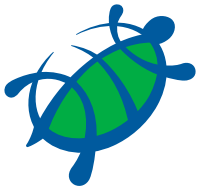
Estonian Health Insurance Fund Annual Report 2011



Estonian Health Insurance Fund

The symbol of the Estonian Health Insurance Fund is the turtle.
Why does the turtle symbolize the health insurance (The Estonian Health Insurance Fund)?

In many cultures the turtle represents the creation of the Earth, longevity and constancy to strive to the goals. Turtles are derided for their slowness but the health insurance itself is a conservative sphere. The progression is calculated and steady symbolizing our Health Insurance Fund and the reliability of the whole system. The shield is protecting the turtle against unexpected and unforeseeable dangers. The Estonian Health Insurance Fund wishes to offer to its insured persons the same protection.

Estonian Health Insurance Fund Annual Report 2011

Estonian
Health Insurance
Fund

Name	Estonian Health Insurance Fund
Registration number in the state register of central and local government agencies	74000091
Address	Lembitu 10, Tallinn 10114
Telephone	+372 620 8430
Fax	+372 620 8449
Email	info@haigekassa.ee
Website	www.haigekassa.ee
Beginning of financial year	1 January 2011
End of financial year	31 December 2011
Principal activity	Public Health Insurance
Management Board	Hannes Danilov (Chairman) Mari Mathiesen Kersti Reinsalu
Auditor	KPMG Baltics OÜ

Table of Contents

Hannes Danilov Chairman of the Management Board

Statement by the Chairman of the Management Board

The time has come once again to look back over the past year and evaluate the importance and results of various activities.

As in 2010, in 2011 prices for the payment for health services were reduced which, when coupled with rapidly growing inflation, caused additional stress. Despite economic difficulties, health service providers and medical staff were able to treat patients at the same levels and in the same numbers as in 2010. This was demonstrated by the satisfaction survey conducted in autumn 2011. People's satisfaction has not decreased, and trust in physicians and nurses has even increased. Perhaps the more economically difficult conditions help to strengthen people's solidarity. Last year we paid more attention to the development of day care and outpatient care and the improvement of their timely availability. We updated the DRG version[1] which is the basis for case-based financing, and this has made payments for day care more transparent. We also increased the amount of outpatient and day care purchased from partner organisations.

Although the amount of outpatient care increased, this did not help to shorten the waiting lists by much. A total of 14% of patients had to wait over two months to see a specialist, and this is definitely too long. The waiting lists could certainly be shortened by increasing the visit fee for a specialist, but this might incur the risk that less privileged people could not afford a visit at all. Waiting list lengths are also affected by the lack of certain specialist physicians and a rising demand due to an aging population. Hopefully the situation will improve in coming years with the implementation of electronic referrals and the national digital registration system.

2011 was also another year of selecting partners. As money is always limited, and needs exceed possibilities, prioritisation constantly causes problems and disappointment. However, we have not found any better method for increasing the availability of outpatient services and providing opportunities for new service providers.

As for the activities of the Health Insurance Fund itself, in my opinion the most important achievement was the completion of the projects involving digital prescriptions and clinical guidelines that had taken several years to implement. Both tasks have required a major effort from us and our partners. Using internationally approved methods for the development of clinical guidelines, we can compare all the new guidelines to those drafted in other countries. Digital prescriptions received the title of the best e-project in the Estonian 2011 Europe Summit Award, and the Finnish Quality Society declared our implementation of a digital prescription system the best innovation act in 2011. We have consistently developed the quality of management services in our organisation in order to fulfil the tasks and achieve the goals as efficiently as possible. In 2011 we participated in the management quality assessment competition organised by the Ministry of Finance, in which the Health Insurance Fund received the title of "Organisation with Excellent Management", together with the Tax and Customs Board and the Unemployment Insurance Fund.

In addition to the above, the previous year included many more activities, which were performed with the support of the employees and partners of the Health Insurance Fund.

I thank all employees and co-operation partners of the Health Insurance Fund for the comprehensive work that was done last year.

[1] DRG – (diagnoses related groups) is the system of case-based financing in which patients with similar clinical problems are assigned into groups with similar resource use.

Introduction

The main task of the Estonian health insurance system is to cover the health care expenses of insured persons for the prevention and treatment of diseases, while other resources of health insurance are used in order to finance the purchase of pharmaceuticals and medical devices and also to pay benefits to people who are temporarily incapacitated for work, need dental care etc.

The Estonian health insurance system follows the principle of equality: all insured persons will receive similar health care irrespective of whether or not they pay social tax or how much they might pay. There is no discrimination between old and young, poor or rich, sick or healthy people.

The Estonian Health Insurance Fund's mission is to ensure that health insurance benefits are available to everyone while maintaining the sustainability of the system.

The Estonian Health Insurance Fund's vision is to foster people's sense of security about their potential health problems and any treatment which they might need.

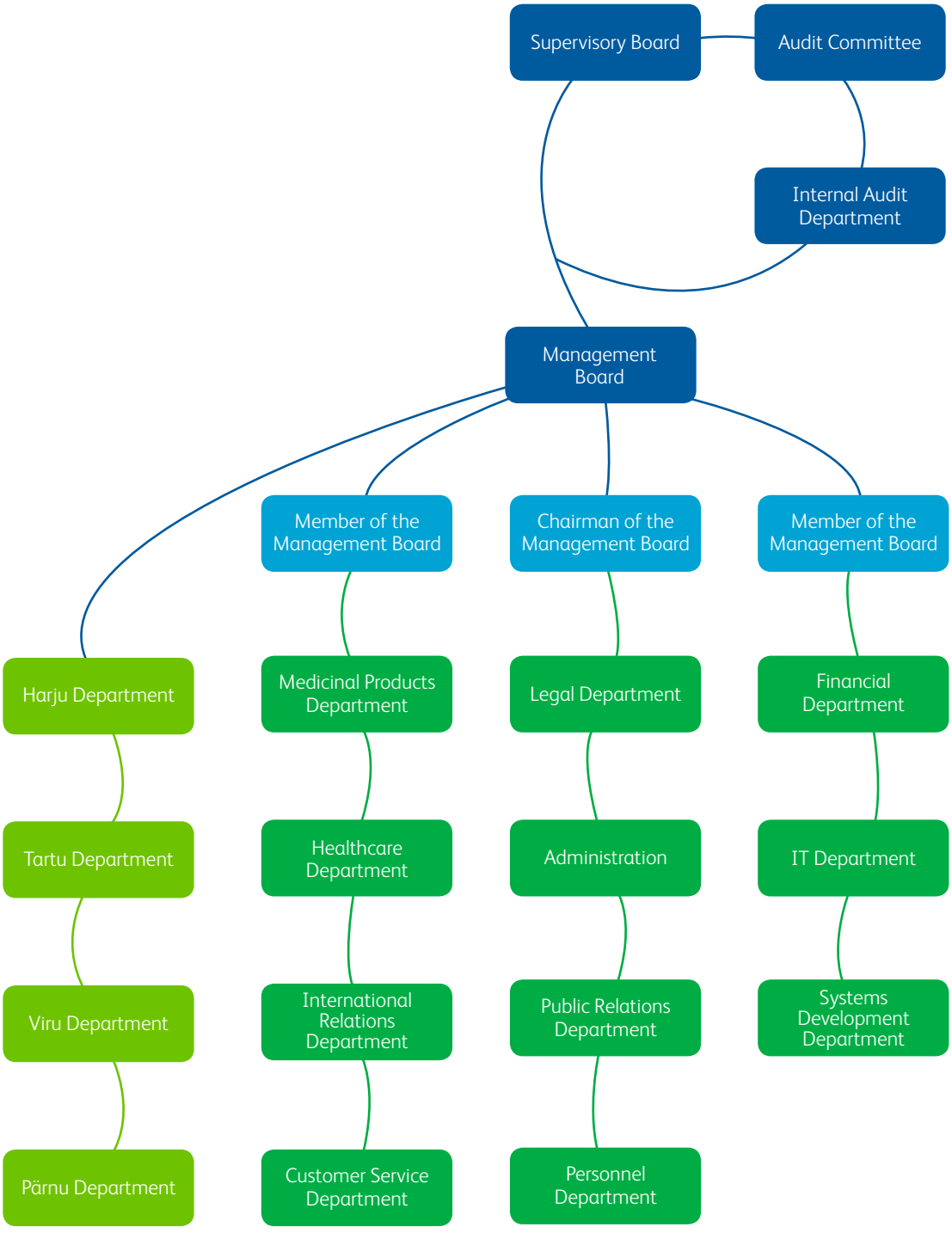
To fulfil its functions the Health Insurance Fund co-operates with partners and employers. Health Insurance Fund partners are hospitals, medical specialists, family physicians, dentists, pharmacies, professional societies, and associations such as health care providers, health promoters, the Ministry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

Organisation and Management

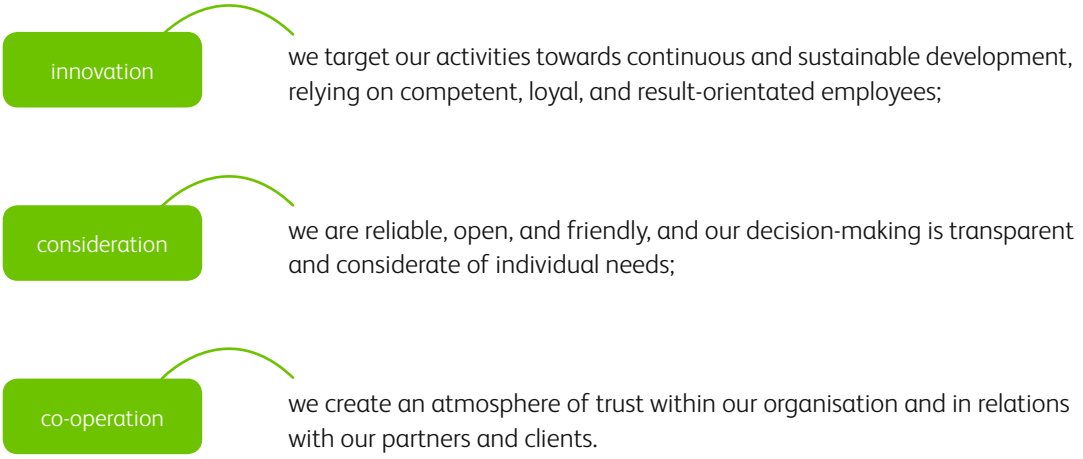
The Estonian Health Insurance Fund was created in 2001.
The highest body of the Health Insurance Fund is its Supervisory Board which consists of fifteen members. Five members are representatives of employers' organisations, five represent the interests of insured persons and the remaining five act on behalf of the state. The Minister of Social Affairs is the Chairman of the Supervisory Board. The Health Insurance Fund's directing body consists of a three-person Management Board. The Health Insurance Fund has an Audit Committee consisting of three members of the Health Insurance Fund's Supervisory Board, and members of the Audit Committee also represent different interest groups.

The Health Insurance Fund has twelve central departments which, in addition to their usual duties, are also involved in development work, and **four regional departments** – Harju, Pärnu, Tartu and Viru – which deal directly with clients, employers and partners (see Figure 1). As at 31 December 2011, the Health Insurance Fund had a staff of 213.

Figure 1. Structure of the Estonian Health Insurance Fund



Core values of the Health Insurance Fund



Estonian Health Care System

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

The pillars of the Estonian health care system are a contractual relationship between health care services providers and the Health Insurance Fund, independent of health care service providers in daily decision-making, and the organisation of the health care system around primary health care centres. The Health Insurance Fund plays no direct role in managing health care providers. Such split of health care providers and purchaser guarantees unbiased funding decisions, aimed above all at meeting insured persons' needs and ensuring the use of health insurance resources for designated purposes.

An overview of the key indicators of the Health Insurance Fund is provided in Table 1.

Table 1. Key indicators 2007–2011

	2007	2008	2009	2010	2011	% of change against 2010
Number of insured persons at year end	1,287,765	1,281,718	1,276,366	1,256,240	1,245,469	–1
Revenue (thousand EUR)	714,712	824,452	730,501	694,438	735,112	6
Health insurance expenditure (thousand EUR)	648,625	781,189	764,336	693,377	718,418	4
Health insurance fund (EHIF) operating expenses (thousand EUR)	6,080	7,435	6,842	6,888	7,080	3
Health insurance expenditure as a percentage of GDP (%)*	4.0	4.8	5.5	4.8	4.5	–0,3
Health service indicators						
Number of insured persons who used specialised health care	810,834	819,055	800,578	797,048	807,875	1
Average length of stay (days)	6.4	6.3	6.1	6.1	6.0	–2
Emergency care as a percentage of expenses for specialised care (%), including:						
outpatient care	18	17	17	18	18	0
day care	7	6	9	9	7	–2
inpatient care	63	63	67	67	64	–3
Average cost per case in specialised health care (EUR), including:						
outpatient care	35	43	44	43	45	5
day care	411	468	449	404	371	–8
inpatient care	871	1,008	1,011	982	1,008	3
Family physician consultations per 1,000 insured persons	3,889	4,039	3,895	3,831	4,228	10
Referral for treatment in a foreign country and benefits arising from EU legislation (thousand EUR)	2,744	3,554	4,352	3,810	8,210	115
Indicators of benefits for pharmaceuticals						
Number of reimbursed prescriptions issued	5,996,843	6,636,410	6,435,700	6,689,886	6,945,735	4
Number of insured persons who used reimbursed pharmaceuticals	830,594	840,847	829,748	822,440	841,533	2
Average cost per reimbursed prescription for EHIF (EUR)	11.95	12.33	13.74	13.56	13.17	–3
Average cost per reimbursed prescription per patient (EUR)	7.48	7.73	8.05	7.73	6.95	–10
Indicators of benefits for those receiving incapacity for work benefits						
Number of days on which incapacity for work benefits were paid by the Health Insurance Fund**	8,888,700	9,182,077	7,379,379	4,600,139	4,937,836	7
Cost per day of incapacity for work benefits (EUR)**	13.9	16.6	19.1	17.7	16.4	–7

* The indicators of 2007–2010 have been revised according to the GDP corrected by the Statistical Office.

** Comparative information for incapacity for work benefits paid in 2010 has been corrected.

Kersti Reinsalu Member of the Management Board

A Stable 2011

Euro-related themes were still vital at the beginning of 2011. The entire financial accounting system could only be electronically converted into euros after the completion of the 2010 report. Thanks to the Health Insurance Fund's system development and information technology department, and the company Intelsys who developed the euro project, this last task was completed successfully.

By the end of 2011 the major components of the Health Insurance Fund's information system were duplicated in two separate locations, essentially improving the management of the system and therefore increasing users' satisfaction levels. Unfortunately the same cannot be said for the prescription centre, where long breaks occurred during the year. This is one of the reasons why the Health Insurance Fund has decided **to accommodate the prescription centre into its infrastructure in 2013**. To enable this to happen, all preparations will be made in 2012 in order to ensure technical readiness for transferring the database.

A major achievement was the approval for the removal of coefficients established **for health services (the so-called crisis coefficient) by the Government**. This has been taken into account in forecasting Health Insurance Fund revenue and expenditure for four years, but it was finally fixed after the establishment of prices for 2012. After 2012 the official price list will be valid again. This change will give a little extra money to health care institutions in order to cover increasing expenses, especially expenses associated with medical staff salaries.

Almost two years ago, in April 2010, the Health Insurance Fund published its report on the sustainable funding of the Estonian health care system, with four recommendations for improving the financing policy of the system, which were: (1) to increase the public sector's revenue base; (2) to improve financial protection by curbing out-of-pocket payments; (3) to improve the performance of the health care system through better allocation of budget resources and strategic purchasing; and (4) to maintain the strong governance of the health care system. Upon completion of the report it was planned to revise the system after a certain period of time. Therefore a follow-up report entitled: **"Responding to the challenge of financial sustainability in Estonia's health system: one year on"** was completed in 2011. This highlighted the positive changes which had taken place in the meantime, as well as referring to the delayed projects. One of the changes is the need to expand the revenue base. There are still many insured persons for whom tax is not paid: at the end of 2011 this percentage was 49%. This is causing a situation whereby the share allocated from the common resource base for all insured persons is constantly decreasing, compared to the growing demand. The follow-up report is available on the Health Insurance Fund's website: http://www.haigekassa.ee/uploads/userfiles/WHO_analuus_ENG.pdf.

For the Health Insurance Fund, the year 2011 went as planned both for revenue and expenditure. **Revenue was at 102% when compared to the plan**, while health insurance benefit expenses were 2% less than planned. Almost 13% less than planned was spent on incapacity for work benefits, while initially only 1% growth was planned in the budget. Due to such changes there was no need for earnings to be incorporated into the figures. However, the economic situation as a whole did not seem to improve much in 2012, and it is anticipated that these reserves will be in constant need in forthcoming years in order to cover the planned expenses. The Health Insurance Fund will make all efforts to take account of the increasing needs of insured persons, simultaneously fitting them within the limits of available resources.

Mari Mathiesen Member of the Management Board

Partnership: Skills to Learn, Experiences to Share

We know from classical literature that in order to stand still you have to run quickly. And if you wish to move on and develop, your efforts should be even greater. Twenty years after the re-foundation of the Health Insurance Fund we still feel that the health insurance system is not complete and there are parts of it which need active attention in order to improve.

Communication is essential in order that we can make conscious choices and ensure that we take the reasonable way forward. In 2011 we saw the end of the cycle of ***flagship* courses** started in co-operation with the Ministry of Social Affairs and WHO, which enabled us to learn from the leading health care organisers of the world and to exchange experiences with other countries. Senior officials and hospital managers of Estonia, Latvia, Lithuania, and Poland gathered as students three times for a week. In addition to theoretical studies, practical tasks were solved and experiences were shared, while a mutual understanding of the partners' way of thinking provided an added value.

At the same time we have gained teaching status: in 2011 an Estonian development co-operation project **which supports the development of Moldova's health insurance system** was approved. This joint project with the Moldovan Health Insurance Fund will last for over a year. During the project we will share experiences with our colleagues, study visits to Estonia will take place and our experts will provide advice in Moldova. We have introduced the concept of Estonian health insurance to representatives of other countries in the past, but for the first time we are now involved in a long-term and systematic development. We try to meet Moldovan expectations and aim to pass our best knowledge to the students.

The Health Insurance Fund has always considered a consistent development to be important and therefore in 2010 we launched assessment and updating of the Estonian system for the creation of clinical guidelines in co-operation with WHO. A major partner of the project was the Tartu University's faculty of medicine, and the resulting "Estonian Handbook for Guidelines Development" was introduced on 14 October 2011. The development project has now ended but we are continuing our activities on the basis of following updated principles, with the objective of creating an integral quality support system.

All this does not mean that we neglected our primary obligations in 2011. The task of the public health insurance is **to allow insured people to receive health insurance benefits**. We must consider and propose solutions for the use of available financial resources in the interests of people's health in the best way possible.

To enable better achievement of this goal, we discussed with family physicians the possibilities for further development of primary health care throughout the year. As a result of this co-operation the financing of primary health care will improve from 2012 onwards, making it also more differentiated. Those lists which include more elderly patients will receive a higher capitation fee. Distance fees have been increased in order to ensure better availability of health care in rural regions. The fee-for-service fund for examinations and tests has been increased for all family physicians and, additionally, a new and a larger fund for people needing examinations and tests has been created for family physicians, who have achieved good results with the performance pay system. The accounting principles for education expenses have been updated. All these innovations serve our goal, which is to ensure **high-quality primary health care** throughout Estonia.

From 2012 the health services list includes **thirty new health care services**, including several services and pharmaceuticals related to organ donation and the cancer council, whose aim is to improve the quality of treatment given to the patients. In addition to health care services and pharmaceuticals it is essential to ensure the availability of **medical devices**. Twenty-eight applications received positive approval in 2011 and as from the start of the new year more options are now available for insured people, eg the range of medical devices for better control of diabetes and prevention of the risk of complications have all increased. It is essential to develop the assessment of new health technologies in order to make well considered financing decisions.

The overview of health insurance benefits paid in 2011 is shown in the financial report below. Attention should also be paid to the pleasing improvement shown in the consistency of health care: the number of users of **reimubrsed pharmaceuticals** has increased, while people's payment for pharmaceuticals has decreased.

A major task continuing **in 2012** will be discussions about the implementation of the directive on the application of patients' rights in cross-border healthcare. The list of 50% reimbursed pharmaceuticals will be completed and questions relating to the treatment of orphan diseases should be resolved. The Health Insurance Fund's development plan includes several major tasks set for 2012 in order to achieve the goal of increasing insured persons' satisfaction with health care through the improvement of the system's efficiency. No result can be achieved alone – it requires the contribution of all our employees and the participation of all our partners.

