools, staff from 95 schools underwent the relevant training and 190 members of such health councils received counselling.
- Within the framework of the project of developing school health the service in 12 schools was subjected to external evaluation, guidelines for preventing postural disorders were prepared and a brochure describing the activities of school nurses was completed.
- Within the framework of the health promotion project for kindergartens the in-service training needs of the staff of pre-school child care institutions were evaluated and methodological guidance materials were created, dedicated to the development of psychosocial skills and evaluating psychosocial profiles.
- Injury prevention projects were continued in 2008 in all counties and in the two largest cities, Tartu and Tallinn. The priorities included prevention of injuries through developing a local support network and empowering trauma teams. The main target groups were children, their parents and the elderly.
- 8,967 persons were given individual counselling in matters concerning sexual health, pregnancy crisis and periods preceding and following delivery.
- Activities aimed at developing parenting schools located at women’s outpatient clinics were undertaken with a view to harmonise their curricula and improve the quality of the service.

The efficiency of health promotion is measured as a share of adults who have started to pursue healthier lifestyles during the past 12 months. According to survey data 37% of the adult population already considered their lifestyles healthy and as high a share as 42% thought that they had improved their lifestyles in 2008 (e.g. through a balanced diet, physical activity, cutting down on alcohol and tobacco consumption).



3. Expenses on Pharmaceuticals Reimbursed to the Insured

The expenses on pharmaceuticals reimbursed to the insured is an open commitment for the Health Insurance Fund, meaning that EHIF has the obligation to compensate the costs on pharmaceuticals incurred by a person to the extent prescribed by law and based on the needs of the person.

1.3 billion EEK worth of expenses on pharmaceuticals were reimbursed to the insured in 2008.

Table 31. Pharmaceuticals reimbursed to the insured (in EEK thousand)

Pharmaceuticals reimbursed to the insured	2007 actual	2008 budget	2008 actual	Budget execution %	Share of expenses by discount %	
					2007	2008
Pharmaceuticals reimbursed fully	480,988	579,912	555,927	96%	43%	43%
Reimbursement of 90% of cost	327,324	373,368	369,263	99%	29%	29%
Reimbursement of 75% of cost	76,584	89,884	83,942	93%	7%	7%
Reimbursement of 50% of cost	235,377	280,688	272,208	97%	21%	21%
Pharmaceuticals reimbursed in special cases	286	148	146	99%	–	–
Total	1,120,559	1,324,000	1,281,486	97%	100%	100%

2008 was characterised by a general increase in the consumption of pharmaceuticals distributed at a discount: while in 2007 830 EEK was reimbursed per one insured person, the amount had grown to 1000 EEK in 2008. The reasons for increased costs are the following:

- At the end of 2008 patients were hoarding pharmaceuticals distributed at a discount in anticipation of the increase of the value added tax rate from 5% to 9% at the beginning of 2009;
- Improved diagnostics and better discipline in the continued use of pharmaceuticals;
- The choice of pharmaceuticals has improved as regards several diagnoses, making innovative and expensive products more readily available for the patients.

For example in the list of pharmaceuticals of whose cost 75% is reimbursed the first angiotensin receptor blocker losartan has started to be widely used for managing hypertension and cardiac insufficiency. The treatment of patients with chronic obstructive pulmonary disease has become more convenient, since preparations combining glucocorticoids and long-acting bronchodilators were included in the list. Starting from 2008 patients with type 2 diabetes can include in their treatment scheme pharmaceuticals to lower the cholesterol levels, preparations of thiazolidinediones and sitagliptin, with 75% of the costs reimbursed. Low-molecular-weight heparins to reduce the thrombosis risk after major orthopaedic surgery, are also available at a 75% discount.

The number of active ingredients which are fully reimbursed has grown as well. Outpatient treatment aimed at stimulating haematopoiesis has been made available for patients with aplastic anaemia. From 2008 multiple sclerosis patients can get interferon beta-1b and glatiramer acetate reimbursed fully. Insulinglulisine was added to insulin preparations available for diabetic patients. Sorafenib, prolonging survival in patients with kidney cancer, has been included in the list of fully reimbursed pharmaceuticals.

The number of prescriptions issued at a discount continues to grow, exceeding that of last year by 10.7% on the average. The growth has been the fastest in prescriptions issued at a 90% discount, corresponding to a 13% increase. One of the reasons that lies behind the growth could be a better choice of pharmaceuticals and better compliance with the treatment scheme. A correlation has been observed between the awareness of patients, better treatment compliance and the number of purchases of prescribed pharmaceuticals.

Table 32. Number of discount prescriptions (DP) and average cost, EEK

	2007		2008		2008/2007	
Discount rate	Number of DP	Average cost of DP for EHIF	Number of DP	Average cost of DP for EHIF	Number of DP %	Average cost of DP for EHIF %
100%	620,426	775	691,256	804	11%	4%
90%	1,901,540	172	2,149,459	172	13%	0%
75%	462,618	166	512,016	164	11%	–1%
50%	3,012,001	78	3,283,679	83	9%	6%
Total	5,996,585	187	6,636,410	193	11%	3%

The average cost of a prescription for the Health Insurance Fund has grown in every discount category, although the biggest increase has occurred in the 50% discount category. The reason for the increase is evidently the use by the insured persons of more expensive medical preparations during the year under review for which no reference price or price agreement existed. The average cost per prescription has also gone up due to a broader selection of fully reimbursed pharmaceuticals – several expensive active ingredients have been made available.

The changes in the increase in the number of discount prescriptions and benefits for pharmaceuticals are the same in 2008 as well, although the increase in costs has outpaced the increase in the number of prescriptions. (14.4% and 10.7% respectively). The reason lies in the continued brisk increase in the average cost of a prescription, which in 2008 was as high as 193 EEK.

The relatively high level of cost-sharing by the patients mainly results from the use of pharmaceuticals offered at a 50% discount. However, it seems that there is still much room for development internally and cost-sharing by patients could drop considerably, if moderately priced generic drugs were used instead of the costly originals. In many cases the use of pharmaceuticals at a 50% discount is quite puzzling in a situation where an equally good evidence-based reasonably priced alternative exists at a 75% discount.

The fully reimbursed medicinal product related costs have changed the least, as the prices are controlled for almost all of these medical preparations. The choice of medical preparations offered at a 75% and 90% discount has also become considerably wider and this is reflected in a certain increase of the costs for the insured (~ 6 EEK per prescription). The increase in cost-sharing by patients is most significant in the 50% discount category, amounting to 164 EEK at the end of 2008.

The insured would be better off if the physicians and patients were more aware of the cheaper, but no less effective alternatives and if they were able to make carefully considered economic decisions along with medically accurate decisions.

The diagnoses that continue to attract the largest costs to be reimbursed are the same as in previous years: essential hypertension, diabetes, asthma, cancer, mental disorders, glaucoma and primary hypercholesterolaemia. The largest reimbursable amounts have been related to essential hypertension for several years already: the number of patients has been growing year-by-year, but due to a wider choice in products the average cost per prescription has been going down instead of increasing.

