Eesti Haigekassa
Estonian Health Insurance Fund

Estonian Health Insurance Fund Annual Report 2009

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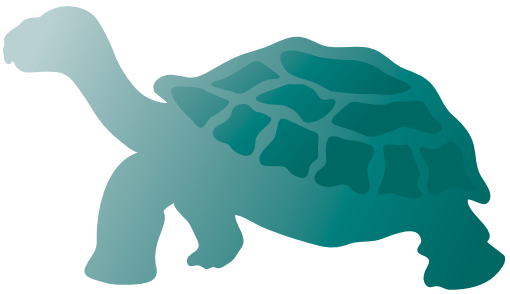
The symbol of the Estonian Health Insurance Fund is the turtle.

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

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

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

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



Estonian Health Insurance Fund Annual Report 2009

Name	Estonian Health Insurance Fund
Registration number in the state register of central and local government agencies	74000091
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Beginning of financial year	January 1st 2009
End of financial year	December 31st 2009
Principal activity	Public health insurance
Management Board	Hannes Danilov (Chairman) Mari Mathiesen Kersti Reinsalu
Auditor	KPMG Baltics AS

Table of Contents

Statement by the Chairman of the Management Board

The previous year was, first and foremost, marked by the economic crisis. Until the beginning of 2009 we could only hope that the financial crisis expanding in the US would not turn into global recession and not have a serious impact on us.

By the beginning of this year, however, it was evident that the crisis would not pass us by and, as a result, all economic estimates were hurriedly revised. During the first half of the year, the Parliament of Estonia (Riigikogu) passed two negative supplementary budgets curbing public sector spending and raising certain taxes.

Health insurance budget was inevitably affected by all this. In the beginning of the year we reduced the number of cases of specialised medical care by 4–5% in the financing agreements thereof and decreased the volume of reimbursing the cost of medicinal products. Consequently, the maximum waiting times for outpatient treatment were extended from four to six weeks.

We hoped that these changes would be sufficient and that we would be able perform our contractual commitments until the end of the year. However, in the middle of the year, the collection of social tax dropped abruptly and we were compelled to put forward a proposal to reduce the prices of health services by 6% to the EHIF Supervisory Board. This decision would hopefully ensure continuing consistency between health insurance expenditure and social tax revenue even in this difficult year.

As of July 1st, the procedure for compensating for incapacity for work changed: no benefit is paid for the first three sick days, on days 4 to 8 the benefit is paid by the employer, and the Health Insurance Fund starts paying the benefit only as of the ninth sick day. This amendment would cut the costs of health insurance by ca 800 million kroons per year. Compared to 2008 Health Insurance Fund budget that of 2010 has shrunk by 1.7 billion kroons.

Regardless of all these reductions, the results for the last year were not bad. Owing to the effort of health care professionals and hospital executives satisfaction with the quality and accessibility of health services was not impaired in any way.

Sadly but surely, the retrenchment must continue. A system is not sustainable if it is constantly working with practically all its might, something will give in, be it the quality or availability.

In order to get a clearer vision of the future, we initiated, in cooperation with the Ministry of Social Affairs and the World Health Organization, an analysis, which would help us to estimate possible scenarios for medical care funding up to 2030.

The analysis would enable us to set aims as to the level of health care funding until 2030 and devise strategies how to attain these aims. It would also assist us in revising existing prognoses and making amendments thereof arising from changes in the reference conditions.

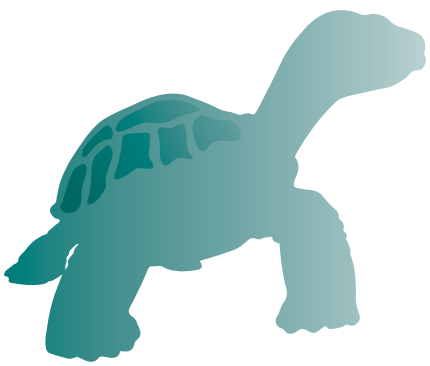
The outcome of this analysis would certainly give rise to a debate as to whether health should be funded by public or private means – revenue from tax or from increasing the contribution of people themselves – in the future.

International experience has shown that in societies, where the use of health services is dependent on patients' needs and not their solvency, people are in general healthier and their lives longer. The average lifespan has grown by 7 years during the last 15 years in Estonia and about 50% of this growth could be attributed to the organisation of our health care system.

Last year was also intriguing seeing a new development in e-health. As a result of the joint effort of all the parties – Health Insurance Fund, Ministry of Social Affairs, software companies Helmes and Microlink – digital prescriptions became a reality as of January 1st 2010. The digitalisation of prescriptions and patient records is aimed at establishing a situation where doctors can observe the whole treatment process in their work computer.

I would like to thank all employees and partners of the Health Insurance Fund both in medical institutions and bodies overseeing the health care system for their efficient work and cooperation in the previous, very difficult year.

Hannes Danilov
Chairman of the Management Board



Management Report 2009

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

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 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 relation 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. Furthermore, 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 objectives, functions, bases for activities and management of the Estonian Health Insurance Fund.

To fulfil its functions the Health Insurance Fund cooperates with partners and employers. The partners of the Health Insurance Fund are the providers of health care: hospitals, medical specialists, family physicians, dentists, pharmacies, professional societies and the associations of health care providers, health promoters, the Ministry of Social Affairs and other state agencies. Hospitals specified in the development plan of the hospital network are strategic partners.

Employers pay social tax, and revenues from social tax designated for health insurance constitute the Health Insurance Fund budget. The employers have an obligation to see to it that data concerning the insurance cover of their employees is communicated to the Health Insurance Fund.

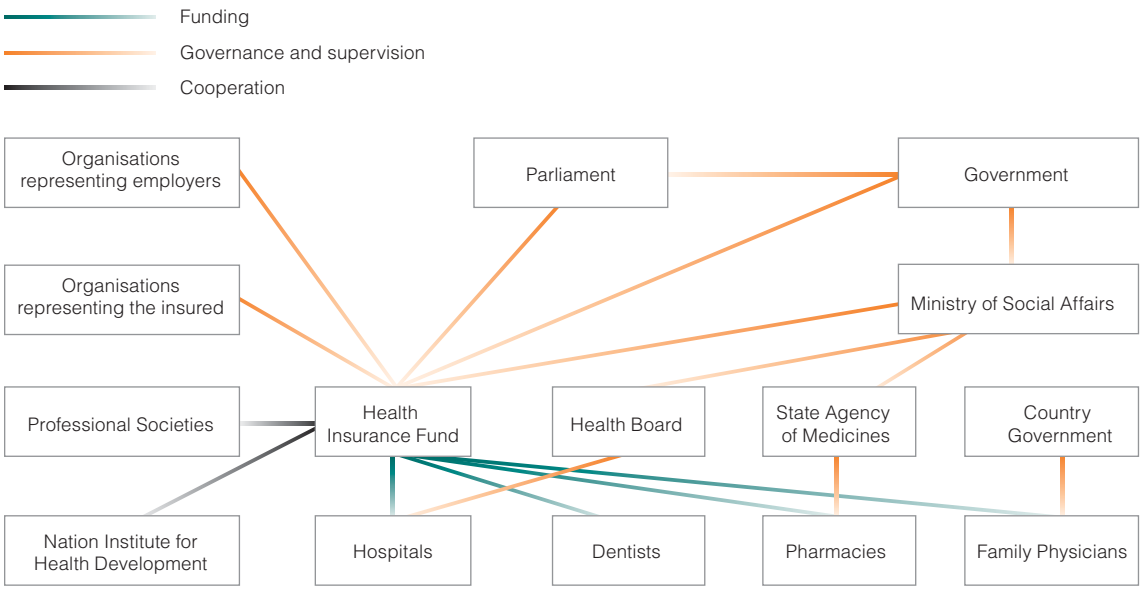
Management

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

Organisation

The Health Insurance Fund has 12 central departments and 4 regional departments. As of December 31st 2009, the Health Insurance Fund had a staff of 224.

Figure 1. Overview of the health care system



Estonian Health Care System: A Brief Overview

The Ministry of Social Affairs is the steward of the Estonian health care system, having to develop the relevant regulations and strategies. There are several agencies within the area of administration of the Ministry of Social Affairs; of which the State Agency of Medicines and the Health Board, founded in 2010, are responsible for health care matters. The latter was established as a result of the joint development of Health Protection Inspectorate and Health Care Board and its functions include granting activity licences to health care providers, registration of health care professionals and funding of emergency medical care. The principal tasks of the State Agency of Medicines include registration of pharmaceuticals, quality control and organisation of trade in pharmaceuticals.

The Health Insurance Fund also operates within the area of administration of the Ministry of Social Affairs, being not its agency but an independent legal body under public law. The 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 insurance funds was changed.

The pillars of the Estonian health care system are separation of the provision of health services and funding thereof 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. Similarly the service providers are not involved in the management of the Health Insurance Fund. Such separation of the health care providers and the funders guarantees unbiased funding decisions, aimed only at meeting treatment needs of the insured and ensuring the use of health insurance resources 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 representative 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. Such organisation adds to the flexibility and efficiency of their management.

Table 1. Key indicators 2005–2009

	2005	2006	2007	2008	2009	% of change from 2008
Number of insured persons at year end	1,271,354	1,278,016	1,287,765	1,281,718	1,276,366	0%
Revenue (in EEK thousand)	7,346,892	8,909,947	11,182,824	12,899,863	11,429,864	-11%
Health insurance expenditure (in EEK thousand)	6,983,752	7,946,048	10,148,769	12,222,956	11,959,257	-2%
EHIF operating expenditure (in EEK thousand)	89,385	87,044	95,132	116,329	107,053	-8%
Health insurance expenditure as a percentage of GDP (%)*	4.1	4.1	4.5	5.2	5.7	0.5%
Number of insured persons who used specialised medical care	778,689	796,815	810,834	819,055	800,578	-2%
Average length of stay (days)	7	6	6	6	6	0%
Emergency care as a percentage of costs on specialised care (%), incl.						
outpatient	15	17	18	17	17	0%
day care**	–	7	7	6	9	3%
inpatient	65	63	63	63	67	4%
Average cost per case in specialised medical care (EEK), incl.						
outpatient	468	447	548	671	687	2%
day care**	–	4,942	6,435	7,324	7,030	-4%
inpatient	10,079	10,981	13,629	15,775	15,821	0%
Number of prescriptions issued at a discount	5,000,602	5,393,102	5,996,843	6,636,410	6,435,700	-3%
Average cost per prescription for EHIF (EEK)	173	179	187	193	215	11%
Number of days of incapacity for work for which benefits were paid	7,685,148	8,195,320	8,888,700	9,182,077	7,379,379	-20%
Cost per day of benefit for incapacity for work (EEK)	165	184	217	260	299	15%

* The indicators have been changed in accordance with GDP corrected by the Statistics Estonia.
** Given the former low proportion of day care the relevant data are available from 2006.

Impact of Economic Environment on Health Insurance Fund

As was indicated in the 2008 annual report, the year 2009 proved to be difficult for both the Health Insurance Fund and the entire health care system. The biggest shortfall occurred in the collection of expected revenue: only 95.1% or 591 million kroons less than planned in the budget was received. Revenue from social tax designated for health insurance, which is mainly paid on wages, constitutes 98% of the revenue of the Health Insurance Fund. The previous, economically good years saw an increase in the social tax revenue thanks to wage growth. Change in average wages or their decline in 2009 had a negative impact on the collection of social tax. In addition, the structure of the insured persons changed: the number of employees, whose social tax is paid on their wages, decreased by 11%, whereas the number of those insured by the state grew by 112% and those treated as insured rose by 4%. On a positive note it is good that people are still insured and receive medical care, but it is rather pessimistic that the state pays tax for them on the minimum wages and no one pays for those treated as the insured. Thus, growth in the number of employed persons would have a positive effect on the revenues of the Health Insurance Fund.

It is evident that in the long run social tax itself is not sufficient to cover the growing need for health services and pharmaceuticals. This fact impelled us to launch an analysis in cooperation with WHO and the Ministry of Social Affairs, which would help us to determine the options for sustainable funding of Estonian health care system. The final report will be finished by the spring 2010.

Compared to the year 2008 the revenues fell by 11.4%, but the expenditure only decreased by 2.2%. This is why trying to cut the costs in the middle of the year is very complicated.

The spending by the Health Insurance Fund on health insurance benefits falls into two categories: open commitments and contractual commitments. Open commitments, such as pharmaceuticals distributed at a discount, benefits for incapacity for work, other cash benefits and medical treatment expenses within the EU, have to be paid by the Health Insurance Fund even if the amount planned for the payment thereof in the budget is not sufficient. The only way to reduce these costs is to decrease the commitments provided by law, and this was the path chosen in 2009, when in the beginning of the year dental care benefits were no longer granted for persons of working age, and the procedure for calculating benefits for incapacity for work changed as of July 1st.

The only option to reduce contractual obligations is negotiating with parties to contracts thereof, which was indeed done in autumn in order to reduce the contractual volumes and thus also the expenditure of the Health Insurance Fund. Thus, as of November 15th a coefficient of 0.94 was applied to services, which imposes a duty to economize on medical institutions that have to ensure quality services at prices that have been reduced by 6%. These efforts are necessary to make the falling revenues meet the needs of expenditure. Regardless of the hard work the year ended with a total net loss that compelled us to use some of the funds saved in the previous years.

In terms of development projects, 2009 was a year that saw finishing of several projects – no new great projects were launched. Preparations for activating digital prescriptions were completed and the Health Insurance Fund played an important role in the development and testing stage of the system, and on January 1st 2010 first pharmaceutical was sold against a digital prescription. Enhancement and development of the system is a continuous process lasting years. The project of transition of the cash benefits system to the SAP platform was nearly completed in 2009: a system for processing dental care benefits and an interface to enable doctors to transfer certificates of incapacity for work by electronic means. 2010 will see the development and entry into use of an effort-consuming interface for forwarding information on benefits for prostheses and certificates of incapacity for work to employers. In addition we need to upgrade our current software versions in the following year if our systems are to be kept up to date. Considering the information systems administered by the Health Insurance Fund and the volume of electronic data thereof, we need to keep giving more attention to the reliability, availability and safety of the systems and making investments thereof.

In spite of the difficult economic climate it may still be said that we have managed to cope well and are better equipped to withstand the continuous pressure of falling revenues.

Kersti Reinsalu
Member of the Management Board
of the Health Insurance Fund

Achievements and Challenges

Already in the beginning of 2009, I considered it to be a great challenge to ensure the availability of medical care in bleak economic circumstances. We were planning several innovations which would make the use of health insurance resources more efficient. Looking back onto the year I have to admit that more changes were necessary than we initially planned.

It is rather odd that within one year the list of health services is repeatedly revised. However, July 1st saw the first important revising of the content of health services and reference prices thereof and the second rearrangement was effected on November 15th. Economic circumstances did not make it possible to wait and plans made for January 2010 had to be executed earlier.

Difficult times call for quick decisions. As of July 1st, changes in benefits for incapacity for work also took effect. These changes were not only of economic nature but established a principal development in dividing responsibility. In addition to the employees and the Health Insurance Fund the payment of health insurance benefits now also involves, for the first time, the employers. In the first decade the expenditure of the Health Insurance Fund on benefits for incapacity for work was almost three times higher than before, and there had been talks of necessary rearrangement for some years, and now we "owe" it to the economic climate that these changes were executed. Thus we take a step closer to other European countries, including the Nordic countries, where employers as an interest group are involved in the payment of sickness benefits.

New contracts for providing general medical care have been entered into with family physicians for the next 5 years. We started negotiations already in the spring 2009 and these bore fruit just before Christmas Eve. Hopefully, these contracts that resulted from careful contemplation and long discussions ensure the insured with smooth accessibility to general medical care free of charge.

Furthermore, as from 2010 family nurses working in family health centres have independent consultation hours and greater opportunities to advise people. This should facilitate the provision of health advice for people.

Pharmaceuticals are gaining in importance in various treatment methods. Having analysed the list of medicines distributed at a discount in Estonia and the use of pharmaceuticals, we put forward several rearrangement proposals in 2009. Both doctors and patients must be able to select a medicine, which corresponds to their clinical needs at the lowest cost possible. A survey on the satisfaction of people has shown that the selection of medicinal products in a pharmacy is considered important, thus pharmaceuticals should mainly be prescribed on the basis of their active ingredient. We started to promote rational use of pharmaceuticals and intend on continuing to do so in 2010. We are convinced that this way we are able to save the money for both the insured and the Health Insurance Fund.

After completing the central system for digital prescriptions, tests were carried out throughout the year 2009, also initiating the preliminary service stage of the medical prescription centre in cooperation with developers and partners in medical institutions and pharmacies. Such a national system with so many parties is unique in the world. This was not only a challenging task for the IT team but an important essential development. Benefits from the new system will be evident starting from 2010 after having overcome possible growing difficulties. Prescribing and purchasing medicines will become easier and quicker for both the patient and the doctor; also facilitating the work of pharmacists. It is important that different levels of health care system function well in combination, relying on patient's needs, in which the implementation of e-health information system plays an important role, creating opportunities for the improved exchange of data between the providers of health services. This facilitates the enhancement of quality and makes the health care system more transparent and human-friendly.

We set the development of the quality of health care system as one of our priorities for 2009, because improved quality leads to better health of the patients, as well as enhancing the performance of the system via optimum use of resources. In spring 2009, we launched a survey in cooperation with a professional society and hospitals, the goal of which is to assess the changes in the quality of life of people who had undergone endoprosthetic replacement of the their knee or hip joint after the procedure. We were able

to introduce the summary of the first results of the survey in December, and the work continues. Within 2009 we also cooperated in the name of developing performance indicators for general surgery, and in 2010 we shall carry on a similar development within another area of activity. Our partners are ever more willing to engage in focused measuring and analysing of treatment results and it is indeed important. We believe that current health care system allows for the improvement of quality within the limits of the present budget.

We are quite convinced that even in the time of recession it is possible and mandatory to develop the content of health services. Updating does not always mean additional expenditure, for equivalent technologies used become less expensive over time and consideration to this fact in price formation makes resources available for new evidence-based technologies. The organisation and rearrangement of health services makes these unequivocally clear and usable for all the parties. Hence we are supporting the establishment of a system for assessing health technologies in Estonia and are developing intra-organisation competency in the field. Preparation and implementation of necessary changes made the year 2009 more labour-intensive than usual for the entire staff of the Health Insurance Fund. We are grateful to our partners who showed understanding and were able to adjust flexibly. Our common interest in ensuring quality health services for the insured as quickly as possible helps us to cope in these difficult times.

The results of the survey disclosed at the end of the year presented a positive surprise: people's satisfaction with the availability of health services was at the same level as it as in 2008. It was confirmed that we have been able to make changes without impinging on the insured more than is inevitable. We studied the changes in the number of insured people especially carefully in 2009 and are glad to admit that even though the proportion of the insured has grown, the total number of the insured has remained unchanged. Thus, a prevailing proportion of people can still access the opportunities the national health insurance provides.

We are aware that the year 2010 continues to be difficult due to the economic situation. The health service providers have to cope in the conditions of lower reference prices and find ways to increase internal efficiency. In our development plan we emphasise that on planning the budget and entering into contracts we prefer cost-effective health services – outpatient, day care and day care surgical services. In this way we can ensure the shortest waiting times possible for a consultation by a medical specialist. At the same time, we also see to it that hospitalisation is available, if necessary. We try to avoid lengthening waiting times and manage without sudden changes. Stability is a key factor in maintaining and developing the established and well-functioning health system of Estonia.

Mari Mathiesen
Member of the Management Board
of the Health Insurance Fund

Health Insurance Fund: 2009 Strategic Goals and Attainment Thereof

Scorecard 2009

Objective	Weight	Performance indicator	Unit	Comments	2008 performance	2009 objective	2009 performance	Performance %
	6.0%	Satisfaction of the insured with the health system	%	Satisfaction of the insured with the health system as determined in the course of a general survey conducted among the insured	61	60	61	6.0%
1. Ensure access to health services, pharmaceuticals and financial benefits	**34.5%**							**34.4%**
	7.5%	Satisfaction with accessibility to medical care	%	A part of the general survey	53	55	54	98%
• Ensure uniform access	7.5%	Involve 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	78	70	85	100%
	7.5%	Timely access of the insured to the 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 % of the insured who could not be seen)	99.9	99	99.9	100%
	6.0%	Maximum waiting time for endoprosthetic replacement	time	Maximum waiting time for endoprosthetic replacement cannot be more than 2.5 yrs	2.5	2.5	2.5	100%
• Develop relations with partners and ensure performance of contractual commitments	6.0%	Satisfaction of the partners with cooperation with EHIF	%	Survey results	84	85	95.4	100%
2. Develop the quality of the health system and its services	**16.0%**							**16.0%**
	4.0%	Satisfaction with the quality of medical care	%	A part of the general survey	73	69	74	100%
• Enhance the quality of health services	4.0%	Clinical practice guidelines prepared in cooperation with EHIF and professional associations	No	Number of jointly prepared clinical practice guidelines	6	5	5	100%
• Improve assessment and control of the quality of health	4.0%	Number of clinical audits	No	Number of clinical audits conducted	5	5	5	100%
	4.0%	Conformity of the documents pertaining to the provision of health services with relevant legislation	No	Number of cases audited	–	12,000	13,698	100%

3. Shape the health behaviour of people through health promotion and disease prevention activities	**17.5%**							**17.4%**
	6.5%	Visibility of social campaigns	%	Measured in the course of specific health promotion projects	75	75	79	100%
• Ensure implementation of health promotion and disease prevention project 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, % (who have received an invitation)	Breast cancer 61% Cervical cancer 57%	Breast cancer 65% Cervical cancer 45%	Breast cancer 69% Cervical cancer 71%	100%
• 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	70	73	71.9	98%
4. Ensure financial sustainability of the health insurance system via targeted and efficient planning and use of health insurance resources	**16.0%**							**15.5%**
	6.0%	Satisfaction with the range of services funded by health insurance	%	A part of the general survey	46	50	46	92%
• Improve the needs assessment and planning of health insurance benefits, balancing the needs and budgetary resources	4.0%	A four-year agreement with professional associations concerning the needs of the insured for their services	No	The number of analysis-based agreements	1	1	1	100%
• Increase the efficiency of using health insurance resources	6.0%	Average cost per case	%	Structural increase of the average cost of an inpatient treated case in comparison with the previous period, %	1.8	4	0.2	100%
5. Improve the operation of the organisation	**10.0%**							**9.8%**
• Develop the competences and motivation of the employees	5.0%	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	3.6	3.5	3.8	100%
• Apply standard and highly functional information systems	5.0%	Availability	%	Availability of information systems	95	100	96	96%
Total	100.0%							99.1%

Attainment of Goals in 2009

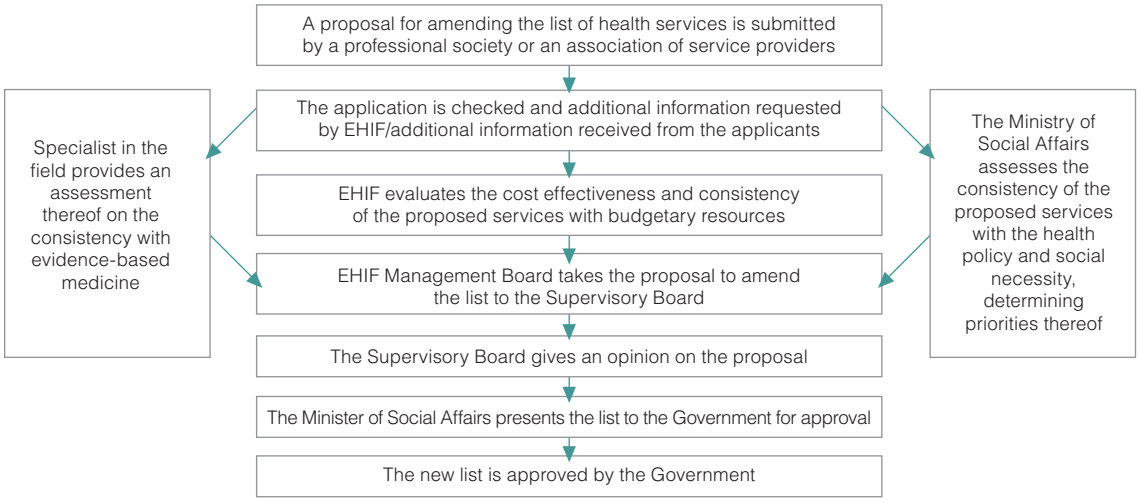
Objective	Performance indicator	Results achieved in 2009
	Satisfaction of the insured with the health system	EHIF conducts a patient satisfaction survey annually in order to measure their satisfaction and changes thereof.
1. Ensure access to health services, pharmaceuticals and financial benefits		
	Satisfaction with accessibility to medical care	Satisfaction with the accessibility to medical care has remained at the same level as in 2008 – 54% of the respondents considered it as "rather good" or "very good" in 2009 (53% in 2008).
• Ensure uniform access	Involve the insured in activities leading to improved monitoring of their health status	85% of family physicians have joined the system based on their quality fees (93% in Pärnu region, 86% in Viru region, 83% in Harju region and 81% in Tartu region). People on the list of family physicians who have joined the quality fee system are more involved in preventive activities and systematic observation of chronic illnesses.
	Timely access of the insured to consultation by a medical specialist	In 2009 timely access to a consultation by a medical specialist was available for 99.8% of the insured in outpatient care and 100% in inpatient care (100% less the % of the insured who could not be seen due to lack of funds).
	Maximum waiting time for endoprosthetic replacement	In 2009 the maximum waiting times for endoprosthetic replacement fell into the allowed limits – less than 2.5 years (the Supervisory Board decision no. 4 of March 6th 2009).
• Develop relations with partners and ensure performance of contractual commitments	Satisfaction of the partners with cooperation with EHIF	A survey titled "Satisfaction of Contractual Partners of the Health Insurance Fund" is conducted once every year to measure the satisfaction of the partners. In 2009, the general satisfaction of contractual partners with cooperation with EHIF was 95%.
2. Develop the quality of the health system and its services		
	Satisfaction with the quality of medical care	Satisfaction with the quality of medical care is assessed once a year with a survey. In 2009, 52% of the respondents considered the quality of medical care as "good" and 22% as "very good"; in 2008, 54% and 19%, respectively, whereas the number of those respondents who did not wish to disclose their opinion had dropped by two per cent.
• Enhance the quality of health services	Clinical practice guidelines prepared in cooperation with EHIF and professional associations	In 2009, 5 clinical practice guidelines were subjected to analysis, three of which were also recognised by signing memoranda thereof: "Estonian Clinical Practice Guidelines for Epilepsy", which memorandum was signed on June 3rd 2009; "Guidelines for Family Nurses", which memorandum was signed on April 7th 2009; "Treatment of Body Traumas", which memorandum was signed on December 15th 2009. Analyses were conducted on "Clinical Practice Guidelines for Osteoarthritis" and diagnostic and clinical practice guidelines meant for nephrologists.
• Improve assessment and control of the quality of health services	Number of clinical audits	Five clinical audits were conducted in 2009: "Treatment of Patients with Myocardial Infarction in Estonian Hospitals", conducted by the Estonian Society of Cardiology; "Treatment of Gynaecological Tumours in Tartu University Hospital and Northern Estonian Regional Hospital (SA Põhja-Eesti Regionaalhaigla)", conducted by the Estonian Society of Oncologists; "Justification and Quality of Apoplexy", conducted by the Ludvig Puusepp Society of Neurologists and Neurosurgeons"; "Quality of Referrals", conducted by professor emeritus Vello Salupere; "Use of the Fund for Examinations and Tests Meant for Family Physicians", conducted by the Estonian Society of Family Doctors.
	Conformity of the documents pertaining to the provision of health services with relevant legislation	An inspection of documentation evidencing 12,000 health insurance benefits (invoices for medical treatment, discount prescriptions, certificates of incapacity for work) was planned to be conducted in 2009. In total, 13,698 documents evidencing health insurance benefits were checked.