Health Insurance Fund: 2011 Strategic Goals and their Attainment

Scorecard 2011

Objective	Weight %	Performance indicator	Unit	Comments	2010 perfor-mance	2011 objec-tive	2011 perfor-mance	Perfor-mance %
	6.0	The satisfaction of insured persons with the health system	%	The satisfaction of insured persons with the health system as determined in the course of a general survey conducted among insured persons	63	64	62	5.8
Ensure access to health services, pharmaceuticals and financial benefits	**28.5**							**27.6**
	7.5	Satisfaction with accessibility of health care	%	Part of the general survey	55	58	51	6.6
Ensure uniform access to health insurance benefits	7.5	The involvement of insured persons in activities leading to improved monitoring of the health status of chronic patients	%	The ratio of the number of insured persons involved against the total number of those insured	90	93	95	7.5
	7.5	Maximum waiting time for cataract surgery	time	Keep the maximum waiting time for cataract surgery at the same level as in 2010	1.5 years	1.5 years	1.5 years	7.5
	6.0	Maximum waiting time for endoprosthetic replacement	time	Keep the maximum waiting time for endoprosthetic replacement operations at the same level as in 2010	2.5 years	2.5 years	2.5 years	6.0
Develop the quality of health services in the health care system	**20.0**							**19.4**
	10.0	Satisfaction with the quality of health care	%	Part of the general survey	74	77	72	9.4
Improve assessment and quality control	5.0	Number of clinical audits	no.	Number of organised clinical audits	5	5	5	5.0
Develop feedback to partners and disclose results of quality improvement	5.0	Partners' satisfaction levels regarding co-operation with EHIF	%	Survey results	95	95	95	5.0

Objective	Weight %	Performance indicator	Unit	Comments	2010 performance	2011 objective	2011 performance	Performance %
Shape people's awareness and healthy behaviour	**20.0**							**18.9**
	7.0	Visibility of social campaigns	%	Determined in the course of a general survey conducted among insured persons	43	46	41	6.2
Increase people's awareness of the health system and health factors	6.0	The awareness of insured persons in regard to their own rights	%	% of the responding insured persons who knew their rights in the following fields rated as being at least "good": primary health care, specialised health care, incapacity for work benefits, reimbursed pharmaceuticals, health insurance coverage	74	77	76	5.9
Ensure implementation of health promotion and disease prevention projects as planned	7.0	Cancer screening coverage	%	Coverage is measured on the basis of the health insurance database, as a percentage of persons invited to the screening	breast cancer 66%; cervical cancer 62%	breast cancer 70%; cervical cancer 70%	breast cancer 65%; cervical cancer 73%	6.8
Ensure efficient use of health insurance resources and sustainable development of health insurance system	**15.0**							**12.5**
Increase the efficiency of using health insurance resources	15.0	Average cost per case	%	Structural increase percentage of the average cost of a case of inpatient specialised health care in comparison with the previous period	–0.1	2	2.4	12.5
Improve the organisation's operation	**10.5**							**10.2**
Improve the organisation's operation and develop the competency of Health Insurance Fund employees	10.5	The satisfaction of employees with the Health Insurance Fund's management and the organisation of its work	%	Percentage of satisfied employees – information derived from the results of the employees survey	93	93	90	10.2
Total	**100.0**							**94.4**

Goal Attainment in 2011

Objective	Performance indicator	Attainment of goals
	The satisfaction of insured persons with the health system	The Health Insurance Fund determines people's satisfaction levels on an annual basis with a satisfaction survey.
Ensure access to health services, pharmaceuticals and financial benefits		
	Satisfaction with accessibility to health care	People's satisfaction with the levels of accessibility to health care has decreased slightly when compared to the previous year. A total of 51% of respondents considered the availability of health care to be good or rather good in 2011 (55% in 2010).
Ensure uniform access to health insurance benefits	The involvement of insured persons in activities leading to improved monitoring of the health status of chronic patients	In 2011, 95% of family physicians joined the performance pay system (95% in the Harju region, 94% in the Tartu region, 94% in the Pärnu region and 96% in the Viru region).
	Maximum waiting time for cataract surgery	The waiting list for cataract surgery fits within the limits approved by the Supervisory Board of the EHIF (length of waiting time 1.5 years).
	Maximum waiting time for endoprosthetic replacement	The waiting list for endoprosthetic replacement fits within limits approved by the Supervisory Board of the EHIF (length of waiting time 2.5 years).
Develop the quality of health services in the health care system		
	Satisfaction with the quality of health care	People's satisfaction is assessed on an annual basis by means of a survey. A total of 72% of Estonians considered the quality of health care to be good or rather good in 2011.
Improve assessment and quality control	Number of clinical audits	Five clinical audits were organised in 2011: "Home Nursing Service", "Quality of Intensive Care Service", the post-audit entitled "An Assessment of the Vascular Surgery Services", "An Assessment of Orthodontics Services", and "An Assessment of Treatments for Prostate Cancer".
Develop feedback to partners and disclose results of quality improvement	The satisfaction levels of partners regarding co-operation with EHIF	The satisfaction levels of health care providers are measured once a year. In 2011, 95% of the partners considered that co-operation with EHIF was good or rather good.

Objective	Performance indicator	Attainment of goals
Shape people's awareness and healthy behaviour		
	Visibility of social campaigns	The campaign concerning the use of medical products, entitled "The difference is in the price of the medical product!", was continued in March and November. The average visibility of the campaign was 41% and 43% (target 46%) in the target group (40–59 years). Advertisements were most visible in outdoor media (50%), while every third respondent had noticed the information on TV (35%) or in a pharmacy (33%). According to the population survey the campaign has had its intended impact on almost half of the respondents: 27% have already started to choose cheaper products and 21% are planning to do so.
Increase people's awareness of the health system and health factors	Insured persons' awareness of their rights	The Health Insurance Fund's Health Information pages were published eight times in the following newspapers: Postimees, Eesti Päevaleht, Maaleht, Õhtuleht, Linnaleht, and Den za Dnjom. The pages covered the topics of cancer screening, the rational use of pharmaceuticals, the 1220 consultation phone number, and other actual health themes.
Ensure the implementation of health promotion and disease prevention projects as planned	Cancer screening coverage	The coverage of breast cancer screening for those women who were invited to screenings was 65.3% (the goal was set at 70%) and the coverage of cervical cancer screening for those women who were invited to screenings was 73% (the goal was set at 70%). Coverage did not include women who had already died (0.1%), uninsured women (9.6%), and women to whom it was not possible to send an invitation because their address was incomplete (0.9%).
Ensure efficient use of health insurance resources and the sustainable development of the health insurance system		
Increase the efficiency of using health insurance resources	Average cost per case	Structural increase of the average cost of a case in inpatient care compared to 2010 was 2.4% in 2011 (target up to 2%).
Improve the organisation's operation		
Improve the organisation's operation and develop the competency of Health Insurance Fund employees	The satisfaction of employees with the Health Insurance Fund's management and the organisation of its work	Satisfaction with the operation of EHIF's central and regional departments has been measured since 2002. The survey covered information, feedback, support, the consideration of proposals, the fulfilment of common tasks by different departments, problem solutions, and ensuring the smooth co-operation and motivation of the team. The satisfaction indicator derived from the results of the survey was at 90%, which was slightly lower than the result obtained in 2010 (93%), but which can still be considered good.

Shorter Waiting Lists: a Priority of the Health Insurance Fund

At the beginning of 2011 the Estonian Hospitals Association (EHA) submitted a proposal to the Health Insurance Fund's Supervisory Board to increase expenditures for the specialised health care in health insurance budget by 3.5 million euros, in order to improve the access to the health care services. EHA itself undertook to apply any measures necessary to ensure that hospital waiting lists would remain within the time limits set by the Health Insurance Fund's Supervisory Board.

The Health Insurance Fund's Supervisory Board specifies the maximum lengths of waiting times, providing the basis for Health Insurance Fund to set the objectives related to the access to health care. The objective is achieved if the maximum length of a permitted waiting time is not exceeded due to financial reasons and a low capacity in the medical institution (ie. lack of physicians or rooms, including operating theatres).

EHIF has analysed the access to of health services on the basis of waiting list data submitted by health care providers. If waiting time becomes longer than allowed, one of EHIF's regional departments will revise the accessibility to these services in the region and find the reasons why waiting times are too long. If necessary, queue data are checked in the medical institution and contract volume will be increased if it helps to improve access to care.

Compared to the beginning of the year, and in spite of additional funding, the access to care has not improved in 2011. The number of persons on the waiting list for outpatient, day, and inpatient care increased compared to the beginning of the year. The average waiting time increased by some days: in the case of outpatient services it is 25 days, in day care it is 43 days and in inpatient care it is 50 days.

Long waiting times are still major problems for people who need to see certain specialists. In outpatient specialities, most people are waiting for visits to gynaecologists and ophthalmologists. Longer waiting times have been noticed in specific outpatient surgical specialities, such as neurosurgery and face and jaw surgery, and also in the specialities of internal medicine – gastroenterology and endocrinology. As for inpatient specialities, the longest waiting times are for general surgery and otorhinolaryngology. Cardiac surgeons and physicians dealing with occupational diseases have the shortest waiting lists of all outpatient specialities, while in inpatient setting the waiting lists are shortest in the specialities of nephrology and internal medicine.

Access to health care is a Health Insurance Fund priority. At the same time it should be said that the shortening of waiting times no longer depends so much on finances as on the number of physicians and nurses available and the organisation of care provision in health care institutions.

Revising Capitation Payment Principles in Family Medicine

The basis for primary health care payment methods was set at the beginning of the primary health care reform in 1997, and no major changes have taken place in its objectives and structure. The system has been rather fine-tuned throughout the years. Since the beginning the main payment method in primary health care was a capitation supplemented by a basic allowance, the fee for service fund for diagnostic tests and procedures and some additional payments being paid upon the fulfilment of certain criteria.

Paying family physicians based on the capitation is the most common method used in most European countries. A pre-condition of the capitation payment is that the needs of persons in a certain group are similar and when they need health care, the family physician would want to provide the necessary care in an efficient and co-ordinated way. Such payment principles also ensure strong incentive to deal with prevention, because a healthy person visits a physician less frequently and needs fewer examinations. However, paying only based on capitation would put too high financial burden on a family physician and therefore, in Estonia as well as in most other countries, it is combined with other payment methods, such as fee-for-service and pay for performance.

After the family physician payment reform of 1998 the capitation fee was similar for all people, irrespective of their age. Age-adjustment was introduced after only one year, forming three groups of capitation fee (up to two years of age, two to seventy years of age and older than seventy years), in order to ensure fair consideration of different patient needs in various situations in which the age structure of patients can vary between different family physicians. This age-adjustment principle was used until the end of 2011. Meanwhile only the capitation fee amount was amended, as well as the mutual relationship of the capitation fee for different age groups.

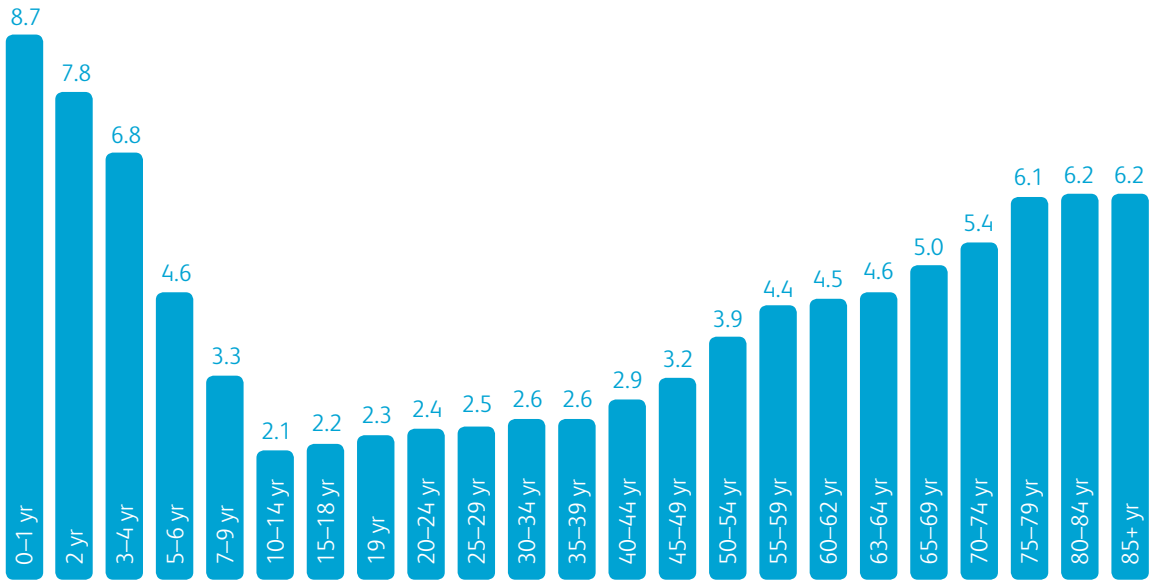
At the end of 2010 the Estonian Association of Family Physicians (EAFP) submitted a proposal to EHIF to increase the differentiation of capitation payments, because the role of family physicians had changed and they had assumed more responsibility for children's health check-ups as well as the prevention of chronic diseases and management of patients' care. The proposal was followed by more than six months of analyses and discussions, resulting in the agreement between EAFP and EHIF that the new capitation payment groups would be as follows: patients aged up to three years, three to seven years, seven to fifty years, fifty to seventy years and over seventy years.

The new system of age groups bases on average number of visits to the family physician and nurse by different age groups in a year. Figure 2 shows that family physicians and nurses are visited mainly by children and elderly people. Thus, for example, in the patient lists which include more people aged over fifty years the workload of physicians

and nurses is higher than in the patient lists which include younger adults. According to the former capitation payment system the capitation fee paid for the persons aged two to seventy years was the same, although pre-school children and people aged over fifty years visited family physicians much more than schoolchildren and adults aged under fifty. As a result of the refinement, those family physicians whose lists include more small children and/or elderly people, therefore bearing a higher workload, will receive more funds.

In conclusion it can be said that increasing the number of age groups in a capitation payment was an essential and major change, mainly brought about due to good co-operation with family physicians.

Figure 2. Visits per insured person per year



Ulla Raid Health Care Specialist of the Department of Health Care

New Level in Developing the Clinical Guidelines in Estonia

Clinical guidelines are generally accepted as an important tool for improving the quality of clinical care provided by health professionals, as well providing guidance to ensure the quality of health care services. Various organisations and professional associations in Estonia have been developing clinical guidelines since 2002 with the support of EHIF. The level of an evidence-based approach and the content of Estonian clinical guidelines has been very inconsistent. An international project set up to develop clinical guidelines was completed in 2011. This project began in 2010 with the goal of updating development principles in order to create clinical guidelines which would take account of the circumstances of a small country and would also meet best international practice in guideline development.

The World Health Organisation (WHO), EHIF, the Faculty of Medicine at Tartu University and various experts thoroughly assessed the Estonian situation in 2010 in order to harmonise the guidelines development principles to raise the level of evidence-based medicine. The main product of the project was the Estonian Handbook for Guideline Development. The new handbook describes the development and uniform principles of contemporary clinical guidelines which aim to unite Estonian experience with international best practice. The handbook explains various aspects of the guidelines, from assessment of the need for their development to their distribution, implementation and updating. During development and approval of these guidelines account shall also be taken of clinical evidence as well as local circumstances. Each nominated Panel and Secretariat member should complete and submit a declaration of interests. The manual was developed in close co-operation with WHO experts, and a guideline for management of hypertension on the primary care level was drafted in order to test its operability. In October the new principles were introduced to the public at open days held in the Faculty of Medicine at Tartu University.

A new broad-based Guideline Advisory Board (GAB) has been established with the intention of improving the quality of health services by supervising the development of efficient and evidence-based Estonian clinical guidelines, taking account of local circumstances. The GAB has twelve members, including representatives of nurses and patients. Members are appointed for to the GAB for a term of three years. Its Chairman is Professor Margus Lember, the Head of the Department of Internal Medicine of the Faculty of Medicine at Tartu University. The Committee's first task is to approve the clinical guideline "Treatment of an adult patient with hypertension on the primary health care" and to choose new topics for clinical guidelines.

The project provided feedback from medical staff, who considered that easy access to the guidelines was essential. Therefore a uniform and easily accessible web site www.ravijuhend.ee was created and will include anything related to clinical, patient and activity guidelines.

Clinical guidelines and related themes are also joined by the creation of a new logo, which is a picture of a compass. The idea behind the use of this image is that it points the way to health care workers in order to help them navigate a versatile landscape of clinical choices.

Quality of Provided Care is High in Estonia

Treatment options offered to patients in Estonia meet international standards. The population survey conducted in 2011 revealed that 72% of respondents considered the quality of health services to be good or rather good. Various indicators have been adopted in recent years in order to assess the quality of care, including invoicing data submitted to EHIF by providers. This enables us to describe the quality of health services of all service providers on a methodologically uniform basis. This measure meets the objective set in the development plan of EHIF – to support continuous improvement and harmonisation of the quality of health services.

Selection and description of quality indicators requires the consideration of international practices and co-operation with relevant professional associations. On the basis of the technical description of the indicator a query is submitted to the EHIF database and data from the registers of birth and/or death are linked, if necessary. The results are discussed with representatives of professional associations, using comparisons with international indicators if possible. The goal is to involve hospital managers more actively, so that they can use this information to help them make well-informed managerial decisions.

In 2011 quality indicators were used for assessing the treatment of both appendectomy and stroke patients in all hospitals which provided those services. In the case of appendectomy the average length of stay in the hospital was five days, more specifically in regional hospitals 95%, in central hospitals 89% and in general hospitals 92% of the patients met the five days criteria. This result meets the European hospital standard. 30-days rehospitalization rates after surgery were 16% in regional hospitals, 6% in central hospitals and 5% in general hospitals. Collection and analysis of data revealed that there are no agreed rules for coding complications by providers; therefore it is not possible to ascertain on the basis of invoicing data alone whether or not a treatment complication was the cause for a patient having to be re-admitted to hospital. The next task, in co-operation with surgeons, will be to improve the quality of coding.

The results for patients receiving treatment for strokes also demonstrated the high quality of provided care. For example, 94% of patients in regional hospitals, 97% of patients in central hospitals and 86% of patients in general hospitals with a stroke had been given computed tomography or magnetic resonance imaging. Early rehabilitation is extremely important for the recovery of stroke patients. In co-operation with neurologists it is now planned to focus on that part of the indicator which is related to rehabilitation, in order to be convinced that the quality of data is good and to develop proper rehabilitation standards for Estonian patients. The use of indicators for appendectomy and stroke for assessing the quality of care by EHIF has been relevant. Therefore it was decided to create an integrated system, bringing together the set of new indicators with new clinical guidelines. Here the first practice is the clinical guideline "Treatment of an adult patient with hypertension on the primary health care" developed in 2011, which includes indicators for the assessment of its implementation and the outcomes of that clinical guideline. Implementation of indicators is an additional method of assessment of the quality of health care which enables us to obtain valuable information with low cost.

Vaike Näripea Head of the Legal Department

Health Service Providers Selection on the Basis of Conditions Specified in Legal Acts

In 2011 the subject of the selection of health care providers for EHIF was much discussed in the public domain. It is quite normal for health service providers to show an active interest in this area, as partners are selected for a three-year period.

The efficient and practical use of health insurance funds ensures the availability of high-quality health care to insured persons which can be regulated through contracts concluded with the service providers. EHIF undertakes the obligation of payment for health care provided to the insured population, based on contracts. If no such contract has been concluded with the service provider, the insured person must pay for their own care.

The hospital network development plan was established on the basis of the Health Care Services Organisation Act in order to ensure the uniform availability of health care and the sustainability of hospital networks. The development plan lists the hospitals which EHIF has to prefer upon the conclusion of contracts following the national health care policy. With these hospitals the contracts will be concluded for at least five years. If those hospitals in the development plan are still unable to ensure the access to health care to the levels that have been estimated by EHIF, those services will be put out to tender amongst a selection of health care providers. Selection of providers is usually conducted after every three years. Selections are also made in the meantime, eg. if a service provider ceases to provide the service or if the actual need for the service exceeds that which was forecast.

The selection criteria are specified in the Health Insurance Act Section 36 (4). The Supervisory Board at EHIF has certified the bases for assessment of the criteria, taking account of the specialisations of specialties belonging to the selection.

The proposal to conclude a contract will be made to those service providers who are licensed to provide the relevant services in specified locations at the time when EHIF's Management Board makes the decision, and who have also achieved the best results during the assessment of the appropriate criteria.

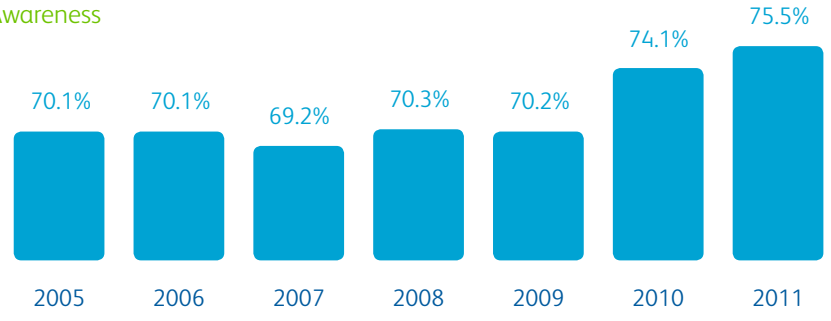
No country's social security system has enough funds to enable unlimited use of all the health care services offered to insured persons in the country where the health insurance provided by the Health Insurance Fund essentially belongs.