Table 33. Diagnoses with highest benefits for pharmaceuticals (in EEK thousand

	2007 actual		2008 budget		2008 actual	
Diagnosis	Reimbursed by EHIF	% of total cost of benefits for pharmaceuticals	Reimbursed by EHIF	% of total cost of benefits for pharmaceuticals	Reimbursed by EHIF	% of total cost of benefits for pharmaceuticals
Essential hypertension	185,074	17%	228,741	17%	195,392	15%
Total diabetes, incl	145,030	13%	179,780	14%	166,843	13%
insulins	118,517	11%	145,075	11%	136,002	11%
administered orally	26,513	2%	34,705	3%	30,841	2%
Cancer	91,895	8%	119,629	9%	113,007	9%
Asthma	67,075	6%	76,017	6%	78,861	6%
Glaucoma	55,854	5%	71,968	5%	60,088	5%
Mental disorders	44,868	4%	64,763	5%	43,611	3%
Hypercholesterolaemia	29,933	3%	35,374	3%	43,082	3%
Total	619,729	55%	776,272	59%	700,884	55%

Summary: an analysis of costs for pharmaceuticals in 2008 shows a significant increase in their use in all discount categories, as well as an increase in the average cost per a discount prescription for both EHIF and the patient.

With the expected shrinking of the revenue base for health insurance and on the assumption that health services continue to be available at the current levels, funds for making available new pharmaceuticals in the future would have to come from the existing budget for benefits for pharmaceuticals. A systematic revision of the list of reimbursed pharmaceuticals may become necessary, aimed at removing from the list products which over time have ceased to be cost-effective and for which cheaper alternatives exist.

4. Expenses on Benefits for Temporary Incapacity for Work

In 2008 expenses on benefits for temporary incapacity for work amounted to 2.4 billion EEK.

Table 34. Expenses on benefits for incapacity for work (in EEK thousand)

	2007 actual	2008 budget	2008 actual	Budget execution %	% of change against 2007
Sickness benefits	1,222,322	1,471,666	1,474,551	100%	21%
Care benefits	212,274	309,067	287,795	93%	36%
Maternity benefits	459,507	593,927	586,209	99%	28%
Occupational accident benefits	32,748	40,894	38,898	95%	19%
Total	1,926,851	2,415,554	2,387,453	99%	24%

Expenses on benefits for incapacity for work are growing in line with changes in social, economic and population indicators:

- Income growth is accompanied by an increase in the average daily cost of the benefit for incapacity for work;
- The increasing birth rate pushes up the costs of maternity benefits and care benefits.

The number of days of incapacity for work goes up or down in line with changes on the labour market. The growth in expenses on benefits for incapacity for work has started to slow down since the economy entered into recession from the beginning of 2008. This trend can be expected to continue, as higher unemployment results in reducing the number of the insured in employment and income subject to social tax.

Sickness benefits are the largest cost item of the expenses on benefits for temporary incapacity for work, followed by maternity benefits, care benefits and occupational accident related benefits (see figure 17). Changes in the respective weight of the expenses on benefits are characterised by some reduction in the share of sickness benefits due to more births and an increasing share of maternity and care benefits.

From 1 May 2004 benefits for temporary incapacity for work are also paid upon illness abroad, based on a certificate issued by a physician in the foreign state concerned. In 2008 ca 2 million EEK was paid on the basis of 499 certificates (446 in 2007).

The reasons for incapacity for work stated in the certificates are the following: illness - 78%, caring for a child under 12 years of age - 8%, occupational accident - 6%, injuries - 6% and pregnancy and maternity leave - 2%. The largest number of the certificates were issued in Latvia (39%), followed by Finland (27%) and Russia (8%).

Figure 17. Distribution of benefits for incapacity for work by types of benefits, 2008

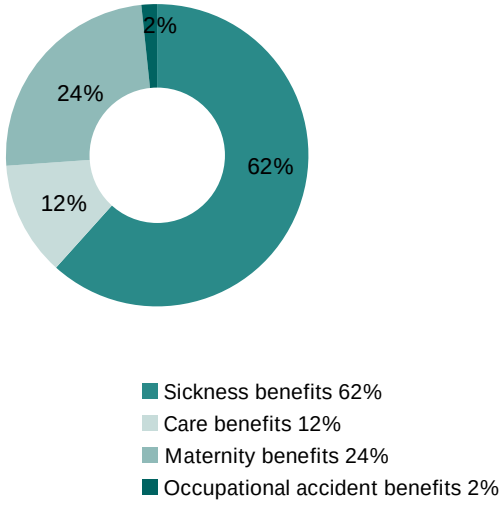


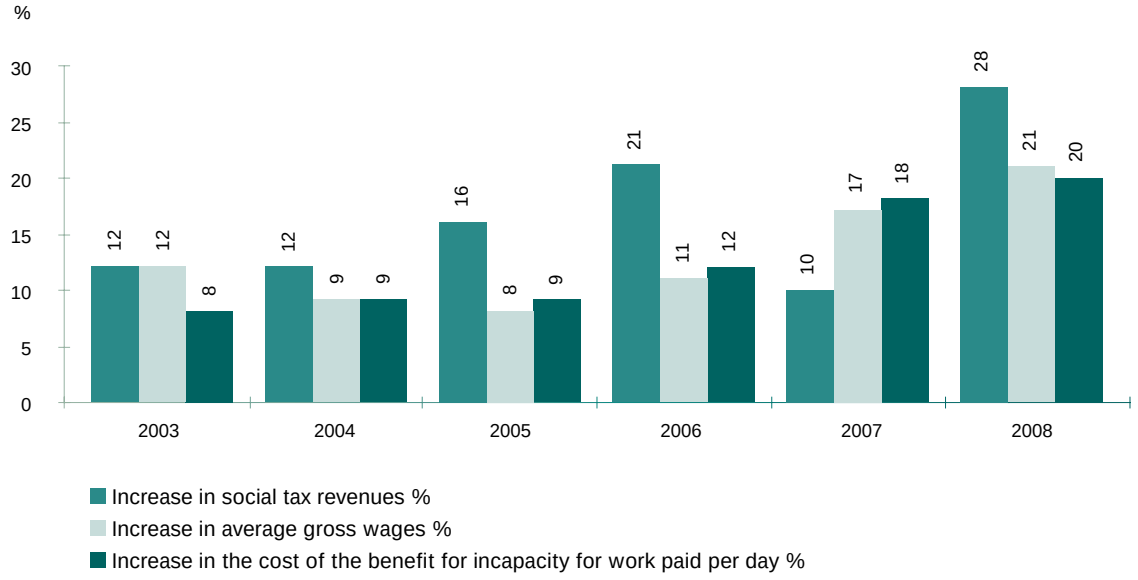
Table 35. Expenses on benefits for incapacity for work