3. Shape the health behaviour of people through health promotion and disease prevention activities		
	Visibility of social campaigns	Cancer screening campaign Kingi endale kindlustunne “Give Yourself Confidence”, incl. raising the awareness, was carried out in 2009. The visibility of the campaign was measured by a satisfaction survey according to which the visibility was 79% (the highest or 83% in western Estonia and the lowest or 75% in Viru County).
• Ensure implementation of health promotion and disease prevention projects as planned	Coverage of cancer screening	The coverage of women who were screened for breast cancer was measured at 69% (61% in 20008 and 54% in 2007). The coverage did not consider the dead, the uninsured and those who did not receive the invitation due to incorrect address. The coverage of women who received the invitation and were screened for cervical cancer was 71% (57% in 2008, 41% in 2007).
• Ensure the awareness of the clients and partners of their rights and obligations	Awareness of the insured of their rights	The awareness of the insured is measured once a year in a survey “Evaluation of Health and Medical Care by Patients”. It emerged from the 2009 survey that 72% of the people knew their rights and obligations.
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 resources	A four-year agreement with professional associations concerning the needs of the insured for their services	A document analysing the services provided in the field of infectious diseases was prepared for the years 2004–2008. In cooperation with the professional association the needs for the next 4 years have been determined and an agreement thereof concluded.
• 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 2009 in comparison with 2008 was 0.2%.
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	A survey is conducted every year to assess the satisfaction. The target in 2009 as to achieve 3.5 points as the level of satisfaction on a 4-point scale. The actual level was 3.8.
• Apply standard and highly functional information systems	Availability	Availability of information means access to information and information services upon the request of the users and subject to their mutual agreement. In 2009 the performance was achieved at the level of 96%, i.e. information and information services were not always available on the conditions agreed upon.

Preparation of Health Services' List

The list of health services (hereinafter as the list) is approved by the Government. The Health Insurance Fund can reimburse the insured for the cost of only such services that are contained in the list. In order to keep the list up to date, it is renewed annually. A special role in this process belongs to professional societies that submit proposals for amending the list (adding new services, deleting old after a period of non use, updating the conditions that apply to implementation thereof) to the Health Insurance Fund and contribute to the price formation process of these health services. The EHIF itself can make proposals to amend the list of health services, discussing the amendments with specialists in the relevant field or service providers thereof.

Figure 2. Steps of amending the list of health services



In the course of one year, the proposals for amending the list are reviewed by various experts, weighting the relevance and consistency of the proposals with the criteria for amending the list as provided in the Health Insurance Act: proven medical efficacy of the service, cost-effectiveness of the service, necessity of the health service in society and the compatibility of the service with national health policy and correspondence to the financial resources of health insurance. Medical efficacy is assessed by a specialist in the field, cost-effectiveness and an impact thereof on the health insurance budget is assessed by experts on health economics, necessity of the service in society and the compatibility thereof with national health policy is evaluated by the Ministry of Social Affairs. In order to make it easier for the applicants to prepare a proposal for amending the list, the Health Insurance Fund revised the guidelines for filling in the application in 2009. Abiding by these guidelines ensures that the proposals for amending the list submitted contain as relevant and consistent overview as possible of the services applied for.

All the proposals submitted are assessed in according to the criteria provided above: whether the proposed service is evidence-based and would have the best possible effect on patient's health; whether the service already has reimbursed or effectively equivalent alternatives that cost less; whether the service can save lives and has no alternatives; how large is the target group that could benefit from the proposed service, and what impact would the service have on the health insurance budget. In addition priorities relevant for the national health policy are also taken into account. In 2009, 74 proposals for amending the list were processed, of which 11 were approved. Four of the 11 proposals contained amendments related to medicinal products and treatments (incl. amendments to reference prices thereof) and the remaining seven specified new health services.

Relying on the processed proposals for amending the list EHIF, the Management Board takes a proposal to amend the list to the Supervisory Board that in turn gives its opinion of it. Thereafter, the Minister of Social Affairs submits a draft to amend the list of health services to the Government for final approval. The entire process from the submission of proposals by professional associations to the approval of the proposed services by the Government takes about one year.

Ensuring Quality of Health Services

For the insured it is most important that necessary health services would be available and that the healing process would take place in a quick manner and without complications.

The availability of services is dependent on the amount of funds to buy the service and the capability of the service provider to offer the service in the extent required. In both cases the performance is measured by the length of waiting times, which in turn impact on the satisfaction of the insured with the service. The Health Insurance Fund observes the conformity of waiting times with the set rules on a regular basis and measures the satisfaction of patients with the waiting list. In cooperation with the service providers EHIF engineers towards the improved availability of health services.

In addition to patients' subjective evaluation it is also necessary to analyse the provision of service as a process as well as the parameters of service results or success. It is important to ensure health services with uniform good quality to everybody. This means continuous and systematic measuring of the quality of provided services using evidence-based indicators. Monitoring the quality of health services has become especially relevant in the last decades owing to the abundance of new technologies and a significant increase in the cost thereof.

Regular performance measurement looks at the correctness of the provision of health service, its safety for the patient and the environment, and service results, including the efficiency of treatment.

Due to the obligation arising from legislation to buy quality services, the Health Insurance Fund has initiated and in cooperation with the service providers developed several measures to ensure and enhance the quality of health services.

- Clinical practice guidelines help practitioners pass evidence-based and cost-efficient decisions while treating the patient, and harmonise thus the quality of treatment throughout the country. To facilitate the development of clinical practice guidelines the Health Insurance Fund chooses a certain number of guidelines, the development of which will be funded, among the applications submitted by professional associations every year, taking account the recommendations of the advisory body for clinical practice guidelines. Furthermore, the Health Insurance Fund shall conduct health economics analyses of new clinical practice guidelines in order to assess potential effects on the implementation thereof.

- To assess the justifiability and relevance of treatment the Health Insurance Fund commissions clinical audits from independent experts in the field, which give the providers of health services objective feedback from renowned specialists. At the audit feedback meetings, which in addition to those audited also bring together the representatives of the ministry, enable different parties to discuss the problems emerged in the course of the audit in a wider context.

- To assess the safety and efficiency of treatment process hospitals have established working groups with the support of EHIF, whose duty is to develop measurable indicators that in addition to in-house monitoring would enable to compare the results obtained with those collected for other Estonian hospitals, and even on an international scale. Member hospitals of the Estonian PATH working group have for some time now been participating in WHO PATH (Performance Assessment Tool for quality improvement in Hospitals) project, contributing to the development of the model and indicators thereof, and partaking in the comparison process of the results obtained. The quality working group of general hospitals has started to search for suitable indicators for measuring these activities.

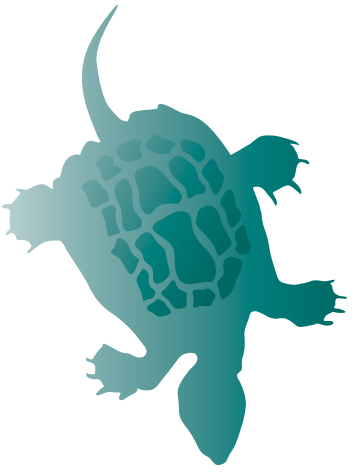
- In cooperation with professional associations and the quality working groups of hospitals clinical indicators are being developed relying on the data of the Health Insurance Fund. This system would enable to retrieve information on the quality of a certain procedure or disease treatment in relatively speedy manner and at low cost. This work is accompanied by the harmonisation of coding leading to improved quality of data.

- To avoid or reduce preventable illnesses and to improve the surveillance of the health status of patients with chronic diseases, family physicians have been subjected to a quality system since 2006, and by 2009 85% of the family physicians had joined the system.

- To assess the remote results of treatment and changes in patients' quality of life, certain international practices and their applicability in Estonia have been studied. In 2009, such efforts were mostly evident in cooperation with the Estonian Association of Traumatology and Orthopaedics and the Estonian Orthopaedic Nurses' Society.

- Satisfaction of the insured is an important indicator of the quality of the entire health care system. For the purposes of assessing the satisfaction of patients with a particular medical institution, quality working groups formed of the representatives of hospitals and EHIF developed and implemented an inpatient and outpatient questionnaire. 2010 will hopefully see the establishment of central processing of the type of data obtained via these questionnaires, using web-based solutions. The goal of the application is to reduce the work load of hospitals in processing and analysing the data and enable inter-hospital comparisons thereof.

Open information exchange in today's world, free movement of services within the European Union, message of the WHO Tallinna Charter and international trends confirm that it is inevitable for the Health Insurance Fund to deal with the quality of health services. It is vital to continue reliable cooperation with the providers of health services and develop international communication searching for the best practices.



Control of Quality and Justification of Health Services

The Health Insurance Fund is obligated to check the justification and quality of health services provided. In general, this is done in two ways: via clinical audits and checking the legitimacy of payment of health insurance benefits. In either case those performing the auditing rely on clinical practice guidelines, codes of practice, good medical practice and legislation thereof.

Clinical audits are commissioned from specialists in the field, who are readily located as a result of a close cooperation between EHIF and professional associations. The principal aim of the audits is to obtain objective evaluation of the medical justifiability and quality of treatment and give the providers of health services a chance to compare themselves with other institutions operating in the same or similar area of activity.

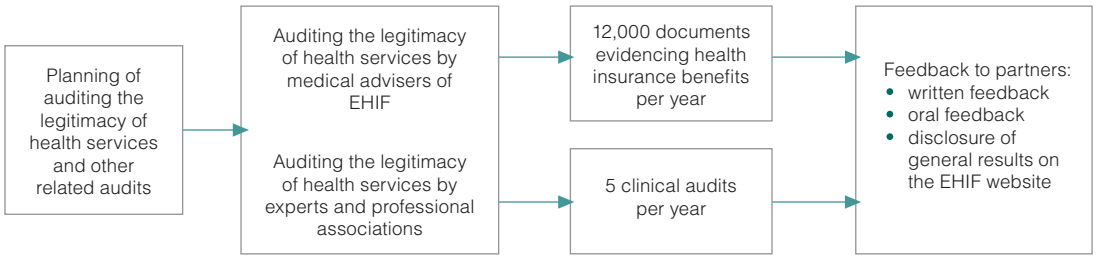
Of the five audits commissioned in 2009 two related to general medical care (using the fund for examinations and tests and the quality of referrals issued) and the remaining three specialised medical care (diagnosis and treatment of acute myocardial infarction, oncogynaecological tumours and apoplexy). Audit results are discussed at a meeting attended by the representatives of institutions audited, EHIF and the Ministry of Social Affairs. These meetings result in an agreement on future policies to resolve the deficiencies specified in the audit.

Medical advisers of the Health Insurance Fund, who check monetary documents (invoices for medical treatment, discount prescriptions, certificated of incapacity for work), also give their attention, in addition to the quality and justification of the service, to the legitimacy of health insurance benefit paid for the service. Health services reimbursed by the Health Insurance Fund must be medically justified and consistent with relevant legislation. Auditing comprises comparing and analysing the information on both original documents submitted to the Health Insurance Fund and documents thereof in the medical institution. Over 12,000 documents are audited in a year; 13,698 documents in 2009. Auditing concerned a total of 29 different topics, 3 of which were follow-ups of clinical audits and 7 were follow-ups of previous audits.

Following the auditing of health insurance benefits it could be said that digital documentation is gaining in importance in both general and specialised medical care. Digital records are the least frequent in dentistry. Although digital documentation leads to improved monitoring of health services, it must be admitted, however, that some problems have not disappeared over the years. Main deficiencies concern the formalisation of referrals, recording of diagnoses in medical files, coding of health services in invoices for medical treatment, mistakes are also made concerning the issuing procedure and length of certificates of incapacity for work. But year after year the justification of health services provided has been improved.

As of 2010 the summaries of audits on health insurance benefits are also made available at the website of EHIF.

Figure 3. Steps of auditing the quality and justification of health services



Medical Adviser's Role in Health Insurance System

Medical advisers play an important part in the medical sphere of health insurance system. Their work is targeted at optimum use of health insurance resources – best results with funds available.

All begins with contracts. Before entering into agreements medical advisers assess the need for health care on the basis of the previous periods and participate in the planning of contracts. After declaring the selected contractual partners medical advisers provide help with filling in the documents, assess the applicants, if necessary, and play a part in the selection of partners.

To prevent problems arising from performance of contracts, medical advisers are continuously monitoring the discharge of financial obligations under the agreements concluded. Furthermore, the advisers also analyse diversions from budgetary allocations. The Health Insurance Fund shall inform the contract person of a medical institution of the results, discussing how the medical institution should plan its activities in order to perform the contract as agreed.

Medical advisers also check the performance of other contractual terms and conditions, e.g. keeping of waiting lists, consistency of the work organisation of family physicians with the requirements, etc. Moreover, they review applications for reimbursement of pharmaceuticals in special cases and take reasoned applications to the Management Board for approval. Medical advisers also communicate with the employers, mainly on the subject of certificates of incapacity for work.

In relation to medical institutions the work of medical advisers constitutes a most labour-intensive part of the auditing of the justification and quality of health insurance benefits paid partly or fully by the Health Insurance Fund. This auditing is based on a randomised selection of certificates of incapacity for work, discount prescriptions issued and invoices for medical treatment paid by the Health Insurance Fund. Medical advisers check the source documents of the provision of services to get an overview of whether the doctors are acting in accordance with the clinical practice guidelines and best medical practice, and whether they document their activities as required.

Topics analysed via randomised selection have different levels of complexity. Medicine is constantly developing and medical advisers must keep up with the changes.

It deserves to be noted that the auditing work carried out through the years has borne fruit, for example, in the proper formalisation of medical files.

In communicating with the insured a medical adviser acts as an intermediate between the insured and the medical institution. If lots of complaints are received against a certain doctor, we have taken his or her activities under scrutiny by auditing their medical files, for example.

Medical advisers are also very active trying to raise the awareness of the insured of their rights: they meet with the insured, write articles for newspapers, and give presentations and lectures.

Many activities of a medical adviser are complete with the preparation of an inspection report – each and every medical institution will get feedback in the form of a report. If in the course of such auditing it emerges that financial losses has been incurred for the Health Insurance Fund for various reasons, a right of recourse shall be filed.

In conclusion it could be said that medical advisers play an important part in the Health Insurance Fund: they work in the name of justified use of monetary resources for the benefit of both Health Insurance Fund and the insured.

Digital Prescription: Purchase of Medicinal Products Quicker and Easier

As of January 2010 Estonia uses digital prescriptions, i.e. an electronic prescribing system. As a result of this innovative project doctors can now prescribe pharmaceuticals to patients using their computer software and sending the prescription to a national database – Prescription Centre. The latter can be accessed by any pharmacy sending inquiry request to the prescription centre to find a particular prescription and dispense the medicinal product thereof. The prescribed medicinal product can be purchased by presenting an identity document with a photo and personal identification code.

The central database (based on business software SAP) uses the data of various state registers, which are synchronised on a regular basis. The centre connects with the register of doctors and pharmacists, the EHIF register of the insured, the register of the activity licences of Estonian pharmacies and the register of medicinal products.

Different parties (doctors, pharmacists, patients) connect with the prescription centre using the secure data exchange layer X-Road. To access the centre via X-Road the users must have a right of entry via a secure server or so-called public security servers using their ID card.

A helpline was also established recently so that parties could communicate error messages and get help in simple problematic situations. Furthermore, in the event of disconnection pharmacists can contact the operator to locate patients' prescriptions to give out medicinal products thereof.

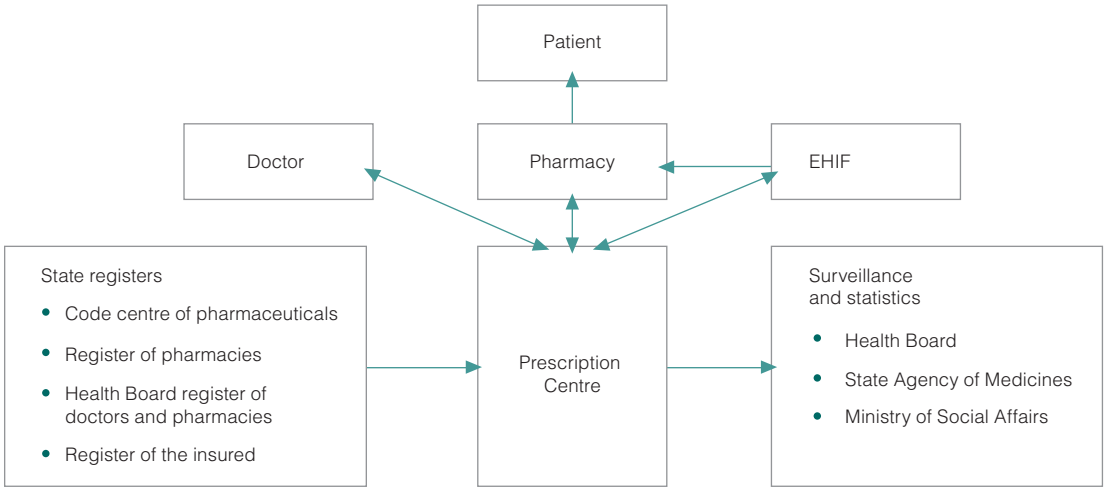
The system adds flexibility to patients. If thus far the patient had to go and see the doctor after a telephone consultation to take the prescription to the pharmacy, they can today buy the medicine merely by presenting their identity document at the pharmacy.

Doctors place the most value on the system's capability to find the right rate of reimbursement discount for a prescription. Doctors are also fond of the overview the system offers of medicinal products prescribed to the same patient by other doctors, and even more importantly, of information whether the medicine was actually purchased. In the future, automatic processing of this information would result in the assessment of interactions of pharmaceuticals prescribed by different doctors, patient compliance, abuse of medicinal products and the like.

The life of pharmacists is also made easier by the fact that a majority of prescription data are already available electronically and all they have to do is add information on the medicinal product actually purchased.

The state will have real-time control over the activities in the field of medicinal products. Even though statistics concerning pharmaceuticals were available in different databases earlier, the information was not as readily usable as it will be from now. With the new system data are ready to use within a maximum delay of one day.

Figure 4. Implementation of digital prescriptions



Establishment and Enhancement of Electronic Information Channels

Preparations for transition to the digital prescription system are most noteworthy of the efforts by the information technology team of the Health Insurance Fund in 2009. In 2008, the development partner presented to EHIF a software solution for the Digital Prescription Centre, which was tested for reliability all through the year 2009. It strictly service-based solution necessitated a complicated process of engaging external parties as extensively as possible and sharing the work between several registers. The fact that each medical institution and pharmacy has a different interface has neither accelerated the test stage nor made it easier, and this was also to be expected. By the end of the year, however, the efforts had made it so far as to introduce the digital prescription on January 1st 2010, and thus began the year when people will be adjusting to the new system.

In 2009, the development of cash benefit solution was also completed. The biggest step of this project is probably the establishment of an interface for medical institutions and family physicians for the electronic transfer of certificates of incapacity for work. The year 2010 will also see a study into providing a service of validating certificates of incapacity for work for medical institutions, possible implementation of electronic transfer of certificates of incapacity for work by employers in production environment as well as into the implementation of other cash benefits (dental treatment benefits, additional benefit for medicinal products, etc.) within the new system. According to today's plans the solution for certificates of incapacity for work shall be connected with the services of e-health and digital medical history in 2010.–2011.

In the course of these projects we have further rooted the X-Road-based exchange of data of the state information system in the Health Insurance Fund. In the future we hope to introduce the additional options of the state information system (notification calendar, eesti.ee email address, document exchange centre, etc.) to the department of EHIF and are brainstorming possible scenarios for implementation thereof.

Upgrading the software of data warehouse solution was a considerable and somewhat risky operation for the Health Insurance Fund as whole, but especially for the IT specialists. The work will bear fruit only in the following years, which see the implementation of opportunities the new system offers.

In addition to these so-called application tasks the Health Insurance Fund has been active in the creation of the so-called semantic assets already since 2008. The creation and use of semantic assets is a relative new trend in the state information system, the implementation of which would hopefully improve the transparency of EHIF information system and facilitate the integration thereof for external parties.

The year 2009 was fairly fertile in two respects: several new electronic channels were created and several new tasks were established.

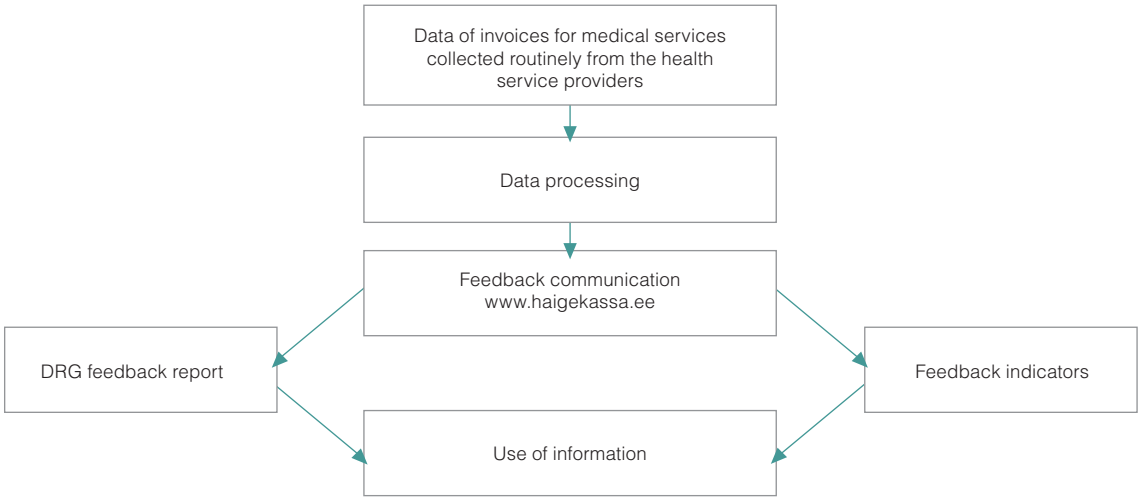
Development of DRG System

A decision on the transition to DRG[1]-based funding was passed in Estonia in the beginning of 2001 with the objective to increase the efficiency of using health insurance resources. In 2003, DRG system served as a means for analysis and a year later, in April 2004, as a funding method in inpatient and day care surgical treatment.