The Supreme Court has considered EHIF's selection criteria and declared them to be consistent with legal acts. The Court system has also assessed the selection principles made in 2011 and declared them to be appropriate.

People's Rising Awareness of their Rights

EHIF has constantly informed the Estonian people of their rights and obligations in the field of health insurance and people's awareness has improved slightly year by year. The survey, "Assessments of residents regarding health and health care in 2011", revealed that the public awareness of rights and obligations in the field of health insurance is higher than ever before: approximately 76% of respondents know their rights and obligations (see Figure 3). At the same time the level of awareness is rather inconsistent. Estonians are more aware of their rights in the field of health insurance than non-Estonians; residents of major cities are less aware than residents of small towns; men are less aware than women.

Figure 3. People's Awareness



The family physician system is best known

Awareness of the family physician system has always been the highest. This year, 97% of respondents knew that if they had a health problem they should first contact their family physician and 96% knew that everyone is entitled to choose another family physician.

People knew slightly less about how quickly they should be given an appointment to see their family physician. 85% of respondents knew that in the case of an acute illness the patient must see the family physician or nurse on the day of contacting the surgery.

The most uncertainty surrounds the family physician's visit fee – 67% of respondents knew that no visit fee is required if a person visits the family physician, but are less certain of the maximum fee payable for a home visit: only 58% of respondents to this year's survey knew that a family physician may ask a maximum of 3.2 euros for a home visit, regardless of how many people are examined during that visit. Last year, 70% of respondents knew the correct answer. Awareness has probably decreased because the currency has changed and people do not know the visit fee rates in euros; also home visits are not frequent.

Fees for specialized health care are well known, but less well known for dental care

Awareness of the fees payable for specialized health care has essentially increased in recent years. 83% of respondents knew that a medical specialist may ask a visit fee. 80% knew that a health care provider may charge an inpatient fee for hospitalization. Some years ago awareness of these facts was lower than 70%.

The majority of people (88%) knew that children under nineteen years of age are entitled to free dental care. 78% of respondents knew that pensioners are entitled to denture benefit. This awareness has been constantly stable. Dental care benefits are much less known. This year, 65% of respondents knew that dental care benefit is no longer paid to all population groups. Some years ago, when everybody could apply for dental care benefit, almost 80% of people were aware of this opportunity.

Awareness of sickness benefit has increased, while awareness of supplementary benefit for medicinal products has decreased

Awareness of the procedure for the payment of sickness benefits, which was enforced in 2009, has increased year by year. Results show that 67% of respondents knew that employers will pay sickness benefit from the fourth to the eighth day of an illness. Compared to 2009, this awareness has increased by 15%. In addition, 67% of respondents knew that all benefits for temporary incapacity to work are paid within thirty days. Also in this respect awareness has increased approximately by 15% compared to 2009.

Results also show that 74% of respondents knew that a pharmacist must offer patients the less costly medicine in the pharmacy. Awareness of this fact has increased compared to the previous year. Knowledge that a physician can prescribe medicines for six months remained at the same level as in the previous year (70%).

People are least aware of the idea of supplementary benefits for medicinal products. Only 48% of respondents knew that an insured person is entitled to apply for this supplement if he/she has paid at least 384 euros in a calendar year for reimbursed medicines. This is the only area in which awareness has constantly decreased. Therefore EHIF is planning to conduct a more thorough analysis of the problem in 2012 and will offer proposals for possible solutions. We also studied how much people knew about their obligation to carry a European health insurance card when travelling within the EU. Almost 80% of Estonian people knew this; however, people knew much less that the European health insurance card does not guarantee free health care – a patient must pay the co-payment (visit fee, inpatient fee, etc) according to the tariffs of the country in which they are travelling. Slightly more than half of the respondents knew that fact. At the same time, awareness of both subjects is growing.

What information, which channel?

We also researched to find out whether or not people would like to have more information about topics related to the Health Insurance Fund. The main topics mentioned were rights of the insured, visit fees, medicines, health services at home and abroad and aspects related to the payment of sickness benefits. Last year, additional information was mainly requested about the budget and activities of EHIF.

Two-third of respondents would like to receive such information via the internet. In addition to the internet, other suitable channels suggested for disseminating information are family physician centers and other medical institutions (37%), television (35%), and periodicals (30%). People's preferences for such channels have remained the same throughout the years; the number of people wishing to receive information from the internet and physicians is constantly growing.

Education will continue

EHIF considers it essential to constantly raise the awareness of Estonian people about their health-related rights and obligations. At the same time we try to unify the level of awareness of various population groups. Thus we actively continue to inform Estonian people of their rights and obligations as well as to tell them about the health insurance system and various opportunities through suitable channels. We are paying more attention to informing "less aware" members of the population, especially about those areas where information is requested more often, while at the same time not forgetting other major topics. We base our activities on the assumption that raising the awareness of our target groups will increase their levels of satisfaction, not only with the health care system but also with the availability and quality of services.

2011 Budget Execution Report

An overview of EHIF's revenue and expenditure is provided in Table 2 and the number of insured persons in Table 3.

Table 2. Budget (in thousands of euros)

	2010 actual	2011 budget	2011 actual	Budget execution %	% of change from 2010
EHIF REVENUE					
Revenue from the health insurance part of social tax	685,882	711,222	725,580	102.0	5.8
Revenue from contracts for persons considered equal to insured persons	3,152	3,068	3,040	99.1	–3.6
Amounts due from other persons	706	639	890	139.3	26.1
Financial income	2,446	3,004	2,760	91.9	12.8
Other revenue received	2,252	2,167	2,842	131.1	26.2
TOTAL BUDGET REVENUE	**694,438**	**720,100**	**735,112**	**102.1**	**5.9**
EXPENDITURE ON HEALTH INSURANCE BENEFITS					
Health service expenses	500,952	523,349	522,525	99.8	4.3
Disease prevention	6,938	7,081	6,528	92.2	–5.9
Primary health care	64,507	68,357	66,108	96.7	2.4
Specialised health care	397,450	414,528	417,017	100.6	4.9
Nursing care	14,255	15,115	14,816	98.0	3.9
Dental care	17,802	18,268	18,056	98.8	1.4
Health promotion expenses	**786**	**831**	**806**	**97.0**	**2.5**
Expenses for pharmaceuticals reimbursed to insured persons	**90,737**	**97,440**	**91,465**	**93.9**	**0.8**
Expenses for benefits for temporary incapacity to work	**81,436**	**93,008**	**80,770**	**86.8**	**–0.8**
Expenses for other cash benefits	**8,964**	**9,838**	**8,295**	**84.3**	**–7.4**
Other expenses	**10,502**	**11,847**	**14,557**	**122.9**	**38.6**
Expenses covered by targeted financing from the state budget	1,136	1,336	1,461	109.4	28.6
Other expenses on health insurance benefits	9,366	10,511	13,096	124.6	39.8
Total expenditure on health insurance benefits	**693,377**	**736,313**	**718,418**	**97.6**	**3.6**

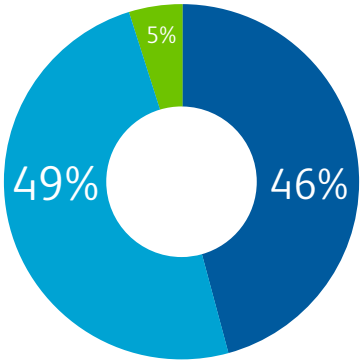
	2010 actual	2011 budget	2011 actual	Budget execution %	% of change from 2010
EHIF OPERATING EXPENSES					
Personnel and administrative expenditure	**4,343**	**4,535**	**4,380**	**96.6**	**0.9**
Wages and salaries	3,235	3,376	3,262	96.6	0.8
including remuneration of the members of the Management Board	133	138	139	100.7	4.5
Unemployment insurance premium	43	45	44	97.8	2.3
Social tax	1,065	1,114	1,074	96.4	0.8
Administrative expenses	**1,052**	**1,081**	**1,011**	**93.5**	**–3.9**
Information technology expenses	**653**	**890**	**834**	**93.7**	**27.7**
Development expenses	**128**	**175**	**159**	**90.9**	**24.2**
Training	64	95	76	80.0	18.8
Consultations	64	80	83	103.8	29.7
Financial expenses	**91**	**96**	**87**	**90.6**	**–4.4**
Other operating expenses	**621**	**664**	**609**	**91.7**	**–1.9**
Supervision over the health insurance system	92	102	53	52.0	–42.4
Public relations / communications	48	72	68	94.4	41.7
Other expenses	481	490	488	99.6	1.4
Total EHIF operating expenditure	**6,888**	**7,441**	**7,080**	**95.1**	**2.8**
TOTAL BUDGET EXPENDITURE	**700,265**	**743,754**	**725,498**	**97.5**	**3.6**
Earnings of budget year	–5,827	–23,654	9,614	–	–
RESERVE					
Change in legal reserve	0	0	0	–	–
Change in risk reserve	1,432	0	0	–	–
Change in retained earnings	–7,259	–23,654	9,614	–	–
Total changes in reserves	–5,827	–23,654	9,614	–	–

Table 3. Number of insured persons

	31.12.2009	31.12.2010	31.12.2011	% of change from 2010	Changes from 31.12.2011 to 31.12.2010 (persons)
Persons considered as equal to incurred persons	599,966	609,467	608,708	0	–759
Employed insured persons	587,254	565,933	568,434	0	2,501
Other insured persons	89,146	80,840	68,327	–15	–12,513
Persons insured by the state	85,387	77,038	65,463	–15	–11,575
Persons insured under international agreements	3,537	3,586	2,600	–27	–986
Persons considered to be equal to insured persons under voluntary agreement	222	216	264	22	48
Total	**1,276,366**	**1,256,240**	**1,245,469**	**–1**	**–10,771**

The share of insured persons from the total number of insured persons and the contribution of insured persons to the payment of the health insurance part of the social tax are shown in Figure 4.

Figure 4. Shares of insured persons among the total number of insured persons and their social tax contributions



- **Employed insured persons**
  - Share of all insured persons 46%
  - Paid social tax per insured person 1,200 euros
- **Persons considered as equal to insured persons**
  - Share of all insured persons 49%
  - Paid social tax per insured person 0 euros
- **Other insured persons**
  - Share of all insured persons 5%
  - Paid social tax per insured person 687 euros

The socio-economic changes are also reflected in the structure of health insurance: the number of employed insured persons has increased due to rising employment, and the number of persons insured by the state has decreased. Also the number of persons insured under international agreements has decreased, because since autumn 2011 Russian army pensioners are entitled to apply for an Estonian retirement pension. Therefore, in future, these persons will be reflected in the statistics of persons insured by the state.

The slight decrease in the total number of insured persons was caused by the addition of long-term unemployed people whose insurance cover was interrupted, and by a continuous increase in the number of people who left the country. An overview of average expenses per insured person by age groups is provided in Table 4.

Table 4. Average expenses per each insured person in 2011

Age of insured persons	Number of insured persons as of 31.12.2011	Expenses on primary health care EUR	Expenses on specialised health care EUR	Expenses on pharmaceuticals EUR	Total expenses EUR
0–9	147,761	60	228	34	322
10–19	131,526	49	217	23	289
20–29	165,544	49	225	34	308
30–39	159,979	51	255	44	350
40–49	157,476	56	267	56	379
50–59	166,549	54	394	94	542
60–69	139,423	55	577	151	783
70–79	116,180	53	743	182	978
80–89	55,073	47	756	153	956
90–99	5,812	47	673	90	810
100–109	146	47	472	35	554

Revenue

An overview of EHIF revenue in 2011 is provided in Table 5.

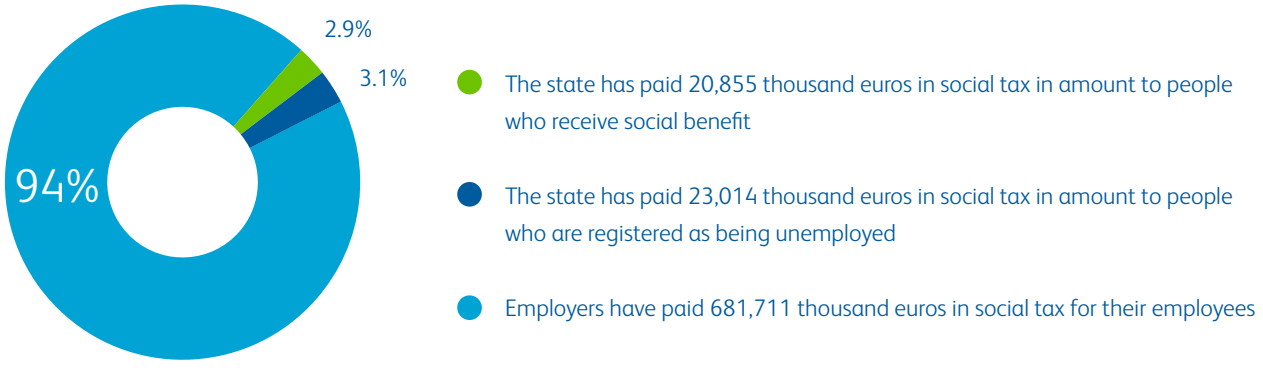
Table 5. Revenue (in thousands of euros)

	2010 actual	2011 budget	2011 actual	Budget execution %	% of change from 2010
Revenue from the health insurance part of social tax	685,882	711,222	725,580	102	6
Revenue from contracts for persons considered equal to insured persons	3,152	3,068	3,040	99	–4
Amounts due from other persons	706	639	890	139	26
Financial income	2,446	3,004	2,760	92	13
Other revenue received	2,252	2,167	2,842	131	26
revenue from targeted financing	1,182	1,336	1,542	115	30
other revenue	1,070	831	1,300	156	21
Total	**694,438**	**720,100**	**735,112**	**102**	**6**

Share of social tax designated for health insurance

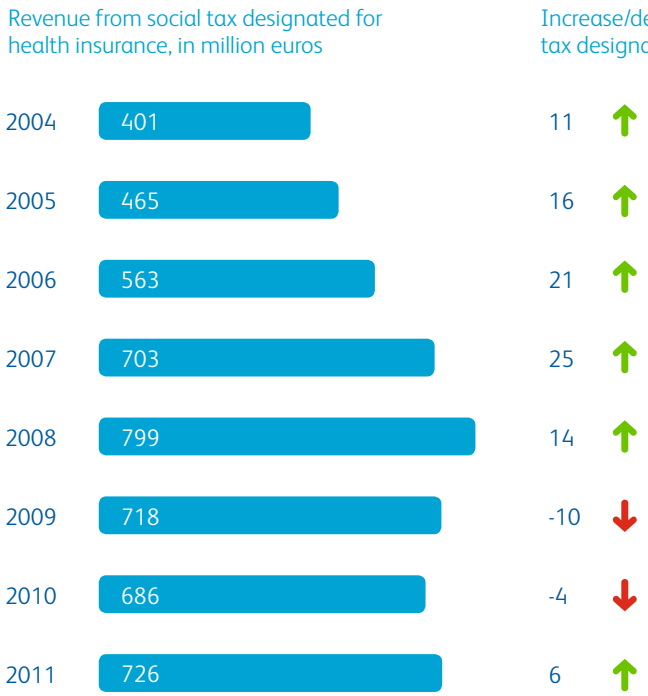
The revenue from social tax was 725.6 million euros, which essentially exceeds the revenue of 2010 and also the planned budget of 2011 (execution of the budget was 102%). 94% of social tax is paid by employers and 6% by the state for those who are unemployed and who receive social benefits (see Figure 5).

Figure 5. Share in the payment of social tax



An overview of the revenue from social tax designated for health insurance, and the increase/decrease of income is provided in Figure 6.

Figure 6. Revenue from social tax designated for health insurance and increase and decrease of income in 2004–2011



The revenue from contracts for persons considered equal to insured persons amounted to 3 million euros, including the revenue from voluntary contracts in the amount of 0.3 million euros, while revenue from the insurance of retired pensioners from the Russian Federation armed forces amounted to 2.7 million euros.

Amounts due from other persons were approximately one million euros. These include the claims submitted to health service providers, pharmacies, insured persons and employers as a result of various revisions.

Financial income for the financial year was at 2.8 million euros. Income was earned from reserves and the investment of free cash, and from the sale of shares in AS Viimsi Haigla.

Income from reserves and the investment of free cash reached 2.7 million euros. Until the end of 2011 EHIF's financial resources were managed by the Ministry of Finance, adhering to established investment restrictions and benchmark portfolios upon the allocation of funds. From 2012 EHIF's funds (legal reserve, risk reserve, retained earnings and available funds) are held within the State Treasury's group account. EHIF will earn interest from the residue of the funds held on the accounts within the State Treasury's group account on the basis of a deposit contract concluded with the Ministry of Finance, which amount is equal to the profitability of the national cash reserve. An overview of the investments made in 2011 is provided in Table 6.

Income from the sale of shares in AS Viimsi Haigla reached 106,109 euros. The Estonian Health Insurance Fund sold at auction its 900 shares in AS Viimsi Haigla to AS Fertilitas (of this, the holding by the Estonian Health Insurance Fund accounted for 10.1534% of AS Viimsi Haigla's share capital).

Table 6. Investments by EHIF

	Investments in risk reserve and earnings		Investments in legal reserve	
	As of 31.12.2010	As of 28.12.2011	As of 31.12.2010	As of 28.12.2011
Volume of fund at acquisition cost (thousand EUR)	136,644	155,772	53,150	52,157
Volume of fund at market value (thousand EUR)	136,906	155,996	53,562	52,434
Realised gains from the beginning of the year (thousand EUR)	1,963	1,727	1,241	1,011
Revaluation gain (thousand EUR)	262	224	413	277
Profitability from the beginning of the year (on annual basis, %)	1.16	1.30	1.53	1.67
Average duration of investments in days (on annual basis)	0.19	0.10	1.18	0.76

Other revenue includes targeted financing, revenue from health services provided to the insured persons of EU member states in Estonia, and other income.

EHIF receives targeted financing from the state budget for payment for pharmaceuticals and health services on the basis of the Artificial Insemination and Embryo Protection Act.

Additionally, revenue was gained from targeted financing for transfer to euro in the sum of 32,594 euros, from the Ministry of Foreign Affairs in order to support the development of the health insurance system in Moldova in the sum of 25,339 euros and from the National Institute for Health Development for covering the expenses relating to the national cancer prevention strategy in the sum of 22,546 euros (see page 105).

Expenditure

Expenditure from the Health Insurance Fund is divided between insurance expenditure and operating expenditure.

Health Insurance Expenditure

1. Health Services

Table 7. Health service expenditure (in thousands of euros)

	2010 actual	2011 budget	2011 actual	Budget execution %	% of change from 2010
Disease prevention expenses	6,938	7,081	6,528	92	–6
Primary health care expenses	64,507	68,357	66,108	97	2
Specialised health care expenses	397,450	414,528	417,017	101	5
Nursing care expenses	14,255	15,115	14,816	98	4
Dental care expenses	17,802	18,268	18,056	99	1
Total	**500,952**	**523,349**	**522,525**	**100**	**4**

Budget funds for health services were used as planned in 2011 (see Table 7). Compared to 2010 this expenditure increased by 4% due to the funding of additional treatment cases[2] (TC) in order to improve access to health services, and the price reduction co-efficient applied to the reference price of the health service list increased from 0.94 in 2010 to 0.95 in 2011.

In the case of some health service expenses the use of the budget differed from the plans. While the expenditure was 1% higher for specialised health care, 8% of the planned funds for disease prevention remained unused. The following chapters explain expenditure by services and benefit types.

1.1. Disease Prevention

The objective of disease prevention is to detect a pre-disease condition as early as possible and to take measures to avoid illness. Disease prevention expenditure in 2011 was 6.5 million euros, which equates to 92% of the budget planned for the same period (see Table 8).

Table 8. Disease prevention (in thousands of euros)

	2010 actual	2011 budget	2011 actual	Budget execution %	% of change from 2010
School health	3,363	3,266	3,198	98	–5
Early detection of breast cancer	861	939	817	87	–5
Youth reproductive health project	805	830	833	100	3
Health examination of young athletes	487	539	550	102	13
Prenatal diagnostics for hereditary diseases	571	529	325	61	–43
Newborn hearing screening	279	285	257	90	–8
Early detection of cervical cancer	200	232	178	77	–11
Phenylketonuria and hypothyroidism screening	184	206	179	87	–3
Prevention of cardiac diseases in risk groups	122	199	149	75	22
Early detection of osteoporosis	66	56	42	75	–36
Total	**6,938**	**7,081**	**6,528**	**92**	**–6**

Compared to the same period in 2010, expenditure has decreased by 6% due to a lower need than planned for invasive diagnostics and a decrease in the number of births. Less funds than planned were also spent on breast and cervical cancer screening, the early detection of cardiac diseases and osteoporosis due either to lower need or participation in the screening, and these factors have been taken into account in the planning of the 2012 budget. An overview of the number of participants in disease prevention projects is given in Table 9.

[2] Treatment case – Invoice which reflects all examinations and services provided to each insured person within each individual case.