	2006	2007	2008	2007/2006	2008/2007
Sickness benefits					
Number of certificates	469,274	508,428	470,950	8%	–7%
Number of days	5,751,163	6,209,512	6,354,414	8%	2%
Benefit amount (in EEK thousand)	957,692	1,222,322	1,474,551	28%	21%
Average daily income (EEK)	167	197	232	18%	18%
Average duration of paid leave	12.3	12.2	13.5	–1%	11%
Maternity benefits					
Number of certificates	11,903	12,982	13,229	9%	2%
Number of days	1,515,333	1,676,152	1,742,868	11%	4%
Benefit amount (in EEK thousand)	358,758	459,507	586,209	28%	28%
Average daily income (EEK)	237	274	336	16%	23%
Average duration of paid leave	127.3	129.1	131.7	1%	2%
Care benefits					
Number of certificates	96,379	104,649	111,299	9%	6%
Number of days	797,316	871,070	949,676	9%	9%
Benefit amount (in EEK thousand)	162,514	212,274	287,795	31%	36%
Average daily income (EEK)	204	244	303	20%	24%
Average duration of paid leave	8.3	8.3	8.5	0%	2%
Occupational accident benefits					
Number of certificates	6,406	6,472	6,173	1%	–5%
Number of days	131,508	131,966	135,119	0%	2%
Benefit amount (in EEK thousand)	27,391	32,748	38,898	20%	19%
Average daily income (EEK)	208	248	288	19%	16%
Average duration of paid leave	20.5	20.4	21.9	0%	7%
Total benefits					
Number of certificates	583,962	632,531	601,651	8%	–5%
Number of days	8,195,320	8,888,700	9,182,077	8%	3%
Benefit amount (in EEK thousand)	1,506,355	1,926,851	2,387,453	28%	24%
Average daily income (EEK)	184	217	260	18%	20%
Average duration of paid leave	14.0	14.1	15.3	1%	9%

Increase in Average Daily Income

The average cost of benefit paid per day influences most directly the expenses on benefits for incapacity for work, as it is in correlation with the income subject to social tax. The increase in income subject to social tax results in the growth of the average cost of benefit paid per day. In comparison with the average cost of the benefit for incapacity for work paid per day the gross wages grow less, since the daily cost is computed on the basis of the total income subject to social tax and not only on the basis of gross wages.

Figure 18. Increase in the cost of the benefit for incapacity for work paid per day, compared with the growth in social tax and gross wages[11] paid.



Increase in the Number of Days of Incapacity for Work

The number of days of incapacity for work per one insured person in employment has increased by 3% on account of the increase in the average duration of paid leave for incapacity for work. With less seasonal illnesses in 2008 the share of certificates for sick leave allowing a longer convalescence period grew.

Table 36. Average indicators of the period, 2005–2008

	2006	2007	2008	2007/2006	2008/2007
Number of insured persons (average of the period)	1,279,680	1,283,356	1,285,177	0%	0%
Number of insured persons in employment (average of the period)	649,910	674,676	670,324	5%	–1%
Insured persons in employment as a percentage of all insured persons (%)	0.50	0.53	0.52	–	–
Number of days of incapacity for work	8,195,320	8,888,700	9,182,077	8%	3%
Number of days of incapacity for work per one insured person in employment	12.7	13.2	13.7	4%	4%
Number of certificates for incapacity for work	583,962	632,531	601,651	8%	–5%
Number of certificates for incapacity for work per one insured person in employment	0.91	0.94	0.90	3%	–4%

[11] The average gross wages do not include the remuneration paid under contracts for services (i.e. average gross wages only include remuneration paid to full-time employees).

Sickness Benefits

Based on certificates for sick leave the reasons for release from work are the following: illness - 90%, domestic injury - 8%, transfer to an easier job - 1%, other causes (occupational disease, traffic injury etc) - 1%. The distribution has remained stable over the years. In 2008 the number of days of sick leave grew by 2%, whereas the number of certificates for sick leave decreased by 7%. The reason lies in the fact that during periods in which the incidence of respiratory diseases decreases, the number of certificates for sick leave issued for shorter periods goes down and at the same time the share of certificates for sick leave for chronic, more serious illnesses allowing a longer convalescence period grows.

Maternity Benefits

The number of days of incapacity for work under maternity benefits grew by 4% in 2008 and the average cost per day went up by 23%. In addition to the general increase in wages demographic changes are at play when it comes to growing maternity benefits: the average age of women giving birth as well as the number of women in fertile age has increased. An analysis of maternity benefits by age reveals that women over 30 years of age get a 30% higher maternity benefit per day than younger women. The average number of days of maternity leave for which maternity benefit is paid per woman giving birth has been steadily increasing as well, resulting from higher numbers of women taking timely maternity leave[12].

Care Benefits

The higher birth rate of the past few years has been the cause for the increase in days of incapacity for work under care benefits. Women, who have exhausted their parental leave are liable to taking out care leave, thus we can anticipate a continued increase in care benefit costs. The average daily cost of care leave is growing as well, since higher income parents tend to take more care leave. An analysis of care benefit payments reveals that in 23% of cases the care giver is the male parent, whose daily income from care leave is almost two times higher than the income of their female counterparts. 5% more fathers took care leave in 2008 in comparison with 2007.

The reasons for release from work under care leave are the following: nursing a child under 12 years of age - 98%, caring for a child under 3 years of age or for a disabled child under 16 years of age – 1%, nursing a family member who is ill - 1%. Most (82%) of the certificates for care leave issued for caring for a child under 12 years of age concern children of 2-6 years of age, an increase by 2% against 2007.

Occupational Accident Benefits

The reasons for release from work under occupational accident leave are the following: occupational accident - 95%, traffic-related occupational injury - 3% and complications arising from occupational accidents - 2%.

[12] According to the Health Insurance Act the number of days for which benefiits are paid are cut, if pregnancy leave of the woman commences later than 30 days before the estimated date of delivery as determined by a doktor

5. Other Cash Benefits

5.1. Dental Care Cash Benefits

In 2008 the costs of dental care benefits were 194 million EEK. The benefits grew on account of higher rates applicable to benefits and a larger number of applicants.

Table 37. Budgeted and actual costs of dental care benefits (in EEK thousand)

	2007 actual	2008 budget	2008 actual	Budget execution %	2008 actual/ 2007 actual
Benefits for dentures	103,566	149,062	110,196	74%	6%
Dental treatment benefits	74,795	102,600	83,860	82%	12%
Total	178,361	251,662	194,056	77%	9%

The share of applicants for dental care benefits over 19 years of age has been steadily growing in 2003–2008, on the one hand, due to the increasing target group of the beneficiaries and on the other hand due to increasing benefit rates. The number of applicants for benefit for dentures increased as a result of making insured persons receiving a pension for incapacity for work also eligible for this benefit along with old age pensioners and persons over 63 years of age.

Table 38. Number of cases of paying dental care benefits

	2007 actual	2008 budget	2008 actual	Budget execution %	2008 actual/ 2007 actual
Benefits for dentures	43,899	60,842	44,658	73%	2%
Dental treatment benefits	267,338	206,342	283,482	137%	6%
Total	311,237	267,184	328,140	123%	5%

A major reduction in dental care benefits can be expected following an amendment in law applicable from 1 January 2009: the 300 EEK dental care benefit can be sought only by persons receiving a pension for incapacity for work or an old-age pension on the basis of the State Pension Insurance Act and insured persons over 63 years of age. Pregnant women, mothers of children under one year of age and persons who have an increased need for dental care services as a result of health services provided to them still continue to be eligible for an increased dental benefit of 450 EEK. The amendment did not concern the procedure of paying benefits for dentures.