DRG-based funding is combined with service-based funding. The proportions of the two funding methods have changed over the years: the ratio 10:90 applied in 2004 became 50:50 in 2005, and starting from July 2009 it has been 70:30. This means that 70% of the invoices for inpatient or day care surgical services are reimbursed based on the DRG system and 30% based on the services. The change in proportion may be considered one of the biggest modifications to the DRG system in 2009.

The other important development was an upgrade to DRG feedback system. Since 2005 the Health Insurance Fund has been giving feedback to hospitals on a regular basis about different indicators of the DRG system. As the options for analysis and data transfer by the Health Insurance Fund have constantly developed, then as of 2009 the DRG feedback is available in a new format consisting of two parts. In the first part, the Health Insurance Fund shall prepare a report on DRG feedback once a year, which will be disclosed on the EHIF website. In the second part, the Health Insurance Fund shall prepare pivot tables about DRG indicators, which would be updated twice a year and made available for the hospitals specified in the development plan of the hospital network. The updated feedback system is illustrated in the following scheme.

Figure 5. DRG feedback system as of 2009



Subsequent development of the DRG system is related to upgrading the DRG grouping version, which would organise Estonian DRG system, leading to its improved consistency with modern medical practice and the DRG logic, which would in turn result in just payments. Activities for transition to the new version already began in 2009, when a new version for Classification of Surgical Procedures (NCSP) was under preparation, which was implemented in 2010. Updated NCSP served as an input for creating a new grouping version. 2010 will see several operations in relation to upgrading the grouping version in order to make the transition as smooth as possible.

1 DRG – diagnoses related group, case-oriented funding system used in Estonia, where patients with similar clinical description and cost of resources are classified in the same group

Disease Prevention by the Example of Breast and Cervical Cancer Screening

In addition to funding health services it is also important to finance health promotion and disease prevention to provide preventive services to people. Prevention projects create possibilities for risk groups leading to early detection of health problems, timely intervention and eventually recovery of their health. Any preventive medical examination must be acceptable and easy to undertake for the patient and give evidence-based information. Timely detection of a disease can result in effective treatment.

Breast cancer is the most frequent among malignant tumours in women in Estonia, with cervical cancer ranking second among gynaecological malignancies in terms of fatalities. Cervical cancer is a type of malignancy that could be avoided by timely detecting and treating of the pre-cancerous conditions. Breast and cervical cancer screenings are evidence-based measures to lower the incidence of illness and mortality rates caused by these malignancies. In 2002, the Health Insurance Fund stared to support national breast cancer screening and in 2003 women were similarly started to screen for cervical cancer. Since 2007 screenings have been part of the national cancer prevention strategy and as from 2009 invitations to and results of screening in Estonia bear the joint logo of the screening examinations "Kingi endale kindlustunne!" (Give Yourself Confidence!).

Breast cancer screening is targeted at women aged 50–62 years; the examinations are performed once in every two years. Women aged 30–55 years are invited to cervical cancer screening once in every five years. In Estonia, as in other developed countries, women are invited to both screening examinations by personal invitations sent to their postal address. Estonia's biggest problem so far has been the low participation of women in preventive examinations, but the coverage of invited women has grown year after year. According to the data of 2008 population study the awareness of women about cancer screening is very good (90%). Upon receiving an invitation from the Health Insurance Fund an equivalent proportion of women reported their readiness to have their health checked.

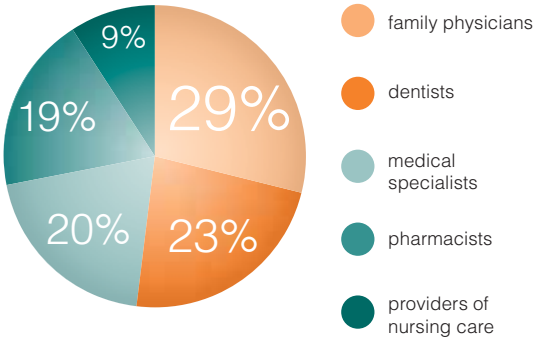
During 2002–2009 in the breast cancer screening participated over 180,000 women and breast cancer was detected in 756 cases (4.2 cases per 1,000 participants). The proportion of early stage breast cancer cases has grown from 71% in 2002 to 80% in 2009. In the years 2003–2009 approximately 63,000 women have participated in cervical cancer screening examinations. From amongst the women studied pre-cancerous condition was detected in 5.8% and cervical cancer was discovered in more than 40 cases. These results are comparable with those of a similar studies conducted in the Nordic countries.

Positive signs are already evident in the health indicators of women. According to the Statistics Estonia 89 women (aged 50–64 years) died of breast cancer in 2002, but by 2008 the number of deaths caused by breast cancer had dropped to 74 in this age group (17% decrease). Cervical cancer mortality has remained at the same level compared to 2003. These types of screening practices are relatively recent in Estonia, thus their long-term effects on illness incidence and mortality rate are not yet had an impact.

Partners Praise Cooperation with Health Insurance Fund

The Health Insurance Fund commissions annual satisfaction surveys at the end of every year to determine its partners' assessment of the cooperation with EHIF. We receive feedback about the sufficiency of information distributed by the Health Insurance Fund and information channels thereof; we examine how our partners assess the circumstances surrounding the contracts entered into with EHIF; we inquire about their satisfaction with the work of the EHIF specialists, etc. This year we compared the results obtained with those of the previous surveys. We received feedback from 593 partners.

Figure 6. Distribution of respondents 2009



The survey revealed that the satisfaction of partners is good in all areas of activity studied and the average proportion of discontented respondents was only 4–6%.

The results indicate that starting from 2006 the general opinion of our contractual partners about the cooperation with the Health Insurance Fund has steadily improved. Thus, in 2009 our partners thought highly of the general cooperation with EHIF: almost 1/3 of the respondents considered the cooperation as "very good" and 2/3 thought it "rather good". Those who were rather or completely dissatisfied with the cooperation constituted less than 5% of the partners questioned.

Partners have placed the most value on cooperation with the Harju and Pärnu Departments of EHIF. In general, among family physicians the level of satisfaction was the lowest, being the highest among the providers of specialised medical care and nursing care.

63% of the partners of EHIF found that cooperation in 2009 was at the same level as in the previous years. One-third of the partners considered the cooperation in 2009 to be somewhat or markedly better than in the previous year. Less than 4% thought the cooperation to have worsened.

Partners regard pleasant communication with the contact persons of EHIF highly but do not have a high opinion of the idea of quick and relevant handling of their questions and problems. They were also not so pleased with the communication of changes and additions made by the Health Insurance Fund.

We also asked our partners to assess treatment funding as negotiation process regarding the contracts for general medical care separately. Majority of the respondents (95%) agreed that the Health Insurance Fund was always well prepared for the negotiations. The respondents were not so readily inclined to agree with the statement that in the case of differences of opinion, these were usually resolved via negotiations (80% of the respondents agreed).

Attention given to different areas of activity in the contract was generally considered to be sufficiently detailed. The partners questioned were, as a rule, satisfied with the organisation of the submission of invoices for medical treatment and other documents specified in the contracts to the Health Insurance Fund as well as with the organisation of electronic data exchange. However, the partners would like that the contracts concerning improved availability of health services to be more thorough.

As regards the process of negotiations and the attention given to different topics family physicians tend to be less satisfied than the other partners questioned.

Among information channels the EHIF website is overwhelmingly the most popular. It offers mainly information about legislation and health services and not so much about the projects of health promotion and disease prevention.

Most of the contractual partners prefer to receive information from the Health Insurance Fund via email and more than a half through the EHIF website. Over 90% of contractual partners thought the information received from the Health Insurance Fund sufficient. Partners would, however, require more or additional information about different changes introduced by EHIF.

Although the survey results were very good, all deficiencies are to be analysed if the cooperation is to be improved further.

Figure 7. Respondents' general opinion of cooperation with EHIF, 2006-2009

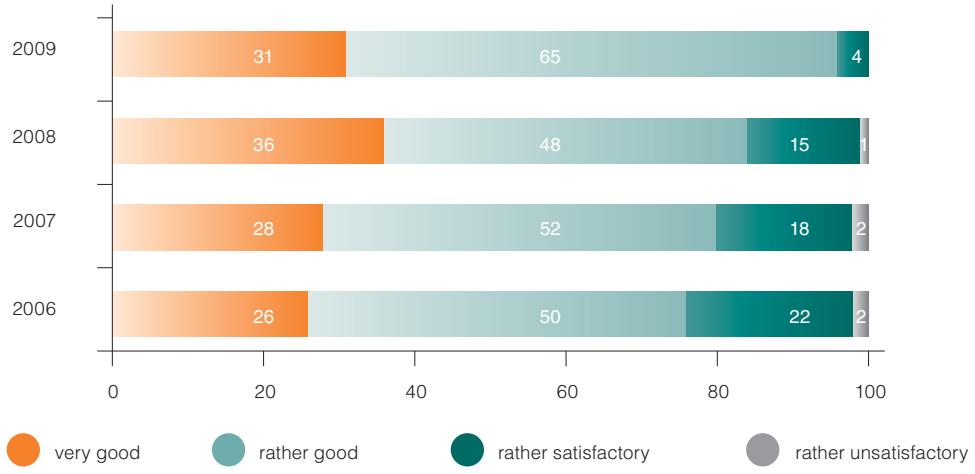
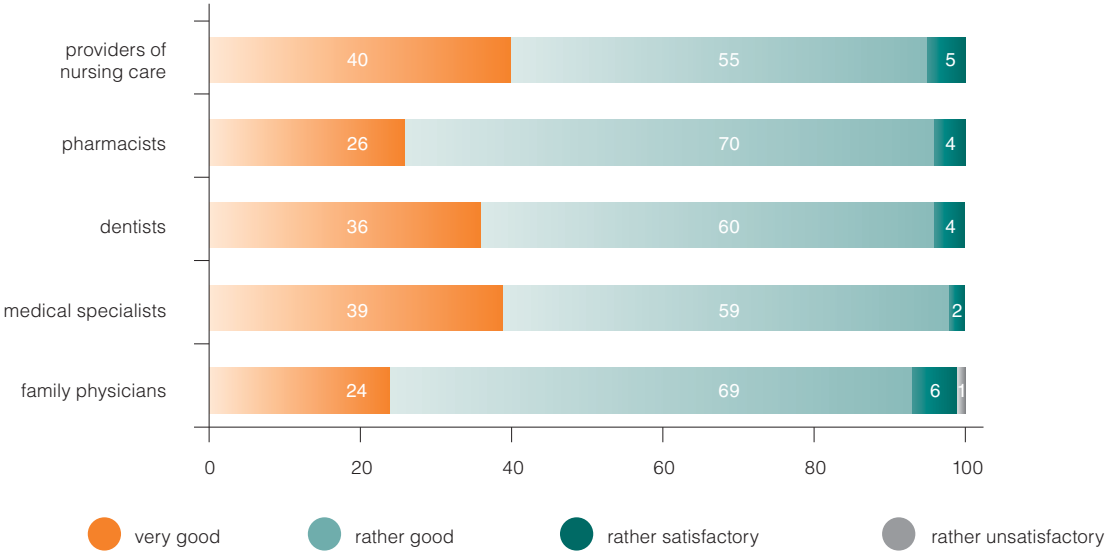


Figure 8. Respondents' general opinion of cooperation with EHIF by contractual partners in 2009



Competent Employees and Friendly Working Environment

The Health Insurance Fund has 12 central departments, which in addition to their usual duties are also involved in development work, and 4 regional departments – Harju, Pärnu, Tartu and Viru –, which deal with clients and partners on a daily basis.

In the beginning of 2009 the Health Insurance Fund had a staff of 234 and in the end of the year 224 employees. Decrease in the need for labour force was caused by the establishment of electronic data transfer channels and a decline in the number of applications for certificates of incapacity for work and benefits for dental care submitted for processing.

The Health Insurance Fund uses activity-based planning for assessing the need for human resources. Over the years the percentage of highly qualified employees has grown and the number of employees taking care of routine tasks has fallen as a result of rearrangement related to working processes. Need for human resource related to development and analyses has grown in recent years. Table 2 provides an overview of the changes in the need for human resources. During the period 2003–2010 labour needs decreased by 63 offices.

Working for the Health Insurance Fund

A strong team is built by recruiting competent employees who meet the values of the organisation. IT is equally important to retain the motivation of employees. Training of and involving employees in the decision-making and acknowledging them for good work are some of the key factors in motivation.

Satisfaction of employees in general and its various aspects are assessed through annual satisfaction surveys. The employees of EHIF are most satisfied with the fact that the Health Insurance Fund has clear and understandable objectives, that its organisation is stable and that it is gaining more and more positive reputation among its employees as well as its clients and partners. Employees are also pleased with the availability of information necessary for work, the communication of information about the decisions of the Management Board to the employees as well as the cooperation between departments within the organisation. The overall satisfaction of the employees with the management and work organisation of EHIF was 94% in 2009, which is 6% higher than that in 2008.

Figure 9. Years of service

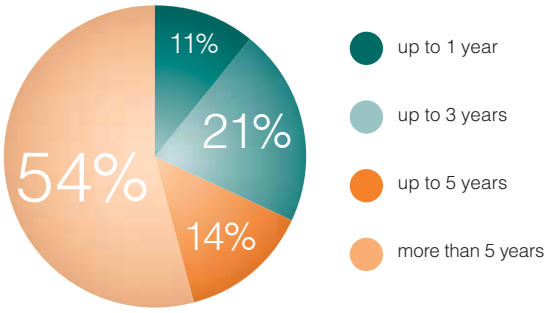


Figure 10. Age

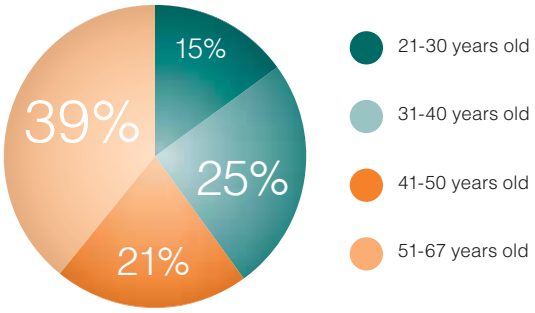


Figure 11. Education

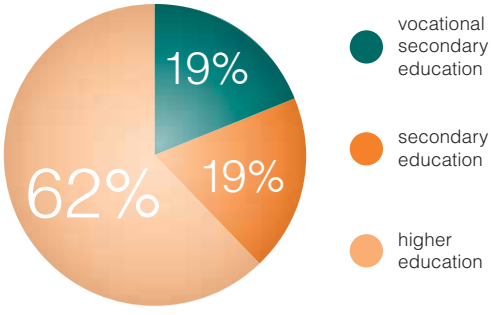


Table 2. Resource needs in the Health Insurance Fund in 2003-2010 (number of people)

Processes/process steps	2003 actual	2004 actual	2005 actual	2006 actual	2007 actual	2008 actual	2009 actual	2010 plan
Health insurance management	39	41.1	36.8	26.7	27.5	22.5	23.2	28
Processing cash benefits	45.8	38.3	37.3	37.2	36.4	40.9	43.5	26.6
Auditing legitimacy of health insurance benefits	30.4	27.7	17.8	17.7	17.7	18.5	20.8	21.6
Processing benefits for medicinal products	14.4	7.3	11	11.6	12.6	12.8	14.1	13.8
Processing claims	8.7	10.2	8.9	10.1	11.1	11.6	11.7	13.3
Processing treatment funding contracts	21.4	19.3	21.3	23.2	17.9	17.7	16.9	13.1
Assessment of needs and budget planning	10.6	13.2	14.1	13.9	13	12.6	12.6	10.5
Processing invoices for medical treatment	14.2	5.7	10.2	9.8	9.9	8.8	8	8.3
Processing contracts for general medical care	18.3	19.1	14.3	7	6.9	5.8	5.8	6.4
Processing the list of health services	0.5	3.5	3.8	2.9	2.5	4.1	4.2	5.2
Processing health insurance benefits arising from the EU or international agreements	2	3.5	3.9	1.5	1.5	3.3	3.6	4.7
Development of quality of health care	0.4	1	1.3	1.5	1.5	2.3	2.2	2.5
Processing of contracts for promotion and prevention	0.6	0.6	0.5	0.5	0.5	1	1	1.3
Support processes (IT, accounting, administration, etc.)	80.1	67	69	66	65.1	62	62.2	64.9
Execution of development projects	1.0	0.4	0.8	1.9	3.0	4.9	4.4	4.0
Total	**287.4**	**257.9**	**251**	**231.5**	**227.1**	**228.8**	**234.2**	**224.2**

Training of Employees

Methodical training of employees follows an annual training plan, which is based on a four-year training strategy. Thanks to the preparation of a well-considered training strategy and a training plan the scheduled trainings covered only ca 70% of the initially estimated costs. This cost saving was possible owing to the EHIF employees, who were ready to conduct internal trainings as principal training providers, grants applied for external trainings, and the use of services of long-term trainings providers, and continuing trainings.

The efficiency of planning training activities (i.e. relationship between means and activity selected, which returns the best value) is evident in the high proportion of scheduled trainings in the training expenditure (ca 66%) and in the percentage of training plan performance (more than 97%).

Internal trainings either encompass the whole organisation or are conducted in the form of information days or training days for the employees of different departments. These types of trainings are characterised by the use of internal training providers, a big number of participants from almost any position and office.

Development Plan of EHIF

The Health Insurance Fund devises an annual strategy for the following four years to evaluate the plans already made for the next three years and set objectives for the fourth year.

For wider involvement of employees and for the success of the process separate working groups were formed for each strategic aim (5 in total). These groups included the members of the Management Board, department managers, directors and office managers, whose task was to collect proposals from the employees of their respective departments. As a result of joint efforts 2010-2013 development plan of EHIF was prepared, which is also available on the EHIF website.

2009 Budget Execution Report

Table 3. Budget (in EEK thousand)

	2008 actual	2009 budget	2009 actual	Budget execution %	% of change from 2008
EHIF REVENUE					
Share of social tax designated for health insurance	12,502,365	11,816,987	11,234,307	95.1%	-10.1%
Revenue from contracts for persons considered equal to insured persons	40,244	40,000	47,841	119.6%	18.9%
Amounts due from other persons	14,208	13,000	14,110	108.5%	-0.7%
Financial income	165,844	120,288	105,131	87.4%	-36.6%
Other income	177,202	30,383	28,475	93.7%	-83.9%
Total budget revenue	**12,899,863**	**12,020,658**	**11,429,864**	**95.1%**	**-11.4%**
HEALTH INSURANCE EXPENDITURE					
Health service expenses	8,190,964	8,222,865	8,049,487	97.9%	-1.7%
Disease prevention expenses	117,284	129,218	114,118	88.3%	-2.7%
Expenses on primary health care	1,047,224	1,091,736	1,056,204	96.7%	0.9%
Expenses on specialised medical care	6,489,220	6,457,414	6,354,972	98.4%	-2.1%
Nursing care expenses	237,972	243,497	237,013	97.3%	-0.4%
Dental care expenses	299,264	301,000	287,180	95.4%	-4.0%
Health promotion expenses	13,970	15,000	13,150	87.7%	-5.9%
Expenses on pharmaceuticals reimbursed to insured persons	1,281,486	1,383,000	1,383,331	100.0%	7.9%
Expenses on benefits for temporary incapacity for work	2,387,453	2,153,275	2,204,104	102.4%	-7.7%
Expenses on other cash benefits	201,678	194,899	160,622	82.4%	-20.4%
Other expenses	147,405	139,346	148,563	106.6%	0.8%
Expenses financed from the state budget	38,391	23,383	18,330	78.4%	-52.3%
Other expenses on health insurance benefits	109,014	118,338	130,233	110.1%	19.5%
Total health insurance expenditure	**12,222,956**	**12,110,760**	**11,959,257**	**98.7%**	**-2.2%**
EHIF OPERATING EXPENDITURE					
Personnel and management expenses	72,543	74,508	69,970	93.9%	-3.5%
Wages and salaries	54,428	55,900	52,215	93.4%	-4.1%
Incl. remuneration paid to the members of the Management Board	3,056	2,310	2,193	94.9%	-28.2%
Unemployment insurance	154	161	533	331.1%	246.1%
Social tax	17,961	18,447	17,222	93.4%	-4.1%
Administrative expenses	20,110	22,315	20,314	91.0%	1.0%
IT expenses	10,283	13,515	9,995	74.0%	-2.8%
Development expenses	3,309	4,628	2,525	54.6%	-23.7%
Training	1,481	2,095	1,151	54.9%	-22.3%
Consultations	1,828	2,533	1,374	54.2%	-24.8%
Financial expenses	132	160	322	201.3%	143.9%
Other operating expenses	9,952	5,839	3,927	67.3%	-60.5%
Supervision of the health insurance system	983	1,716	1,436	83.7%	46.1%
Public relations/communication	1,311	1,651	1,167	70.7%	-11.0%
Other expenses	7,658	2,472	1,324	53.6%	-82.7%
Total EHIF operating expenditure	**116,329**	**120,965**	**107,053**	**88.5%**	**-8.0%**
Total budget expenditure	**12,339,285**	**12,231,725**	**12,066,310**	**98.6%**	**-2.2%**
Total changes in reserves	**560,578**	**-211,067**	**-636,446**	**x**	**x**
Transfer to legal reserve	196,907	–	–	x	x
Transfer to risk reserve	65,636	–	-58,773	x	x
Retained earnings	298,035	-211,067	-577,673	x	x
TOTAL	**12,899,863**	**12,020 658**	**11,429,864**	**95.1%**	**-11.4%**

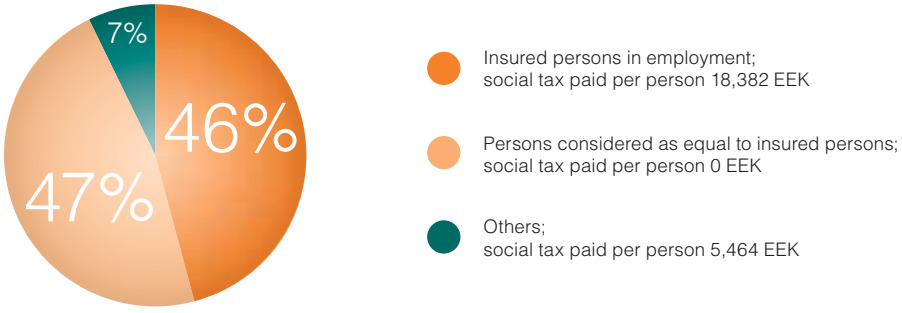
The socio-economic changes that took place in 2009 are also reflected in the structure of health insurance: rising unemployment has reduced the number of employed insured persons and the number of persons insured by the state has increased. The slight decrease in the total number of insured persons was caused by addition of long-term unemployed persons with expired insurance cover and by increase in the number of persons who left the country.

Table 4. Number of insured persons

Persons	31.12.2007	31.12.2008	31.12.2009	% of change from 2008	Changes from 31.12.2008 to 31.12.2009 (persons)
Insured persons in employment	672,706	658,079	587,254	-10.8%	-70,825
Persons insured by the state	31,942	40,477	85,609	111.5%	45,132
Persons considered as equal to insured persons	579,698	579,752	599,966	3.5%	20,214
Persons insured under international agreements	3,419	3,410	3,537	3.7%	127
Total	1,287,765	1,281,718	1,276,366	-0.4%	-5,352

The number of insured persons in employment amounted, in 2009, to nearly 46% of the total number of insured persons (51% in 2008) and the percentage of persons considered as equal to insured persons, 47%, was almost at the same level (45% in 2008). The shares of different categories of insured persons among the total number of insured persons and the contribution of the insured persons to the payment of the health insurance part of the social tax are presented on Figure 12.

Figure 12. Types of insured persons among the total number of insured persons and their social tax contributions



An overview of average expenses per insured person by age groups is provided in Table 5.