Table 9. Number of participants in disease prevention projects

	Actual number of participants 2010	Planned number of participants 2011	Actual number of participants 2011	Reaching of goals %
School health	158,091	156,671	155,476	99
Early detection of breast cancer	33,419	34,000	31,287	92
Youth reproductive health project	33,165	32,500	32,929	101
Health examination of young athletes	8,806	9,600	10,026	104
Pre-natal diagnostics for hereditary diseases	2,064	2,100	1,406	67
Newborn hearing screening	14,534	14,600	13,324	91
Early detection of cervical cancer	12,541	16,000	13,111	82
Phenylketonuria and hypothyroidism screening	15,648	16,600	14,459	87
Prevention of cardiac diseases in risk groups	3,429	5,200	3,943	76
Early detection of osteoporosis	1,114	1,300	947	73

School health services formed the majority of disease prevention expenses (49%). From 2011, state-funded schools for students with special educational needs caused by health conditions employ one full-time nurse for every 200 students; the total number of students in such schools is approximately 2,000. The information on preventive medical examinations of healthy students reveals that the main health problems in children of school age are: visual disorders (24%), posture problems (18%) and being overweight (9.7%). Service provision was assessed in twenty schools during the year in co-operation with the Estonian Nurses Union. A positive conclusion was that first aid training has been harmonised. In small schools in which the service is not provided on school premises, shortages were detected in the areas of health promotion and supervision of students. More attention should be paid to co-operation with dentists and family physicians in order to ensure more efficient and consistent monitoring of students' health and development.

One objective of the screening process for early detection of breast and cervical cancer was to increase participation rate. This objective was partially achieved – cervical cancer screening coverage increased. In January women were informed of the prevention measures against cervical cancer (by means of articles and posters), in May the Breast Cancer Week was held (utilising a poster and TV clips), and in autumn women were once more reminded of the need to participate in screening. In addition to providing information to the media, 104,710 postal invitations calling for women to attend breast and cervical cancer screenings were sent out in 2011. Over 80% of cytological cervical tests are performed during regular health examinations. Half of the patients invited to scree-nings preferred to visit their gynaecologist instead of having the screening performed by a midwife. According to initial information, 140 breast cancer and seven cervical cancer cases were detected in those women who had been screened during the year.

Counselling services for the development of the reproductive health of young people and the prevention of sexually transmitted diseases were used in 2011 by 25,725 people, 6% of whom were male (see Table 9). Approximately one fifth (22%) of young people were counselled for the first time in a youth centre this year. Sexually transmitted diseases were detected in 727 cases, including one case of HIV. A total of 237 young women of up to nineteen years of age visited the centres to receive counselling related to pregnancy and 63% of them decided to undergo an abortion.

Health examination for young athletes is targeted to young people between the ages of seven and nineteen who regularly participate in sports for at least five hours a week in addition to physical education lessons held in school. The need for examining the health of young athletes was 14% higher than in 2010 and the number of examined persons exceeded the rate of the previous year by 1,220. It was noted that 73% of the examined people played sport for over eight hours per week. The increased need was caused by actively advertising health examinations in sports clubs. The criteria for examining the health of young athletes were revised: it is important to provide this service to those young athletes with the highest need (sporting intensity, age, results of former examinations). In 2012 the age limit for examining the health of young athletes will be lifted to nine years, because all children have passed pre-school medical examinations at their family physicians at the age of seven. Sporting was banned for 28 young athletes examined in 2011, while in 927 it was recommended to adjust their training load.

Pre-natal diagnostics of hereditary diseases take account of the positive results of previous screenings. In 2011 the need for chromosome studies was lower and invasive procedures were needed in 1,112 cases, while in other cases the consultation of a geneticist was sufficient. A foetal chromosomal anomaly was detected in 58 cases (including Down syndrome in 23 cases).

The size of the target group for phenylketonuria and hypothyroidism screening and hearing screening of the newborns is related to the number of births. The screening enabled the detection of phenylketonuria in three and hypothyroidism in two cases. The speed of notification of test results is problematic: in half of the cases the diagnosis or the lack of it is confirmed after 21 days, which is a major factor worsening the disease prospect; 35 parents refused the test. Hearing screenings detected hearing disability in nine children born in 2011; the final diagnosis was also confirmed for five children born in 2010. Two children, whose disability was detected during the screening, received cochlear implants.

The project for the prevention of cardiovascular diseases supported screening conducted at primary level. County-wide counselling centres for the prevention of cardiac diseases, to which family physicians can send their patients with higher risk factors, are operating within the framework of the project, and also offer secondary prevention or post-disease counselling. Due to the latter aspect the volume of the project was increased, but implementation of secondary prevention took more time. Within the project, a service was needed for secondary prevention in 78 cases.

The project for early detection of osteoporosis is targeted towards patients of the risk group (mainly the patients receiving corticoid treatment). Due to the improved availability of biological treatments the number of persons receiving corticoid treatment has decreased and therefore so has the target group, and as a consequence expenses for the osteoporosis project have become smaller. During the project, osteoporosis or osteopenia was detected in 65% of the examined persons, of whom 27% had suffered a bone fracture. Osteoporosis treatment was prescribed to 250 patients.

1.2. Primary Health Care

Expenditure on primary health care has increased compared to 2010 mainly due to the replacement of the price co-efficient 0.94 with the co-efficient 0.97.

The structure of expenditure on primary health care remained the same compared to the previous period: capitation fees constituted the largest portion (67%), the fee for service fund for examinations and tests accounted for 19% and basic allowance for 11% (see Table 10). Expenditure of the fee for service fund in capitation fees was 29%.

Table 10. Health services of primary health care (in thousands of euros)

	2010 actual	2011 budget	2011 actual	Budget execution %	% of change from 2010
Basic allowance	7,152	7,408	7,375	100	3
Distance allowance	303	337	329	98	9
Capitation fee on insured persons of up to 2 years of age	2,233	2,304	2,275	99	2
Capitation fee on insured persons aged 2–70	34,458	35,648	34,966	98	1
Capitation fee on insured persons over 70	6,650	6,840	6,984	102	5
Fee for service fund	12,150	13,886	12,787	92	5
Family physician performance pay*	992	1,190	813	68	–18
General practitioners' advisory line	569	615	579	94	2
Primary health care reserve**	0	129	0	–	–
Total	**64,507**	**68,357**	**66,108**	**97**	**2**

* Performance pay is budgeted for and paid on the basis of the results of the preceding calendar year(s) as a single payment in the third quarter.
** Funds for monitoring pregnancies and for conducting autopsies are budgeted for under the primary health care reserve, but any relevant expenses are shown under "Fee-for-service fund".

In 2011 there were 802 practice lists of family physicians in Estonia (see Table 11). A basic allowance at a co-efficient of 1.5 was paid to 54 family physicians which provided services at several locations.

Compared to 2010, the expenditure of the fee for service fund increased by 5%. For the first time family physicians received payment for services which exceeded the sum allocated for the fee for service fund which had been specified for the calendar year at a price co-efficient of 0.3, which in total is an amount of 16,000 euros.

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

	2010 actual	2011 actual	% of change from 2010
Number of practice lists	803	802	0
Average practice list (number of insured persons)	1,583	1,566	–1
Below normative (< 1,200 persons)	63	70	11
Lists exceeding the normative (> 2,000 persons)	188	189	1
including especially large lists (> 2,300 persons)	48	47	–2
Number of lists receiving distance allowance	187	198	6
Number of persons			
Number of persons aged up to 2 years for whom capitation fee was paid	28,900	28,537	–1
Number of persons aged 2–70 for whom capitation fee was paid	1,071,678	1,054,023	–2
Number of persons aged over 70 for whom capitation fee was paid	170,504	173,411	2
Total number of persons for whom capitation fee was paid	**1,271,082**	**1,255,971**	**–1**

The total number of lists has decreased by one list and the number of insured persons on the lists by 1%. The number of persons aged from ought to two and two to seventy has decreased, while the number of those over seventy is continuously increasing.

There were fifteen small practice lists with the service area of less than 1,200 permanent residents, which received additional capitation fees for total of 1,200 insured persons.

Of the budgeted amounts designated for the primary health care reserve, 13,000 euros was spent on monitoring normal pregnancies and 32,000 euros on conducting autopsies.

The number of family physicians participating in the performance pay system has constantly increased since 2007 (see Table 12). In 2011, 95% of family physicians participated in the performance pay system (90% in 2010). The insured persons on the practice lists of family physicians who participate in the performance pay system are better covered by preventive activities and systematic monitoring of chronic illnesses.

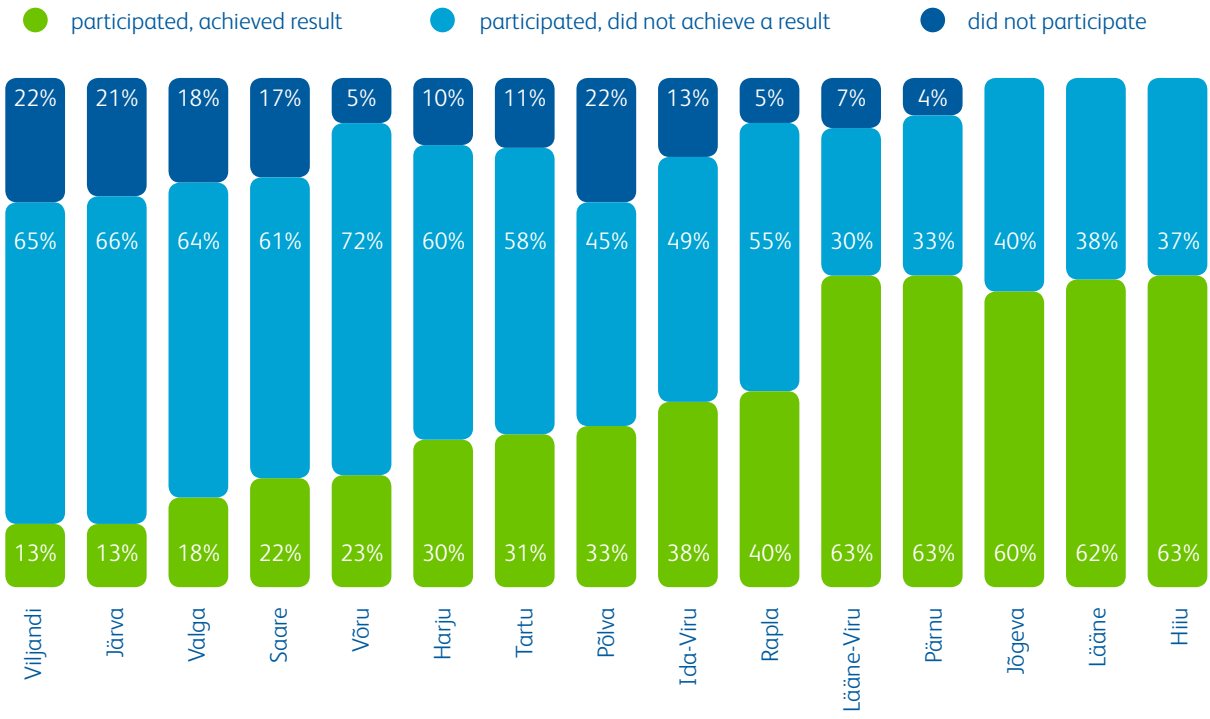
The results of family physicians who participate in the performance pay system are revised annually. Thus the expenses of 2011 reflect the pay results for 2010.

Table 12. Participation of family in the performance pay system 2009–2010 and results

	2009	2010
Number of family physicians who applied for performance pay	678	718
Number of family physicians who received performance pay for preventive activities and monitoring of chronic illnesses	355	282
including with co-efficient of 1.0	231	182
with co-efficient of 0.8	124	100
Performance pay for professional competency (valid certification, performing of gynaecological examinations and minor operations in a certain volume)	194	155

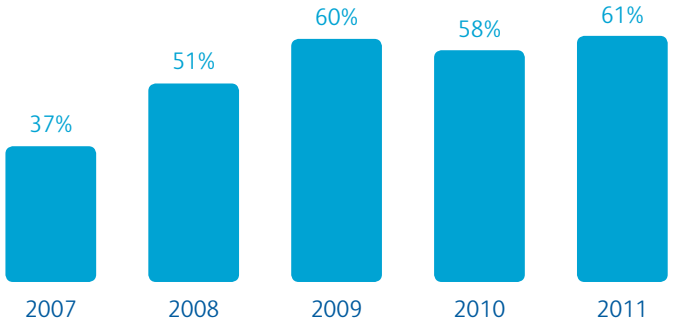
In 2010, all family physicians of Hiiu, Lääne and Jõgeva counties participated in the performance pay system (see Figure 7). The percentage of family physicians of these counties, who achieved excellent results, was respectively 63%, 62% and 60%. A similar result was also achieved by 63% of family physicians in the Pärnu and Lääne-Viru counties; however, the total number of participants was lower in these counties (respectively 96% and 93%).

Figure 7. Distribution of family physicians in the performance pay system by counties in 2010



In 2007 certain indicators were added into the performance pay system, in order to assess how a family nurse has counselled patients with type 2 diabetes and hypertension patients with risk level 1, with the objective of ensuring more efficient monitoring of chronic illnesses and improving treatment results. In an early stage of diseases, when no complications are present, health counselling has the highest positive effect and family nurses are quite competent to undertake this. Figure 8 shows that in 2011 a family nurse counselled 61% of the patients with type 2 diabetes at least once (37% in 2007).

Figure 8. Coverage of patients with type 2 diabetes who received family nurse counselling in 2007–2011



The total number of visits by a family nurse has increased 1.8 times in 2007–2011, proving that the role of family nurses in patient counselling has increased (see Table 13).

Table 13. Number of consultations by family physicians and nurses in 2007–2011

	2007	2008	2009	2010	2011
Consultations by family physicians	4,299,302	4,368,668	4,182,361	3,994,334	4,411,214
Consultations by family nurses	299,857	370,853	418,305	480,269	535,240
Prophylactic consultations	401,153	450,309	387,782	394,360	363,182
Total number of consultations	**5,000,312**	**5,189,830**	**4,988,448**	**4,868,963**	**5,309,636**
Persons consulted	978,973	983,466	973,129	957,090	981,575
Number of persons on practice lists	1,285,652	1,286,597	1,280,795	1,271,082	1,255,971
Share of persons consulted by family physicians included in the practice lists (%)	76	76	76	75	78

The General Practitioners' Advisory Line 1220 operates 24/7 in Estonia in order to provide prompt medical advice in case of health problems. Also information can be asked about the organisation of health care. Use of the line has increased: in 2011 physicians and nurses answered 216,984 calls, with an average of 595 calls in 24 hours (in 2010, 213,739 calls were answered with an average of 586 calls in 24 hours). The majority of the callers required consultation about a health problem and 1% needed advice on the organisation of health care.

1.3. Specialised Health Care

The total expenditure on specialised health care in 2011 amounted to 417 million euros, which exceeded the plan by 1%. This expenditure was divided between outpatient, day and inpatient care and centrally contracted health services.

1.3.1. Specialised Health Care, Except Centrally Contracted Services

Expenses and cases by settings

The 2011 budget for outpatient, day and inpatient specialised health care was used as planned, and treatment cases were financed at 2% more than planned (see Table 14). The funding for outpatient cases saw the highest growth and was increased during the reporting year in order to shorten outpatient waiting lists and improve access to care.

The number of treatment cases in day care met the plan. However, 9% fewer funds than planned were spent, which refers to a lower average cost of a treatment case[3] (ACTC). Its main reason was the new DRG version implemented in 2011, which mainly influenced the day surgery. In the new version account is taken of the patient's length of stay in hospital, and treatment cases which were completed on the same day are differentiated from cases which needed a longer stay. This is also revealed in the lowering of the ACTC of day surgery cases compared to the plan.

Compared to 2010 the expenses increased by 4% and the number of treatment cases by 3%. The increase was different according to setting of treatment, being highest among outpatient treatment expenses (9%). The amount of expenses and number of cases by specialties compared to the budget and changes from 2010 are provided in Appendices 1, 2 and 3.

[3] Average cost of treatment case – the average amount of an invoice for treatment that is calculated by dividing the sum by the number of treatment cases.

Table 14. Expenses for specialised health care (in thousands of euros) and treatment cases by settings

	2010 actual	2011 budget	2011 actual	Budget execution %	% of change from 2010
Expenses for specialised health care					
Total (without 24/7 preparedness fee)	**378,798**	**393,378**	**395,025**	**100**	**4**
Outpatient care	119,383	124,726	130,233	104	9
Day care	23,398	26,429	24,061	91	3
Inpatient care	236,017	242,223	240,731	99	2
24/7 preparedness fee	**8,334**	**8,423**	**8,423**	**100**	**1**
Total	**387, 132**	**401,801**	**403,448**	**100**	**4**
Treatment cases					
Total (without 24/7 preparedness fee)	**3,101,782**	**3,157,484**	**3,207,049**	**102**	**3**
Outpatient care	2,803,452	2,852,134	2,903,380	102	4
Day care	57,919	64,892	64,899	100	12
Inpatient care	240,411	240,458	238,770	99	–1
24/7 preparedness fee	**380**	**380**	**380**	**100**	**0**
Total	**3,102,162**	**3,157,864**	**3,207,429**	**102**	**3**

While outpatient and day care cases last year amounted to 93% of all treatment cases needing specialised health care (except the 24/7 preparedness fee), the relevant percentage for expenses was 39%. This ratio has remained stable for the last couple of years, but compared to previous years both the percentage of expenses and the number of outpatient and day care cases have constantly increased, which is related to the general positive trend to provide less inpatient care wherever possible.

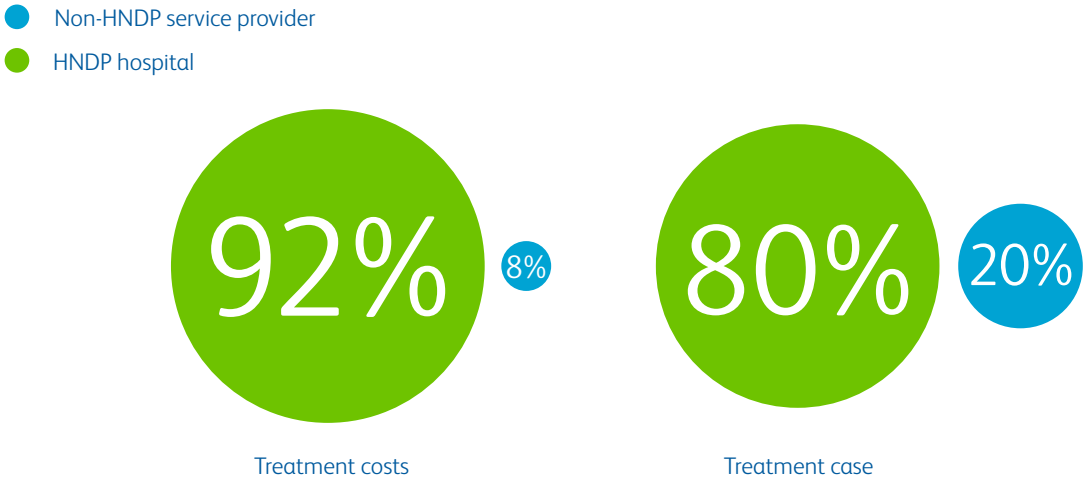
The 24/7 preparedness fee of those hospitals in the hospital network development plan (HNDP) belonging into the total expenditure of specialised health care has been funded by EHIF pursuant to the budget planned for 2011.

Distribution of budget between HNDP and non-HNDP hospitals

The funds planned into the budget for specialised health care will be paid on the basis of contracts to health care providers, who use them for diagnostics and treatment of the insured persons. In 2011 EHIF had valid contracts with 191 service providers, including 19 HNDP hospitals, which are in turn divided into regional, central, general, and local hospitals.

In spite of the relatively small number of HNDP hospitals (10% of all health care providers of EHIF for specialised health care in 2011), they use the majority of the budget of specialised health care. From the expenditure planned in the 2011 budget, HNDP hospitals used 92% or 370 million euros (see Figure 9). Of this, 54% was spent on funding health care services provided in regional (Tartu University Hospital, North Estonia Medical Centre and Tallinn Children's Hospital) and 31% in central hospitals (Pärnu Hospital, East Tallinn Central Hospital, West Tallinn Central Hospital and Ida-Viru Central Hospital). The rest was divided between eleven general hospitals and one local hospital.

Figure 9. Distribution of budget expenses between health care providers and indicating whether or not they belong in the HNDP



The share of treatment cases in HNDP hospitals is relatively lower compared to expenses, forming four-fifths of all treatment cases needing specialised health care. The different percentages for treatment expenses and treatment cases in HNDP and non-HNDP hospitals refers to different expensesACTC in both groups. Non-HNDP partners provide mainly outpatient health care services closer to people's places of residence. The ACTC in HNDP hospitals is approximately three times higher, as they provide mainly more complicated services with higher price.

Use of budget by EHIF regional departments per 1,000 insured persons

The budget for specialised health care was divided between four regional departments in 2011, proceeding from the number of insured persons (*per capita* principle). In spite of the fact that the budget is uniformly distributed between the insured, the actual number of treatment cases planned in the budget differs in various regions. There are several reasons for these differences, the majority of which are because of hospitals' distances from the place of residence of the insured, the number of providers of outpatient care in the region, treatment of chronic illnesses by family physicians, and length of waiting times, but also the types of travel available between the home and service providers, support of family before or after treatment and other aspects.