5.2. Supplementary Benefit for Pharmaceuticals

Supplementary benefits for pharmaceuticals were introduced in 2003. The awareness of patients concerning this type of benefit has been growing year by year, along with the number of patients receiving the benefit. The average benefit paid for one insured person has been growing during the past three years as well.

Table 39. Supplementary benefits for pharmaceuticals

	2007 actual	2008 budget	2008 actual	Budget execution %	% of change against 2007
Amount of benefit (in EEK thousand)	6,304	6,500	7,622	117%	21%
Number of persons receiving the benefit	1,721	2,783	1,936	70%	12%
The average benefit paid per person (EEK)	3,663		3,937		7%

The supplementary benefit for pharmaceuticals is a cash benefit paid on the basis of the expenses incurred by a person in a calendar year to purchase pharmaceuticals distributed at a discount. Patients who have spent more than 6 thousand kroons per year to purchase pharmaceuticals found on the EHIF list of pharmaceuticals are eligible for the benefit.

6. Other Expenses on Health Insurance Benefits

6.1. Benefits Paid on the Basis of Regulations Coordinating Social Security Systems of EU Member States

From its accession to the EU in 2004 Estonia has the obligation to pay benefits for health services arising from the EU regulations coordinating social security systems.

Persons insured with the Estonian Health Insurance Fund have the right to:

- the necessary health care when staying temporarily in another member state;
- all health care when residing in another member state.

The costs of the above health care shall be covered by the Estonian Health Insurance Fund.

Persons insured in another EU member state have the right in Estonia to

- the necessary health care when staying temporarily in Estonia;
- all health care when residing in Estonia.

The health care costs related to persons insured in another EU member state are first reimbursed to health care providers by the Estonian Health Insurance Fund, which then submits the invoices for payment to the competent authority of the other member state. Thus eventually the EU member state in which a person is insured picks up the health care bill for the person.

The traffic of invoices from Estonia to other member states and vice versa has been growing year by year. Although the amount of benefits decreased in 2008, the number of invoices issued continued to grow, leading to the conclusion that a larger number of persons were given medical care while staying abroad. On the one hand people have become more aware of their right to receive the necessary health care when staying temporarily in another member state and on the other hand they travel more. The sense of security among our insured persons has grown as well: they are not afraid to see a doctor while abroad, since they know that health insurance covers the costs of health services and they only have to provide the cost-sharing part.

Table 40. Benefits for health services arising from the EU regulations (in EEK thousand)

	2005 actual	2006 actual	2007 actual	2008 actual	% of change against 2007
Benefits	15,317	20,833	34,200	32,470	–5%

6.2. Benefits for Medical Devices

The Health Insurance Fund has the obligation to pay benefits for medical devices for everyone 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 issued by the Health Insurance Fund. Thus here is another open commitment for EHIF, similar to that related to the pharmaceuticals reimbursed to the insured persons.

In 2008 a total of 53.4 million EEK was paid to 26,408 persons in reimbursement of the costs of medical devices.

The budgeted amounts planned for the period under review were not entirely used up due to the more modest use of glucometer test strips, insulin pumps and other medical devices. 15.4 million EEK was designated for reimbursing new devices to be added to the list and as a buffer for a potential increase in reference prices of the devices currently included in the list in the 2008 budget. However, no new additions appeared in the list during the year and the manufacturers did not seek the increase in prices of medical devices, thus the released funds were spent on primary prostheses and orthoses and stoma appliances.

Table 41. Benefits for medical devices (in EEK thousand)

	2007 actual	2008 budget	2008 actual	Budget execution %	% of change against 2007
Primary prostheses and orthoses	11,814	11,904	12,647	106%	7%
Glucometer test strips	21,078	43,848	27,837	63%	32%
Stoma appliances	9,756	10,500	10,899	104%	12%
IInsulin pumps	1,066	2,000	1,332	67%	25%
Other medical devices	624	16,183	707	4%	13%
Total	44,338	84,435	53,422	63%	20%

Primary prostheses and orthoses. The Health Insurance Fund reimburses the cost of primary prostheses and orthoses to insured persons. These are medical devices which are put in place during up to six months following an amputation or trauma of a limb. 5,949 insured persons were reimbursed the costs of prostheses and orthoses (832 more than in 2007). The costs of prostheses have remained stable over the years, whereas those of orthoses have been growing steadily. In comparison with 2007 the number of recipients of orthoses increased by 17%, at the same time the awareness of the insured about the possibilities of getting orthoses and purchasing them at a discount has improved.

The limit amounts for glucometer test strips that can be used for measuring the blood sugar levels in diabetic patients have been increased from 2007 onwards and the target group has been extended to include all diabetic patients instead of the earlier practice to reimburse the costs of glucometer test strips only to patients suffering from a more serious diabetic condition.

In 2008 18,619 insured persons were reimbursed the costs of test strips, constituting 81% of the planned target group. The average cost of test strips per one person was also lower than budgeted: it is possible that cheaper test strips were preferred or that some of the users did not have to purchase the whole allowed amount.

In comparison with 2007 number of test strip users grew by 43%, an indication of better awareness among the diabetic patients about the need for self-testing in order to avoid complications.

Access to stoma appliances improved and the number of users grew in 2008 after contracts were concluded with pharmacies for the sale of the appliances (only manufacturers and stoma facilities teaching the use of stomas were selling the appliances prior to that). 1,498 insured persons were reimbursed the costs of stoma appliances and the average cost per on insured person was 7,276 EEK.

Insulin pumps are currently used for treatment by 59 insured persons under 19 years of age. In comparison with 2007 the number has grown by 11 children. The lower than budgeted use of insulin pump accessories is caused by the fact that not all the items permitted during a six-month period have actually been purchased. Given that the required amount of accessories depends on the age and weight of the insured person, the costs cannot be budgeted with very high precision.

The budget line for other medical devices was used by EHIF to compensate the following costs: pressure garments for patients with burn wounds, contact lenses for treatment of ophthalmologic diseases, disposable bladder catheters and spacer devices for delivering pharmaceuticals for treating asthma.

7. Personnel and Management Expenses

Table 42. Personnel expenses (in EEK thousand)

	2007 actual	2008 budget	2008 actual	Budget execution %	% of change against 2007
Wages and salaries	45,038	54,826	54,428	99%	21%
Basic salary	37,338	44,270	44,565	101%	19%
Performance pay	5,587	8,249	6,805	82%	22%
Basic and performance pay of Management Board members	2,109	2,302	3,056	133%	45%
Remuneration of Supervisory Board members	4	5	2	40%	–50%
Unemployment insurance premium	129	158	154	97%	19%
Social tax	14,863	18,093	17,961	99%	21%
Total	60,030	73,077	72,543	99%	21%

The budget for basic salaries was exceeded by 1%, for in planning the budget the obligation related to holiday pay earned but not paid during the year could not be estimated with sufficient precision. As a result of an inventory conducted for the above obligation as of 31.12.2008 the wages and salaries cost was increased by 786 thousand kroons.