Table 5. Average expenses per one insured person

Age of persons	Number of insured persons		Expenses on primary health care, EEK		Expenses on specialised medical care, EEK		Expenses on pharmaceuticals, EEK		Total health insurance expenses, EEK	
	31.12.2008	31.12.2009	2008	2009	2008	2009	2008	2009	2008	2009
0-9	139,887	143,236	796	884	3,869	3,675	325	413	4,990	4,972
10-19	153,470	144,452	693	722	3,358	3,262	290	328	4,341	4,312
20-29	177,209	176,267	738	736	3,576	3,364	474	508	4,788	4,608
30-39	171,520	169,679	808	757	3,720	3,574	584	627	5,112	4,959
40-49	167,548	165,725	788	803	4,135	3,975	773	836	5,696	5,614
50-59	168,027	168,161	867	850	6,411	5,887	1,304	1,399	8,582	8,135
60-69	138,129	139,067	962	932	9,118	8,895	2,153	2,244	12,233	12,070
70-79	112,737	113,996	932	983	11,969	11,838	2,669	2,905	15,570	15,726
80-89	47,780	50,552	858	902	11,322	11,412	2,249	2,402	14,429	14,716
90-99	5,302	5,111	774	821	9,575	9,911	1,221	1,408	11,570	12,140
100-109	109	120	735	773	9,035	8,668	–	639	9,770	10,080

Revenue

Table 6. Revenue (in EEK thousand)

	2008 actual	2009 budget	2009 actual	Budget execution %	% of change from 2008
Share of social tax designated for health insurance	12,502,365	11,816,987	11,234,307	95%	-10%
Revenue from contracts for persons considered equal to insured persons	40,244	40,000	47,841	120%	19%
Amounts due from other persons	14,208	13,000	14,110	109%	-1%
Financial income	165,844	120,288	105,131	87%	-37%
Other income	177,202	30,383	28,475	94%	-84%
Total	**12,899,863**	**12,020,658**	**11,429,864**	**95%**	**-11%**

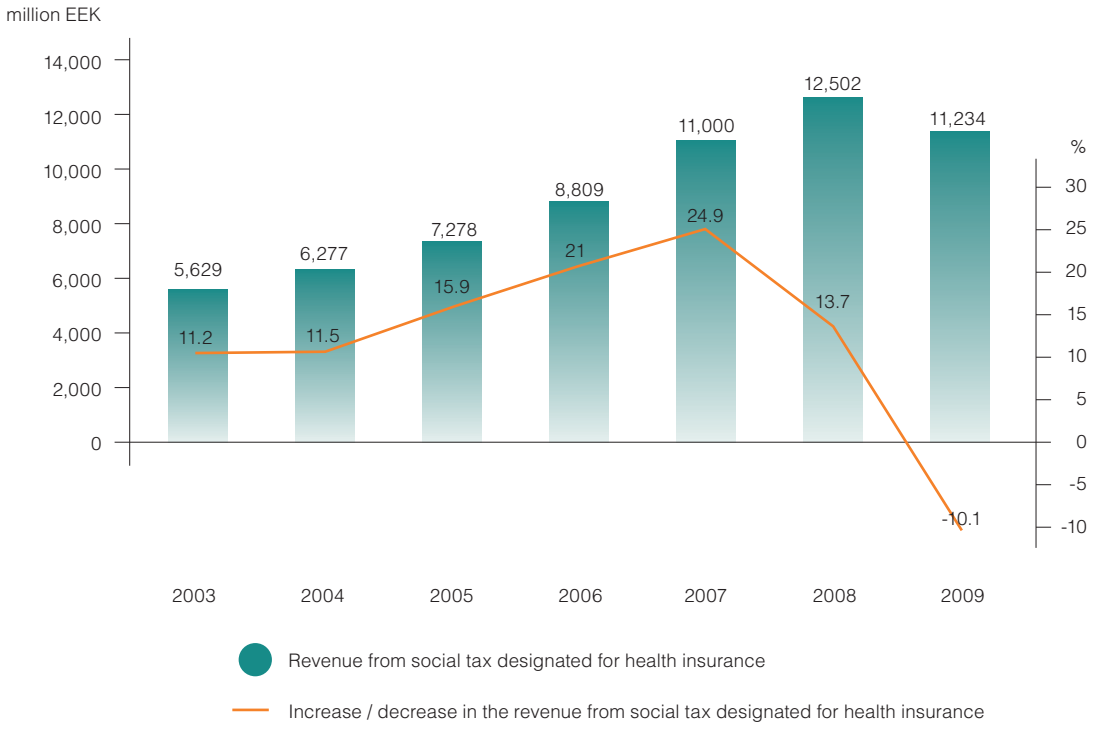
Share of Social Tax Designated for Health Insurance

The share of social tax designated for health insurance constitutes 98% of the revenue of the Health Insurance Fund.

The economic situation deteriorated during 2009 and tax revenue decreased, fording the Supervisory Council of the EHIF to adopt a negative supplementary budget, reducing budgeted revenue by 988.8 million EEK. Unfortunately, this reduction was insufficient. Only 95% of the budgeted revenue was collected by the end of the year (a deficit of 582.7 million EEK).

The changes in the payment of the health insurance part of the social tax in 2009 are illustrated on Figure 13.

Figure 13. Revenue from social tax designated for health insurance, 2003-2009



Revenue from Contracts for Persons Considered Equal to Insured Persons

Pursuant to the Health Insurance Act, a person without an insurance cover may obtain the insurance independently by signing a contract with the Health Insurance Fund and making monthly insurance payments. Revenue from the voluntary contracts amounted to 4.6 million EEK during the accounting period.

The revenue from contracts for considering persons as equal to insured persons also includes the revenue from the insurance of non-working pensioners of the armed forces of the Russian Federation. This revenue amounted to 43.2 million EEK during the accounting period.

Amounts Due from Other Persons

13.2 million EEK worth of claims for recovery of unjustified payments were submitted to health care providers, insured persons and employers. The total value of claims based on the actions of the Prison Board amounted to 855.5 thousand EEK.

Financial Income

Financial income was budgeted on the basis of the amount of reserves, average balance of available funds and the forecasted rate of return according to the Ministry of Finance. The budget was under-executed, because the actual balance of available funds and the rate of return turned out to be lower than predicted.

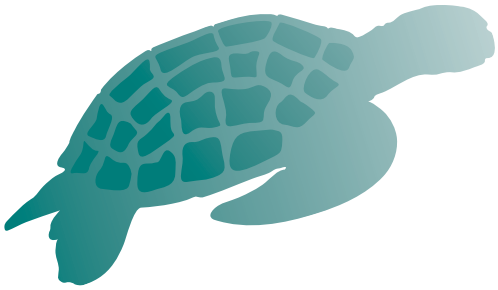
Financial resources of the EHIF are managed by the Ministry of Finance.

Table 7. Investments by EHIF

	Investments in risk reserve and earnings		Investments in reserve capital	
	As of 31.12.2008	As of 31.12.2009	As of 31.12.2008	As of 31.12.2009
Volume of fund at acquisition cost, in EEK thousand	2,938,251	2,292,621	467,002	812,333
Volume of fund at market value, in EEK thousand	2,971,558	2,297,589	483,884	825,852
Realised gains from the beginning of the year, in EEK thousand	134,201	113,889	13,534	19,932
Revaluation gain, in EEK thousand	33,307	4,968	16,882	13,519
Profitability from the beginning of the year (on annual basis)	5.07%	3.37%	5.69%	3.82%
Average duration of investments in days (on annual basis)	0.17	0.25	1.21	0.93

Other Income

During the accounting period, 18.4 million EEK were allocated for specific purposes from the state budget, 9.6 million EEK were received for services provided to the nationals of other EU member states, and revenue from economic activities amounted to 557.4 thousand EEK.



Expenditure

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

Health Insurance Expenditure

1. Health Services

Table 8. Health service expenses (in EEK thousand)

	2008 actual	2009 budget	2009 actual	Budget execution %	% of change from 2008
Disease prevention	117,284	129,218	114,118	88%	-3%
Primary health care	1,047,224	1,091,736	1,056,204	97%	1%
Specialised medical care	6,489,220	6,457,414	6,354,972	98%	-2%
Nursing care	237,972	243,497	237,013	97%	0%
Dental care benefits	299,264	301,000	287,180	95%	-4%
Total	**8,190,964**	**8,222,865**	**8,049,487**	**98%**	**-2%**

1.1. Disease Prevention

The objective of disease prevention is to detect a pre-disease condition in a person as early as possible and to take measures to avoid illness.

The expenditure on disease prevention in 2009 was 114.1 million EEK, constituting 88% of the budgeted expenditure for the same period. Half of the funds spent on prevention are used for school health services.

Table 9. Disease prevention (in EEK thousand)

	2008 actual	2009 budget	2009 actual	Budget execution %	% of change from 2008
School health	58,933	61,081	56,175	92%	-5%
Youth reproductive health project	13,138	14,180	13,815	97%	5%
Early detection of breast cancer	12,760	15,186	13,024	86%	2%
Early detection of cervical cancer	2,307	3,926	2,778	71%	20%
Prevention of cardiac diseases	2,565	2,773	1,985	72%	-23%
Early detection of osteoporosis	1,216	1,440	1,108	77%	-9%
Phenylketonuria and hypothyroidism screening	3,155	3,368	3,038	90%	-4%
Prenatal diagnostics for hereditary diseases	10,373	12,469	8,894	71%	-14%
Newborn hearing screening	4,191	4,837	4,429	92%	6%
Immunisation against hepatitis B	18	49	7	14%	-61%
Health examination for young athletes	8,189	9,270	8,539	92%	4%
Other preventive activities (evaluation of projects)	439	639	326	51%	-26%
Total	**117,284**	**129,218**	**114,118**	**88%**	**-3%**

The total expenditure has decreased by 3% in comparison to 2008 at it was mainly caused by the decreased volume of the school health services and prenatal diagnostics for hereditary diseases. In the case of school health services, the number of students decreased more than expected and, in the case of the prenatal diagnostics project, the principles for establishing the criteria for screening were changed.

Table 10. Results of disease prevention projects

Preventive activity	Actual number of participants 2008	Planned number of participants 2009	Actual number of participants 2009	Actual 2009/ planned 2009	Results
School health	167,422	173,525	160,358	92%	21% of students participated in activities related to health education; 8% of students received first aid training. Preventive medical examinations for students of grades 1, 3, 5, 6, 9 and 11 are carried out in the framework of the school health services. The results of medical examinations indicated that 18% of students had posture problems and 20% of students suffered from decreased vision. 10% of students were overweight, 2% were underweight, and 2% of students had increased blood pressure. School health boards have been established in 34% of the schools.
Youth reproductive health project (number of cases)	32,077	32,000	33,759	105%	22% of the visitors visited the youth centre for the first time; 5% of the visitors were young men. Sexually transmitted diseases were detected in 523 cases, incl. 3 cases of HIV. 117 young women of up to 19 years of age who visited the counselling centres were given referrals to register their pregnancies and 156 to undergo abortion.
Early detection of breast cancer	30,177	36,000	30,576	85%	3.2% (976 women) of all women examined were referred to undergo further examination. 150 women were referred to consultations by a breast specialists, with 125 discovered cases of cancer and 80% of the cases were in an early stage.
Early detection of cervical cancer	12,063	16,000	13,887	87%	A pre-cancer condition or cancer was discovered in ~7% of the women examined, incl. 12 cases of cervical cancer and 7 cases of an early form of cervical cancer (carcinoma in situ).
Prevention of cardiac diseases	4,979	4,600	3,400	74%	Non-pharmaceutical management of risk factors was initiated for 39% and pharmaceutical treatment was prescribed to 7% of the project participants. Pathology was discovered during ECG in 19% of the participants. The project achieved an average drop in systolic pressure by 6.2 mmHg in persons with hypertension and a drop in average cholesterol levels by 0.3 mmol/l in persons with higher cholesterol levels. 33% of the participants in the project were men.
Early detection of osteoporosis	1,188	1,300	1,098	84%	Osteoporosis was detected in 22% of the persons examined and osteopenia a pre-osteoporosis state) in 31%. 41% of the patients with discovered osteoporosis or osteopenia used calcium supplements and vitamin D, while the figure was 85% among those who underwent a repeat examination.
Phenylketonuria and hypothyroidism screening	16,224	16,400	15,595	95%	100% of newborns were screened. 25 parents refused the test. The tests resulted in the discovery of 3 children with phenylketonuria and 3 children with hypothyroidism.
Prenatal diagnostics for hereditary diseases	2,100	2,200	1,776	81%	63% of the examinations were undertaken on the basis of the results of serum screening and 15% because of age risk. A foetal chromosomal anomaly was detected in 61 cases, incl. 30 instances of Down syndrome.
Newborn hearing screening	13,301	14,200	13,951	98%	92-100% of newborns were screened in the participating health care institutions. 18 children were diagnosed with a loss of hearing. Five children whose loss of hearing was discovered during the 2008 screening received cochlear implants in 2009.
Health examination for young athletes	10,449	8,620	9,682	112%	14% of the examined young athletes required further examination and treatment; six athletes were instructed to stop practicing sports and 586 young people were given guidance on adjusting their training load. The main type of pathology discovered was associated with the cardiovascular system (14%). Exercise-induced asthma was discovered in 58 and pathology of the support and mobility system in 259 young athletes. Iron deficiency anaemia was discovered in 38 persons examined.
Immunisation against hepatitis B	152	200	52	26%	The immunisation was conducted mainly among the students of the Faculty of Medicine.

In the majority of prevention projects, the budget execution percentages have been lower than the percentages of cases executed, because the average cost of a treated case (ACTC) was lower than expected. The ACTC has decreased, because additional examinations are prescribed selectively and the need for such examinations has been lower. For instance, the decrease in the average cost of medical examinations for young athletes has enabled to examine more young people than initially planned. Application of the coefficient of 0.94 on the reference prices of health services from November 2009 also contributed to the reduction of the ACTC.

General disease prevention proceeded according to plans in 2009, with the following main actions and changes that diverged from the plans:

- A positive development was the significant increase in the volume of screening for cervical cancer in comparison to 2008. A positive contribution in this respect was made by the Cervical Cancer Week (public session, photo competition, etc.) organised in January 2009 in cooperation with the Estonian Cancer Society. In addition, media clips promoting the screening have been presented throughout the year in Estonian- and Russian-language media channels. The Breast Cancer Week (press conference, flyers, etc.) was organised in May. A recurrent problem that limits participation in cancer prevention screening has been the fact that around 5% of the women invited to screening have not received the invitation due to incorrect residence addresses. Therefore, the use of addresses from the population register in the invitations to screening was implemented from the second half of 2009.

- The project for prevention of cardiac diseases only targets adults with high risk levels and the project for early detection of osteoporosis only targets a narrow group of patients with rheumatic conditions. In the case of these projects, patients are referred to examinations mostly by their family physicians and also by rheumatologists in the case of the second project. The lower-than-expected level of execution of both projects can be associated with the fact that the need for referrals to further examination in the assessment of family physicians and rheumatologists was lower than anticipated.

- The criteria for determining the necessity of examination have been improved in the prenatal diagnostics of hereditary diseases (age of the woman is not the only indication for invasive examination) and this has reduced the number of women who need additional examination and the consequent expenditure on such examinations.

- The newborn hearing screening was expanded in 2009 into the private clinics Elite and Fertilitas and this has increased the volume of this measure in comparison to 2008.

- Immunisation against hepatitis B was mostly limited to students of the Faculty of Medicine. The actual expenditure was lower than budgeted, because the budget also included funds for immunisation of the students of health care colleges. The lower-than-budgeted need for immunisation is associated with the fact that many students have been given the vaccine at the age of 13 and re-immunisation is not required.

Two audits were carried out in 2009 to assess the impact and efficiency of the projects for early detection of cervical cancer and screening for phenylketonuria and hypothyroidism. As the audits will be completed in 2010, some of the expenses are included in the budget for 2010, which is the reason why the level of budget execution was lower than expected in 2009.

This impartial analysis will provide a detailed overview of the performance of the project and the results of the analysis will enable the EHIF and the project partners to improve the work on the projects and to become more efficient in achieving the established targets.

In the audit of the screening for cervical cancer, the auditors suggested inclusion of women of 25 years of age in the screening, if possible, and recommended that the professional association improve the action and treatment guidelines to reduce the percentage of opportunistic examinations. The results of the screening should be analysed in terms of population, not only in terms of the ratio of women invited to women screened. Several suggestions of the auditors pertain to the register of screening – there is a need for an overview of quality indicators and further management of discovered pathologies, as well as mapping of the subsequent expenses associated with treatment. It would be advisable for the Ministry of Social Affairs to cover the cost of screening women without insurance cover, as this would make a significant contribution towards reducing morbidity and mortality.

1.2. Primary Health Care

The organisation of Estonian health care is centred on family medicine: a family physician is the first point of entry for a patient in the health care system; the family physician settled a treatment or refers the patient to a relevant medical specialist if necessary.

The cost of primary health care in 2009 was over one billion EEK. Capitation fee constituted the largest portion of the total expenditure with 68%, the fund for examinations and tests accounts for 18% (17% in 2008) and the basic allowance for 11%.

Table 11. Health services of primary health care (in EEK thousand)

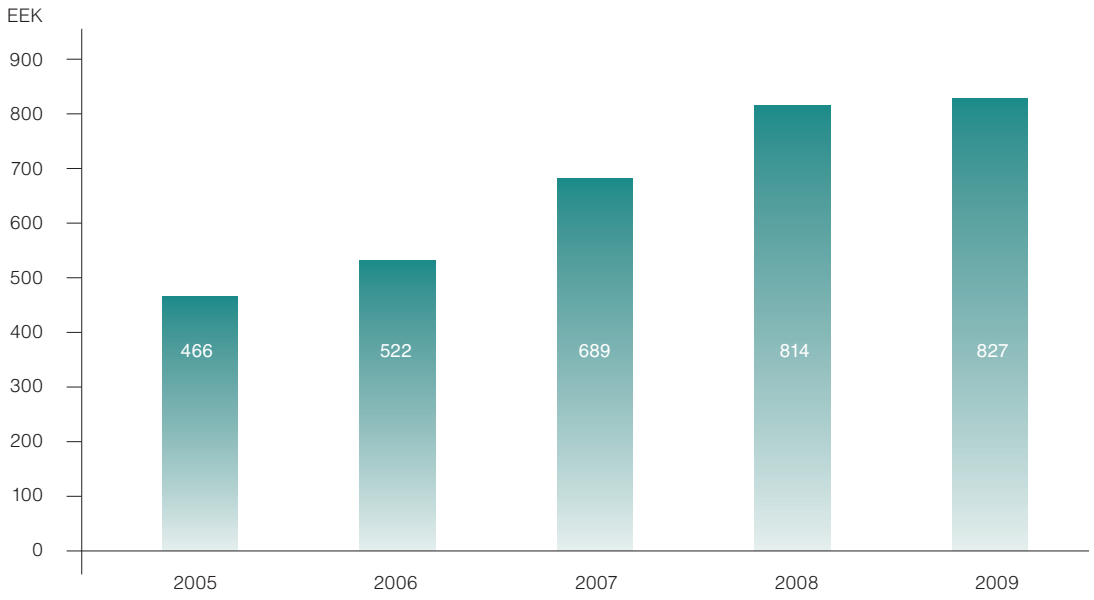
	2008 actual	2009 budget	2009 actual	Budget execution %	% of change from 2008
Basic allowance	119,135	119,359	118,279	99%	-1%
Distance allowance	5,205	5,222	5,099	98%	-2%
Capitation fee on insured persons of up to 2 years of age	35,295	36,191	36,539	101%	4%
Capitation fee on insured persons from 2 to 70 years of age	584,120	583,272	575,292	99%	-2%
Capitation fee on insured persons of over 70 years of age	105,096	105,575	107,209	102%	2%
Fund for examinations and tests (fee for service)	178,927	217,003	192,138	89%	7%
Family physician's performance pay*	11,574	12,276	12,276	100%	6%
Family doctor hotline	7,872	9,838	9,372	95%	19%
Primary health care reserve**	0	3,000	0	0%	–
Total	1,047,224	1,091,736	1,056,204	97%	1%

* In the first half of 2008, performance pay was effected in monthly instalments based on the results of 2006; from the second half of 2008, it is budgeted and paid on the basis of the results of the preceding calendar year as a single payment in the third quarter.

** Funds for monitoring pregnancies and for conducting autopsies are budgeted under the primary health care reserve, but the corresponding expenses, if incurred, are shown on the line of the fund for examinations and tests.

Primary health care expenses increased by 9 million EEK in comparison to 2008 as a result of the increase in capitation fees from 1 July 2009. At the same time, the increase in expenses was restricted by the coefficient of 0.94 applicable to health services from 15 November 2009. The aforementioned developments are also reflected in a moderate increase in the expenses of primary health care per insured person.

Figure 14. Annual primary health care expenses per insured person (2005-2009)

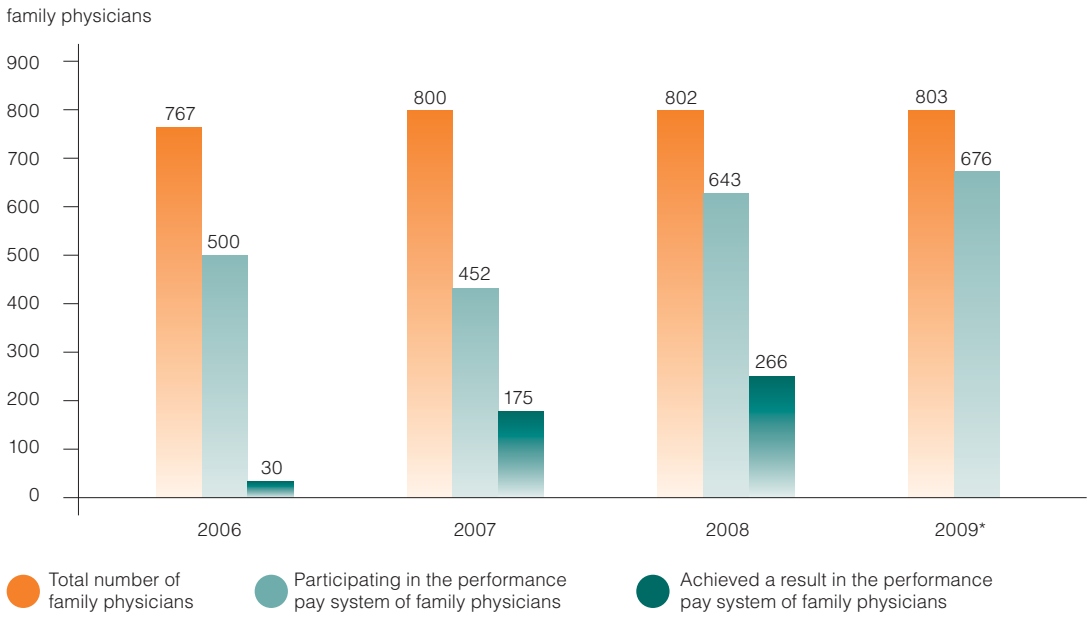


Performance pay system of family physicians. In 2009, the activities of family physicians were evaluated for the third time under the performance pay system and family physicians could receive additional pay for their quality performance.

The payments in 2009 were based on the performance in 2008. In 2008, there were 802 practice lists of family physicians in total and 643 of them applied for performance pay. Consequently, 80% of insured persons were covered by targeted preventive activities and monitoring of chronic diseases under the performance pay system.

Based on the performance results in 2008, in July 2009, additional remuneration for high-quality work in disease prevention and monitoring of patients with chronic diseases with a coefficient of 1.0 was paid to 169 family physicians and with a coefficient of 0.8 to 97 family physicians, from among whom 120 family physicians received an allowance for additional professional qualifications.

Figure 15. Performance pay system of family physicians



* The 2009 results of the performance monitoring of family physicians will be determined by 1 July 2010.

41% of those who applied for performance pay achieved a good result (6% in 2006 and 39% in 2007).

The performance pay system will increase the efficiency of the work of the family physicians in preventing diseases and monitoring chronic diseases among the persons on the practice lists of family physicians and will, in the long run, improve the general health condition of the population.

Fund for examinations and tests. 27% of the capitation fee and 32% of the capitation fee in the case of family physicians participating in the performance pay system was scheduled for conducting examinations and tests in 2009. 89% of the amount planned for examinations and tests was actually used in 2009, which indicates that the size of the fund is sufficient for comprehensive examination and monitoring of the health condition of the patients.

Capitation fee. The number of persons in the age groups of under 2 years and over 70 years has increased by 4% and 3%, respectively, which is reflected in the over-expenditure on respective budget lines.