Data for treatment cases in the specialised health care budget for 2008–2011 (see Table 15) show that regional use of health services has remained equal throughout the years. In 2008 the result from the Pärnu region (covering Pärnu, Rapla, Lääne, Hiiu and Saare counties) was approximately 7% lower than the Estonian average; by 2011 this difference had decreased by 3%. At the same time the difference from the Estonian average in the Harju region has decreased, amounting to 2% in 2011. In 2011 the amount of specialised heatlh care services used per 1,000 insured persons in the Pärnu region were lower than average. At the same time the level of use of hospital services by insured persons was the highest in this region: 14.1% of the insured persons of the Pärnu region had been hospitalised at least once in 2011, while in the Harju region (including Tallinn) the relevant figure was 11.8%. Although in the Viru region the trend regarding inpatient care was similar to that of the Pärnu region, the Viru region does not differ much from an average use of specialised health care. This is caused by a higher use of outpatient care per 1,000 insured persons in the Viru region compared to the Pärnu region.

Table 15. Treatment cases per 1,000 insured persons in regional departments of EHIF by treatment types

		Treated persons per 1,000 insured					Difference from Estonian average use %			
	Year	Estonian average	Harju	Pärnu	Tartu	Viru	Harju	Pärnu	Tartu	Viru
Total	2008	636	660	591	633	632	4	–7	0	–1
	2009	624	631	606	626	627	1	–3	0	0
	2010	624	635	597	629	621	2	–4	1	0
	2011	**643**	**653**	**616**	**646**	**644**	**2**	**–4**	**0**	**0**
Outpatient care	2008	618	644	570	614	612	4	–8	–1	–1
	2009	606	616	586	607	606	2	–3	0	0
	2010	607	620	576	611	601	2	–5	1	–1
	2011	**626**	**637**	**596**	**629**	**624**	**2**	**–5**	**0**	**0**
Day care	2008	28	25	27	36	28	–11	–4	29	0
	2009	27	23	27	35	27	–15	0	30	0
	2010	29	26	28	38	24	–10	–3	31	–17
	2011	**33**	**33**	**33**	**38**	**28**	**0**	**0**	**15**	**–15**
Inpatient care	2008	131	122	142	127	145	–7	8	–3	11
	2009	127	117	142	124	141	–8	12	–2	11
	2010	126	118	141	124	137	–6	12	–2	9
	2011	**127**	**118**	**141**	**125**	**142**	**–7**	**11**	**–2**	**12**

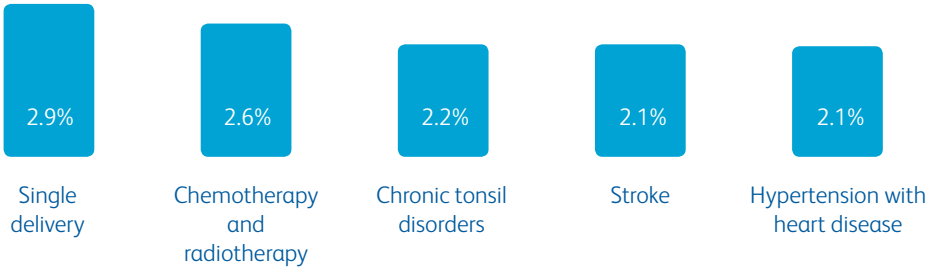
Use by diagnosis related groups (DRG)

Distribution of resources and treatment cases planned in the budget between contracts is based on various specialities, in which the execution of treatment cases and expenditure are monitored. At the same time, billing system enables us to receive a more detailed and thorough overview of the use of the budget, monitoring it by DRGs. On the basis of DRG, invoices for treatment are divided into clinically meaningful groups with homogenous resource expenditure, thus enabling us to assess and analyse the performance and expenses of hospitals.

Below is an overview of inpatient cases depending on the principal diagnosis coded on the invoice and inpatient expenses according to DRG.

According to ICD-10 (International Statistical Classification of Diseases and Related Health Problems 10th Revision), the principal diagnosis on the invoice refers to a condition that had caused the main need for treatment or investigation of the patient during hospitalisation. In 2011 approximately one-fifth of all inpatient treatment invoices for HNDP hospitals were divided between six main diagnoses. The percentage was highest (9%) among invoices which are mainly related to the stay of a healthy person accompanying the sick child. As these invoices do not directly characterise the performance of hospitals, Figure 10 shows the share of five other major diagnoses. According to this, the leading diagnoses on invoices for treatment in HNDP hospitals are deliveries, chemotherapy and radiotherapy, chronic tonsil disorders, stroke and hypertension with heart disease. In total, the invoices with six main diagnoses formed one-fifth of all inpatient invoices of HNDP hospitals.

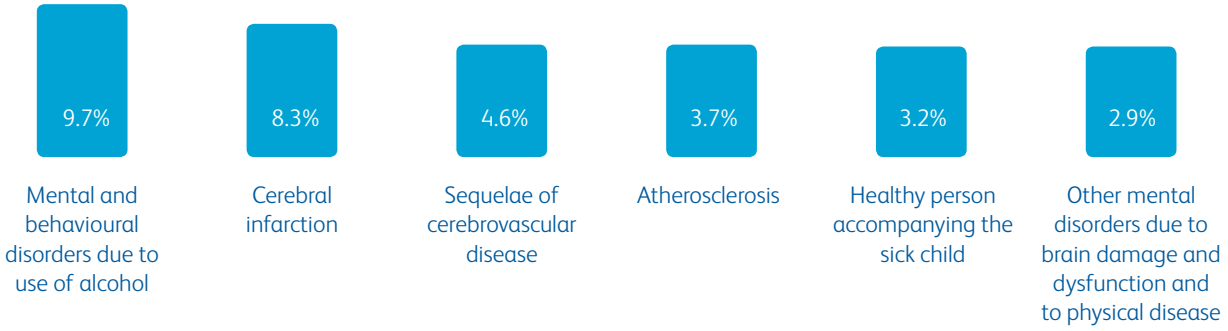
Figure 10. Percentage of inpatient treatment cases depending on main diagnosis in HNDP hospitals



The same indicators in non-HNDP hospitals are somewhat different (see Figure 11). There, the main diagnoses (10% or approximately 800 treatment cases) are F10 (Mental and behavioural disorders due to use of alcohol) and I63 (Cerebral infarction). The percentage of treatment cases with the main diagnosis of I69 (Sequelae of cerebrovascular disease), I70 (atherosclerosis), Z76 (healthy person accompanying the sick child), and F06 (Other mental disorders due to brain damage and dysfunction and to physical disease) is a bit lower. All listed diagnoses refer to services provided mainly in non-HNDP hospitals: they are usually related to psychiatric care and rehabilitation following an acute illness.

In total, the invoices with six main diagnoses form one-third of all inpatient invoices of non-HNDP hospitals.

Figure 11. Percentage of inpatient treatment cases depending on main diagnosis in non-HNDP hospitals



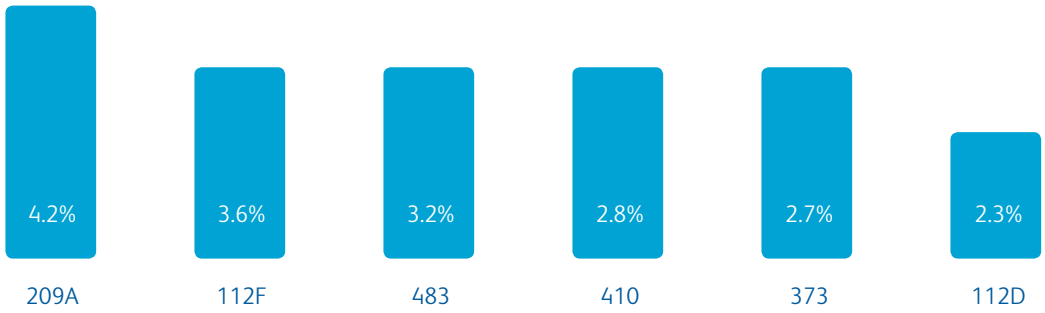
An explanation of inpatient expenses in the budget is based on DRGs. These data show that 19% of inpatient expenses are related to six DRGs (see Table 16 and Figure 12).

Table 16. Six more resource-loaded DRGs in inpatient care

DRG code	Name of DRG	Percentage of cost (all service providers) %
209A	Major joint and limb re-attachment procedure of lower extremity	4.2
112F	Percutaneous cardiovascular procedures, with acute myocardial infarction, with complicating diagnoses	3.6
483	Tracheostomy	3.2
410	Chemotherapy without acute leukemia as secondary diagnosis	2.8
373	Vaginal delivery without complicating diagnoses	2.7
112D	Percutaneous cardiovascular procedures, without acute myocardial infarction, with complicating diagnoses	2.3

The percentage of expenses is the highest (approximately 10.2 million euros) for DRG 209A, which mainly includes the invoices for treatment related to hip replacement. However, higher total expenses (approximately 14.2 million euros) are related to percutaneous cardiovascular procedures, amounting to 6% of inpatient expenses. Furthermore, 3% of the funds planned for hospital care were spent on patients who were subjected to tracheotomy due to a complicated general condition (7.6 million euros). Also vaginal deliveries and chemotherapy without acute leukemia belong under six major DRGs.

Figure 12. Distribution of inpatient treatment expenses by DRGs



Special cases of specialised health care

For the purposes of budget planning and monitoring, demands for the following health services are considered separately: endoprosthetic replacements, cataract surgery, cardiac surgery, deliveries, implementation of cardioverters and organ transplants.

The treatment need for deliveries, organ transplants and emergency cardiac surgery is considered separately, because their numbers cannot be forecast. In the case of endoprosthetic replacements and cataract surgery the waiting times are longer than average and these cases are planned as special ones, in order to ensure equal access to these services for the insured persons and to keep the list of patients on the basis of uniform principles. Tables 17 and 18 provide overviews of the expenses and cases of these services.

Table 17. Cost of special cases (in thousands of euros)

	Cost					% of change			
Special case	**2007**	**2008**	**2009**	**2010**	**2011**	**2008/ 2007**	**2009/ 2008**	**2010/ 2009**	**2011/ 2010**
Deliveries	10,819	12,616	12,284	11,808	11,027	17	–3	–4	–7
Endoprosthetic replacements	9,538	10,667	10,263	10,291	10,735	12	–4	0	4
Cardiac surgery	9,281	10,439	9,479	9,313	9,131	12	–9	–2	–2
Cataract surgery	5,839	6,583	6,454	6,342	6,551	13	–2	–2	3
Cardioverters*	–	–	217	1,324	1,633	–	–	–	23
Organ transplants**	–	–	–	483	622	–	–	–	29
Total	**35,477**	**40,305**	**38,697**	**39,561**	**39,699**	**14**	**–4**	**2**	**0**

*Funding for cardioverters as special cases began in 2009.
**Funding for organ transplants as special cases began in 2010.

Table 18. Number of cases

	Number of special treatment cases, actual					% of change			
Special case	**2007**	**2008**	**2009**	**2010**	**2011**	**2008/ 2007**	**2009/ 2008**	**2010/ 2009**	**2011/ 2010**
Deliveries	15,439	15,627	15,338	15,503	14,339	1	–2	1	–8
Endoprosthetic replacements	2,743	2,870	2,734	2,851	2,851	5	–5	4	0
Cardiac surgery	1,081	1,115	995	993	997	3	–11	0	0
Cataract surgery	10,236	11,211	11,320	12,867	13,484	10	1	14	5
Cardioverters*	–	–	21	105	132	–	–	–	26
Organ transplants**	–	–	–	48	62	–	–	–	29

*Funding for cardioverters as special cases began in 2009.
**Funding for organ transplants as special cases began in 2010.

EHIF considers also organ transplants to be special cases. Since 2010 EHIF has financed kidney transplants as special cases, and from 2011 liver transplants were added to the list. Six livers were transplanted in 2011. Compared to the same period of 2010 the number of kidney transplants has increased, as in 2011 there were more donor organs suitable for transplantation. In 2011 EHIF funded 41 kidney transplant operations in total.

1.3.2. Centrally Contracted Health Services

Centrally contracted health services are high-cost medical services for the treatment of severe and relatively rare cases. Compared to 2010, the use of centrally contracted health services has increased by one third (see Tables 19 and 20). In addition to the increase in the use of the services, funding for the typification of bone marrow began in 2011, biological treatment was extended to patients suffering from acute asthma and psoriasis, and a new pharmaceutical (romiplostim) intended for rare blood diseases was added to the list of centrally contracted pharmaceuticals.

Table 19. Centrally contracted health services (in thousands of euros)

	2010 actual	2011 budget	2011 actual	Budget execution %	% of change from 2010
Centrally contracted pharmaceuticals	5,899	7,864	8,742	111	48
Peritoneal dialysis	1,461	1,660	1,391	84	–5
Haematological treatment	1,373	1,377	1,673	121	22
Bone marrow transplants	1,025	1,219	1,142	94	11
Cochlear implants	297	300	300	100	1
Emergency transport of insured persons (aircraft)	150	167	214	128	43
Pathoanatomical autopsies	56	71	49	69	–13
Artificial urinary sphincters	45	57	46	81	2
Antidotes, serums	12	12	12	100	0
Total	**10,318**	**12,727**	**13,569**	**107**	**32**

Table 20. Cases of and average cost for centrally contracted health services (in euros)

	2010 actual		2011 actual		% of change from 2010	
	TC	ACTC	TC	ACTC	TC	ACTC
Centrally contracted pharmaceuticals	3,943	1,496	5,376	1,626	36	9
Peritoneal dialysis	888	1,645	837	1,662	–6	1
Haematological treatment	336	4,086	365	4,584	9	12
Bone marrow transplants	97	10,567	181	6,309	87	–40
Cochlear implants	20	14,850	18	16,667	–10	12
Emergency transport of insured persons (aircraft)	91	1,648	131	1,634	44	–1
Pathoanatomical autopsies	368	152	355	138	–4	–9
Artificial urinary sphincters	8	5,625	8	5,750	0	2
Antidotes, serums	2	6,000	2	6,000	0	0

The budget for centrally contracted pharmaceuticals was used for meeting the expenses of biological treatment for patients of rheumatology, gastroenterology, acute asthma and psoriasis; for enzyme therapy for Type 1 Gaucher's Disease and Fabry Disease; for risperidone depot ejections used in treating psychiatric cases; for hormone treatment for neuroendocrine tumours and acromegaly; for inpatient erythropoietin therapy and, as a new service, for the treatment of idiopathic thrombocytopenic purpura in adults with romiplostim therapy. The budgeted amounts for the largest treatment group – the biological treatment of rheumatological patients – were exceeded by 25%. The increased use of biological treatment was caused by the fact that unlike before, hospitals started the treatment for most new patients as early as in the first months of the year. The budget was based on previous years, when new patients arrived proportionally over the course of the year or at the end of the year. The budget was also exceeded in enzyme therapy, where the need for pharmaceuticals depends on the weight of the patient, and where one patient was added to the treatment list. In 2011 the total number of insured persons who were receiving the pharmaceuticals service amounted to 1,183, of whom one fifth were primary patients who were starting the treatment. The total number of patients receiving biological treatment in 2011 was 631.

The peritoneal dialysis is needed in cases involving serious renal diseases. Kidney transplantation is indicated for several patients suffering from renal failure, after which the need for outpatient peritoneal dialysis will end. Based on information from previous years, an increase in the number of patients was planned for 2011. In reality, the number of patients of peritoneal dialysis has decreased.

Haematological treatment concerns patients with coagulation problems in relation to operations and traumas. In 2011 the number of patients increased along with the quantity of coagulation factors needed for one patient. The cost of haematological treatment may vary greatly depending on the seriousness of each case and the choice of the coagulation factor: in 2011 it ranged from 50 euros to 57,000 euros.

From the budget for bone marrow transplants, where formerly only bone marrow transplant service were planned, EHIF started to fund the typification of bone marrow donors in 2011. Following this typification of bone marrow, voluntary donors can join the register of bone marrow donors held by the blood service of the Finnish Red Cross. Therefore, the list of donors will increase inside as well as outside Estonia, as information on the registers of bone marrow donors are exchanged worldwide. In the reporting period, the bone marrow typification service was provided to 96 volunteers who had joined the register of donors. The bone marrow collection and transfer service was needed in 85 cases, which is ten cases less than planned in the budget on the basis of 2010. As the typification of bone marrow is cheaper than transplanting, the addition of the typification service will reduce the average cost of bone marrow transplant cases when compared to the previous years.

The budget for cochlear implants included funds for fourteen cochlear implants and six bone anchored hearing implants. Altogether, eighteen operations were performed: to four adults and fourteen children, while in the case of two children the installation of two implants was indicated to both sides during a single operation.

The emergency air transport service is provided to patients who are in a critical condition, who need urgent health care in a hospital of a higher stage. The former stabile number of calls increased essentially in the second half of 2011. Most calls were made due to worsened or sudden illnesses. One tenth of patients needed emergency transportation after suffering injury.

Artificial urinary sphincters were planned for ten patients, whereas actual operations were performed on eight patients.

The use of the services for bone marrow transplants, peritoneal dialysis, artificial urinary sphincters and pathoanatomic autopsies was lower than planned in the reporting period.

1.3.3. Comparison of Main Indicators in Specialised Health Care

Table 21 provides an overview of the indicators in specialised health care in 2007–2011.

Table 21. Main indicators for inpatient and outpatient specialised health care

						% of change			
	2007 actual	2008 actual	2009 actual	2010 actual	2011 actual	2008/ 2007	2009/ 2008	2010/ 2009	2011/ 2010
Average cost of a treatment case (EUR)									
outpatient care	35	43	44	43	45	23	2	–2	5
day care	411	468	449	404	371	14	–4	–10	–8
inpatient care	871	1,008	1,011	982	1,008	16	0	–3	3
Number of inpatient bed days	1,590,749	1,560,768	1,449,960	1,458,555	1,436,100	–2	–7	1	–2
Average length of stay (days)	6.4	6.3	6.1	6.1	6.0	–2	–3	0	–2
Number of outpatient consultations	3,695,585	3,797,861	3,647,303	3,671,655	3,801,950	3	–4	1	4
outpatient care	3,624,744	3,722,259	3,573,286	3,609,613	3,732,239	3	–4	1	3
day care	70,841	75,602	74,017	62,042	69,711	7	–2	–16	12
Number of outpatient consultations per treatment case	1.35	1.34	1.32	1.18	1.28	–1	–1	–11	8
outpatient care	1.35	1.34	1.31	1.29	1.29	–1	–2	–2	0
day care	1.33	1.35	1.34	1.07	1.07	2	–1	–20	0
Number of persons using specialised health care services	810,834	819,055	800,578	797,048	807,875	1	–2	0	1
outpatient care	786,178	795,791	777,144	774,589	786,099	1	–2	0	1
day care	45,612	45,911	44,474	47,063	52,230	1	–3	6	11
inpatient care	168,912	169,755	163,911	162,514	161,550	0	–3	–1	–1
Number of treatment cases per person	3.67	3.78	3.76	3.89	3.97	3	–1	3	2
outpatient care	3.41	3.5	3.5	3.62	3.69	3	0	3	2
day care	1.16	1.22	1.24	1.23	1.24	5	2	–1	1
inpatient care	1.47	1.47	1.47	1.48	1.48	0	0	1	0
Share of emergency care expenses (%)									
outpatient care	18	17	17	18	18	–1	0	1	0
day care	7	6	9	9	7	–1	3	0	–2
inpatient care	63	63	67	67	64	0	4	0	–3

						% of change			
	2007 actual	2008 actual	2009 actual	2010 actual	2011 actual	2008/ 2007	2009/ 2008	2010/ 2009	2011/ 2010
Share of emergency care cases (%)									
outpatient care	17	16	17	17	17	–1	1	0	0
day care	17	13	15	12	9	–4	2	–3	–3
inpatient care	57	57	61	62	62	0	4	1	0
Number of operations	167,027	164,819	155,010	160,403	163,718	–1	–6	3	2
outpatient care	20,359	19,517	20,302	21,154	19,808	–4	4	4	–6
day care	48,394	45,838	42,620	46,911	52,507	–5	–7	10	12
inpatient care	98,274	99,464	92,088	92,338	91,403	1	–7	0	–1

The overall average cost of a treatment case increased in 2011 in outpatient as well as inpatient care.

The number of bed days decreased due to a decrease in the number of inpatient treatment cases as well as the **average length of stay**. **The length of stay** has decreased to six days, showing that hospitals are providing the service more efficiently.

The total number of persons using specialised health care services has increased slightly. A positive indicator is the growing number of persons treated as outpatients and in day care.

The share of emergency care for outpatients has remained at the same level in the last two years, but has decreased in day care and inpatient care settings. The share of emergency care in treated cases has remained at the same level in recent years. EHIF has constantly monitored the share of treatment cases as well as the expenses of emergency care, because any increase in the share of emergency services may point to the possibility that an insured person might not reach a specialist in time. Compared to 2010, emergency treatment cases in 2011 were cheape.