The budget for amounts payable to the Management Board members has also been exceeded, caused first, by remuneration paid to a Management Board member upon termination of the member's contract (the amount was not budgeted) and secondly, by changes in the principles of recording performance pay in the accounts. Earlier performance pay was recorded on a cash basis. From 2008 performance pay is recorded on an accrual basis and therefore the costs of 2008 include performance pay for two years (i.e. the amounts paid for 2007 and those calculated for 2008).

8. Administrative Expenses

Table 43. Administrative expenses (in EEK thousand)

	2007 actual	2008 budget	2008 actual	Budget execution %	% of change against 2007
Office expenses	2,977	3,228	3,590	111%	21%
Maintenance expenses of premises	7,701	8,543	8,143	95%	6%
Supplies and equipment	1,410	1,498	1,414	94%	0%
Maintenance expenses of vehicles	1,861	1,958	1,701	87%	–9%
Official travel	544	723	693	96%	27%
Bank fees	1,267	1,440	1,518	105%	20%
Administrative costs related to State Treasury	93	139	126	91%	35%
Other administrative expenses	2,768	3,568	2,925	82%	6%
Total	18,621	21,097	20,110	95%	8%

The budget for office expenses was exceeded because of higher postal expense arising from the delivery of European health insurance cards. More than planned bank transfers were carried out, resulting in overspending of bank fees.

9. IT Expenses

Table 44. IT expenses (in EEK thousand)

	2007 actual	2008 budget	2008 actual	Budget execution %	% of change against 2007
Personal hardware and software	1,805	4,307	5,031	117%	179%
IT systems development	1,280	2,120	972	46%	–24%
IT systems maintenance	3,976	3,716	3,830	103%	–4%
Other IT costs	962	258	450	174%	–53%
Total	8,023	10,401	10,283	99%	28%

Of the personal hardware and software costs depreciation of servers and amortisation of software constitutes 2.8 million EEK. Barely 46% of the IT systems development budget was used, the reason being failure to complete the project of transition of the cash benefits system to the SAP platform in 2008 and postponement thereof until 2009. The final deadline could not be kept by the developer due to the developer's other engagements.

10. Development Expenses

Table 45. Development expenses (in EEK thousand)

	2007 actual	2008 budget	2008 actual	Budget execution %	% of change against 2007
Training	1,527	1,791	1,481	83%	–3%
Consultations, incl	2,211	2,730	1,828	67%	–17%
business consultations	1,870	2,090	1,423	68%	–24%
legal consultations	341	640	405	63%	19%
Total	3,738	4,521	3,309	73%	–11%

The business consultations budget was used to commission five clinical practice guidelines (see the section for scorecard for details), to pay user fees to NordDRG and to commission expert opinions of proposals to amend the List of Health Services.

Legal costs were mostly spent on proceeding with the interest claim against the Tallinn Diagnostic Centre in the Supreme Court and on establishing the legality of choosing health service providers, also in the Supreme Court.

11. Financial Expenses

Table 46. Financial expenses (in EEK thousand)

	2007 actual	2008 budget	2008 actual	Budget execution %	% of change against 2007
Other financial expenses	90	100	132	132%	47%
Total	90	100	132	132%	47%

Other financial expenses consist of foreign exchange losses and interest expense. Overspending resulted from a higher volume of transactions.

12. Other Operating Expenses

Table 47. Other operating expenses (in EEK thousand)

	2007 actual	2008 budget	2008 actual	Budget execution %	% of change against 2007
Pre-printed forms and publications	948	932	974	105%	3%
Supervision	1,033	1,285	983	76%	–5%
Public relations/communication	1,101	1,147	1,311	114%	19%
Other expenses	1,548	2,254	6,684	297%	332%
Total	4,630	5,618	9,952	177%	115%

974 thousand kroons was spent on pre-printed forms designated for medical institutions.

Of the amount budgeted for supervision 268 thousand kroons was used to pay for auditing the EHIF accounts and 714,500 EEK for conducting clinical audits (see the list of audits in the scorecard section).

Costs related to the publication of brochures on health insurance, publication of the EHIF journal, website development costs etc come under public relations and communication costs (see for more details on p 28, in the chapter “Information”). In addition a brochure describing the reform of family medicine and the 2007 EHIF Annual Report were issued in English. These materials were designed for the WHO conference “Health Systems, Health and Wealth” in Tallinn. The costs of satisfaction surveys commissioned every year also come under this budget line (see for more details on p 30, in the chapter “Satisfaction Surveys”).

The following is recorded under “Other expenses”: uncollectible claims, costs related to internal information and social events, social tax and income tax on fringe benefits. The costs arising with respect to liability insurance of the Management Board members are budgeted here as well. The budget for other expenses was exceeded as a result of writing off the interest for delay claimed from the Tallinn Diagnostic Centre (5 million EEK).

13. Legal Reserve

The legal reserve is 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, on the basis of the Estonian Health Insurance Fund Act.

The legal reserve constitutes 6% of the budget. As of 31 December 2008 the legal reserve amounted to 800.3 million EEK.

14. Risk Reserve

Pursuant to the Estonian Health Insurance Fund Act the size of the risk reserve shall be 2% of the health insurance budget of the Health Insurance Fund.

As of 31 December 2008 the risk reserve amounted to 266.8 million EEK.

15. Retained Earnings

As of 31 December 2008 the Health Insurance Fund had 3.1 billion EEK in retained earnings.

ANNUAL FINANCIAL STATEMENTS 2008

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 74 to 88 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 31 March 2009, have been duly recognised and presented in the annual financial statements;
- The Estonian Health Insurance Fund is continuously operating.

	Date	Signature
Chairman of Management Board Hannes Danilov	31.03.09	
Member of Management Board Mari Mathiesen	31.03.09	
Member of Management Board Kersti Reinsalu	31.03.09	

BALANCE SHEET

Assets

(in EEK thousand)	31.12.2007	31.12.2008	Note
Current assets			
Cash and cash equivalents	674,312	990,081	2
Bonds and other securities	2,045,688	2,145,095	3
Receivables and prepayments	1,291,863	1,563,622	4,7
Inventories	130	142	5
Total currents assets	4,011,993	4,698,940	
Non-current assets			
Long-term financial investments	291,060	323,389	6,7
Property, plant and equipment	7,591	11,819	8
Intangible assets	2,749	2,274	8
Total non-current assets	301,400	337,482	
TOTAL ASSETS	4,313,393	5,036,422	

Liabilities and equity

(in EEK thousand)	31.12.2007	31.12.2008	Note
Liabilities			
Current liabilities			
Loans and prepayments	709,363	871,814	10
Total current liabilities	709,363	871,814	
Total liabilities	709,363	871,814	
Equity			
Reserves	804,512	1,067,055	
Surplus for previous periods	1,860,595	2,536,975	
Surplus for financial year	938,923	560,578	
Total equity	3,604,030	4,164,608	
TOTAL LIABILITIES AND EQUITY	4,313,393	5,036,422	