The reserve included funds required for monitoring normal pregnancies and conducting autopsies. In the annual report, the respective costs are included in the expenses of the fund for examinations and tests. Of the budgeted amounts designated for the primary health care reserve, 283 thousand EEK was spend on monitoring pregnancies and 453 thousand EEK in connection with autopsies.

Table 12. Number of practice lists of family physicians and the number of insured persons on the lists

	2008 actual	2009 actual	% of change from 2008
Number of practice lists			
Number of practice lists	802	803	0%
Distance allowance	193	191	-1%
Average practice list	1,606	1,595	-1%
Number of persons*			
Number of persons of up to 2 years of age, for whom capitation fee was paid	27,488	28,700	4%
Number of persons from 2 to 70 years of age, for whom capitation fee was paid	1,096,321	1,084,648	-1%
Number of persons of over 70 years of age, for whom capitation fee was paid	162,788	167,447	3%
Total number of persons for whom capitation fee was paid	1,286,597	1,280,795	0%

* The number of persons for whom capitation fee was paid and the number of insured persons in the general statistics of the EHIF is not exactly the same, because capitation fee is calculated on the basis of the number of persons as of 15.12.2009, while the statistics are as of 31.12.2009. In addition, if the service area of a family physician includes less than 1,200 permanent residents, the family physician is paid additional capitation fees to cover the difference between the actual number of residents and 1,200.

As of the end of 2009, 69 practice lists were smaller than the standard size (1,200-2,000 persons[2] per list) and 178 practice lists were larger than the standard, incl. 50 lists with more than 2,300 persons. 14 family physicians worked in service areas with less than 1,200 permanent residents. These family physicians received capitation fees for 1,200 insured persons from the EHIF. A basic allowance at a coefficient of 1.5 was paid to 59 family physicians who provided services at several locations due to the special nature of the region.

Table 13. Consultations of family physicians

	2008 actual		2009 actual		% of change from 2008	
	Consultations	Persons	Consultations	Persons	Consultations	Persons
Primary consultation	1,665,688	784,488	1,606,570	769,112	-4%	-2%
Subsequent consultation	2,382,556	698,294	2,222,541	679,663	-7%	-3%
Prophylactic consultation	450,309	231,071	387,782	213,962	-14%	-7%
Home visit	93,507	62,829	85,925	58,911	-8%	-6%
Independent consultation of family nurse	353,066	199,084	401,786	224,142	14%	13%
Planned consultation for uninsured persons	10,277	6,771	9,233	6,222	-10%	-8%
Home visits by family nurse	17,787	9,697	16,519	9,521	-7%	-2%
Telephone contacts	216,640	134,507	258,092	158,337	19%	18%
Total	**5,189,830**	**983,466**	**4,988,448**	**973,129**	**-4%**	**-1%**

The number of consultations of family physicians has decreased across all types of consultations in comparison to the previous year. The total number of persons consulted has decreased as well. The increasing role of family nurses is evident from the increased number of consultations of family nurses and the number of persons consulted independently by a family nurse. The number of telephone contacts of family physicians has increased.

The national family doctor hotline took a total of 213,596 calls in 12 months (174,031 calls in 2008), amounting to an average of 585 calls per day. This is an increase by almost 23% in comparison to 2008. The majority of the callers required consultation on a health problem; 1% needed advice on the organisation of health care. The number of calls increased significantly in November and December, during the high period of acute viral diseases. The increase in the number of calls can be explained by the increasing knowledge about and trust in the hotline service.

2 "Persons" includes both insured and uninsured persons.

1.3. Specialised Medical Care

Total expenditure on specialised medical care in 2009 amounted to 6.4 billion EEK.

1.3.1. Specialised Medical Care, Except Centrally Contracted Services

The 2009 negative supplementary budget reduced the budget of specialised medical care by 520 million EEK, resulting in a decrease in expenses by 3% comparison to 2008.

The budget was under-executed by 1%, mainly as a result of the coefficient of 0.94 applicable to health services from 15 November 2009.

A total of 3 million cases were financed in 2009, including 92% as outpatient or day care cases and 8% as inpatient cases. A similar distribution of cases between care types was registered in 2008 as well. The share of expenditure on inpatient care has decreased somewhat, amounting to 61% of total expenditure on specialised medical care in 2009 (62% in 2008).

Due to the decrease of financial resources of specialised medical care, the maximum length of the waiting list for outpatient specialised medical care was extended from four to six weeks. The maximum length of the waiting list for planned inpatient care was not extended, but the actual waiting times increased to the maximum permissible length.

Table 14. Waiting list for specialised medical care, by causes, 2008-2010 (number of persons on the list)

Reason for inclusion on the waiting list	As of 01.01.2008	As of 01.01.2009	As of 01.01.2010
Persons receiving care within the permitted waiting period	102,786	116,815	116,273
Lack of financial resources	402	98	2,975
Lack of capacity	1,897	1,549	1,553
Patients' reasons	48,957	46,635	40,692
Follow-up monitoring	29,314	26,486	34,770
Other reason	3,636	2,375	1,691
Total	186,992	193,958	197,954

The EHIF monitors the waiting lists (duration and the number of people on waiting lists) on the basis of reports received from all medical institution. Availability of specialised medical care has been kept at the same level as in 2008. According to the 2009 satisfaction survey, 54% respondents said that the availability of medical care was good or rather good, while 41% said it was poor or rather poor.

The increase in the number of persons on the waiting list for specialised medical care due to a lack of financial resources was affected by the reduction of expenditure on specialised medical care in the health insurance budget during 2009. However, no hospital included in the Hospital Network Development Plan reported waiting lists that exceeded the maximum duration as a result of financial reasons at the end of the year. Waiting lists due to financial reasons were reported at the end of the year only by contractors that were not included in the Hospital Network Development Plan in the fields of outpatient ophthalmology, gynaecology and endocrinology.

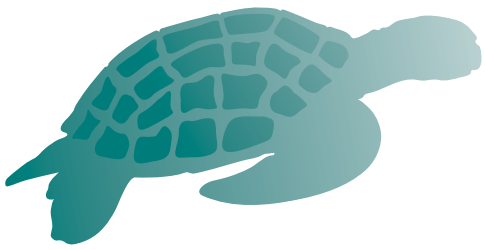
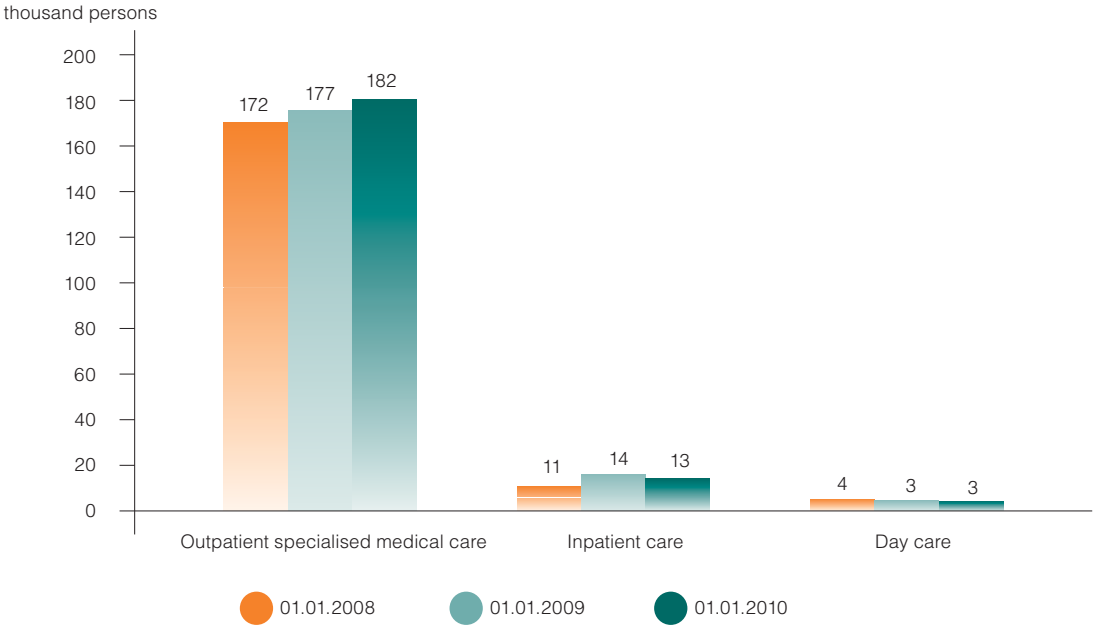


Figure 16. Comparison of waiting lists for specialised medical care in outpatient care, day care and inpatient care



Contractors with waiting lists that exceeded the permitted length were audited if necessary: 72 contractors in total in 2009.
Tables 15-16 present the distribution of resources and cases by specialties and care types.

Table 15. Expenses on specialised medical care (in EEK thousand)

	2008 actual	2009 budget	2009 actual	Budget execution %	% of change from 2008
Surgery	1,209,721	1,165,786	1,149,539	99%	-5%
outpatient care	210,164	210,503	204,253	97%	-3%
day care	43,018	43,992	44,878	102%	4%
inpatient care	956,539	911,291	900,408	99%	-6%
Otorhinolaryngology	187,407	176,547	170,434	97%	-9%
outpatient care	82,461	82,438	79,811	97%	-3%
day care	32,279	27,478	25,934	94%	-20%
inpatient care	72,667	66,631	64,689	97%	-11%
Neurology	205,999	197,093	198,086	101%	-4%
outpatient care	93,099	92,647	88,428	95%	-5%
day care	–	214	270	126%	–
inpatient care	112,900	104,232	109,388	105%	-3%
Ophthalmology	251,535	251,877	246,457	98%	-2%
outpatient care	129,206	126,931	124,188	98%	-4%
day care	106,503	110,585	108,170	98%	2%
inpatient care	15,826	14,361	14,099	98%	-11%
Orthopaedics	519,769	520,395	501,320	96%	-4%
outpatient care	113,009	119,894	110,747	92%	-2%
day care	33,163	30,238	27,371	91%	-17%
inpatient care	373,597	370,263	363,202	98%	-3%

Oncology	552,967	570,627	569,816	100%	3%
outpatient care	276,959	286,881	295,391	103%	7%
day care	38,628	46,800	33,357	71%	-14%
inpatient care	237,380	236,946	241,068	102%	2%
Obstetrics and gynaecology	626,704	645,244	629,157	98%	0%
outpatient care	269,439	287,134	282,025	98%	5%
day care	31,337	31,832	33,179	104%	6%
inpatient care	325,928	326,278	313,953	96%	-4%
Pulmonology	199,939	198,544	196,748	99%	-2%
outpatient care	91,310	95,022	89,634	94%	-2%
inpatient care	108,629	103,522	107,114	103%	-1%
Dermatovenereology	74,595	73,319	72,896	99%	-2%
outpatient care	61,073	60,870	61,086	100%	0%
day care	1,471	1,263	1,225	97%	-17%
inpatient care	12,051	11,186	10,585	95%	-12%
Paediatrics	279,164	265,539	276,658	104%	-1%
outpatient care	62,957	64,112	64,452	101%	2%
day care	6,196	5,804	6,318	109%	2%
inpatient care	210,011	195,623	205,888	105%	-2%
Psychiatry	290,092	290,764	286,712	99%	-1%
outpatient care	75,428	79,033	79,065	100%	5%
day care	1,023	1,042	1,262	121%	23%
inpatient care	213,641	210,689	206,385	98%	-3%
Infectious diseases	88,934	85,542	91,314	107%	3%
outpatient care	26,158	26,027	28,060	108%	7%
inpatient care	62,776	59,515	63,254	106%	1%
Internal diseases	1,553,589	1,523,053	1,500,966	99%	-3%
outpatient care	299,729	298,816	288,512	97%	-4%
day care	115,599	106,452	105,215	99%	-9%
inpatient care	1,138,261	1,117,785	1,107,239	99%	-3%
Follow-up care	22,184	22,238	21,041	95%	-5%
inpatient care	22,184	22,238	21,041	95%	-5%
Rehabilitation	144,658	145,554	143,257	98%	-1%
outpatient care	66,658	70,837	71,055	100%	7%
inpatient care	78,000	74,717	72,202	97%	-7%
Unspecified specialties	13,335	–	–	–	–
outpatient care	13,335	–	–	–	–
Specialised medical care total	**6,220,592**	**6,132,122**	**6,054,401**	**99%**	**-3%**
Total outpatient care	1,870,985	1,901,145	1,866,707	98%	0%
Total day care	409,217	405,700	387,179	95%	-5%
Total inpatient care	3,940,390	3,825,277	3,800,515	99%	-4%
On-call duty fee	**150,095**	**155,573**	**154,485**	**99%**	**3%**
Total	**6,370,687**	**6,287,695**	**6,208,886**	**99%**	**-3%**

Table 16. Specialised medical care cases

	2008 actual	2009 budget	2009 actual	Budget execution %	% of change from 2008
Surgery	380,201	370,649	361,888	98%	-5%
outpatient care	323,534	318,082	308,676	97%	-5%
day care	8,839	8,699	8,826	101%	0%
inpatient care	47,828	43,868	44,386	101%	-7%
Otorhinolaryngology	210,239	203,476	199,117	98%	-5%
outpatient care	191,138	186,392	182,206	98%	-5%
day care	5,890	5,023	4,937	98%	-16%
inpatient care	13,211	12,061	11,974	99%	-9%
Neurology	137,270	133,224	130,272	98%	-5%
outpatient care	129,931	126,434	122,881	97%	-5%
day care	–	47	63	134%	–
inpatient care	7,339	6,743	7,328	109%	0%
Ophthalmology	363,742	353,175	337,879	96%	-7%
outpatient care	350,104	339,306	323,853	95%	-7%
day care	11,916	12,293	12,496	102%	5%
inpatient care	1,722	1,576	1,530	97%	-11%
Orthopaedics	263,959	268,584	254,414	95%	-4%
outpatient care	245,812	251,411	237,286	94%	-3%
day care	4,293	3,865	3,573	92%	-17%
inpatient care	13,854	13,308	13,555	102%	-2%
Oncology	95,186	95,976	93,009	97%	-2%
outpatient care	82,942	83,579	81,164	97%	-2%
day care	2,735	3,039	2,574	85%	-6%
inpatient care	9,509	9,358	9,271	99%	-3%
Obstetrics and gynaecology	522,729	509,667	520,754	102%	0%
outpatient care	471,334	459,755	471,233	102%	0%
day care	15,912	15,554	16,177	104%	2%
inpatient care	35,483	34,358	33,344	97%	-6%
Pulmonology	67,130	67,197	64,750	96%	-4%
outpatient care	63,671	63,794	61,177	96%	-4%
inpatient care	3,459	3,403	3,573	105%	3%
Dermatovenereology	169,788	166,783	171,701	103%	1%
outpatient care	167,785	164,994	169,916	103%	1%
day care	484	383	472	123%	-2%
inpatient care	1,519	1,406	1,313	93%	-14%
Paediatrics	142,373	140,032	142,431	102%	0%
outpatient care	111,632	110,797	110,975	100%	-1%
day care	1,583	1,461	1,518	104%	-4%
inpatient care	29,158	27,774	29,938	108%	3%
Psychiatry	212,774	212,897	220,233	103%	4%
outpatient care	201,410	201,994	208,715	103%	4%
day care	176	171	224	131%	27%
inpatient care	11,188	10,732	11,294	105%	1%

Infectious diseases	29,030	28,634	33,812	118%	16%
outpatient care	19,456	19,429	23,011	118%	18%
inpatient care	9,574	9,205	10,801	117%	13%
Internal diseases	416,492	411,393	415,561	101%	0%
outpatient care	355,736	354,017	358,061	101%	1%
day care	4,048	3,871	4,214	109%	4%
inpatient care	56,708	53,505	53,286	100%	-6%
Follow-up care	1,939	1,886	1,921	102%	-1%
inpatient care	1,939	1,886	1,921	102%	-1%
Rehabilitation	61,115	64,427	65,330	101%	7%
outpatient care	53,822	57,558	58,617	102%	9%
inpatient care	7,293	6,869	6,713	98%	-8%
Unspecified specialties	18,172	–	–	–	–
outpatient care	18,172	–	–	–	–
Specialised medical care total	**3,092,139**	**3,028,000**	**3,013,072**	**100%**	**-3%**
Total outpatient care	2,786,479	2,737,542	2,717,771	99%	-2%
Total day care	55,876	54,406	55,074	101%	-1%
Total inpatient care	249,784	236,052	240,227	102%	-4%
Payment of on-call duty fee	**126**	**228**	**203**	**89%**	**61%**
Total	**3,092,265**	**3,028,228**	**3,013,275**	**100%**	**-3%**

Notable changes were recorded in the following specialties:

- **Oncology:** the expenses have increased by 3% from 2008, mainly on account of outpatient care as the more efficient type of care. The number of cases decreased by 2%. The budget as a whole was executed as planned; the number of actual cases was lower than estimated by 3%, mainly on account of outpatient cases. The number of cases in oncology in Tartu region decreased by 11% in comparison to 2008. The EHIF opinions that relocation of the Oncology Clinic of the Tartu University Hospital affected the provision of services in oncology. Moving had the strongest impact on the provision of radiation therapy. The cost of pharmaceuticals remains highest in oncology where this category of expenditure amounted to around 40% of the total expenditure in the specialty (41% in 2008).

- **Paediatrics:** the number of cases remained at the same level as in 2008, but expenses decreased by 1%. A larger decrease in the number of cases and expenses was expected to occur in budget estimations.

- **Psychiatry:** the number of cases was up by 4% from 2008, with a larger increase recorded in outpatient cases. The EHIF opinions that the increase could be partially explained by growing frequency of mental health problems caused by the difficult economic situation. Another factor contributing to the increase in the number of cases was the inclusion of cases of a previously unspecified specialty (clinical psychology) among the cases of psychiatry.

- In comparison to the previous reporting period, the care costs of **infectious diseases** increased by 3% in total (incl. outpatient costs 7%, inpatient costs 1%). The total number of cases in the specialty increased by 16% and increase was recorded with regard to all care types (with a larger increase in outpatient cases). The reason for the rising number of cases in the specialty is the continuing increase in the number of persons with HIV and AIDS. The number of such patients in the specialty of infectious diseases has increased by 12% and the number of respective cases has increased by 16%, especially in outpatient care.

- **Rehabilitation:** the number of cases has increased on account of outpatient cases as cheaper care cases. A factor contributing to the increase in the number of cases was the inclusion of cases of a previously unspecified specialty (speech therapy) among the cases of rehabilitation.

- The expenses on the 24-hour **on-call duty** fee payable to the hospitals included in the Hospital Network Development Plan have increased, because the financing principles have changed in the past two years. The EHIF pays to the hospitals included in the Hospital Network Development Plan the on-call duty fee for 95 on-call rounds per quarter.

Endoprosthetic Replacements, Cataract Operations, Cardiac Surgery and Deliveries

For the purposes of budget planning and monitoring, demands for the following four specialised services are considered separately: deliveries, cardiac surgery, endoprosthetic replacements and cataract operations. Given that deliveries and emergency cardiac surgery cannot be forecast in precise terms and given the long waiting lists for endoprosthetic replacements and cataract operations, it is the aim of the EHIF to ensure access to these services for the insured persons and to keep these cases under separate monitoring. Tables 17 and 18 provide an overview of the care needs and expenses of these services.

Table 17. Cost of endoprosthetic replacements, cataract operations, cardiac surgery and deliveries

	Cost, actual				% of change		
Special case	2006	2007	2008	2009	2007/2006	2008/2007	2009/2008
Endoprosthetic replacements	128,824	149,243	166,904	160,587	16%	12%	-4%
Cataract operations	78,967	91,362	102,995	100,987	16%	13%	-2%
Cardiac surgery	127,433	145,210	163,335	148,313	14%	12%	-9%
Deliveries	126,782	169,283	197,755	192,203	34%	17%	-3%
Total	**462,006**	**555,098**	**630,989**	**602,090**	**20%**	**14%**	**-5%**

Table 18. Number of endoprosthetic replacements, cataract operations, cardiac surgeries and deliveries

	Number of special cases, actual				% of change		
Special case	2006	2007	2008	2009	2007/2006	2008/2007	2009/2008
Endoprosthetic replacements	2,643	2,743	2,870	2,734	4%	5%	-5%
Cataract operations	9,102	10,236	11,211	11,320	12%	10%	1%
Cardiac surgery	1,062	1,081	1,115	995	2%	3%	-11%
Deliveries	14,573	15,439	15,628	15,338	6%	1%	-2%
incl. by caesarean section	2,805	3,128	3,171	3,209	12%	1%	1%
Share of caesarean sections	19%	20%	20%	21%	–	–	–

1.3.2. Centrally Contracted Health Services

Centrally contracted health services are high-cost medical services for treatment of severe and relatively rare cases. In order to ensure equal access to these services for residents of all regions and to control costs, provision of these services is based on a single waiting list for entire Estonia. Even though the List of Health Services, applicable from 15 November 2009, established a coefficient of 0.94 for all reference prices of health services, the cost of centrally contracted health services has increased in comparison to 2008 (except for the costs of peritoneal dialysis, antidotes and serums, and pathoanatomical autopsies).

The increase in costs was caused by changes in reference prices, because the reference prices of some bone marrow transplants and centrally contracted pharmaceuticals rose from 1 July, by addition of new pharmaceuticals to the expenses on centrally contracted pharmaceuticals, as well as by increased use of emergency air transport, haematological treatments, cochlear implants, artificial urinary sphincters, and centrally contracted pharmaceuticals.

Table 19. Centrally contracted health services (in EEK thousand)

	2008 actual	2009 budget	2009 actual	Budget execution %	% of change from 2008
Bone marrow transplants	14,473	17,306	17,887	103%	24%
Peritoneal dialysis	26,598	30,470	25,384	83%	-5%
Emergency transport of the insured	2,102	3,400	2,549	75%	21%
Haematological treatment	17,505	20,360	20,618	101%	18%
Antidotes, serums	200	200	199	100%	-1%
Artificial urinary sphincters	754	848	848	100%	12%
Cochlear implants	3,499	4,942	4,925	100%	41%
Pathoanatomical autopsies	935	1,700	722	42%	-23%
Centrally contracted pharmaceuticals	52,467	90,493	72,954	81%	39%
Total	**118,533**	**169,719**	**146,086**	**86%**	**23%**

Table 20. Cases of centrally contracted health services

	2008 actual		2009 actual		% of change from 2008	
	Cases	ACTC	Cases	ACTC	Cases	ACTC
Bone marrow transplants	94	153,968	85	210,435	-10%	37%
Peritoneal dialysis	972	27,364	947	26,805	-3%	-2%
Emergency transport of the insured	80	26,275	91	28,011	14%	7%
Haematological treatment	294	59,541	304	67,822	3%	14%
Antidotes, serums	2	100,000	2	99,500	0%	-1%
Artificial urinary sphincters	8	94,250	10	84,800	25%	-10%
Cochlear implants	12	291,583	20	246,250	67%	-16%
Pathoanatomical autopsies	596	1,569	451	1,601	-24%	2%
Centrally contracted pharmaceuticals	1,828	28,702	2,801	26,046	53%	-9%

The actual use of financial resources in 2009 was 14% lower than planned. All categories of costs under centrally contracted health services cannot be forecast in exact terms, because the distribution of severe and milder cases differs from year to year.

An increased use was expected on the basis of data from previous years in the case of the **peritoneal dialysis**, which is required for severe kidney conditions. However, the actual figures remained lower than expected with regard to both the number of patients and the number of care days per patient (i.e., the average cost of a treated case).

The cost of one flight in **emergency air transport** depends on the duration of flight and the type of transportation used (the hourly rate of a helicopter is higher than the hourly rate of a plane).

The money designated for **centrally contracted pharmaceuticals** is used to pay for the biological treatment of rheumatic and gastroenterological diseases, enzyme replacement therapy for type 1 of Gaucher's disease, risperidone depot injections for treating psychiatric cases, treatment of Fabry disease, acromegaly and neuroendocrine tumours and, from the second half of 2009, inpatient erythropoietin therapy for patients with renal anaemia or for underweight and premature infants.

An increase in the cost of centrally contracted pharmaceuticals was anticipated in 2009 in connection with the addition of new patients, but the actual use was lower than expected. The under-execution was caused by the fact that the hospitals started to treat patients who required biological treatment, which is the most frequently used pharmaceutical in this category, later than anticipated (more than half of new treatment cases were added only in Q4).

The availability of centrally contracted pharmaceuticals to the insured person more than redoubled during the reporting year. 647 persons received treatment at the end of the year (299 insured persons were treated with centrally contracted pharmaceuticals in 2008).

The amounts budgeted for 2009 were exceeded in the fields of bone marrow transplants and haematological treatment.

The number of **bone marrow transplants** was lower than planned, but the annual costs rose above the planned level as a result of two post-transplantation complications.