The total number of operations increased in 2011, because more operations were performed in day care. In outpatient and inpatient care the number of operations was lower than in 2010.

1.4. Nursing Care

In 2011, EHIF paid 14.8 million euros for nursing care provided to insured persons, which is 4% more than in 2010 (see Table 22).

The expenses of inpatient nursing care increased by 2% when compared to 2010. The expenses of outpatient nursing care increased by 11% when compared to 2010. EHIF aim is to improve the access to outpatient nursing care.

Table 22. Nursing care expenses (in thousands of euros)

	2010 actual	2011 budget	2011 actual	Budget execution %	% of change from 2010
Inpatient nursing care	11,408	12,124	11,670	96	2
Outpatient nursing care, incl	2,847	2,991	3,146	105	11
home nursing	2,435	2,569	2,705	105	11
home care for cancer patients	333	344	363	106	9
geriatric assessment	79	78	78	100	–1
Total	**14,255**	**15,115**	**14,816**	**98**	**4**

Compared to 2010, the number of cases of nursing care increased by 12%, showing an increase in both inpatient and outpatient care (by 1% and 19% respectively). The number of treatment cases in home nursing has increased by 23%, which is in line with the EHIF goal of improving the access to outpatient nursing care (see Table 23 and Figure 13).

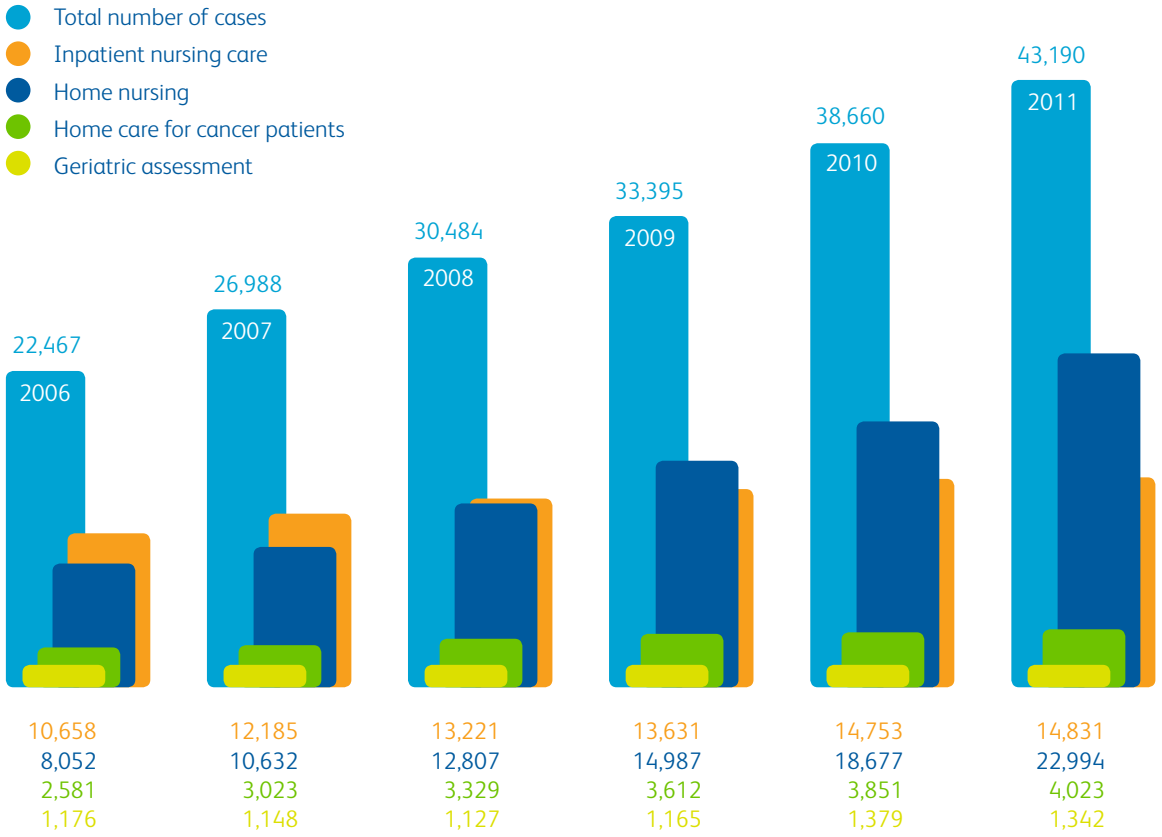
Table 23. Cases of nursing care and ACTC (in euros)

	2010 actual		2011 actual		% of change from 2010	
	TC	ACTC	TC	ACTC	TC	ACTC
Inpatient nursing care*	14,753	773	14,831	787	1	2
Outpatient nursing care, incl**	23,907	119	28,359	111	19	–7
home nursing	18,677	130	22,994	118	23	–9
home care for cancer patients	3,851	86	4,023	90	4	5
geriatric assessment	1,379	57	1,342	58	–3	2
Total	**38,660**	**369**	**43,190**	**343**	**12**	**–7**

* Treatment cases for inpatient nursing care: inpatient nursing care services provided 24/7 (prescribed by a physician) for the treatment of patients suffering from chronic diseases, recovering from acute illnesses, or with limited functional ability, with the objective of achieving the independence of the patient from the care of other people and to prepare the patient for being sent home or entering a nursing facility.

** Treatment cases for outpatient nursing care: a set of services provided by a nurse and/or the accompanying team for the treatment of patients suffering from chronic diseases, recovering from acute illnesses, or with limited functional ability (prescribed by a physician) and/or in order to ensure more efficient management in the patient's home environment.

Figure 13. Nursing care cases, 2006–2011



In 2011 the access to outpatient nursing care improved and the number of visits as well as the number of cases being treated increased (see Table 24).

Table 24. Outpatient nursing care visits

	2010 actual		2011 actual		% of change from 2010	
	Visits	Persons	Visits	Persons	Visits	Persons
Home nursing	149,991	4,753	169,920	5,951	13	25
Home care for cancer patients	14,356	890	16,587	1,030	16	16

1.5. Dental Care

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

In 2011 the dental care expenditure was under-executed (see Table 25), while the number of treatment cases exceeded the plan (see Table 26).

Table 25. Dental care expenses (in thousands of euros)

	2010 actual	2011 budget	2011 actual	Budget execution %	% of change from 2010
Dental care for children	13,866	14,231	13,963	98	1
Orthodontics	2,936	2,989	3,033	101	3
Emergency dental care for adults	651	657	732	111	12
Preventive dental care	349	391	328	84	–6
Total	**17,802**	**18,268**	**18,056**	**99**	**1**

Table 26. Cases of dental care

	2010 actual	2011 budget	2011 actual	Budget execution %	% of change from 2010
Dental care for children	306,100	297,601	311,786	105	2
Orthodontics	39,877	40,057	41,809	104	5
Emergency dental care for adults	17,530	17,489	19,031	109	9
Preventive dental care	25,147	26,974	23,359	87	–7
Total	**388,654**	**382,121**	**395,985**	**104**	**2**

In 2011 the indicators for preventive dental care in children decreased. The cost and number of cases of preventive dental care decreased, because less children belonging to the target group participated in preventive dental care.

2. Health Promotion

EHIF is engaged in health promotion through health promotion projects, based on the priorities that were approved by the EHIF Supervisory Board and in coordination with the Ministry of Social Affairs. The EHIF health promotion activities are related to the objectives contained in the national health strategies. Of the 831 thousand euros that were set aside for health promotion, 97% or 806 thousand euros were spent on the execution of projects (see Tables 27 and 28).

Table 27. Health promotion expenses (in thousands of euros)

	2010 actual	2011 budget	2011 actual	Budget execution %	% of change from 2010
Prevention of domestic and leisure time injuries (incl alcohol consumption)	339	313	337	108	–1
Health promotion activities for children	232	262	262	100	13
Activities aimed at patient awareness	192	160	162	101	–16
Early detection of cancer	8	58	18	31	125
Prevention of cardiovascular diseases	15	38	27	71	80
Total	**786**	**831**	**806**	**97**	**3**

Table 28. Quantitative indicators of project activities

	2007 actual	2008 actual	2009 actual	2010 actual	2011 actual
Total print run of publications	354,700	362,600	415,512	702,450	606,400
The number of participants in training, sports and other events aimed at the general population	39,300	53,890	60,250	70,400	44,368
Number of persons who received individual counseling	8,240	8,967	11,051	12,687	7,285
Number of participants in training events for teachers	2,310	1,227	2,136	1,961	2,493
Number of participants in training events for other stakeholders (social workers, managers, task forces)	2,181	1,605	1,354	1,368	1,423
Number of participants in training events for health care professionals	1,830	427	193	229	367
Number of printed publications	24	18	18	25	20
Number of radio and TV programmes/clips	11	8	15	8	4

In 2011, a major proportion of the funds – 42% of all expenses – were spent on activities related to the prevention of injuries. Prevention was carried out in all counties and two major cities. A reissue of the material covering the prevention of injuries to infants and small children was published and the campaign aimed at the prevention of injury-related cases of death among young people was repeated.

Expenses for health promotion activities for children have increased year-on-year, including the project entitled "Children's dental health", and health promotion in schools and nursery schools. Events are no longer targeted directly at the entire population, but now concentrate instead on risk groups or on stakeholders through whom the risk group is reached. Medical and education staff have been trained. From 2011 no more counselling on sexual health is provided via the internet.

The development of infrastructure and activities aimed at stakeholders

A total of 374 employees from 294 educational institutions were trained through the project "Health Promotion in School and Nursery School". In Estonia there are 31 local coordinators counselling schools or nursery schools on health promotion. On 10 June the national health promotion conference, "Key to the Future – Children and Youths", was held in cooperation with the National Institute for Health Development (NIHD), the Ministry of Social Affairs, and the Estonian office at the World Health Organisation. The conference adopted a memorandum covering those activities that should remain the focus of attention in the promotion of the health of children. In April and November an international training course on the rationalisation of health care systems was held, with the participation of over forty people from Estonia, Latvia, Lithuania, Moldova and Poland. The objective of the training exercise was to provide skills for analytical thinking and the development of a purpose-orientated health policy.

Media communications

The information campaign on the reasonable use of pharmaceuticals took place in March and November 2011, while an injury prevention campaign for youths entitled "What is the Formula for your Life?", was held in April. The EHIF health information pages, covering the topics of cancer screening, the rational use of pharmaceuticals, consultation phone number 1220, and other actual health themes, were published eight times in the newspapers, Postimees, Eesti Päevaleht, Maaleht, Õhtuleht, Linnaleht and Den za Dnjom.

Publications

The following publications were issued in 2011 in cooperation with medical publishing offices and experts (in Estonian and Russian):

"Health Development of a Student";
"Stress and Heart Health";
"Hypertension Diary";
"How to Prevent Skin Cancer";
"The Manual for Nursing at Home";
"The Prevention of Injuries to Infants and Children" (reissue);
"Health Development of a Child" (from birth to seven years);
A brochure "The roles of the family nurse ";
A brochure "Home nursing".
"Infant Feeding Guide" (Estonian Paediatric Association) and "Major infectious diseases in childhood and home treatment" (Estonian Association of Family Physicians) are awaiting publication.

County injury prevention projects concentrated on certain target groups and the risk groups and abilities of stakeholders. Information days were organised for family nurses and parents to ensure the prevention of accidents involving small children. Young people were involved in discussions on the theme of injury prevention, risks related to elderly people at home were explained, and a safety camp was organised for sixth grade pupils. Five projects passed an external assessment, in four cases the efficiency level of the project team increased, and all of these areas received important feedback on the development and needs of the organisation.

In the projects for stakeholders , insured persons received pregnancy crisis counselling in 7,184 cases. An attempt was made to implement a system of family schools to enable the participation of risk groups, increase awareness in risk families, and ensure the normal development of children. Based on certain criteria, free training coupons were distributed, and these were returned in only 29 cases.

3. Pharmaceuticals Reimbursed to Insured Persons

EHIF is obliged to reimburse the cost of pharmaceuticals to insured persons to the extent prescribed by law and based on the needs of the individual.

A total of 91.5 million euros worth of expenses on pharmaceuticals were reimbursed to insured persons in 2011. For this purpose, 94% of the planned budget was executed (see Table 29).

Table 29. Expenses for pharmaceuticals reimbursed to insured persons (in thousands of euros)

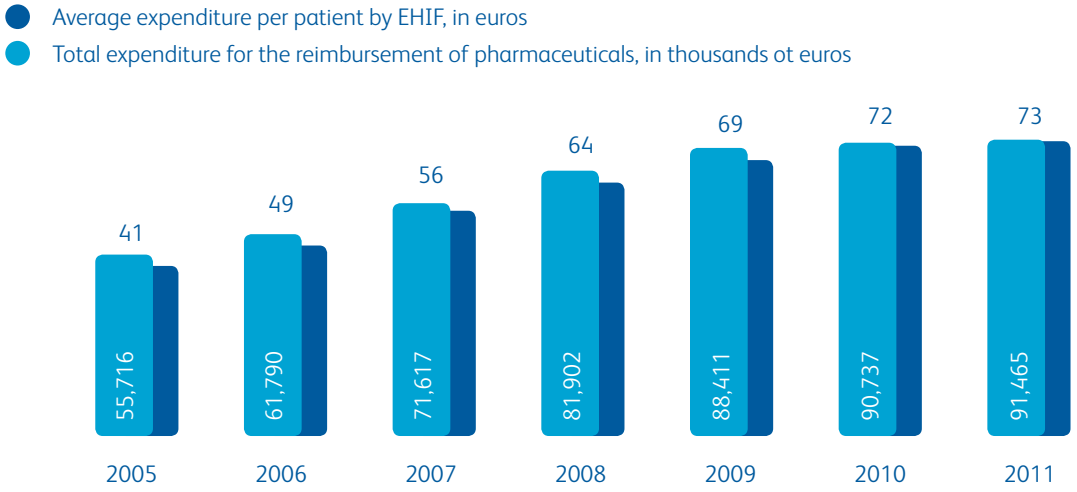
					Share of expenses by type of reimbursement %	
	2010 actual	2011 budget	2011 actual	Budget execution %	2010	2011
Reimbursement of 100% of cost	43,161	46,771	45,755	98	48	50
Reimbursement of 90% of cost	26,621	27,283	26,294	96	29	29
Reimbursement of 75% of cost	5,416	5,944	5,306	89	6	6
Reimbursement of 50% of cost	15,539	17,442	14,110	81	17	15
Total	**90,737**	**97,440**	**91,465**	**94**	**100**	**100**

Compared to 2010 the expenses for pharmaceuticals that have had to be reimbursed to insured persons have increased by 1% in 2011 (see Figure 14). This increase is caused by the increase in reimbursement of 100% of the cost, while expenses for other cost types have decreased in comparison to 2010. It is important to note that the use of pharmaceuticals (expressed in the number of reimbursed prescriptions) has increased with all types of discount. Price control measures have been excellent in terms of the budget for the reimbursement of pharmaceuticals. In 2011, insured persons received more pharmaceuticals for less money.

Efficient work in terms of price controls and the implementation of the reasonable use of pharmaceuticals has enabled pharmaceuticals containing thirteen new active ingredients to be added to the list. The reimbursement level was increased for fifteen ingredients, extending the range or improving the availability of care for some diseases. In many cases restrictions on prescriptions were changed.

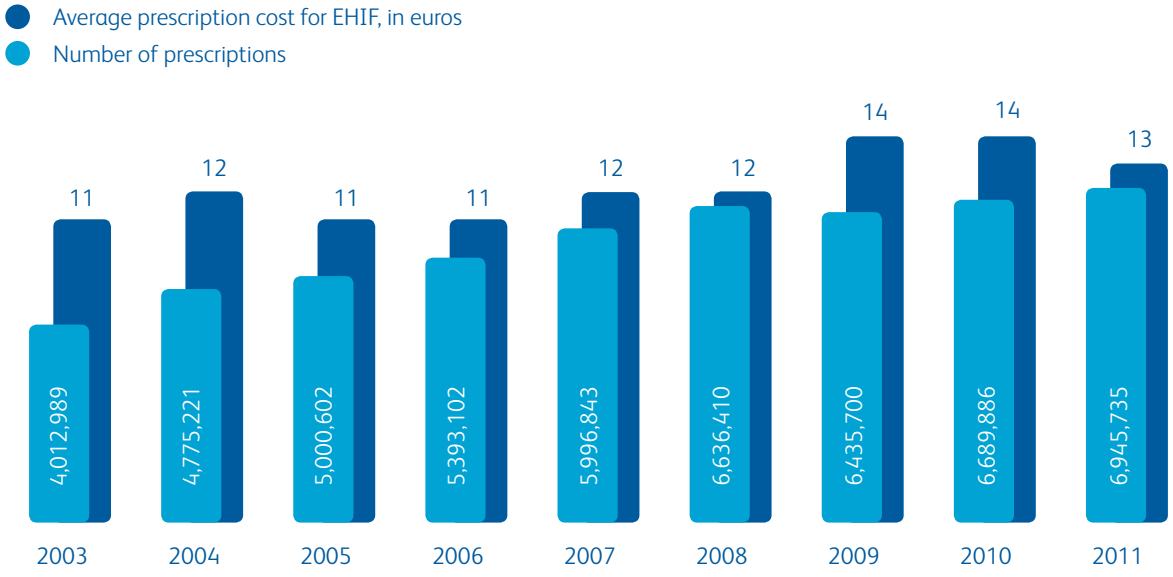
Major changes in 2011 saw the total reimbursement of expenses related to thrombosis care (formerly set at 75%), an extension of the range of pharmaceuticals for children suffering from attention deficit hyperactivity disorder, and in the treatment of post-transplantation conditions. Indications for the reimbursement of antiarrhytmics and some pharmaceuticals for diabetes were extended. The availability of pharmaceuticals for chronic renal insufficiency was improved: reimbursement levels are now at 100% (where they were formerly at 75%). New treatment options were added for the treatment of essential thrombocytopenia, myelodysplastic syndrome, pulmonary hypertension, chronic obstructive pulmonary disease, thrombosis prevention, migraine, osteoporosis and phenylketonuria.

Figure 14. Total expenditure for the reimbursement of pharmaceuticals and expenditure per patient



The number of reimbursed prescriptions has increased continuously, as it has done in previous years (see Table 30 and Figure 15). In 2011, EHIF reimbursed 255,849 prescriptions more than in 2010 (an increase of 3.8%). The number of prescriptions reimbursed has increased in all discount types. In addition, the average number of reimbursed prescriptions per patient who has used reimbursed pharmaceuticals has increased (a total of 8.1 against 8.3), which can be a sign of better care consistency and availability in pharmaceuticals.

Figure 15. Changes in the number and average cost of reimbursed prescriptions



The average prescription cost for EHIF has decreased in all reimbursement levels, except where there is a reimbursement of the full amount of the cost. This is very probably caused by the range of pharmaceuticals that are subject to full and total reimbursement, including generally more expensive pharmaceuticals which frequently lack a generic alternative.

The average cost has decreased the most in prescriptions that are subject to a 50% reimbursement rate. This can have several reasons: various measures used to control prices, a more rational prescription of pharmaceuticals, the application of correct discount rates, etc.

Table 30. Number of reimbursed prescriptions (DP) and average cost in euros

	2010		2011		2010/2011	
	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 %
Reimbursement of 100% of cost	744,866	57.94	771,256	59.33	4	2
Reimbursement of 90% of cost	2,319,683	11.48	2,420,785	10.86	4	–5
Reimbursement of 75% of cost	498,772	10.86	516,034	10.28	3	–5
Reimbursement of 50% of cost	3,126,565	4.97	3,237,660	4.36	4	–12
Total	**6,689,886**	**13.56**	**6,945,735**	**13.17**	**4**	**–3**

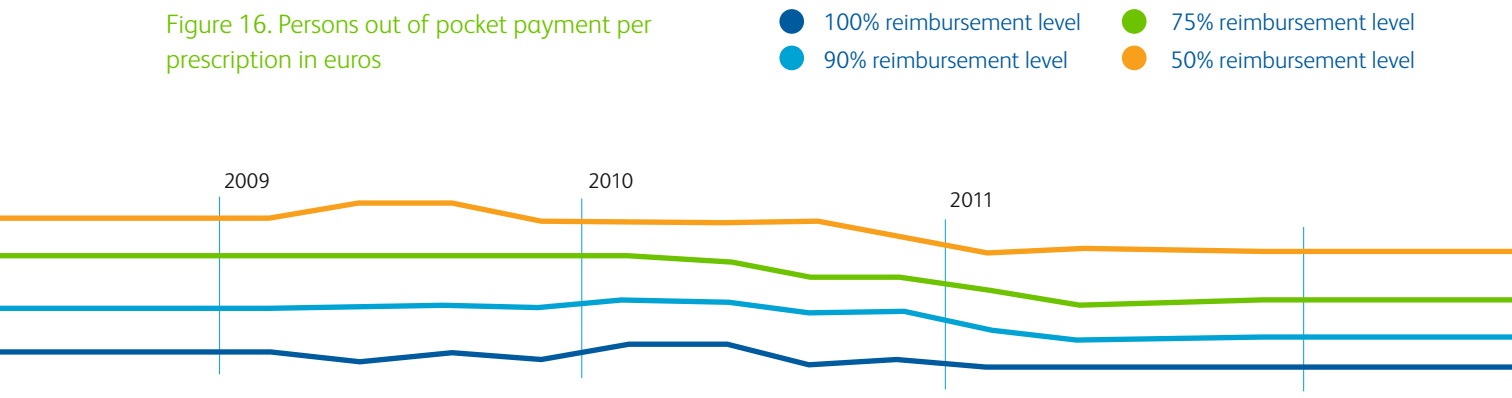
The number of people using reimbursed pharmaceuticals is increasing: while in 2010 the number of insured persons using reimbursed pharmaceuticals reached 822,440, in 2011 it was higher, at 841,533.