STATEMENT OF FINANCIAL PERFORMANCE

(in EEK thousand)	2007	2008	Note
Revenue from the health insurance part of social tax and claims collected from other persons	11,009,776	12,516,573	11
Income from government grants	29,549	163,104	15
Expenses related to government grants	–29,549	–163,104	15
Expenditure on health insurance	–10,119,220	–12,059,852	12
Gross surplus	890,556	456,721	
Administrative expenditure	–89,052	–106,245	13
Other operational revenue	46,395	54,342	
Other operational expenditure	–4,630	–9,952	
Operating surplus	843,269	394,866	
Financial income and expenses			
Interest and financial income	97,104	165,844	
Financial expenses	–1,450	–132	
Total financial income and expenses	95,654	165,712	
Net surplus for the period	938,923	560,578	

CASH FLOW STATEMENT

(in EEK thousand)	2007	2008
Cash flows from operating activities		
Social tax received	10,682,923	12,225,837
Payments to suppliers	–10,095,738	–12,098,584
Personnel expenses paid	–43,416	–52,044
Payroll expenses paid	–15,006	–17,853
Other revenue received	106,978	301,686
Net cash flows from operating activities	635,741	359,042
Cash flows from investing activities		
Purchase of fixed assets	–4,559	–8,316
Proceeds from disposal of financial assets	2,573,804	2,940,177
Purchase of financial assets	–3,068,688	–2,975,134
Net cash flows from investing activities	–499,443	–43,273
Net increase/(-) decrease in cash and cash equivalents	136,298	315,769
Cash and cash equivalents at the beginning of the period	538,014	674,312
Change in cash and cash equivalents	136,298	315,769
Cash and cash equivalents at the end of the period	674,312	990,081
incl. short-term deposits	645,476	983,284

STATEMENT OF CHANGES IN EQUITY

(in EEK thousand)	2007	2008
Reserves		
Reserves at the beginning of the year	641,512	804,512
Increase of reserves	163,000	262,543
Reserves at the end of the year	804,512	1,067,055
Net surplus for previous periods		
Net surplus at the beginning of the year	2,023,595	2,799,518
Increase of reserves	–163,000	–262,543
Net surplus for financial year	938,923	560,578
Net surplus at the end of the year	2,799,518	3,097,553
Equity at the beginning of the year	2,665,107	3,604,030
Equity at the end of the year	3,604,030	4,164,608

NOTES TO THE ANNUAL FINANCIAL STATEMENTS

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

General principles
The annual financial statement for 2008 of the EHIF has been prepared in accordance with the generally accepted accounting principles in Estonia based on internationally recognised accounting and reporting principles. The main requirements of the generally accepted accounting principles are laid down in the Accounting Act, which is supplemented by guidelines of the Accounting Standard Board.

The financial year began on 1 January 2008 and ended on 31 December 2008. 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 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.

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

Foreign exchange accounts
Transactions in a foreign currency are recorded in Estonian kroons on the basis of the exchange rate published by the Bank of Estonia applicable on the transaction day. Assets and liabilities established in a foreign currency are re-valuated on the basis of the exchange rate valid on the balance sheet date and the currency transaction reserve is shown in the statement of financial performance.

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.

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.

Receivables and loan accounts
Receivables and granted loans are assessed individually and reflected on the balance sheet on conservative basis in view of the amounts collectible. Receivables and granted loans, which are uncollectible, are expensed for the period and shown on the balance sheet with a minus. 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 put to expenses.

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

Property, plant and equipment accounts
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, which have a shorter expected useful life and a smaller acquisition cost, are put to expenses at the time of acquisition.

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 (in years) are applied:

- Buildings 10–20
- Inventories 2–4
- Equipment and computers 3–5
- Intangible fixed assets 2–4

Intangible asset accounts
Intangible assets are identifiable non-monetary assets, which have no physical substance, have an expected useful life of more than one year, are used for own activities and have an acquisition cost of more than 30,000 kroons. Intangible assets are recognised at their acquisition cost and depreciated on a straight-line basis.

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.

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.

Operating and financial lease accounts
A lease is deemed to be financial lease, if all the main risks and benefits related to the ownership of the assets are transferred to the lessee. In the opposite case the lease is deemed to be an operating lease.

The property leased by way of financial lease is recognised on the balance sheet as assets and liabilities, according to the just value of the leased property. The lease payments are divided into finance costs and 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
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 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 § 39^1 of the Estonian Health Insurance Fund Act as follows:

- The risk reserve of the EHIF is the reserve formed from the budgetary funds of the EHIF in order to minimise the risks arising for the health insurance system from the obligations assumed
- The risk reserve equals 2% of the health insurance budget of the EHIF
- The funds of the risk reserve may be used upon 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 § 39^1 to it.

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

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 2008, 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 EEK thousand	31.12.2007	31.12.2008
Deposits at call	28,836	6,797
Fixed term deposits	645,476	983,284
Total	674,312	990,081
Fixed term deposits:		
Due within 1 month	424,876	746,784
Due within 1 to 3 months	220,600	236,500
Total	645,476	983,284