The cost of **haematological treatments** was higher than expected, because the average cost of a treated case rose by 8% above the expected level. Such increase in the ACTC was caused by the postoperative treatment needs of a patient with severe coagulation abnormality.

1.3.3. Comparison of Main Usage Indicators in Specialised Medical Care

Table 21. Main usage indicators of inpatient and outpatient specialised medical care

	2008 actual	2009 actual	% of change from 2008
Average cost of a case of treatment., EEK			
outpatient care	671	687	2%
day care	7,324	7,030	-4%
inpatient care	15,775	15,821	0%
Number of inpatient bed days	1,560,768	1,449,960	-7%
Average length of stay in inpatient care	6.3	6.1	-3%
Number of outpatient consultations	3,797,861	3,647,303	-4%
outpatient care	3,722,259	3,573,286	-4%
day care	75,602	74,017	-2%
Number of outpatient consultations per case of treatment	1.34	1.32	-1%
outpatient care	1.34	1.31	-2%
day care	1.35	1.34	-1%
Number of persons using specialised medical care services	819,055	800,578	-2%
outpatient care	795,791	777,144	-2%
day care	45,911	44,474	-3%
inpatient care	169,755	163,911	-3%
Number of case of treatment per person	3.78	3.76	-1%
outpatient care	3.50	3.50	0%
day care	1.22	1.24	2%
inpatient care	1.47	1.47	0%
Share of emergency care in treatment costs			
outpatient care	17.0%	17.0%	0%
day care	6.0%	9.0%	3%
inpatient care	63.0%	67.0%	4%
Share of emergency care in treated cases			
outpatient care	16.0%	16.6%	0.6%
day care	13.0%	14.8%	1.8%
inpatient care	57.0%	61.3%	4.3%
Number of operations*	164,819	155,010	-6%
outpatient care	19,517	20,302	4%
day care	45,838	42,620	-7%
inpatient care	99,464	92,088	-7%

* The reference data from 2008 have been adjusted as a result of a change in calculation principles.

The overall average cost of a case of treatment (ACTC) across all care types did not change. By individual care types, only the ACTC in outpatient care increased.

The number of bed days has gone down by 7 % as a result of the decrease in the number of inpatient cases and reduction in **the average number of days in inpatient care**. The average length of stay in inpatient care has dropped to 6.1 days, indicating that the medical institutions are increasingly efficient in providing the service.

The number of persons using specialised medical care services has decreased in all care types. A positive indication is that the number of persons using specialised medical care services has decreased less in outpatient care than in inpatient and day care, even though the Supervisory Board of the Health Insurance Fund extended the maximum length of the waiting list for outpatient specialised medical care from four weeks to six weeks from March 2009.

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 a situation where insured persons do not have timely access to medical specialists. In addition, emergency care is more expensive than planned care.

Operations. The total number of operations decreased by 6% in 2009, particularly on account of operations in day care and inpatient care. The decrease in the overall number of treated cases in specialised medical care is also one of the reasons for the decrease in the number of operations. The number of outpatient operations increased by 4%. The majority of operations is still performed in inpatient care, but their share in the total number of operations has been constantly decreasing in recent years. The share of outpatient and day care operations in 2009 was 41%.

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

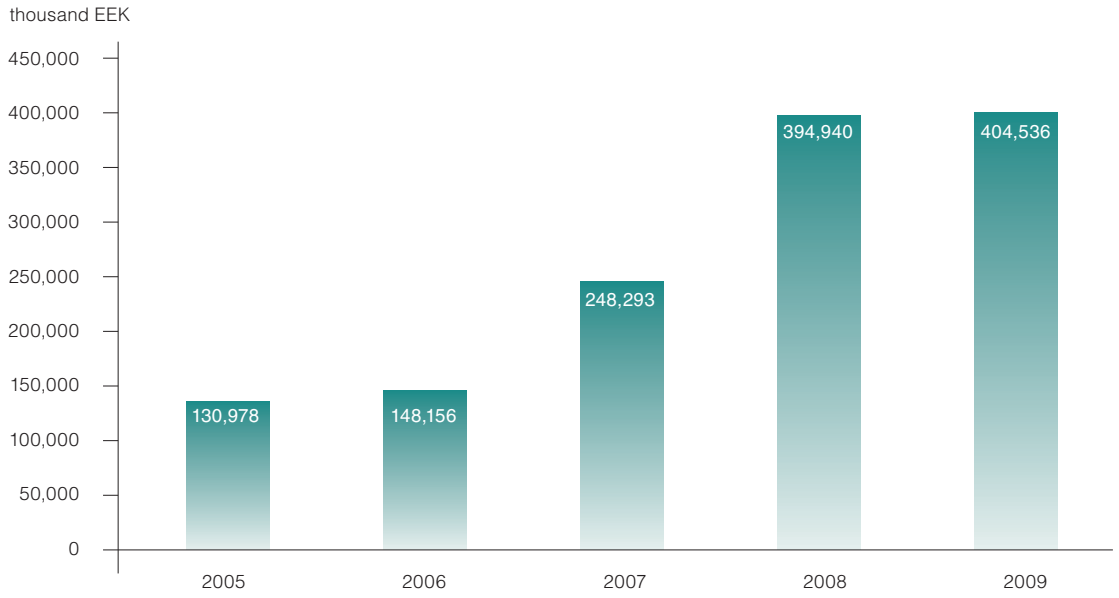
During 2009, the Health Insurance Fund paid 404.5 million EEK for pharmaceuticals used for the provision of specialised medical care services (i.e., the pharmaceuticals included in the List of Health Services, but not included in the bed day reference price). In comparison to 2008, the cost of pharmaceuticals in specialised medical care increased by ca 2.5%.

The List of Health Services of the EHIF included 53 different treatments with pharmaceuticals in 2009. The Health Insurance Fund considers it important to ensure uniform availability of pharmaceuticals to patients in different disease groups. On 1 January 2009, active substance erythropoietin was added to the list of subsidised pharmaceuticals in outpatient care, having previously been subject to compensation only in the case of specialised medical care on the basis of the List of Health Services. From 1 July 2009, compensation of the respective pharmaceutical on the basis of the List of Health Services is applicable only to the treatment of hospitalised patients with a specific diagnosis.

On 1 July 2009, preventive treatment for cytomegalovirus infection was added to the List of Health Services as a new service and accessibility to oncological chemotherapy treatments was improved. Instead of the previous three chemotherapy treatments, the List of Health Services was supplemented by 11 new chemotherapy treatments in the fields of urology and gynaecology and for the treatment of tumours of the digestive system.

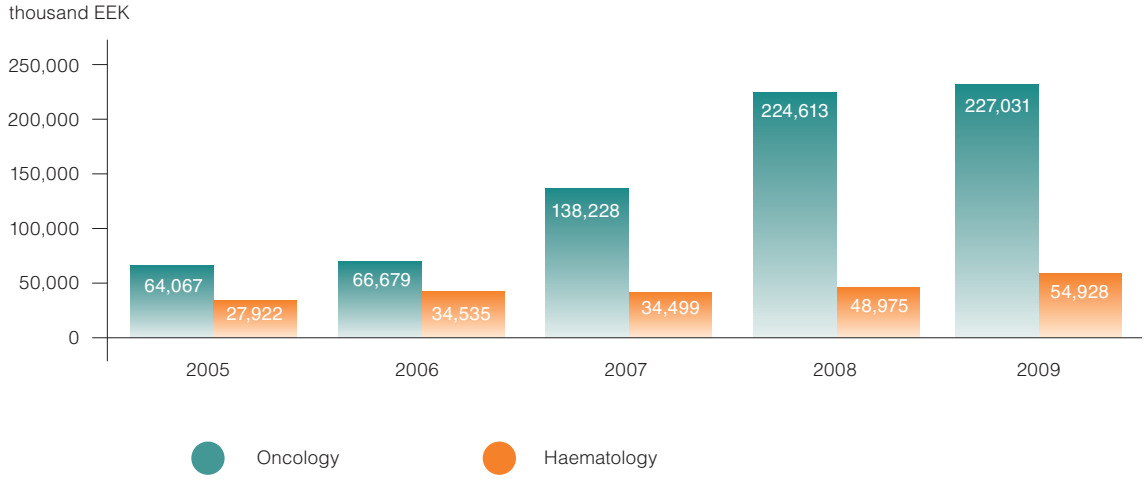
Modernisation of treatments was made possible by increased utilisation of generic medicinal products, which considerably reduced the reference prices applicable to various treatments.

Figure 17. Cost of pharmaceuticals in specialised medical care services, 2005-2009



Oncology and haematology have been the two specialties with highest expenditure on pharmaceuticals, with the cost of pharmaceuticals accounting for 40% and 36%, respectively, of the total expenditure in these specialties.

Figure 18. Specialties with the highest cost of pharmaceuticals, 2005-2009



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 persons who need care would be able to stay at home for as long as possible. In 2009, the EHIF paid 237 million EEK for nursing care services.

Table 22. Expenses on nursing care (in EEK thousand)

	2008 actual	2009 budget	2009 actual	Budget execution %	% of change from 2008
Inpatient nursing care	198,835	204,964	197,916	97%	0%
Outpatient nursing care, incl.	39,137	38,533	39,097	101%	0%
home nursing	32,996	32,176	32,855	102%	0%
home care for cancer patients	5,095	5,249	5,155	98%	1%
geriatric assessment	1,046	1,108	1,087	98%	4%
Total	**237,972**	**243,497**	**237,013**	**97%**	**0%**

The reasons for under-execution of the budget are lower-than-planned average cost of a treated case (the ACTC was roughly 6% lower than budgeted in inpatient nursing care and 8% lower than budgeted in outpatient nursing care) and the coefficient of 0.94 applicable to reference prices of health services from 15 November 2009. The decrease in prices enabled to buy 10% more treated cases than in 2008 (even 17% more in home nursing).

Table 23. Cases of nursing care

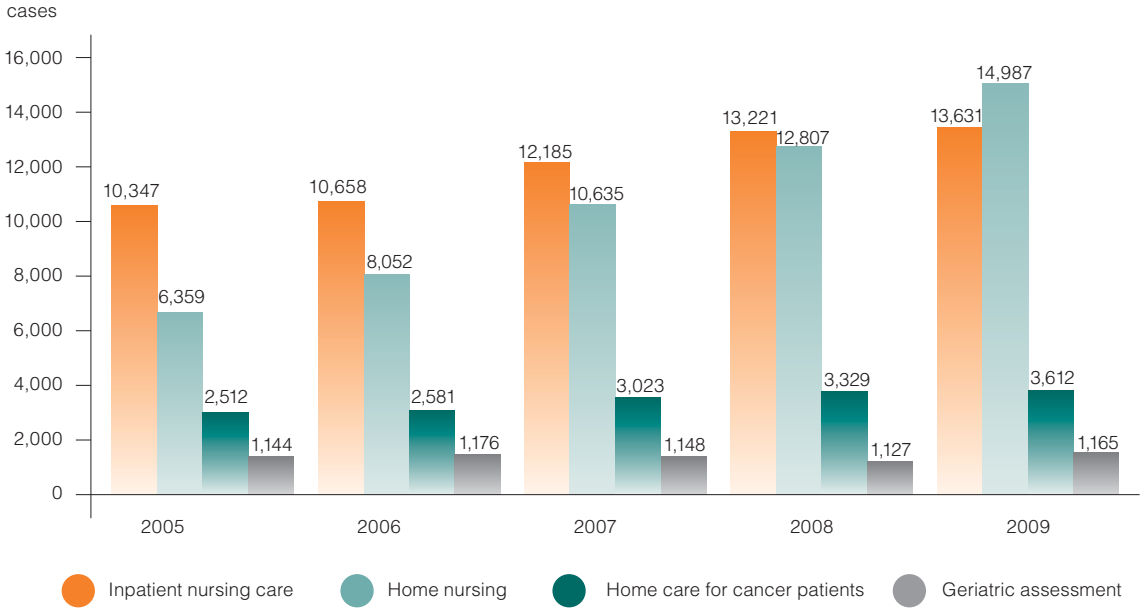
	2008 actual		2009 actual		% of change from 2008	
	RJ	RJKM (EEK)	RJ	RJKM (EEK)	RJ	RJKM
Inpatient nursing care	13,221	15,039	13,631	14,520	3%	-3%
Outpatient nursing care, incl.	17,263	2,267	19,764	1,978	14%	-13%
home nursing	12,807	2,576	14,987	2,192	17%	-15%
home care for cancer patients	3,329	1,530	3,612	1,427	9%	-7%
geriatric assessment	1,127	928	1,165	933	3%	1%
Total	**30,484**	**7,806**	**33,395**	**7,097**	**10%**	**-9%**

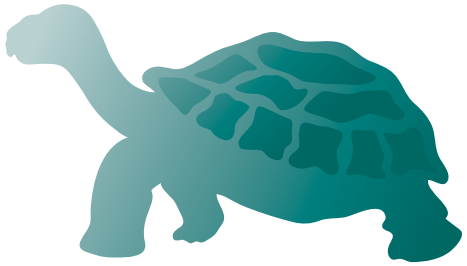
The providers of home nursing care made more visits in 2009 and the number of receiving nursing patients increased as well. The number of cancer patients receiving home care grew, but the total number of visits decreased by 1%.

Table 24. Outpatient nursing care visits

	2008 actual		2009 actual		% of change from 2008	
	Visits	Persons	Visits	Persons	Visits	Persons
Home nursing	122,781	3,715	123,065	3,971	0%	7%
Home care for cancer patients	14,643	869	14,459	927	-1%	7%

Figure 19. Nursing care cases, 2005–2009





1.5. Dental Care

Pursuant to the Health Insurance Act, the Health Insurance Fund shall assume a payment obligation for dental care services for the benefit of insured persons of up to 19 years of age. In the case of dental care services for adults, the Health Insurance Fund only assumes the payment obligation for services provided as part of emergency care.

In 2009, the EHIF paid 287.2 million EEK for dental care services provided to insured persons, which constitutes 95% of the planned budget. One of the reasons for under-execution of the budget was the coefficient of 0.94 applicable to health services from 15 November 2009.

Table 25. Expenses on dental care (in EEK thousand)

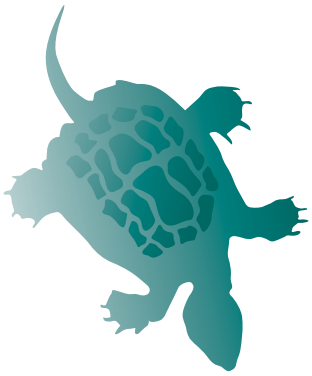
	2008 actual	2009 budget	2009 actual	Budget execution %	% of change from 2008
Dental care for children	231,151	235,702	226,500	96%	-2%
Orthodontics	43,658	43,032	43,081	100%	-1%
Preventive dental care	10,545	8,744	6,391	73%	-39%
Emergency dental care for adults	13,910	13,522	11,208	83%	-19%
Total	**299,264**	**301,000**	**287,180**	**95%**	**-4%**

In comparison to 2008, the expenditure on dental services decreased by 4% and the number of cases decreased by 6%. The decrease was largest in the cost and the number of cases of preventive dental care for children. The description of target groups of preventive dental care for children was specified in 2009 and the number of children included in the target groups decreased as a result. The contract for financing medical treatment provided a more detailed description of preventive dental care, making a clearer distinction between prevention and treatment of discovered pathologies.

The cost and the number of cases in emergency dental care for adults have decreased in comparison to 2008, because the procedure of compensation was amended in 2009. It is also possible that the decrease can be associated with efficient monitoring work by EHIF´s medical advisers.

Table 26. Cases of dental care

	2008 actual	2009 budget	2009 actual	Budget execution %	% of change from 2008
Dental care for children	300,889	285,249	299,081	105%	-1%
Orthodontics	37,719	34,505	36,409	106%	-3%
Preventive dental care	45,738	33,881	28,109	83%	-39%
Emergency dental care for adults	20,617	19,267	17,260	90%	-16%
Total	**404,963**	**372,902**	**380,859**	**102%**	**-6%**



2. Health Promotion Expenses

The Health Insurance Fund is engaged in health promotion through project-based work according to the priorities approved by the Supervisory Board of the EHIF in coordination with the Ministry of Social Affairs. Health promotion activities of the EHIF form a part of national health strategies. Of the 15 million EEK designated for health promotion, 13.2 million EEK were actually used. The lower level of costs was caused mainly by implementation of planned activities in a more cost-effective manner.

Table 27. Health promotion expenses (in EEK thousand)

Priority area	2008 actual	2009 budget	2009 actual	Budget execution %	% of change from 2008
Health promotion activities for children	3,226	3,100	3,360	108%	4%
Prevention of cardiovascular diseases	711	800	463	58%	-35%
Early detection of malignant tumours	582	1,500	837	56%	44%
Prevention of domestic and leisure injuries and intoxication	4,153	5,400	4,423	82%	7%
Prevention of alcohol-induced health damage	2,064	1,000	1,000	100%	-52%
Activities aimed at multiple priority areas	3,234	3,200	3,067	96%	-5%
Total	**13,970**	**15,000**	**13,150**	**88%**	**-6%**

Economical use of the budget for prevention of cardiovascular diseases and early detection of malignant tumours was a result of efficient implementation of procurements of awareness activities. Prevention of alcohol-induced health damage is carried out in the framework of local projects for prevention of injuries.

Table 28. Quantitative indicators of project activities

Health promotion activity	2006	2007	2008	2009
Number of participants in training, sports and other events aimed at general population	25,100	39,300	53,890	60,250
Number of persons who received individual counselling	4,470	8,240	8,967	11,051
Number of participants in training events for health care professionals	600	1830	427	193
Number of participants in training events for teachers	3,300	2,310	1,227	2,136
Number of participants in training events for other stakeholders (social workers, managers, task forces)	2,440	2,181	1,605	1,354
Number of various printed publications	24	24	18	18
Total print run of publications	346,500	354,700	362,600	415,512
Number of radio and TV programmes/clips	19	11	8	15

Development of Infrastructures and Activities Aimed at Stakeholders

The project “Health Promotion in Nursery Schools and Schools” has been used to provide training to 210 nursery school employees and 215 school employees, while institutional counselling has been provided by regional coordinators to 202 nursery schools and 160 schools all over Estonia. On 5 June, the Health Insurance Fund organised, in cooperation with the National Institute for Health Development (NIHD), the Ministry of Social Affairs and the Estonian Country Office of the World Health Organization, a national health promotion conference “Equal Opportunities for Each Community” for over 200 health promotion specialists and local government representatives. Before the conference, there was a review of the results of the survey “Mapping the activities and needs of disease prevention and health promotion at the level of primary medical care” in cooperation with the World Health Organization and the NIHD and the report on the survey is now completed. Over forty senior officials from various Estonian, Latvian, Lithuanian and Polish organisations participated, in the second half of June in Estonia, in an international training event on increasing the efficiency of health care systems. The purpose of training was to refine the participants’ skills of analytical thinking and development of targeted health policy.

Media Communications

A social campaign was conducted in 2009 to raise the participation rate in cancer screenings. Clips with the campaign slogan "Gift yourself a sense of security" were broadcast from January to May and in September: the campaign also included distribution of posters and stickers through health care institutions. Visibility of the campaign was measured with the "Population satisfaction survey", which indicated that the visibility of the campaign was 79%.

Health promotion pages of the Health Insurance Fund were printed once a month (except for July) in newspapers Postimees, Eesti Päevaleht, Maaleht, SL Õhtuleht, Linnaleht and Den za Dnjom.

Publications

The following publications in Estonian and Russian were completed in 2009:

- "Prevention of injuries in infants and young children";
- "Endoprosthetic replacement of knee joint";
- "Endoprosthetic replacement of hip joint ";
- "Lucky heart. How to avoid cardiovascular diseases?";
- "Health journal for patients with hypertension";
- "How to prevent skin cancer? Skin cancer is curable when detected at an early stage";
- "Development of children. On the health of children in play age (2-6 years)";
- "Detection and prevention of mental health problems in school", reprint;
- "Assistance of a support person during delivery";
- "ABC of child safety: toxic mushrooms and plants and behaviour with dogs";
- Breastfeeding booklets, parts 1-4.

The cost of injury prevention projects in the counties was over 5 million EEK. Prevention of injuries at the local level is believed to be one of the most cost-effective areas of health promotion. Safety-related training events were organised for representatives of local governments and employees of educational institutions. In the case of three county projects, the EHIF concluded that the projects did not satisfy the criteria. The main flaws were problems with implementation of planned activities and failure to coordinate changes made in the project action plans with the funders. The EHIF has explained the faults to all steering institutions of the projects and has improved measures for prevention of future deficiencies.

A total of 11,051 counselling sessions were conducted **in the framework of projects for stakeholders.** There were 1,887 cases of pregnancy crisis counselling, 5,024 young people received web-based advice on sexual health, and 4,051 persons were given pre-delivery and post-delivery counselling. In addition, counselling was provided to residents with alcohol problems in Võru County.

Long-term project teams carried out a self-assessment of the capacity of the project organisation and the results were presented in a report. External assessment was carried out in the case of the injury prevention projects of Jõgeva, Lääne-Viru and Ida-Viru counties to measure the accuracy of the results of self-assessment. Feedback from self-assessment and external assessment was positive. It motivated the teams to approach project work in a systematic manner and helped the project team to understand the meaning of key areas. The results of the assessment will be taken into account when planning activities for the future years.

3. Pharmaceuticals Reimbursed to the Insured Persons

The expenditure on reimbursing the cost of pharmaceuticals to the insured persons is an open commitment for the Health Insurance Fund, which means that the EHIF is under an obligation to pay compensation to persons for the cost of pharmaceuticals to the extent prescribed by law and based on the needs of the person.

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

Almost 1.4 billion EEK worth of expenses on pharmaceuticals were reimbursed to the insured persons in 2009.

Table 29. Pharmaceuticals reimbursed to the insured (in EEK thousand)

Level of reimbursement	2008 actual	2009 budget	2009 actual	Budget execution %	Share of expenses by type of reimbursement	
					2008	2009
Pharmaceuticals reimbursed fully	555,927	623,454	644,276	103%	43.4%	46.6%
Reimbursement of 90 % of cost	369,263	382,676	384,187	100%	28.8%	27.8%
Reimbursement of 75 % of cost	83,942	90,770	85,040	94%	6.6%	6.1%
Reimbursement of 50 % of cost	272,208	285,981	269,710	94%	21.2%	19.5%
Pharmaceuticals reimbursed in special cases	146	119	118	99%	0%	0%
Total	**1,281,486**	**1,383,000**	**1,383,331**	**100%**	**100%**	**100%**

Despite the difficult economic situation, the year 2009 was characterised by a general increase in the consumption of subsidised pharmaceuticals.

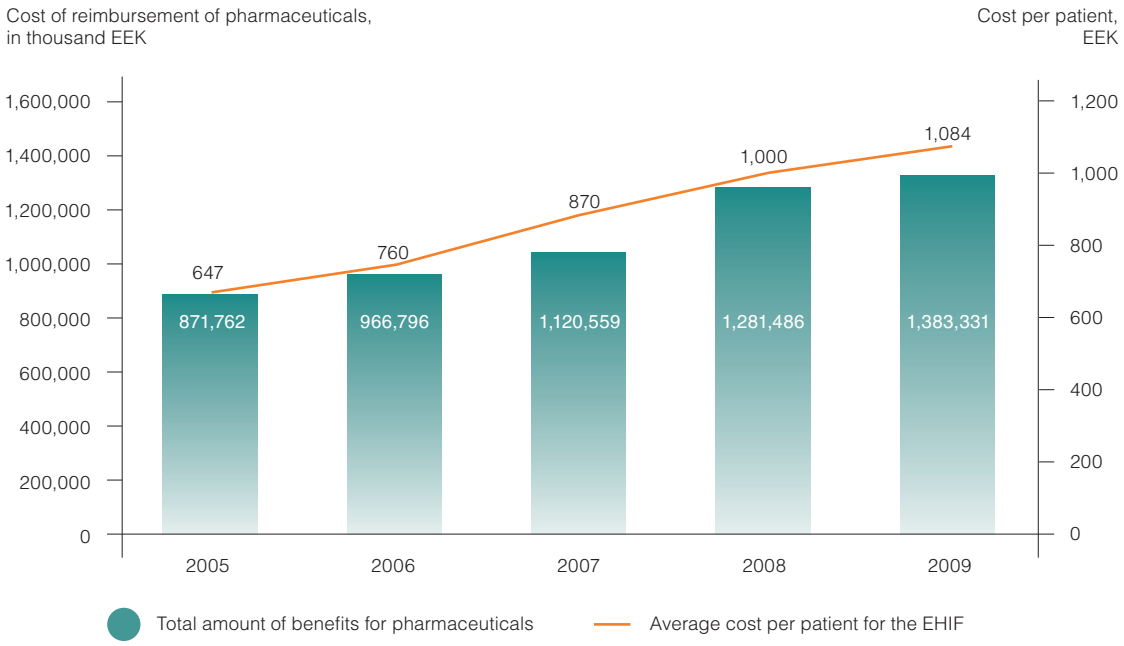
As a result of the change of the VAT rate on pharmaceuticals on 1 January 2009, the share of expenses of the EHIF in the first quarter was modest due to previously amassed reserves. From the second quarter, the expenditure on pharmaceuticals continued in line with the trend of the preceding years.