The measures initiated in 2010 for reducing patients' out of pocket expenses have been efficient, with these measures obliging the pharmacist to offer patients the most favourable alternative and launching a social campaign entitled "The difference is in the price of medicine", which was aimed at increasing patient awareness.

The 2011 survey of satisfaction with the health care system revealed the importance of the theme of pharmaceuticals for people and the effect of the campaign on their behaviour. A pleasing fact is that the aforementioned campaign had a major effect on the behaviour of people: almost half of patients who had bought pharmaceuticals in the last year said that as a result of the campaign they have chosen or were going to choose a cheaper product. Only 19% of them did not plan to do so.

Patients' out of pocket expenses are decreasing for the second year (see Figure 16). At the end of 2011 an insured person who bought pharmaceuticals at a pharmacy had to pay 10% less out of pocket per prescription than in 2010. The average expenditure per prescription in 2011 was 6.95 euros.

Figure 16. Persons out of pocket payment per prescription in euros



1st Qtr	2nd Qtr	3rd Qtr	4th Qtr	1st Qtr	2nd Qtr	3rd Qtr	4th Qtr	1st Qtr	2nd Qtr	3rd Qtr	4th Qtr
2.06	1.86	1.97	1.85	2.18	2.23	1.78	1.90	1.73	1.70	1.70	1.70
5.69	5.77	5.74	5.74	5.91	5.82	5.63	5.59	5.09	4.88	4.94	4.90
8.07	8.12	8.03	8.05	8.24	8.04	7.67	7.49	7.08	6.84	6.90	6.86
10.60	11.03	11.09	10.67	10.63	10.58	10.64	10.19	9.73	9.82	9.79	9.74

An analysis of the results of the campaign shows that a major leap forwards in the use of generic pharmaceuticals took place in the last quarter of 2010, immediately after the start of the campaign.

Table 31. Financial participation by an insured person (%)

	2010 actual	2011 actual	% of change from 2010
Reimbursement of 100% of cost	3.4	2.8	–0.6
Reimbursement of 90% of cost	33.3	31.1	–2.2
Reimbursement of 75% of cost	42.0	40.0	–2.0
Reimbursement of 50% of cost	67.9	69.1	1.2
Average financial participation by an insured person	36.2	34.5	–1.7
incl prescriptions subject to 75%, 90% and 100% reimbursement	19.9	17.8	–2.1

The most expensive diagnoses did not show any changes in comparison to 2010: hypertension is still the diagnosis with the highest number of medicinal users (see Table 32).

However, where the most expensive diagnoses are concerned, the out of pocket payments have decreased. The major change has taken place in the diagnosis of hypercholesterolemia, where in 2011 a person had to pay 21 euros out of pocket annually instead of the former cost of 33 euros for reimbursed pharmaceuticals.

The out of pocket expenses for cases with a diagnosis of hypertension have also decreased remarkably. While in 2010 a person had to co-pay approximately 41 euros per year for hypertension pharmaceuticals, in 2011 this sum was 35 euros. As these are chronic diseases, lower expenses should also ensure better treatment adherence.

Table 32. Diagnoses with the highest expenditure on benefits for medicines (in thousands of euros)

	2010 actual		2011 actual	
Diagnoos	Reimbursed by EHIF	% of total cost of benefits for medicinal products	Reimbursed by EHIF	% of total cost of benefits for medicinal products
Hypertension	13,056	14	13,012	14
Total diabetes, incl	13,144	15	12,921	14
insulin	9,763	11	9,215	10
orally administrated products	3,381	4	3,706	4
Cancer	9,314	10	10,6	12
Bronchial asthma	5,4	6	5,601	6
Glaucoma	4,132	5	3,738	4
Mental disorders	3,047	3	3,027	3
Hypercholesterolemia	3,2	4	2,599	3
Chronic hepatitis C	2,153	2	1,966	2
Total	**53,446**	**59**	**53,464**	**58**

In conclusion we can be satisfied with the expenditure on reimbursed pharmaceuticals in 2011, as many new treatment options have been added, the number of users of pharmaceuticals has increased, there are indications of better treatment adherence, and the average cost of a prescription drug is cheaper for EHIF as well as the patient.

Another important fact is that 20% of the prescriptions drafted by physicians have not been used. The main reason is that prescription's validity period has expired or the physician has deleted the drafted prescription for some reason.

At the beginning of 2012 a control was implemented in the prescription centre, to support the drafting of active ingredient-based prescriptions. The results of the first weeks gave cause for hope: the percentage of ingredient-based prescriptions has increased from 45% to 69%.

The funds from the health services budget spent on pharmaceuticals

Every year a question remains regarding whether sufficient health insurance funds have been used for the treatment of insured persons with pharmaceuticals.

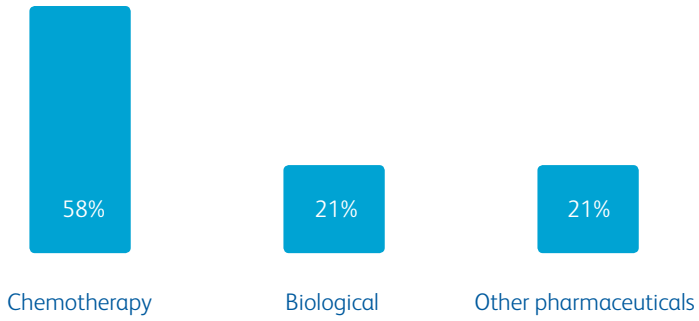
According to the EHIF information, expenses for the pharmaceutical treatment of insured persons has increased year-on-year. In addition to pharmaceuticals expenses that have been reimbursed to insured persons, EHIF will also pay fees to the health service providers.

- ➜ for pharmaceutical treatment described in the list of health services as separate services (pharmaceuticals or treatment with R-code);
- ➜ for pharmaceutical expenses included in services if pharmaceuticals are needed for the provision of the service (eg. bed days, various operations, anaesthesia and other examinations or procedures).

The expenses incurred by the two aforementioned pharmaceutical types in 2011 were around 46 million euros.

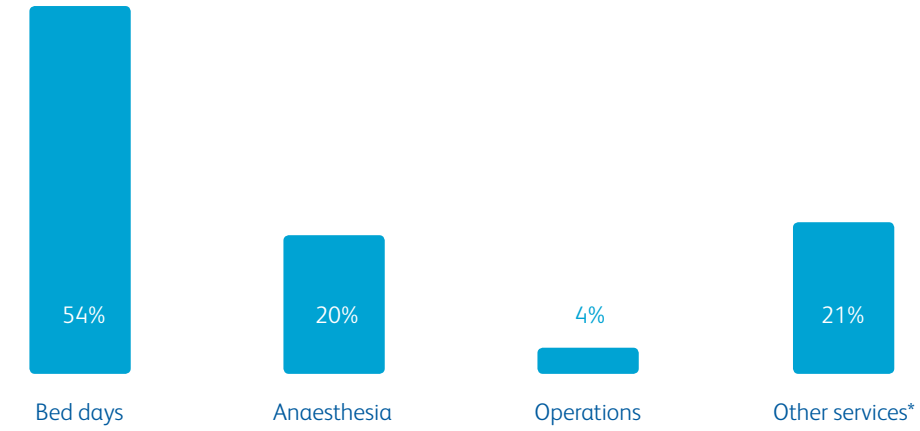
The majority of pharmaceutical expenses paid for the codes in the list of health services (around 7.4 million euros or 58%) was spent on chemotherapy, while the remaining resources were divided between biological treatment and other pharmaceutical services (see Figure 17).

Figure 17. The percentage of pharmaceutical expenses in services from the list of health services (%)



54% of pharmaceutical expenses included in the limit prices for health services was paid out for bed days, while the percentage of pharmaceutical expenses in terms of anaesthesia and operations was lower (see Figure 18).

Figure 18. The distribution of pharmaceutical expenses in health care



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

The total sum spent in 2011 on pharmaceuticals from health insurance (encompassing the budget for health care services, the budget for outpatient pharmaceutical benefit, and the budget for additional pharmaceutical benefits), amounted to 138.6 million euros, which is 27% of the budget for health care services (see Table 33).

Table 33. Funds from the health insurance budget spent on pharmaceuticals (in thousands of euros)

	2011 actual
Pharmaceuticals reimbursed to insured persons	91,465
The use of pharmaceutical codes in the list of health services	31,029
Pharmaceutical expenses in health services	15,675
Additional pharmaceutical benefits	440
Total pharmaceutical expenses	**138,609**

4. Benefits for a Temporary Incapacity to Work

Expenditure on benefits for a temporary incapacity to work

The expenses incurred in benefits for a temporary incapacity to work in 2011 amounted to 80.8 million euros, which is 666 thousand euros less than in the previous year (see Table 34).

Table 34. Expenses incurred in benefits for a temporary incapacity to work (in thousands of euros)

	2010 actual	2011 budget	2011 actual	Budget execution %	% of change from 2010
Sickness benefits	33,175	40,125	35,943	90	8
Maternity benefits	36,118	38,760	31,140	80	–14
Care benefits	10,250	12,138	11,626	96	13
Occupational accident benefits	1,893	1,985	2,061	104	9
Total	**81,436**	**93,008**	**80,770**	**87**	**–1**

Figure 19 provides an overview of the distribution of expenditure on benefits for a temporary incapacity to work. As can be seen, sickness benefits form the majority of these expenses. A comparison with the expenses of the previous year is provided in Table 35. Compared to 2010 the share of expenses for sickness benefits has increased by 4%, with the expenses for care benefits increasing by 2%, maternity benefits decreasing by 6%, and no significant change being experienced with expenses related to occupational accident benefits.

Figure 19. The distribution of benefits for a temporary incapacity to work by types of benefits in 2011

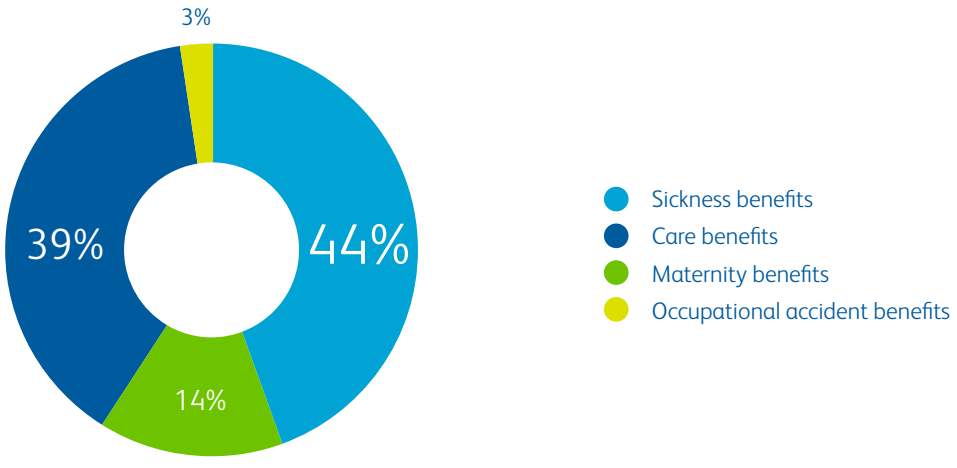


Table 35. A comparison of expenses for benefits for a temporary incapacity to work

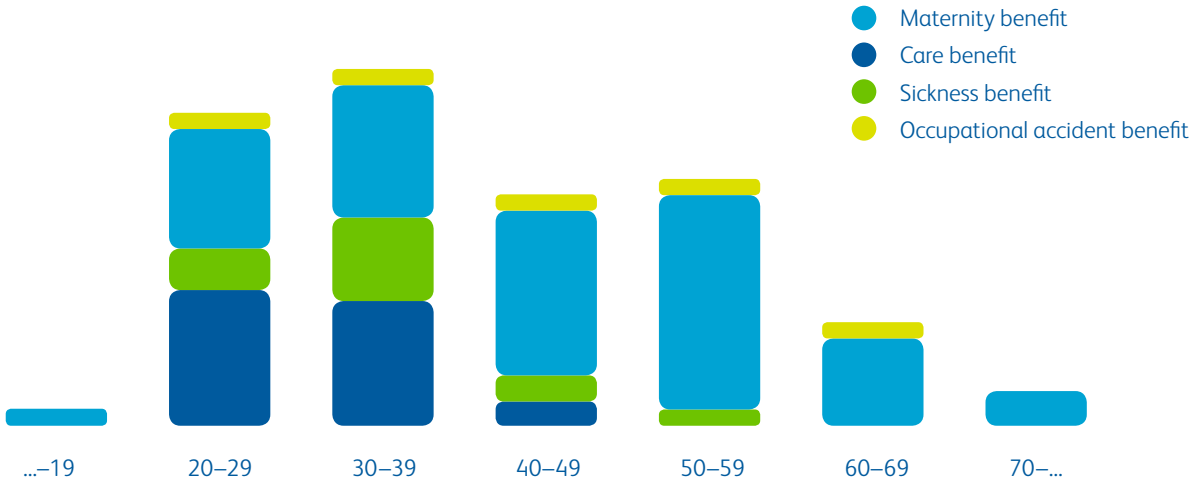
	2010 actual	2011 actual	% of change from 2010
Sickness benefits			
Total number of certificates issued to insured persons*	246,737	274,564	11
Number of days paid for by EHIF	2,332,976**	2,698,258	16
Total number of sickness days *	3,213,757**	3,776,329	18
Total average duration of leave paid for by EHIF *	13.0**	13.8	6
Amount of benefit paid for by EHIF (thousands of euros)	33,175	35,943	8
Average daily income (euros)	14.2**	13.3	–6
Maternity benefits			
Number of certificates	11,007	10,012	–9
Number of days	1,533,010	1,395,109	–9
Average duration of leave	139.3	139.3	0
Benefit amount (thousands of euros)	36,118	31,140	–14
Average daily income (euros)	23.6	22.3	–6
Care benefits			
Number of certificates	76,141	89,716	18
Number of days	643,276	742,621	15
Average duration of leave	8.4	8.3	–1
Benefit amount (thousands of euros)	10,250	11,626	13
Average daily income (euros)	15.9	15.7	–1
Occupational accident benefits			
Number of certificates	4,154	4,796	15
Number of days	90,877	101,848	12
Average duration of leave	21.9	21.2	–3
Benefit amount (thousands of euros)	1,893	2,061	9
Average daily income (euros)	21.0	20.2	–4
Total benefits			
Number of certificates*	**338,039**	**379,088**	**12**
Number of days paid for by EHIF	**4,600,139****	**4,937,836**	**7**
Benefits paid by EHIF (thousands of euros)	**81,436**	**80,770**	**–1**
Average daily income (euros)	**17.7****	**16.4**	**–7**

* All certificates and leave days issued for the leave period are included (including the financial participation of employers of insured persons and EHIF).
** Comparative data for the 2010 certificates has been corrected.

EHIF also pays benefits for a temporary incapacity to work if medical conditions have developed abroad, based on certificates from foreign physicians. Compared to 2010 the number of certificates for a temporary incapacity to work issued abroad has increased by 61%. In 2011, approximately 380 thousand euros were paid based on 454 certificates, while a year before this was approximately 46 thousand euros paid based on 282 certificates. Similarly to 2010, the majority of certificates were issued in Latvia (27%), Ukraine (22%) and Finland (16%). In 2011, the reasons for leave included: sickness (80%), occupational accidents (7%), domestic injuries (5%), caring for a child under twelve years of age (5%), pregnancy and maternity leave (2%), traffic injuries (1%).

When we analyse the leave days by age groups, we can see that their number is at its highest among persons in the 30–39 year-old age group (see Figure 20). The main factor influencing the number of certificates in this age group is the high percentage of maternity and care benefits. The number of sickness days is the highest among the 50–59 year-old age group. A more specific overview of the distribution of leave days with sickness benefit by age groups and by reasons is provided in Appendix 4 to the report.

Figure 20. Distribution of leave days by age groups



In spite of a 7% increase in leave days paid for by EHIF, expenses for benefits for a temporary incapacity to work have decreased by 1% in 2011 when compared to 2010. The main reason for the increase in the number of certificates was a larger outbreak of cold diseases in spring 2011, while employment conditions improved and the number of insured persons who were employed increased. The expenses for benefits for a temporary incapacity to work decreased, as the average income per calendar day decreased by 7%, because the income in 2010 that was subject to social tax decreased.

Due to the combined effect of the increase in the number of insured persons who were employed and in sickness cases, the number of incapacity to work certificates for each insured person increased in 2011 (see Table 36).

Table 36. Number of insured persons and the use of incapacity to work certificates

	2010 actual	2011 actual	% of change from 2010
Number of insured persons (period average)	1,264,624	1,251,473	–1
Number of insured persons in employment (period average)	570,506	571,858	0
Share of insured persons in employment out of all insured persons (%)	45	46	1
Number of incapacity to work certificates *	338,039**	379,088	12
Number of incapacity to work certificates per insured person in employment	0.59**	0.66	12

* The number of incapacity to work certificates also includes information on 1–8-day certificates, which are not paid for by EHIF from 1 July 2009.
** Comparative data for 2010 benefits has been adjusted.

Changes in income that is subject to social tax

In 2011 the average payment for each incapacity to work certificate was 178 euros for sickness benefits, 130 euros for care benefits, 3,110 euros for maternity benefits, and 430 euros for occupational accident benefits. In addition to the duration of the incapacity to work, the amount of benefit for incapacity to work depends most directly on the amount of income that is subject to social tax for each insured person. EHIF calculates the benefit for incapacity to work from the income of each insured person based on the social tax calculated or paid in the calendar year preceding the year for which the leave commencement date is indicated on the incapacity to work certificate. If the insured person had no income in the previous year (the majority of these include persons returning from maternity leave or who were employed after long periods of unemployment), EHIF shall calculate the benefit based on the minimum monthly wage laid down by the Government of the Republic. Compared to 2010, the average cost per day of an incapacity to work certificate decreased by 7% in 2011.

Sickness benefits

Based on the certificates for sick leave, the reasons for leave are distributed as follows: illness 83% (against 84% in 2010), domestic injury 11% (12% in 2010), transfer to an easier job 3% (3% in 2010), sickness or injury during pregnancy 2%, other causes (including traffic injury, occupational disease, etc) 1% (1% in 2010). By treatment type, in 2011, 88% of certificates for sick leave were issued after the provision of outpatient care and 11% after inpatient care. A total of 1% of all certificates for sick leave were issued after outpatient or inpatient medical rehabilitation. Compared to 2010, the share of incapacity to work certificates that were related to inpatient care has decreased by 1%.

The number of sick leave days that have been reimbursed by EHIF increased by 16% and the number of certificates for sick leave by 19% in 2011 (see Table 37). Certificates for sick leave that were not reimbursed by EHIF (the first three days of an patient's financial contribution or days 4–8 which were reimbursed only by employers) made up 26% of all certificates for sick leave in 2011.

Table 37. The number of certificates for sick leave and sick leave days

Number of certificates for sick leave			
	Certificates issued for days 1–8 (financial contribution by insured persons and employers)	Certificates subject to reimbursement by EHIF	Total
2011	72,301	202,263	**274,564**
2010	77,346	169,391	**246,737**

Maternity benefits

The number of days of incapacity to work under maternity benefits decreased by 9% and the number of certificates for maternity leave by 9% in 2011. The average cost per day decreased by 6%. These changes have reduced EHIF's expenditure for maternity benefits by 14%. The average age of persons receiving maternity benefits was 29.6 years and the share of women over thirty among persons receiving maternity benefits was 46% (against a Figure of 48% in 2010).

Care benefits

The number of certificates for care leave increased by 18% and the number of reimbursed days by 15% in 2011. The average duration of certificates for care leave was eight days and this remained largely the same. Certificates for caring for a child of under twelve years of age constituted 98% of all certificates for care leave, certificates for caring for a child of under three years of age or for a disabled child under sixteen years of age constituted 1%, and certificates for caring for a sick family member also constituted 1%. Compared to 2010 there were no significant changes in the reasons for leave. A total of 24% of all certificates for care leave were issued to men, which is 2% less than in 2010. Certificates issued for caring for children between the ages of two and six constituted 82% of all certificates for care leave that were issued for caring for children under twelve years of age, which is approximately 4% more than in 2010. The average cost of a care day decreased by 1%.

Occupational accident benefits

The number of certificates for sick leave due to occupational accidents increased in 2011 by 15% in comparison to 2010. As regards certificates for sick leave due to occupational accidents the reasons for leave were distributed as follows: occupational accidents 95%, complications arising from occupational accidents 4%, and traffic-related occupational injuries 1%. There were no significant changes with respect to the reasons for occupational accidents in comparison to 2010.