Note 3. Bonds and other securities

In EEK thousand						
Depfa Bank	Date of acquisition	Maturity date	Underlying currency	Acquisition cost	Fair value	Rate of return
The Government of France	31.03.2008	5.01.2009	EEK	95,435	100,000	6.15%
The Government of the Netherlands	30.09.2008	12.01.2009	EUR	62,479	64,740	4.07%
The Government of the Netherlands	29.08.2008	15.01.2009	EUR	31,097	32,128	4.35%
The Government of France	25.09.2008	30.01.2009	EUR	30,865	31,259	3.94%
Depfa Bank	24.09.2008	12.02.2009	EUR	30,792	31,229	4.16%
FIH Bank	15.05.2008	16.02.2009	EEK	185,450	192,757	6.30%
Danske Bank A/S Estonia branch	19.08.2008	19.02.2009	EUR	152,029	155,882	5.71%
BCP Bank	30.09.2008	26.02.2009	EEK	29,222	29,674	6.59%
The Government of the Netherlands	31.03.2008	27.02.2009	EUR	149,894	155,777	4.74%
The Government of France	24.09.2008	27.02.2009	EUR	46,118	46,834	4.11%
The Government of Germany	14.07.2008	12.03.2009	EUR	49,394	50,684	4.41%
The Government of Belgium	24.10.2008	13.03.2009	EUR	62,836	64,765	2.64%
The Government of the Netherlands	16.06.2008	28.03.2009	EUR	23,328	24,251	4.52%
BFCM Bank	15.09.2008	31.03.2009	EUR	39,783	40,530	4.19%
The Government of the Netherlands	4.07.2008	6.04.2009	EUR	103,529	106,859	5.23%
The Government of Belgium	15.09.2008	15.04.2009	EUR	31,015	31,992	4.29%
The Government of Germany	28.05.2008	16.04.2009	EUR	33,174	34,268	4.20%
The Government of Finland	30.09.2008	17.04.2009	EUR	46,763	48,256	3.90%
The Government of Finland	29.08.2008	25.04.2009	EUR	62,802	65,326	4.38%
The Government of France	14.11.2008	25.04.2009	EUR	15,821	16,332	2.40%
Danske Bank A/S Estonia branch	14.08.2008	7.05.2009	EUR	45,489	46,657	4.32%
Depfa Bank	30.09.2008	15.05.2009	EEK	28,760	29,165	6.84%
The Government of France	19.05.2008	19.05.2009	EEK	50,000	51,923	6.70%
Kommunalkredit Bank	14.08.2008	4.06.2009	EUR	49,126	50,472	4.30%
Depfa Bank	15.09.2008	15.06.2009	EUR	124,083	127,325	5.29%
The Government of France	19.06.2008	19.06.2009	EEK	100,000	103,740	7.30%
The Government of Austria	16.06.2008	12.07.2009	EUR	23,206	24,066	4.59%
Depfa Bank	4.11.2008	15.07.2009	EUR	31,634	32,242	2.38%
Hansapank	15.09.2008	15.09.2009	EEK	50,000	50,735	6.85%
General Electric	19.10.2004	19.10.2009	EUR	31,278	31,576	2.41%
Citigroup	10.05.2004	4.05.2011	EUR	15,603	14,188	2.24%
Danske Bank	3.11.2004	3.06.2011	EUR	24,974	21,943	2.34%
ING Grupp	29.06.2007	29.06.2012	EUR	31,265	29,158	4.29%
Barclays Bank	26.06.2006	18.09.2013	EUR	46,874	41,330	3.57%
General Electric	23.11.2005	23.11.2015	EUR	7,796	7,420	2.92%
ING Grupp	17.03.2006	22.02.2016	EUR	15,608	12,474	2.88%
General Electric	11.04.2006	11.04.2016	EUR	31,212	26,167	2.99%
Danske Bank A/S Estonia branch	17.01.2007	17.05.2021	EUR	15,577	10,107	4.14%
Kommunalkredit Bank	30.04.2008	26.02.2009	EEK	18,952	19,782	6.59%
The Government of France	15.09.2008	15.06.2009	EUR	26,348	27,036	5.29%
The Government of Austria	15.08.2008	2.07.2009	EUR	6,481	6,670	4.28%
The Government of the Netherlands	10.10.2007	15.07.2009	EUR	6,256	6,448	4.02%
The Government of France	15.10.2007	15.07.2009	EUR	15,557	16,070	4.09%
Dexia Bank	13.11.2007	12.09.2009	EUR	22,699	23,313	3.96%
Total	8.10.2007	21.09.2009	EUR	11,248	11,545	4.33%
Kokku				2,111,852	2,145,095	

Short-term investments are bonds maturing in 2009 and bonds acquired for the purpose of contributing to the risk reserve which in the opinion of the EHIF, shall probably be redeemed in 2009. The revenue and expenditure of the revaluation are reflected in the statement of revenue and expenditure.

Note 4. Receivables and prepayments

In EEK thousand	31.12.2007	31.12.2008
Trade receivables	10,889	13,354
Claim to Tallinn Diagnostic Centre	6,577	0
Short-term part of loans granted (see Note 7)	3,397	0
Advance payment of wages	38	48
Claims for government grants*	4,661	5,874*
Claims for reimbursement of maintenance costs	62	75
Contractual claims against insured persons	145	245
Allowance for doubtful receivables	–3	–7
Interest receivables	2,132	3,629
Social tax receivable	1,260,479	1,536,447
Prepaid expenses	3,486	3,957
Total	1,291,863	1,563,622

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

EHIF received from Tallinn Diagnostic Centre 1,622 thousand kroons pursuant to court agreement in 2008. Receivables in the amount 4,955 thousand kroons were classified as uncollectible and written off from Balance sheet.

Social tax receivable in the amount of 1,536 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 31.12.2008, the EHIF has unused prescription forms worth 142 thousand kroons (as of 31.12.2007, 130 thousand kroons). Inventories belonging to the EHIF are deposited into storage with liability with other persons with balance sheet value of 51 thousand kroons (as of 31.12.2007, 56 thousand kroons).

Note 6. Long-term financial investments

1. The EHIF has acquired shares with the following nominal value:
Shares of AS Viimsi Haigla (at cost)

In EEK thousand	31.12.2007	31.12.2008
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.

2. The EHIF has acquired long maturity bonds as follows:

In EEK thousand						
Bond	Date of acquisition	Maturity date	Underlying currency	Acquisition cost	Fair value	Rate of return
The Government of Austria	16.12.2008	15.01.2010	EUR	44,499	46,803	2.26%
The Government of Germany	12.11.2008	9.04.2010	EUR	15,828	16,309	2.39%
The Government of France	9.05.2008	25.04.2010	EUR	17,722	18,644	3.90%
Swedish Export Credit Bank	18.01.2008	7.06.2010	EUR	20,528	21,387	4.08%
Land Nordrhein-Westfalen	25.06.2007	30.06.2010	EUR	15,050	16,073	4.63%
The Government of the Netherlands	8.09.2008	15.07.2010	EUR	28,037	29,493	4.12%
The Government of Finland	16.12.2008	15.09.2010	EUR	15,751	15,964	2.35%
Danske Bank A/S Estonia branch	30.04.2008	28.01.2011	EEK	19,978	19,976	6.88%
The Government of Finland	25.01.2008	23.02.2011	EUR	15,417	16,195	3.48%
The Government of France	13.08.2008	25.04.2011	EUR	24,844	26,731	4.15%
The Government of France	19.12.2008	12.07.2011	EUR	10,671	10,888	2.45%
The Government of the Netherlands	9.07.2008	15.07.2011	EUR	31,657	34,053	4.58%
The Government of Germany	15.09.2008	14.10.2011	EUR	30,997	32,912	3.83%
European Investment Bank	6.06.2005	24.03.2020	EUR	12,340	11,211	3.14%
Total				303,319	316,639	

3. Other long-term receivables

In EEK thousand	31.12.2007	31.12.2008
Long-term tax claim against the Tax and Customs Board	410	969
Long-term part of the amount paid to the Social Insurance Board for renovating the premises of the Pärnu Department and Rapla Office	5,732	5,691
Total	6,142	6,660

Note 7. Loans

In EEK thousand			
Põhja-Eesti Regionaalhaigla SA (The North Estonia Medical Centre)	Receivables	Incl. short-term receivables	Incl. long-term receivable
Loan balance as of 31.12.2007	3,397	3,397	0
Received	3,397	3,397	0
Loan balance as of 31.12.2008	0	0	0

The average interest rate of loans is 4%, the loans have been granted in Estonian kroons.