The use of pharmaceuticals in December 2009 differed markedly from the remaining months, which could be partially explained by the anticipation of the implementation of digital prescriptions from January 2010 among patients, doctors and pharmacists.

While the average amount of reimbursement per one insured person was 1,000 EEK in 2009, it rose to 1,084 EEK in 2009. This can be probably associated with continuing positive trends in diagnosing and more consistent use of pharmaceuticals. Another important factor is better selection of pharmaceuticals, which improves the availability of modern and more expensive pharmaceuticals to patients.

On 1 January 2009, the selection of pharmaceuticals in the list of pharmaceuticals of the EHIF was expanded in the case of the following diagnoses: hypertonia, breast cancer, kidney cancer, anaemia of chronic renal failure, Parkinson's disease and osteoporosis.

Figure 20. Total expenditure on reimbursement of pharmaceuticals and expenditure per patient



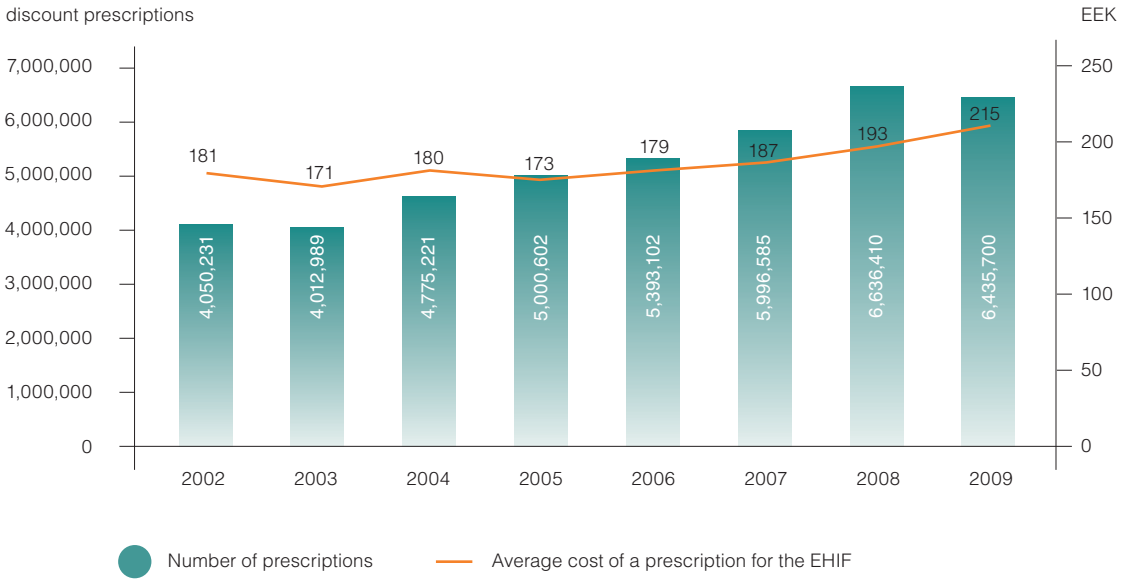
The number of reimbursed prescriptions was by 3% lower than in 2008. There could be several reasons for that: patients only bought medicinal products, which they considered as most essential for their health, and/or the general practice of prescribing medicinal products has improved and doctors have started to prescribe pharmaceuticals required for treatment of chronic diseases as treatment courses for at least two months. The decrease in the number of prescriptions issued at a discount was most noticeable in the case of chronic patients who are financially the most vulnerable target group.

Table 30. Number of discount prescriptions (DP) and average cost in EEK

Level of reimbursement	2008		2009		2009/2008	
	Number of DPs	Average cost of DP for EHIF	Number of DPs	Average cost of DP for EHIF	Number of DPs %	Average cost of DP for EHIF %
100% reimbursement	691,256	804	703,877	915	2%	14%
90% reimbursement	2,149,459	172	2,077,851	185	-3%	8%
75% reimbursement	512,016	164	486,978	175	-5%	7%
50% reimbursement	3,283,679	83	3,166,994	85	-4%	2%
Total	**6,636,410**	**193**	**6,435,700**	**215**	**-3%**	**11%**

The average cost of a prescription for the Health Insurance Fund has increased at every level of reimbursement, but the increase was largest in the category of pharmaceuticals subject to 100% reimbursement. The reason for the increase is evidently the fact that the insured persons have used more expensive life-saving medicinal products that contribute to survival.

Figure 21. Changes in the number of discount prescriptions and average cost



The changes in the increase in **the number of discount prescriptions and benefits for pharmaceuticals** differed in 2009 from previous periods. Despite the fact that the number of prescriptions decreased by 3% in the reporting period, the average cost of prescription has increased by 11%, causing the entire budget of benefits for pharmaceuticals to increase by 8%.

The changes in **the cost for the patient** are smallest for the users of pharmaceuticals subject to 100% reimbursement, because the prices of almost all medicinal products that are subject to reimbursement are controlled by respective measures. Therefore, insured persons taking pharmaceuticals required for severe diseases have had to pay, on average, only 30 EEK per prescription. It would be important to compare this to the users of pharmaceuticals subject to 50% reimbursement (where the prices of most medicinal products are not controlled by price regulation measures), who have to pay, on average, 170 EEK per prescription. In order to reduce this expenditure, the Health Insurance Fund launched in 2009 a communication campaign on rational use of pharmaceuticals, helping patients to understand their rights in making decisions on treatment also from the financial point of view.

Overall, the level of cost sharing by patients has remained stable in comparison to the previous year.

Table 31. Cost-sharing by insured persons (%)

Level of reimbursement	2008	2009	% of change from 2008
100% reimbursement	3.8	3.2	-0.6
90% reimbursement	33	32.7	-0.3
75% reimbursement	42.4	42	-0.4
50% reimbursement	66.4	66.6	0.2
Average cost sharing by insured persons	38.5	36.9	-1.6
incl. prescriptions subject to 75%, 90% and 100% reimbursement	20.6	19.5	-1.1

The diagnoses that continue to attract the largest costs to be reimbursed have been similar throughout the years. This was the first year when diabetes required the largest expenditure, followed by hypertension, which was in the leading position in previous years.

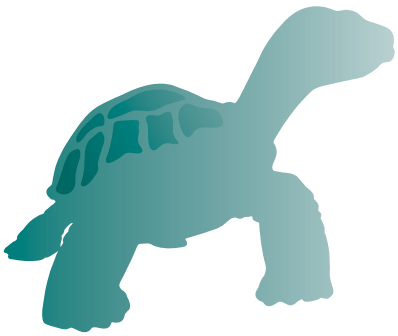
The decrease in the costs on hypertension could be explained by a wider selection of pharmaceuticals and effective control over prices through reference prices and price agreements.

Table 32. Diagnoses with the highest expenditure on benefits for pharmaceuticals (in EEK thousand)

	2008 actual		2009 budget		2009 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
Total diabetes, incl.	166,843	13%	192,665	14%	205,477	15%
insulin	136,002	11%	157,117	11%	160,016	12%
orally administered products	30,841	2%	35,548	3%	45,461	3%
Hypertension	195,392	15%	229,154	17%	203,167	15%
Cancer	113,007	9%	126,337	9%	128,619	9%
Bronchial asthma	78,861	6%	90,571	7%	83,240	6%
Glaucoma	60,088	5%	68,774	5%	71,565	5%
Chronic hepatitis C	28,456	2%	54,277	4%	35,228	3%
Mental disorders	43,611	3%	35,212	3%	47,078	3%
Hypercholesterolemia	43,082	3%	46,698	3%	57,102	4%
Total	**729,340**	**57%**	**843,688**	**61%**	**831,476**	**60%**

A concluding analysis of the expenditure on benefits for pharmaceuticals in 2009 indicates an increase in the use of pharmaceuticals (the EHIF reimbursed the cost of pharmaceuticals to 829,748 insured persons), especially considering the increased expenditure on pharmaceuticals subject to 100% reimbursement. It is perfectly understandable, because pharmaceuticals with this level of reimbursement are the cheapest for the insured persons.

With the expected shrinking of the revenue base for health insurance and on the assumption that the availability of health services is not reduced, the funds for making available new pharmaceuticals in the future would have to be found in the existing budget of benefits for pharmaceuticals. A systematic review of the list of reimbursed pharmaceuticals is required to exclude any pharmaceuticals that are no longer beneficial and for which cost-effective alternatives exist.



4. Expenses on Benefits for Temporary Incapacity for Work

The expenses on benefits for temporary incapacity for work in 2009 amounted to 2.2 billion EEK, which is over 183 million EEK less than in the previous year.

Table 33. Expenses on benefits for incapacity for temporary work (in EEK thousand)

Type of benefit	2008 actual	2009 budget	2009 actual	Budget execution %	% of change from 2008
Sickness benefits	1,474,551	1,147,105	1,192,085	104%	-19%
Care benefits	287,795	309,928	318,444	103%	11%
Maternity benefits	586,209	664,210	661,232	100%	13%
Occupational accident benefits	38,898	32,032	32,343	101%	-17%
Total	**2,387,453**	**2,153,275**	**2,204,104**	**102%**	**-8%**

Legislative amendments that entered into force on 1 July 2009 were the main factors of change for the expenditure on benefits for incapacity for work:

- no benefit is paid during the first three days of sickness or injury;
- the employer pays the benefit from day 4 to day 8 of sickness or injury;
- the EHIF starts to pay the benefit from day 9 of sickness or injury;
- the rate of sickness benefit in the case of sickness or injury was reduced from 80% to 70% of the insured person's income subject to social tax in the previous calendar year;
- the rate of sickness benefit in the case of caring for a child under 12 years of age was reduced from 100% to 80% of the insured person's income subject to social tax in the previous calendar year;
- the maximum length of maternity leave was reduced from 154 days to 140 days.

Sickness benefits are the largest cost item of the expenses on benefits for temporary incapacity for work, but the share of maternity benefits and care benefits is noticeably increasing as a result of the increasing birth rate.

Figure 22. Distribution of benefits for incapacity for work by types of benefits in 2009

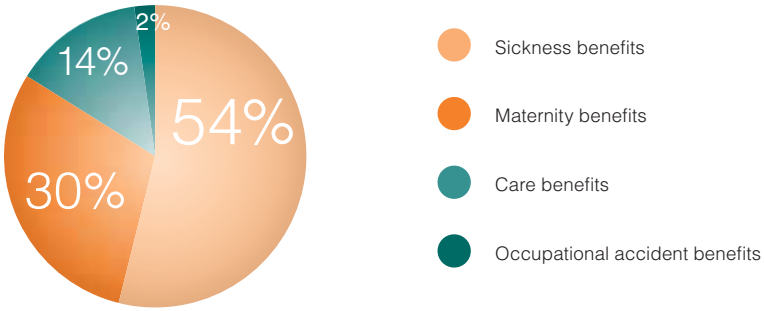


Table 34. Comparison of expenses on benefits for temporary incapacity for work

	2007	2008	2009	2008/2007	2009/2008
Sickness benefits					
Number of certificates	508,428	470,950	305,476	-7%	-35%
Number of days	6,209,512	6,354,414	4,708,595	2%	-26%
Benefit amount (in EEK thousand)	1,222,322	1,474,551	1,192,085	21%	-19%
Average daily income (EEK)	197	232	253	18%	9%
Average duration of paid leave	12.2	13.5	15.4	11%	14%
Care benefits					
Number of certificates	104,649	111,299	103,883	6%	-7%
Number of days	871,070	949,676	902,775	9%	-5%
Benefit amount (in EEK thousand)	212,274	287,795	318,444	36%	11%
Päeva keskmine tulu (kr)	244	303	353	24%	17%
Average duration of paid leave	8.3	8.5	8.7	2%	2%
Maternity benefits					
Number of certificates	12,982	13,229	12,456	2%	-6%
Number of days	1,676,152	1,742,868	1,676,535	4%	-4%
Benefit amount (in EEK thousand)	459,507	586,209	661,232	28%	13%
Average daily income (EEK)	274	336	394	23%	17%
Average duration of paid leave	129.1	131.7	134.6	2%	2%
Occupational accident benefits					
Number of certificates	6,472	6,173	4,191	-5%	-32%
Number of days	131,966	135,119	91,474	2%	-32%
Benefit amount (in EEK thousand)	32,748	38,898	32,343	19%	-17%
Average daily income (EEK)	248	288	354	16%	23%
Average duration of paid leave	20.4	21.9	21.8	7%	0%
Total benefits					
Number of certificates	632,531	601,651	426,006	-5%	-29%
Number of days*	8,888,700	9,182,077	7,379,379	3%	-20%
Benefit amount (in EEK thousand)	1,926,851	2,387,453	2,204,104	24%	-8%
Average daily income (EEK)	217	260	299	20%	15%
Average duration of paid leave	14.1	15.3	17.3	9%	13%

* In order to enable data comparisons, the table includes all leave days (incl. the days that are not subject to compensation by the EHIF from 1 July 2009).

The consequences of the legislative amendment that entered into force in the second half of 2009 are particularly noticeable in the comparison of the use of benefits for temporary incapacity for work by half-years.

Table 35. Comparison of expenses on temporary benefits for incapacity for work (half-years)

	2008 2nd half-year	2009 2nd half-year	2009/2008 2nd half-year
Sickness benefits			
Number of certificates	211,281	88,287	-58%
Number of days	3,058,993	1,628,473	-47%
Benefit amount (in EEK thousand)	700,723	335,063	-52%
Average daily income (EEK)	229	206	-10%
Average duration of paid leave	14.5	18.4	27%
Care benefits			
Number of certificates	42,766	36,620	-14%
Number of days	363,770	311,569	-14%
Benefit amount (in EEK thousand)	108,499	90,305	-17%
Average daily income (EEK)	298	290	-3%
Average duration of paid leave	8.5	8.5	0%
Maternity benefits			
Number of certificates	6,157	5,530	-10%
Number of days	804,453	764,703	-5%
Benefit amount (in EEK thousand)	257,310	286,981	12%
Average daily income (EEK)	320	375	17%
Average duration of paid leave	130.7	138.3	6%
Occupational accident benefits			
Number of certificates	2,979	1,894	-36%
Number of days	66,710	40,673	-39%
Benefit amount (in EEK thousand)	19,434	14,695	-24%
Average daily income (EEK)	291	361	24%
Average duration of paid leave	22.4	21.5	-4%
Total benefits			
Number of certificates	263,183	132,331	-50%
Number of days	4,293,926	2,745,418	-36%
Benefit amount (in EEK thousand)	1,085,966	727,044	-33%
Average daily income (EEK)	253	265	5%
Average duration of paid leave	16.3	20.7	27%

Based on a certificate from a foreign doctor, the EHIF also pays the benefit for temporary incapacity for work in the case of medical conditions developed abroad. Ca 1.7 million EEK were paid in 2009 on the basis of 378 certificates. Based on the reason for leave, the certificates can be divided in the following groups: sickness 75%, occupational accident 10%, caring for a child under 12 years of age 8%, injuries 5%, and pregnancy and maternity leave 2%. The majority of the certificates have been issued in Latvia (33%), Finland (20%), Bulgaria (11%), and Russia (8%).

Change in Average Daily Income

The average cost of benefit paid per day has a most direct influence on the expenditure on benefits for incapacity for work, as it is in correlation with the income subject to social tax. Any change in the income subject to social tax results in a change of the average cost of benefit per day. The budget of the Health Insurance Fund suffered extra stress in 2009 from the reduced revenue from social tax and increased average cost of a day of incapacity for work, because the benefit is calculated on the basis of wages and salaries in the previous year, and they increased by 20% in 2008.

Figure 23. Increase in the cost of the benefit for temporary incapacity for work per day, compared with the revenue from the health insurance part of social tax and change in gross wages[3]

Change in the Number of Days of Incapacity for Work

While the number of certificates of incapacity for work decreased by 23%, the number of days of incapacity for work per one insured person decreased by 12%. The difference between the use of incapacity certificates and the number of days were caused by an increase in the average duration of the leave period indicated on the certificates. The decrease in the issue of certificates was a result of reduced number of insured persons in employment and the legislative amendments that entered into force on 1 July 2009.

Table 36. Use of certificates and days of incapacity for work

	2007	2008	2009	Change 2008/2007	Change 2009/2008
Number of insured persons (average of the period)	1,283,356	1,285,177	1,278,911	0%	0%
Number of insured persons in employment (average of the period)	674,676	670,324	613,332	-1%	-9%
Percentage of insured persons in employment of all insured persons (%)	53%	52%	48%	-1%	-4%
Number of days of incapacity for work	8,888,700	9,182,077	7,379,379	3%	-20%
Number of days of incapacity for work per one insured person in employment	13.2	13.7	12.0	4%	-12%
Number of certificates of incapacity for work	632,531	601,651	426,006	-5%	-29%
Number certificates of incapacity for work per one insured person in employment	0.94	0.90	0.69	-4%	-23%

Sickness Benefits

Based on the certificates for sick leave, the reasons for leave are distributed as follows: illness 87%, domestic injury 10%, transfer to an easier job 2%, other causes (occupational disease, traffic injury, etc.) 1%. The number of days of paid sick leave decreased in 2009 by 26% and the number of certificates decreased by 35%. The downward trend is even more marked in comparison to only the second half-year of 2008 – the number of sick leave days decreased by 47% and the number of certificates for sick leave by 58%. At the same time, the average duration of sick leave has risen from 14 to 18 days, mainly as a result of the reduced use of the certificates for sick leave in the case of mild illnesses, following the change in the principles of compensation (see Figure 24).

3 Changes in gross wages in 2009 are based on the data of Statistics Estonia from Q3.

Figure 24. Number of acute infections of the upper respiratory tract, influenza[4] and the number of certificates for sick leave in 2009

Care Benefits

The increased birth rate of recent years has resulted in a higher number of days of incapacity for work under care benefits. With 98%, the overwhelming majority of certificates for care leave are certificates for nursing a child under 12 years of age, 1% are certificates for nursing a child under 3 years of age or a disabled child under 16 years of age, and 1% are certificates for nursing a family member who is ill. Compared with previous periods, the distribution of reasons for leave on the certificates for care leave has not significantly changed.

A continued increase in the use of certificates for care leave can be predicted. In addition, the average cost of a care leave day will increase as well, as the certificates for care leave are issued more often to parents with higher income. An analysis of the care benefit payments indicates that the male parent is indicated as the caregiver on almost 28% of the certificates for care leave and the average income used for the calculation of their care leave benefit is almost two times higher than the income of female caregivers. In comparison to 2008, the share of male caregivers has increased by 5%.

Maternity Benefits

The reduction of the maximum length of maternity leave resulted in the loss of the option of additional benefit for 14 calendar days on the basis of so-called 'follow-up certificates' of certificates for maternity leave, which were previously issued in the case of deliveries with complications or multiple births. A decrease in the use of the certificates for maternity leave and the days of maternity benefits could be noticed, partially due to the aforementioned reasons and partially due to a decrease in the number of women giving birth in 2009. The number of days of incapacity for work under maternity benefits decreased by 4% in 2009, while the average cost of one day has gone up by 17%. The certificates for maternity leave are the most expensive category of benefits, with an average amount paid to one person being around 55 thousand EEK. An analysis of payments by the age of the women indicates that the share of women over 30 years of age is 45%. The average cost of a maternity leave day of women over 30 years of age is ca 100 EEK higher than that of younger women. The average number of days of maternity leave for which maternity benefit is paid continues to increase, because the number of women taking the leave at the prescribed time[5] has grown.

Occupational Accident Benefits

The decrease in the number of occupational accidents in 2009 has resulted in a drop in the number of days of incapacity for work under occupational accident benefits and the number of certificates for leave due to occupational accident by 32%[6].

Looking at the structure of the certificates for sick leave due to occupational accidents, the reasons for leave are distributed as follows: occupational accidents 95%, complications arising from occupational accidents 3%, and traffic-related occupational injury 2%.

4 According to www.terviseamet.ee

5 The maternity leave is shortened if a woman takes the leave later than the term of 30 days before the estimated date of delivery as indicated by a physician.

6 According to the Labour Inspectorate, the number of occupational accidents decreased by 30%.

5. Other Cash Benefits

5.1. Dental Care Cash Benefits

In 2009, the costs of dental care benefits were 153.9 million EEK, which was nearly 40 million EEK less than in 2008.

This drop in expenditure was expected and was a result of legislative amendments that entered into force on 1 January 2009 – previously, all insured persons of at least 19 years of age could apply for the dental care benefit of 300 EEK, but from 2009, only insured persons over 63 years of age and persons eligible for a pension for incapacity for work or an old-age pension retained this right. The increased benefit of 450 EEK is still available to pregnant women, mothers of children under one year of age, and persons who have an increased need for dental care.

Table 37. Dental care benefits (in EEK thousand)

	2008 actual	2009 budget	2009 actual	Budget execution	% of change from 2008
Benefits for dentures	110,196	153,410	121,918	79%	11%
Dental care benefits	83,860	34,632	31,950	92%	-62%
Total	**194,056**	**188,042**	**153,868**	**82%**	**-21%**

The expenses on the benefits for dentures have increased in comparison to 2008 primarily because the right to the benefit of 4,000 EEK once in a period of three years was extended to persons receiving a pension for incapacity for work from 1 August 2008.

Nearly 78% of the persons who received benefits for dentures from the EHIF in 2009 applied for the benefit through a provider of denture services and the amount of the benefit was subtracted from the amount they had to pay for the service. In 22% of the cases, persons initially paid the full price of the service to the provider and submitted a subsequent application to the Health Insurance Fund.

Table 38. Number of cases of dental care benefits

	2008 actual	2009 budget	2009 actual	Budget execution	2009 actual/ 2008 actual
Benefits for dentures	44,658	49,682	47,073	95%	5%
Dental care benefits	283,482	90,016	107,653	120%	-62%
Total	**328,140**	**139,698**	**154,726**	**111%**	**-53%**

5.2. Supplementary Benefit for Pharmaceuticals

The supplementary benefit for pharmaceuticals is available to insured persons from 2003.

Table 39. Supplementary benefit for pharmaceuticals

	2008 actual	2009 budget	2009 actual	Budget execution	% of change from 2008
Amount of benefit (in EEK thousand)	7,622	6,857	6,754	98%	-11%
Number of persons receiving the benefit	1,936	2,698	1,830	68%	-5%
Average amount paid per person (EEK)	3,937	x	3,691	x	-6%

The actual amount of the supplementary benefit paid in 2009 was 2% lower than the budgeted amount for the reporting period. This can be explained by the increased level of purchase of pharmaceuticals subject to 100% reimbursement and the lower cost-sharing by insured persons in the case of such prescriptions.

The decrease in the number of patients could be caused by the fact that insured persons have started to use cheaper medicinal products and, as a result, their expenditure on pharmaceuticals per calendar year does not exceed the benefit eligibility threshold of 6,000 EEK.

6. Other Expenses on Health Insurance Benefits

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

Referral to Treatment in a Foreign Country

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

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

Table 40. Planned treatment abroad (in EEK thousand)

	2006 actual	2007 actual	2008 actual	2009 budget	2009 actual	Budget execution %	% of change from 2008
Planned treatment abroad	6,455	8,740	23,122	21,000	20,686	99%	-11%

The number of invoices received for the treatment or examination of persons in a foreign country was almost the same in 2009 as in 2008. 88 of the 104 treatment invoices concerned treatment or examination of an insured person and 16 invoices were associated with a search of a bone marrow donor for an insured person. The principal countries of destination for treatment and examination from 2006 to 2009 have been Finland, the Netherlands, Germany and Belgium.

Table 41. Number of cases of planned treatment and average cost of a treated case (EEK)

	2008 actual		2009 actual		% of change from 2008	
	Cases	ACTC	Cases	ACTC	Cases	ACTC
Planned treatment abroad	105	220,208	104	198,912	-1%	-10%

Over the years, the most expensive procedures have been transplantations, treatment of cardiac diseases and the field of orthopaedics. The number of examinations and tests conducted abroad is growing, which indicates that increasing attention is paid to the health of insured persons.

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

As Estonia is a member of the European Union, the Health Insurance Fund has the obligation to pay benefits for health services arising from the EU regulations coordinating social security systems.

Persons insured with the EHIF, while staying in another Member State, have the right to:
- the necessary health care when their stay in another Member State is temporary;
- all health care when they reside in another Member State.

The costs of this health care are covered by the Estonian Health Insurance Fund.

Persons insured in another EU Member State, while staying in Estonia, have the right to:
- the necessary health care when their stay here is temporary;
- all health care when they reside in Estonia.

The health care costs related to persons insured in other EU Member States are first reimbursed to health care providers by the EHIF, which then submits the invoices for payment to the competent authorities of the other EU Member States. The number and amounts of invoices submitted to Estonia and the number and amounts of our invoices to other Member States have increased over the years.

The benefit paid by the EHIF to other Member States for health services and subsidised pharmaceuticals received in another Member States by persons insured with the EHIF increased by 68% in 2009 in comparison to 2008. The increase of this expenditure is a sign of better awareness of the availability of the necessary health care during a temporary stay in another EU Member State and also an indication that people are travelling more than before. At the same time, the benefit for health services provided to persons who reside in another Member State as a result of work obligations has increased, because the number of persons sent into service abroad has grown.

Table 42 presents the expenses on benefits for health services provided in other Member States to persons insured with the EHIF and the cost of health services provided in Estonia to persons insured in other Member States.

Table 42. Expenses on health services on the basis of the Regulations of the Council of the EU (in thousand EEK)

	2006 actual	2007 actual	2008 actual	2009 budget	2009 actual	Budget execution %	% of change from 2008
Payments for health services provided in other Member States to persons insured with the EHIF	15,425	25,259	22,119	18,900	37,093	196%	68%
Payments for health services provided in Estonia to persons insured in other Member States	5,408	8,941	10,351	12,600	10,312	82%	0%
Total	20,833	34,200	32,470	31,500	47,405	150%	46%

The treatment costs of pensioners of other EU Member States who reside in Estonia and of the family members of persons employed in another EU Member State and residing in Estonia are reimbursed by the insuring country on the basis of the average cost of treatment. The implementing regulation of the EC specifies the rules for calculating the average cost of treatment (the average cost of treatment does not include the cost of benefits for incapacity for work). Estonia calculates the average cost of treatment for two age groups: 0-62 and from 63 years of age and has made such calculations for the period 2004-2008.

Table 43. Average cost of treatment in the age group 0-62, 2004-2008

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

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

Table 44. Average cost of treatment in the age group 63+, 2004-2008

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

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

6.2. Benefits for Medical Devices

The Health Insurance Fund has to pay benefits for medical devices to all insured persons whose need to use a medical device has been established by a physician on the basis of the terms and conditions of the List of Medical Devices. Consequently, the benefit for medical devices is another open commitment for the EHIF like the reimbursement of the cost of pharmaceuticals to insured persons. A total of 62.1 million EEK was paid in reimbursement of the cost of medical devices in the reporting period.

Table 45. Benefits for medical devices (in thousand EEK)

	2008 actual	2009 budget	2009 actual	Budget execution %	% of change from 2008
Primary prostheses and orthroses	12,647	14,637	14,861	102%	18%
Glucometer test strips	27,837	33,219	33,053	100%	19%
Stoma appliances	10,899	12,146	11,908	98%	9%
Insulin pumps	1,332	2,076	1,720	83%	29%
Other medical devices	707	3,760	600	16%	-15%
Total	**53,422**	**65,838**	**62,142**	**94%**	**16%**

In comparison to 2008, the cost of medical devices (except for 'other medical devices') was affected by the increase of VAT from 5% to 9%, which raised the reference prices of the devices. In addition, the number of recipients of the benefit increased by more than one fifth – 32,101 insured persons received the benefit in 2009.

The actual amount spent in 2009 on medical devices was slightly lower than the budgeted amount.

Orthoses and prostheses benefits were granted to 7,669 insured persons during the reporting period, which is 1,720 persons more than in 2008. The use of orthoses after injuries and surgeries has increased. The number of prostheses used after amputation has remained stable. The increase in the number of orthoses benefits is a result of better awareness of the available options among the insured persons and improving availability of orthoses in different regions.

Benefits for **glucometric test strips** were granted to 22,982 diabetic patients (i.e. one fifth more than in 2008). The increase in the number of recipients of the benefit indicates that diabetic patients are increasingly aware of the importance of self-testing for determination of correct treatment, which helps to prevent complications of the disease.

A specific number of test strips can be purchased by each patient in a six-month period depending on diagnosis or other factors that can affect the progression of the disease. The average cost per insured person was 1,438 EEK in 2009, which is 57 EEK less than in 2008. The decrease in the average cost is a result of the fact that the number of persons with a milder form of diabetes, enabling treatment with pills, has increased and they need less test strips than diabetic patients who require injections.

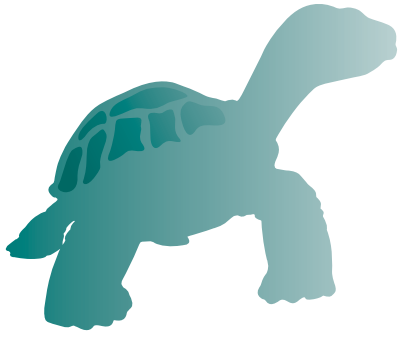
Benefits for **stoma appliances** were granted to 1,521 persons in the reporting period (1,498 persons in 2008), at an average cost of 7,829 EEK per person. The quantity of stoma appliances that can be purchased in a period of six months is restricted as well. The average level of appliances purchased has increased from 2008 by 8%, but it remains below the maximum limit. The maximum quantities can vary to a great degree between stoma patients. The maximum limits are established with consideration of the needs of socially active (studying, working) insured persons who need more appliances than an average user.

Benefits for **insulin pumps** and insulin pump accessories were granted to 66 insured persons in total in 2009. In addition to persons receiving continued treatment, the budget included funds for 10 additional patients. In reality, seven new diabetic patients under 19 years of age started treatment with insulin pump in 2009 and, consequently, all budgeted funds were not used.

The number of persons who needed **other medical devices** (intermediate containers for administration of asthma medication, disposable urinary catheters, pressure garments for burn patients and therapeutic contact lenses) was by one fifth lower than estimated. The majority of the 3 million EEK designated to cover an increase in demand for medical devices remained unused as well. The lower-than-expected use of medical devices was not caused by reduced availability but by decreased incidence of cases that required medical devices, which is a positive development.

6.3. Expenses Covered from Targeted Financing from the State Budget

The Health Insurance Fund received 18.3 million EEK from the state budget as funding for infertility treatment. The state assistance is designated to cover the cost of pharmaceuticals and services associated with infertility treatment.



EHIF Operating Expenses

Table 46. EHIF operating expenses

	2008 actual	2009 budget	2009 actual	Budget execution %	% of change from 2008
Total personnel and management expenses	72,543	74,508	69,970	94%	-4%
Wages and salaries	54,428	55,900	52,215	93%	-4%
incl. remuneration of the Management Board members	3,056	2,310	2,193	95%	-28%
remuneration of the Supervisory Board members	2	5	3	60%	50%
Unemployment insurance premium	154	161	533	331%	246%
Social tax	17,961	18,447	17,222	93%	-4%
Administrative expenses	20,110	22,315	20,314	91%	1%
IT expenses	10,283	13,515	9,995	74%	-3%
Development expenses	3,309	4,628	2,525	55%	-24%
incl. training	1,481	2,095	1,151	55%	-22%
consultations	1,828	2,533	1,374	54%	-25%
Financial expenses	132	160	322	201%	144%
Other operating expenses	9,952	5,839	3,927	67%	-61%
incl. supervision of the health insurance system	983	1,716	1,436	84%	46%
Public relations/communication	1,311	1,651	1,167	71%	-11%
Other expenses	7,658	2,472	1,324	54%	-83%
Total EHIF operating expenses	**116,329**	**120,965**	**107,053**	**88%**	**-8%**

Changes in revenue during 2009 created a need for critical review of the operating expenses of the EHIF during the year. Economical use of the budget resulted in a surplus of 12% in the budget of operating expenses at the end of the year.

Amendments in tax law (increased rates of the unemployment insurance premium and VAT) also affected the operating expenses of the Health Insurance Fund. Therefore, the budget of unemployment insurance expenses was exceeded and the administrative expenses and unemployment insurance premiums were higher than in 2008.

Financial expenses have increased, because the term of investments has changed to some extent.

The expenses on the supervision of the health insurance system have increased significantly in comparison to the previous accounting year. Supervision expenses include the expenses of clinical audits and the costs associated with verification of certifying documents (medical records, disease files, discount prescriptions, certificates for incapacity for work) required for health insurance benefits. For clinical audits, the Health Insurance Fund uses experts and the remuneration of experts increased, resulting in increased expenditure on supervision. More information on supervision is presented in the performance report (see page 18).

The expenditure on other costs remained lower than budgeted and the expenses have significantly decreased as a result of savings and changes in calculation principles. The category of other expenses includes the cost of doubtful receivables, social events and tax expenses on fringe benefits. Until 2008, other expenses also included the cost of prescription forms distributed by the EHIF.

Legal Reserve

The legal reserve is a reserve formed, pursuant to the Estonian Health Insurance Fund Act, of the budget funds of the EHIF for the reduction of risks arising from potential macro-economic changes. The legal reserve constitutes 6% of the budget.

As of 31 December 2009, the legal reserve of the EHIF amounted to 800.3 million EEK. The amount of the mandatory legal reserve in 2010 is 692.1 million EEK.

Risk Reserve

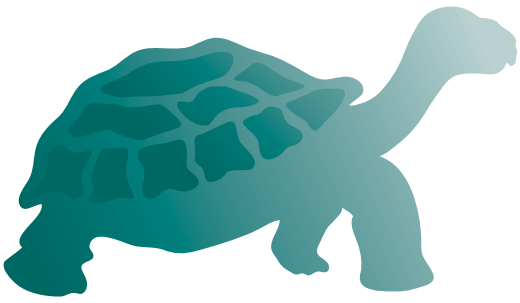
The risk reserve is a reserve formed of the budget funds of the EHIF for the reduction of risks arising from the obligations assumed for the health insurance system. The risk reserve constitutes 2% of the health insurance budget of the EHIF and its use is subject to a decision of the Supervisory Board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

In 2009, the Supervisory Board decided to take 58.8 million EEK from the risk reserve to cover the cost overrun of the budget. 50,829,000 EEK was used to cover the cost overrun of the benefits for temporary incapacity for work, caused by an increased wave of illness at the end of the year. 7,944,000 EEK was spent to cover the cost overrun of health care provided to Estonian insured persons in other EU Member States.

As of the end of the financial year, the risk reserve of the EHIF included 208 million EEK. The amount of the mandatory risk reserve in 2010 is 228.4 million EEK. In order to comply with this legal requirement, an additional 20.4 million EEK should be transferred to the risk reserve during 2010.

Retained Earnings

As of 31 December 2009, the Health Insurance Fund had 2.5 billion EEK in retained earnings.



Annual Financial Statements 2009

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 75 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 2010, 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	31.03.2010	
Member of Management Board Mari Mathiesen	31. 03. 2010	
Member of Management Board Kersti Reinsalu	31.03.2010	

Balance Sheet

Assets			
In EEK thousand	31.12.2008	31.12.2009	Note
Current assets			
Cash and cash equivalents	990,081	1,337,960	2
Bonds and other securities	2,145,095	1,424,337	3
Receivables and prepayments	1,563,622	1,137,392	4
Inventories	142	88	5
Total currents assets	4,698,940	3,899,777	
Non-current assets			
Long-term financial investments	323,389	371,859	6
Property, plant and equipment	11,819	9,153	7
Intangible assets	2,274	1,422	7
Total non-current assets	337,482	382,434	
Total assets	**5,036,422**	**4,282,211**	

Liabilities and equity			
Liabilities			
Current liabilities			
Loans and prepayments	871,814	754,049	9
Total current liabilities	871,814	754,049	
Total liabilities	871,814	754,049	
Equity			
Reserves	1,067,055	1,008,282	
Surplus for previous periods	2,536,975	3,156,326	
Surplus for financial year	560,578	-636,446	
Total equity	4,164,608	3,528,162	
Total liabilities and equity	**5,036,422**	**4,282,211**	

Statement of Financial Performance

In EEK thousand	2008	2009	Note
Revenue from the health insurance part of social tax and claims collected from other persons	12,516,573	11,248,417	10
Income from government grants	163,104	18,350	14
Expenses related to government grants	-163,104	-18,330	14
Expenditure on health insurance	-12,059,852	-11,940,927	11
Gross surplus	**456,721**	**-692,490**	
Administrative expenditure	-106,245	-102,804	12
Other operational revenue	54,342	57,966	
Other operational expenditure	-9,952	-3,927	
Operating surplus	394,866	-741,255	
Financial income and expenses			
Interest and financial income	165,844	105,131	
Financial expenses	-132	-322	
Total financial income and expenses	165,712	104,809	
Net surplus for the period	**560,578**	**-636,446**	

Cash Flow Statement

(in EEK thousand)	2008	2009
Cash flows from operating activities		
Social tax received	12,225,837	11,643,871
Payments to suppliers	-12,098,584	-12,108,926
Personnel expenses paid	-52,044	-53,452
Payroll expenses paid	-17,853	-18,145
Other revenue received	301,686	156,217
Net cash flows from operating activities	**359,042**	**-380,435**
Cash flows from investing activities		
Purchase of fixed assets	-8,316	-1,629
Proceeds from disposal of financial assets	2,940,177	3,705,496
Purchase of financial assets	-2,975,134	-2,975,553
Net cash flows from investing activities	**-43,273**	**728,314**
Net increase/(-) decrease in cash and cash equivalents	**315,769**	**347,879**
Cash and cash equivalents at the beginning of the period	674,312	990,081
Change in cash and cash equivalents	315,769	347,879
Cash and cash equivalents at the end of the period	990,081	1,337,960
incl. short-term deposits	983,284	1,235,233

Statement of Changes in Equity

(in EEK thousand)	2008	2009
Reserves		
Reserves at the beginning of the year	804,512	1,067,055
Increase/decrease of reserves	262,543	-58,773
Reserves at the end of the year	1,067,055	1,008,282
Net surplus for previous periods		
Net surplus at the beginning of the year	2,799,518	3,097,553
Increase/decrease of reserves	-262,543	58,773
Net surplus for financial year	560,578	-636,446
Net surplus at the end of the year	3,097,553	2,519,880
Equity at the beginning of the year	3,604,030	4,164,608
Equity at the end of the year	**4,164,608**	**3,528,162**

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 2009 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 2009 and ended on 31 December 2009. 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 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 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 provisjon 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 2009, 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	31.12.2008	31.12.2009
Deposits at call	6,797	7,982
Fixed term deposits	983,284	1,329,978
Total	990,081	1,337,960
Fixed term deposits:		
Due within 1 month	746,784	887,622
Due within 1 to 3 months	236,500	442,356
Total	**983,284**	**1,329,978**

Note 3. Bonds and other securities

	Risk reserve and earnings		Legal reserve	
In EEK thousand	31.12.2008	31.12.2009	31.12.2008	31.12.2009
Volume of fund at cost	2,004,311	1,049,406	107,541	370,136
Volume of fund at market value	2,034,231	1,050,231	110,864	374,106

In EEK thousand

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

Short-term investments are bonds maturing in 2010 and bonds acquired for the purpose of contributing to the risk reserve which in the opinion of the EHIF, shall probably be redeemed in 2010. The revenue and expenditure of the revaluation are reflected in the statement of revenue and expenditure.

Note 4. Receivables and prepayments

In EEK thousand	31.12.2008	31.12.2009
Trade receivables	13,354	12,046
Advance payment of wages	48	0
Claims for government grants*	5,874	851
Claims for reimbursement of maintenance costs	75	66
Contractual claims against insured persons	245	275
Allowance for doubtful receivables	-7	-6
Interest receivables	3,629	4,443
Social tax receivable	1,536,447	1,118,434
Prepaid expenses	3,957	1,283
Total	**1,563,622**	**1,137,392**

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

Social tax receivable in the amount of 1,118 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 31.12.2009, the EHIF has unused prescription forms worth 88 thousand kroons (as of 31.12.2008, 142 thousand kroons). Inventories belonging to the EHIF are deposited into storage with liability with other persons with balance sheet value of 45 thousand kroons (as of 31.12.2008, 51 thousand kroons).

Note 6. Long-term financial investments

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

In EEK thousand	31.12.2008	31.12.2009
Balance at the beginning of the year	90	90
Balance at the end of the year	90	90

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

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

Legal reserve		
In EEK thousand	31.12.2008	31.12.2009
Volume of fund at cost	303,319	347,451
Volume of fund at market value	316,639	356,701

In EEK thousand

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

6.3. Other long-term receivables

In EEK thousand	31.12.2008	31.12.2009
Long-term tax claim against the Tax and Customs Board	969	9,419
Long-term part of the amount paid to the Social Insurance Board for renovating the premises of the Pärnu Department and Rapla Office	5,691	5,649
Total	**6,660**	**15,068**

Note 7. Property, plant and equipment

7.1 Tangible assets

In EEK thousand			
Acquisition cost	Land and buildings	Other inventories	Total
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
Purchase of fixed assets	472	621	1,093
Written off	0	-8,274	-8,274
31.12.2009	6,009	23,076	29,085
Accumulated depreciation			
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
Calculated depreciation	292	3,467	3,759
Written off	0	-8,274	-8,274
31.12.2009	3,073	16,859	19,932
Residual value			
31.12.2007	1,860	5,731	7,591
31.12.2008	2,756	9,063	11,819
31.12.2009	2,936	6,217	9,153

7.2 Intangible assets

In EEK thousand	
Acquisition cost	Purchased licences
31.12.2007	6,304
Purchase of fixed assets	378
Written off	0
31.12.2008	6,682
Purchase of fixed assets	0
Written off	0
31.12.2009	6,682
Accumulated depreciation	
31.12.2007	3,555
Calculated depreciation	853
Written off	0
31.12.2008	4,408
Calculated depreciation	852
Written off	0
31.12.2009	5,260
Residual value	
31.12.2007	2,749
31.12.2008	2,274
31.12.2009	1,422

Note 8. Leased assets

Operating lease

The Statements of financial performance include operating lease payments in the amount of 6,109 thousand kroons from which 447 thousand kroons was paid for the lease of means of transport and 5,662 thousand kroons pursuant to commercial lease contracts of premises.

In 2008 the operating lease payments were 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 2010 the amount of operating lease payments is 2,250 thousand kroons.

Note 9. Loans and prepayments

9.1. Supplier payables

In EEK thousand	31.12.2008	31.12.2009
Accounts payable for medical care services	609,935	523,923
Accounts payable for medicinal products subject to discount	114,110	117,961
Supplier payables for health insurance benefits	79,368	56,947
Other supplier payables	3,623	2,680
Total	**807,036**	**701,511**

9.2. Tax liabilities

In EEK thousand	31.12.2008	31.12.2009
Individual income tax	47,609	32,360
Social tax	5,324	4,831
Income tax from fringe benefits	48	34
Unemployment insurance premium	87	367
Mandatory funded pension premium	98	20
VAT	94	47
Total	**53,260**	**37,659**

The individual income tax liability include individual income tax in the amount of 31,018 thousand kroons (as of 31.12.2008 – 46,145 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 889 thousand kroons (as of 31.12.2008 – 1,037 thousand kroons) calculated from the holiday pay not disbursed to the employees.

9.3. Other loans

In EEK thousand	31.12.2008	31.12.2009
Payables to employees	10,548	9,618
Other loans	928	934
Prepayments received	42	4,327
Total	**11,518**	**14,879**

Note 10. Revenue from operating activity

In EEK thousand	2008	2009
Revenue from the health insurance part of social tax	12,502,365	11,234,307
Amounts due from other persons	14,208	14,110
Total	**12,516,573**	**11,248,417**

Note 11. Expenditure on health insurance

In EEK thousand	2008	2009
Health service benefits, incl	8,089,373	8,049,487
Disease prevention	109,095	114,118
General medical care	1,047,224	1,056,204
Specialised medical care*	6,395,818	6,354,972
Nursing care	237,972	237,013
Dental care	299,264	287,180
Health promotion activities	13,970	13,150
Expenditure on benefits of medicinal products, incl	1,281,486	1,383,331
Pharmaceuticals reimbursed in special cases	146	118
Expenditure on benefits for temporary incapacity for work	2,387,453	2,204,104
Other monetary benefits	201,678	160,622
Other expenditure on health insurance benefits, incl**	85,892	130,233
Health service benefits arising from international agreements	32,470	68,091
Benefit for medical devices	53,422	62,142
Total	**12,059,852**	**11,940,927**

* 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 14) is included in the budget on the line of expenditure.
** The expenditure of 2009 differs from the expenditure on the budget implementation sheet as government grants from the state budget in amount 18,330 thausand kroons.

Note 12. Administrative expenditure

In EEK thousand	2008	2009
Personnel and administrative expenditure	72,543	69,970
Remuneration	54,428	52,215
incl. remuneration of the members of the Management Board	3,056	2,193
incl. remuneration of the members of the Supervisory Board	2	3
Unemployment insurance premium	154	533
Social tax	17,961	17,222
Management costs	20,110	20,314
Information technology costs	10,283	9,995
Development costs	3,309	2,525
Total	**106,245**	**102,804**

Remuneration of the members of the Management Board include performance pay in the amount of 308 thousand kroons (2008 – 554 thousand kroons), shall be paid in 2010, after a decision of the Supervisory Board.

Note 13. 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 12.

Note 14. Government grants

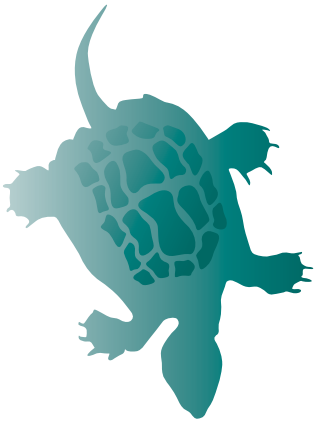
Government grants is made by the Ministry of Social Affairs pursuant to subsection 5 of § 35[1] of Artificial Insemination and Embryo Protection Act reimbursing the expenditure on the medicinal products in external in vitro fertilisation and paying to the insured person for the infertility treatment based on the agreements with the providers of the services.

In 2008, the Ministry of Social Affairs compansated for the depreciation of the building included in the reference price of health services in accordance with § 52 p 4 and p1.10 of the Health Services Organisation Act.

Expenses related to government grants

(in EEK thousand)	2008	2009
Reimbursing the expenditure on the medicinal products in external in vitro fertilisation	12,072	11,933
Reimbursement of the infertility treatment pursuant to health services	25,932	6,397
Depreciation costs of buildings of health care providers	125,100	0
Total	163,104	18,330

The revenues from targeted financing are 20 thousand kroons higher than the costs, since the revenues depict the cost of the land transferred by the Ministry of Social Affairs in Jõhvi in 2009.



Signatures to the Annual Report

The Management Board of the Estonian Health Insurance Fund has prepared the 2009 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 2009 Annual Report.

Name	Date	Signature
Chairman of Management Board Hannes Danilov	31.03.2010	
Member of Management Board Mari Mathiesen	31.03.2010	
Member of Management Board Kersti Reinsalu	31.03.2010	
Chairman of Supervisory Board Hanno Pevkur	16.04.2010	
Members of Supervisory Board		
Jürgen Ligi	16.04.2010	
Urmas Reinsalu	26.04.2010	
Jaak Aab	16.04.2010	
Ivi Normet	23.04.2010	
Lagle Suurorg	16.04.2010	
Aare Kitsing	16.04.2010	
Ulvi Tammer	16.04.2010	
Kaia Vask	16.04.2010	
Merle Smutov	16.04.2010	
Tõnis Allik	16.04.2010	
Tarmo Kriis	26.04.2010	
Jaan Pillesaar	16.04.2010	
Tiit Kuuli	23/04/2010	
Taavi Veskimägi	22.04.2010	

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Independent Auditors' Report

(Translation from Estonian)

To the Council of Eesti Haigekassa

We have audited the accompanying financial statements of Eesti Haigekassa, which comprise the balance sheet as at 31 December 2009, and the income statement, the statement of changes in equity and the statement of cash flows 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 misstatements, whether due to fraud or error; selecting and applying appropriate accounting policies; and making accounting estimates that are reasonable in the circumstances.

Auditors' 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 guidelines require that we comply with relevant ethical requirements and plan and perform the audit to obtain reasonable assurance whether the financial statements are free of material misstatement.

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

Opinion

In our opinion, the financial statements present fairly, in all material respects, the financial position of Eesti Haigekassa as at 31 December 2009, 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 2010

KPMG Baltics AS
Licence No 17
Narva mnt 5, Tallinn

/signature/

Andres Root

Authorized Public Accountant

www.haigekassa.ee