Note 8. Property, plant and equipment

Tangible assets

In EEK thousand			
Acquisition cost	Land and buildings	Other inventories	Total
31.12.2006	4,170	22,177	26,347
Purchase of fixed assets	246	2,792	3,038
Written off	0	–825	–825
31.12.2007	4,416	24,144	28,560
Purchase of fixed assets	1,121	6,817	7,938
Written off	0	–232	–232
31.12.2008	5,537	30,729	36,266
Accumulated depreciation			
31.12.2006	2,339	16,456	18,795
Calculated depreciation	217	2,779	2,996
Written off	0	–822	–822
31.12.2007	2,556	18,413	20,969
Calculated depreciation	225	3,368	3,593
Written off	0	–115	–115
31.12.2008	2,781	21,666	24,447
Residual value			
31.12.2006	1,831	5,721	7,552
31.12.2007	1,860	5,731	7,591
31.12.2008	2,756	9,063	11,819

Intangible assets

In EEK thousand	
Acquisition cost	Purchased licences
31.12.2006	4,783
Purchase of fixed assets	1,521
31.12.2007	6,304
Purchase of fixed assets	378
31.12.2008	6,682
Accumulated depreciation	
31.12.2006	2,868
Calculated depreciation	687
31.12.2007	3,555
Calculated depreciation	853
31.12.2008	4,408
Residual value	
31.12.2006	1,915
31.12.2007	2,749
31.12.2008	2,274

Note 9. Leased assets

Operating lease
The Statements of financial performance include operating lease payments in the amount of 5,659 thousand kroons from which 392 thousand kroons was paid for the lease of means of transport and 5,267 thousand kroons pursuant to commercial lease contracts of premises.

In 2007 the operating lease payments were 5,704 thousand kroons from which 622 thousand kroons was paid for the lease of means of transport and 5,082 thousand kroons pursuant to commercial lease contracts of premises.

In 2009 the amount of operating lease payments is 5,960 thousand kroons.

Note 10. Loans and prepayments

1. Supplier payables

In EEK thousand	31.12.2007	31.12.2008
Accounts payable for medical care services	496,460	609,935
Accounts payable for medicinal products subject to discount	86,965	114,110
Supplier payables for health insurance benefits	79,106	79,368
Other supplier payables	3,211	3,623
Total	665,742	807,036

2. Tax liabilities

In EEK thousand	31.12.2007	31.12.2008
Individual income tax	29,386	47,609
Social tax	4,459	5,324
Income tax from fringe benefits	84	48
Unemployment insurance premium	77	87
Mandatory funded pension premium	91	98
VAT	2	94
Total	34,099	53,260

The individual income tax liability include individual income tax in the amount of 46,145 thousand kroons (as of 31.12.2007 - 28,004 thousand kroons) deducted from the benefits for incapacity for work paid by the EHIF to the insured persons. The social tax liability include social tax in the amount of 1,037 thousand kroons (as of 31.12.2007 - 778 thousand kroons) calculated from the holiday pay not disbursed to the employees.

3. Other loans

In EEK thousand	31.12.2007	31.12.2008
Payables to employees	8,098	10,548
Other loans	886	928
Prepayments received	538	42
Total	9,522	11,518

Note 11. Revenue from operating activity

In EEK thousand	2007	2008
Revenue from the health insurance part of social tax	11,000,420	12,502,365
Amounts due from other persons	9,356	14,208
Total	11,009,776	12,516,573

Note 12. Expenditure on health insurance

In EEK thousand	2007	2008
Health service benefits, incl	6,795,919	8,089,373
Disease prevention	90,148	109,095
General medical care	886,076	1,047,224
Specialised medical care*	5,390,436	6,395,818
Nursing care	189,267	237,972
Dental care	239,992	299,264
Health promotion activities	12,688	13,970
Expenditure on benefits of medicinal products, incl	1,120,559	1,281,486
Centrally equipped medicinal products	286	146
Expenditure on benefits for temporary incapacity for work	1,926,851	2,387,453
Other monetary benefits	184,665	201,678
Other expenditure on health insurance benefits, incl	78,538	85,892
Health service benefits arising from international agreements	34,200	32,470
Benefit for medical devices	44,338	53,422
Total	10,119,220	12,059,852

* The expenditure of 2008 differs from the expenditure on the budget implementation sheet as government grants from the state budget in amount 163,104 thousand kroons (see Note 15) is included in the budget on the line of expenditure. In 2007 the different was 29,549 thousand kroons.

Note 13. Administrative expenditure

In EEK thousand	2007	2008
Personnel and administrative expenditure	60,030	72,543
Remuneration	45,038	54,428
incl. remuneration of the members of the Management Board	2,109	3,056
incl. remuneration of the members of the Supervisory Board	4	2
Unemployment insurance premium	129	154
Social tax	14,863	17,961
Management costs	17,261	20,110
Information technology costs	8,023	10,283
Development costs	3,738	3,309
Total	89,052	106,245

Remuneration of the members of the Management Board include performance pay in the amount of 554 thousand kroons, shall be paid in 2009, after a decision of the Supervisory Board.

Note 14. Transactions with related parties

Related parties are the members of the management Board and Supervisory Board as well as business connected with them.

No transactions have been made with the members of the management Board and Supervisory Board or with companies connected with them.

Remuneration paid to the members of the Management Board and Supervisory Board in 2008 is indicated in Note 13.

Note 15. Government grants

Government grants is 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 EEK thousand	2007	2008
Reimbursing the expenditure on the medicinal products in external *in vitro* fertilisation	12,715	12,072
Reimbursement of the infertility treatment pursuant to health services	16,834	25,932
Depreciation costs of buildings of health care providers	0	125,100
Total	29,549	163,104

SIGNATURES TO THE ANNUAL REPORT

The Management Board of the Estonian Health Insurance Fund has prepared the 2008 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 2008 Annual Report.

Name	Date	Signature
Chairman of Management Board Hannes Danilov	31.03.09	
Member of Management Board Mari Mathiesen	31.03.09	
Member of Management Board Kersti Reinsalu	31.03.09	
Chairman of Supervisory Board Hanno Pevkur	14.04.09	
Members of Supervisory Board		
Ivari Padar	17.04.09	
Heljo Pikhof	21.04.09	
Jaak Aab	17.04.09	
Ivi Normet	17.04.09	
Lagle Suurorg	17.04.09	
Aare Kitsing	17.04.09	
Senta Michelson	17.04.09	
Harri Taliga	23.04.09	
Merle Smutov	17.04.09	
Tõnis Allik	17.04.09	
Tarmo Kriis	17.04.2009	
Jaan Pillesaar	17.04.09	
Tiit Kuuli	17/04/2009	
Tarmo Noop	17.04.2009	

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INDEPENDENT AUDITOR'S REPORT

To the Council of Eesti Haigekassa

(translation from the Estonian original)

We have audited the accompanying financial statements of Eesti Haigekassa, which comprise the balance sheet as at 31 December 2008, and the statement of financial performence, statement of changes in equity and cash flow statement for the year then ended, and a summary of significant accounting policies and other explanatory notes, as set out on pages 75 to 88.

Management's Responsibility for the Financial Statements

Management is responsible for the preparation and fair presentation of these financial statements in accordance with the accounting principles generally accepted in Estonia. This responsibility includes: designing, implementing and maintaining internal control relevant to the preparation and fair presentation of financial statements that are free from material misstatement, whether due to fraud or error; selecting and applying appropriate accounting policies; and making accounting estimates that are reasonable in the circumstances.

Auditor's Responsibility

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

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

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

Opinion

In our opinion, the financial statements present fairly, in all material respects, the financial position of Eesti Haigekassa as of 31 December 2008, and its financial performance and its cash flows for the year then ended in accordance with the accounting principles generally accepted in Estonia.

Tallinn, 31 March 2009

KPMG Baltics AS

(signature)

Andres Root
Authorized Public Accountant

(signature)

Eeli Lääne
Authorized Public Accountant

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