5. Other Cash Benefits

5.1. Dental Care Cash Benefits

The expenditure on dental care benefits for adults in 2011 was 7.9 million euros, which amounted to 84% of the annual budget.

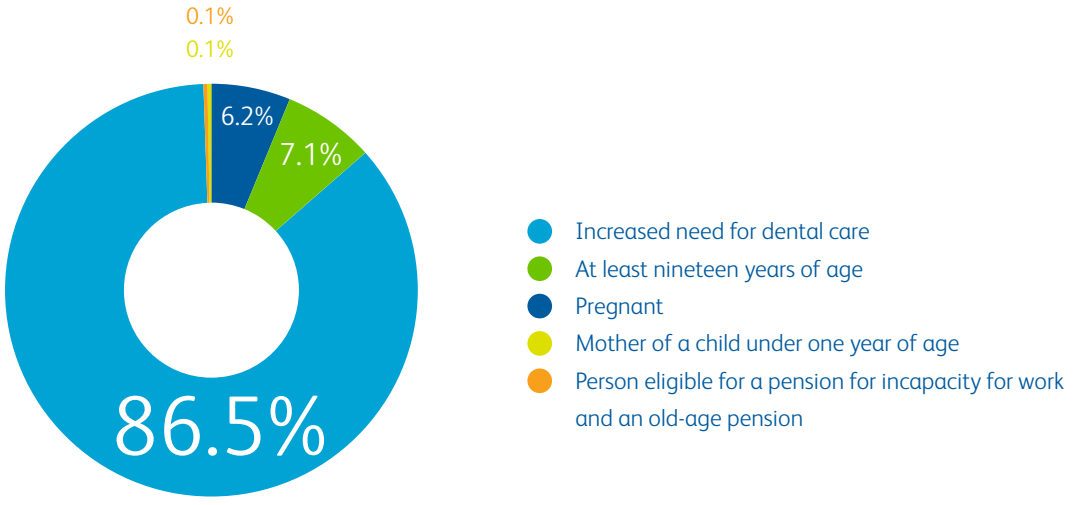
EHIF reimburses expenditure from the annual dental care service to groups of insured persons as follows:

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

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

Applications submitted by pensioners form the majority (87%) of applications submitted to EHIF for dental care benefits (see Figure 21).

Figure 21. Applications by types of benefit



The expenditure on dental care benefits has decreased by 8% compared to 2010 (see Table 38). In the same period the number of denture benefits has decreased by 4%, as based on a population satisfaction survey the use of denture services decreased due to the higher expenses involved (see Table 39). However, applications for dental care benefits remained at the same level as in 2010.

Table 38. Dental care benefits (in thousands of euros)

	2010 actual	2011 budget	2011 actual	Budget execution %	% of change from 2010
Denture benefits	6,733	7,478	6,064	81	–10
Dental care benefits	1,807	1,876	1,791	95	–1
Total	**8,540**	**9,354**	**7,855**	**84**	**–8**

Table 39. The number of dental care service benefits

	2010 actual	2011 budget	2011 actual	Budget execution %	% of change from 2010
Denture benefits	40,674	45,000	39,165	87	–4
Dental care benefits	91,366	94,400	92,687	98	1
Total	**132,040**	**139,400**	**131,852**	**95**	**0**

5.2. Supplementary Benefit for Medicinal Products

Supplementary benefit for medicinal products is a financial benefit granted to insured persons whose expenditure on medicinal products in the EHIF list of medicinal products exceeds 384 euros in a calendar year.

In 2011 both the number of insured persons and the amount spent on benefits was smaller than planned in the budget (see Table 40). The reason for this could lie in the raised awareness of insured persons when purchasing medicinal products in pharmacies: people are more likely to ask for and prefer cheaper alternatives, which keeps the patient's expenditure under better control and ensures that there will be no need for supplementary benefits. At the same time, the average sum paid to each receiver of the benefit has increased by almost twenty euros.

Table 40. Supplementary benefit for medicinal products

	2010 actual	2011 budget	2011 actual	Budget execution %	% of change from 2010
Benefit amount (thousands of euros)	424	484	440	91	4
Number of persons receiving the benefit	1,774	1,850	1,710	92	–4
Average amount paid per person (euros)	239	–	257	–	8

6. Other Health Insurance Benefits

6.1. Benefits Paid on the Basis of EU Legislation and Referral for Planned Treatment in Another Country

An insured person must possess a European health insurance card in order to qualify for insurance in other EU member states, EHIF began issuing these cards from August 1 2004. The European health insurance card proves that a person has insurance in the country of issue, and this is necessary in order for them to receive necessary health care in another EU member state on an equal basis with local insured persons. Between 2004 and 2008 health insurance cards were issued to adult insured persons for one year, but since 2008 cards are now valid for three years. For children, health insurance cards are issued for five years.

In 2011 the number of cards ordered increased, because the term of validity of those cards ordered in 2008 began to expire. Statistics for the cards issued from 2004 to 2011 are provided in Table 41.

Table 41. Number and total expenditure of the issued European health insurance cards (printing, packing, posting, extra sheets) from 2004 to 2011

	2004 (from Aug)	2005	2006	2007	2008	2009	2010	2011	Total
Number of cards	57,795	100,574	78,301	99,590	100,005	52,118	55,790	69,693	**613,866**
Sum (in euros)	20,408	33,996	34,428	40,076	48,296	30,363	17,396	33,448	**258,411**

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

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

The number of e-forms processed by EHIF has increased greatly throughout the years. In 2011 the number of processed forms increased by 41% when compared to 2010. The most common forms are E 125 and E 106.

The number of international reimbursement forms for actual expenses, E 125, which were sent to EHIF in 2011 was 5,192, while EHIF sent 8,072 similar forms to other countries. Therefore, the number of persons receiving treatment in other member states has increased. A form may not be based on a treatment case, ie. health services provided to one person may be entered on several forms. The practice is different in various countries, which means that we cannot put an equals sign between the number of forms sent to or from EHIF and the number of persons who have needed treatment.

Form E 106 is used to prove that a posted employee has insurance cover. This form entitles an employee who has been sent to another country for longer than one year to receive anymedical treatment in the new country of location after the registration of the form has been completed. In 2011 the number of forms issued increased by 1,084. This was caused by a legal amendment which simplified the execution of long-term assignments (which exceed a year). A detailed overview of the number of E-forms between 2004 to 2011 is provided in Appendix 5.

6.1.1. Referral for Planned Treatment in another Country

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

An insured person can be referred for planned treatment abroad 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%.

In 2011 the number and average cost of planned treatment cases increased: in 2011 there were 37 treatment cases more than in 2010 and the average cost of a case increased by 40% compared to 2010 (see Table 42 and 43).

Table 42. Expenditure on planned treatment abroad (in thousands of euros)

	2008 actual	2009 actual	2010 actual	2011 budget	2011 actual	Budget execution %	% of change from 2010
Planned treatment abroad	1,478	1,322	971	1,476	1,745	118	80

Table 43. Number of cases of planned treatment and average cost of each treated case (in euros)

	2010 actual		2011 actual		% of change from 2010	
	TC	ACTC	TC	ACTC	TC	ACTC
Planned treatment abroad	129	7,527	166	10,512	29	40

In 2011 EHIF took over the obligation of payment for planned health services provided abroad from 166 insured persons (including 76 children). Of these, 51 persons were referred for treatment abroad, 85 were referred to examinations and thirty searched for unrelated bone marrow donors through the Finnish Red Cross. In the reporting period, nineteen applications were rejected and processing of the applications of six persons was terminated without decision of the Management Board. 90% of all submitted applications were satisfied in 2011.

In 2011 the majority of patients were treated in Finland and Germany, while the number of examinations was highest in the Netherlands and Belgium (see Table 44).

Table 44. Countries in which insured persons received planned treatment or examinations in 2011

Country	Total	Treatment	Examination
Finland	35	25	10
Netherlands	31	0	31
Germany	24	13	11
Belgium	20	0	20
Sweden	8	5	3
Lithuania	6	0	6
UK	6	3	3
Russia	2	2	0
Austria	2	2	0
Latvia	1	0	1
Ukraine	1	1	0
Total	**136**	**51**	**85**

6.1.2. Benefits for Health Services Arising from EU Legal Acts

Persons insured with the EHIF are entitled to receive necessary health care when their stay in another member state is temporary, and to receive any type of health care when they reside in another member state, if Estonia remains the insuring country. As the insuring country, EHIF will pay to other countries for the costs of medical services provided to its insured persons. At the same time the insured persons of other EU member states are entitled to the necessary health care during their temporary stay in Estonia and to any type of health care when they reside here. The health care costs related to persons insured in other EU member states are first reimbursed by EHIF (to the health care providers), but the final body covering the health care costs will be the insuring country.

Reimbursement of the expenses of cross-border health care is an open commitment for EHIF. The planned expenses for 2011 were 3.3 million euros, but actual expenses were much higher: 6.5 million euros (see Table 45).

Table 45. Expenses for health services on the basis of the Regulations of the EU Council (in thousands of euros)

	2008 actual	2009 actual	2010 actual	2011 budget	2011 actual	Budget execution %	% of change from 2010
Payments for health services provided in other member states to persons insured with EHIF	1,414	2,371	2,060	2,474	5,266	213	156
Payments for health services provided in Estonia to persons insured in other member states	662	659	779	856	1,199	140	54
Total	**2,076**	**3,030**	**2,839**	**3,330**	**6,465**	**194**	**128**

A total of 1.1 million euros was paid to health service providers for treatment provided in Estonia to persons insured in other EU member states, and 49 thousand euros were reimbursed to pharmacies for subsidised pharmaceuticals.

EHIF paid 5.3 million euros to other EU member states for health services provided to posted employees and pensioners residing in other EU member states and those persons staying temporarily in another EU member state. The portion of capitation fee paid for persons residing in other EU member states and receiving pensions from Estonia was 1.5 million euros, actual expenses of health services provided to the persons residing or staying in another country amounted to 3.7 million euros and the portion of reimbursements to persons was 64 thousand euros. Some insured persons received reimbursements if for some reason they were not carrying the European health insurance card during their stay in another member state and an invoice was submitted to them for the health services provided.

The expenditure in 2011 was very high, especially taking account of the fact that in 2010 expenditure decreased when compared with 2009. A possible reason for the increase of expenditure in 2011 was the improvement of the economic situation, which enabled people to travel. Another reason was increased employment in other member states. Social tax is collected in Estonia from many people working in other member states and therefore they remain insured with EHIF. Persons working in other member states are entitled to any type of health care in the relevant country, but in most countries this health care is several times more expensive than in Estonia.

Another reason for the increased expenditure was an amendment made to EU legislation in 2010 which changed the procedure of payment for treatment expenses of pensioners residing in another country. While in the former procedure the payment was based on the average cost of treatment, now the actual cost of treatment can be specified for pensioners (some countries still use average costings as the basis for payment). The enacted amendment accelerated the submission of invoices and in 2011 the number of invoices submitted as actual expenses increased.

6.2. Benefits for Medical Devices

Benefits for medical devices are reimbursed to all insured persons whose need to use a medical device has been established by a physician on the basis of the terms and conditions of the List of Medical Devices. Benefit for medical devices is an open commitment for EHIF similar to the reimbursement of the cost of pharmaceuticals to insured persons.

In co-operation with manufacturers of medical devices and professional associations, EHIF annually processes applications submitted for amendment of the List of Medical Devices. Based on this, EHIF's Supervisory Board will submit a proposal to the Minister of Social Affairs for the addition of new cost-efficient and medically verified devices into the list. At the beginning of 2011, glucometer test strips, insulin pump accessories, and new contemporary devices in the stoma appliances group were added to the List of Medical Devices. Also a new group of medical devices was added to the list: wound dressings and patches for the treatment of venous and diabetic ulcers, bedsores and burns.

Table 46. Benefits for medical devices (in thousands of euros)

	2010 actual	2011 budget	2011 actual	Budget execution %	% of change from 2010
Glucometer test strips	2,370	3,179	2,547	80	7
Primary prostheses and orthoses	1,119	1,380	1,201	87	7
Stoma appliances	843	895	888	99	5
Insulin pumps	139	161	204	127	47
Wound dressings and patches	–	45	13	29	–
Other medical devices	36	45	33	73	–8
Total	**4,507**	**5,705**	**4,886**	**86**	**8**

Table 47. Treatment cases involving benefits for medical devices and average cost in euros

	2010 actual		2011 actual		% of change from 2010	
	TC	ACTC	TC	ACTC	TC	ACTC
Glucometer test strips	26,711	89	29,048	88	9	–1
Primary prostheses and orthoses	8,937	125	9,475	127	6	2
Stoma appliances	1,551	544	1,589	559	2	3
Insulin pumps	91	1,527	155	1,316	70	–14
Wound dressings and patches	–	–	377	34	–	–
Other medical devices	220	164	123	268	–44	64
Total	**37,510**	**120**	**40,767**	**120**	**9**	**0**

Compared to 2010 more funds were planned in the budget, because an increase in the use of primary prostheses, orthoses, glucometer test strips, and new wound dressings and patches was expected. The actual number of insured persons who needed benefits for medical devices in 2011 was three times lower than budgeted on the basis of the size of target groups (see Tables 46 and 47).

In the largest group – **glucometer test strips** – the use has not yet reached the expected level. Based on the data of the use of pharmaceuticals, approximately 56 thousand diabetics received treatment at the beginning of the year. Only half of them used the option of self-testing in 2011. Diabetics who receive insulin treatment are aware of the need for self-testing and purchase all necessary test strips. Those patients who are treated with pills check their blood sugar level less frequently and many of them have not used the option of obtaining benefits at all. However, the number of users of test strips has increased annually, showing that the awareness of the need for self-testing in order to determine the correct dose of medication and prevent complications is increasing.

The number of users of post-operative and post-traumatic **prostheses and orthoses** and **stoma appliances** was also less than expected. The need for orthoses and prostheses depends on the number of traumas, operations and amputations. While the number of patients purchasing prostheses has been steady throughout the years,

approximately 200, the number of users of orthosis benefit has increased year by year as they are more aware of their rights, and also the network of dealers in orthoses has expanded. The use of stoma appliances has increased compared to the previous period, but is still lower than the maximum amount possible. Stoma appliances are used differently: employed and more socially active insured persons purchase more of these devices.

Unlike other medical devices, the expenditure on **insulin pumps and related accessories** exceeded expectations in 2011. The number of users of these pumps increased due to the campaign initiated by a manufacturer, in which free insulin pumps were distributed to many diabetic children in 2011. As EHIF reimburses the cost of pump accessories to all diabetics under nineteen years of age who use an insulin pump, the number of users of insulin pump accessories increased on account of the increased numbers of children receiving the campaign pumps. EHIF was not informed of the campaign in advance and thus we could not plan for this increase in expenses. EHIF found extra funds for pump accessories from the budget of other medical devices which had not been used as much as was expected.

Use was lowest in the group of **wound dressings and patches**, because only a quarter of the planned target group started treatment of wounds with these dressings on the list. Although EHIF informed hospitals and family physicians of the added medical devices at the beginning of the year, it has taken time to implement the transfer.

Other medical devices include less frequently used medical devices: intermediate containers for the administration of asthma medication, disposable urinary catheters, pressure garments for burn patients and therapeutic contact lenses. Based on the usage data of 2010, an increased need for other medical devices was planned in the budget for 2011. The actual number of users of the benefits remained at the same level as in 2010. However, the average cost per person of other medical devices increased compared to the previous year, because many insured persons with visibility disorders purchased the maximum amount of therapeutic contact lenses, and this had not happened in previous years.

6.3. Expenses Covered by Targeted Financing from the State Budget

Infertility treatment is funded from the state budget through targeted financing. A total of 1.5 million euros was paid for infertility treatment during the reporting period: 883,174 euros for pharmaceuticals and 578,122 euros for health services. Income from targeted financing is shown in other income (see page 37).

The option of having infertility treatment and receiving benefits for the necessary medicine is available for insured women up to and including forty years of age with medical indications for external in vitro fertilisation and/or embryo transfer. A total of 1,872 infertility treatment procedures was performed and reimbursement for pharmaceuticals was paid to 1,247 women in 2011.

Health Insurance Fund Operating Expenses

An overview of EHIF operating expenses is provided in Table 48.

Table 48. EHIF operating expenses (in thousands of euros)

	2010 actual	2011 budget	2011 actual	Budget execution %	% of change from 2010
Total personnel and management expenses	**4,343**	**4,535**	**4,380**	**97**	**1**
Wages and salaries	3,235	3 376	3,262	97	1
including remuneration of the members of the Management Board	133	138	139	101	5
Unemployment insurance premium	43	45	44	98	2
Social tax	1,065	1,114	1,074	96	1
Administrative expenses	**1,052**	**1,081**	**1,011**	**94**	**–4**
Information technology expenses	**653**	**890**	**834**	**94**	**28**
Development expenses	**128**	**175**	**159**	**91**	**24**
training	64	95	76	80	19
consultations	64	80	83	104	30
Financial expenses	**91**	**96**	**87**	**91**	**–4**
Other operating expenses	**621**	**664**	**609**	**92**	**–2**
supervision of the health insurance system	92	102	53	52	–42
public relations/communication	48	72	68	94	42
other expenses	481	490	488	100	1
Total EHIF operating expenditure	**6,888**	**7,441**	**7,080**	**95**	**3**

Personnel expenses amounted to 4.4 million euros in 2011. The planning for personnel expenses was decided on the basis of an operation-based need for resources. The estimated need for 2011 was 216 posts, while actually 213 people were employed in EHIF as at 31 December 2011. The management board´s fee for 2011 includes pre-calculated fee for fulfilling the scorecards, the actual amount is approved by the supervisory board after the annual report is approved.

All expenses related to the transfer to euro have been incurred from the IT expenses budget. In 2011, EHIF received a grant from the Estonian Information Systems Authority for a transfer to euro in the amount of 32,594 euros (the total grant was 47,933 euros, of which 15,339 euros were received in 2010 and 32,594 euros in 2011). A major IT service operation which was performed in the reporting period was the updating of data communications in the Viru department. Also regular system maintenance operations were performed. Of the IT expenses total, depreciation of fixed assets amounted to 332,345 euros.

Development expenses include training expenses and expenses for legal and business consultations. Expenses for business consultations also include expenditure for the development project concerning clinical guidelines, including the drafting and design of the web site (www.ravijuhend.ee). Expenses for legal consultations include services ordered from experts in relation to the choice of health care providers and the sale of shares in Viimsi Hospital.

As for supervision, five clinical audits were organized during the year (see page 20).

In the public relations and communication projects, most funds were spent on information materials and video clips of digital prescriptions.

Other expenses also include the targeted financing cost of the project, "Supporting the development of Moldova's health insurance system", which totalled 25,339 euros. EHIF receives funds for this project from the budget for development and humanitarian aid held by the Ministry of Foreign Affairs. The objective of this project is to support the development of Moldova's health insurance system through sharing Estonian experience. EHIF receives assistance from WHO to co-ordinate the project. WHO is an active supporter of health reforms in Moldova on a regional level. WHO's participation in the project ensures the compliance of essential assistance with current reforms and its integration into a broader support program in the field of health care funding, if this becomes necessary. More than ten experts from EHIF, who train and share their knowledge, are participating in the Moldovan project.

Legal Reserve

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

As at 31 December 2011, EHIF's legal reserve amounted to 51.1 million euros. The amount of the mandatory legal reserve in 2012 is 47.2 million euros.

Risk Reserve

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

As at the end of the financial year, EHIF's risk reserve included 14.7 million euros. The amount of the mandatory legal reserve in 2012 is 15.6 million euros. In order to comply with this legal requirement, an additional 857 thousand euros transferre to the risk reserve in 2012.

Retained Earnings

As at 31 December 2011, the Health Insurance Fund had 163.4 million euros in retained earnings.

Notes to the 2011 Budget Execution Report

Note 1. Expenses for specialized health care (in thousands of euros)

	2010 actual	2011 budget	2011 actual	Budget execution %	% of change from 2010
Internal medicine	**94,440**	**96,869**	**98,969**	**102**	**5**
outpatient care	18,620	19,612	21,514	110	16
day care	6,050	6,711	6,216	93	3
inpatient care	69,770	70,546	71,239	101	2
Surgery	**71,137**	**72,583**	**72,518**	**100**	**2**
outpatient care	12,995	13,313	14,192	107	9
day care	3,110	3,201	3,042	95	–2
inpatient care	55,032	56,069	55,284	99	0
Obstetrics and gynaecology	**39,325**	**40,805**	**40,093**	**98**	**2**
outpatient care	17,997	18,404	19,242	105	7
day care	2,204	2,281	2,308	101	5
inpatient care	19,124	20,120	18,543	92	–3
Oncology	**35,549**	**38,918**	**39,242**	**101**	**10**
outpatient care	19,096	20,041	21,034	105	10
day care	1,125	2,533	1,286	51	14
inpatient care	15,328	16,344	16,922	104	10
Orthopaedics	**31,809**	**33,567**	**33,757**	**101**	**6**
outpatient care	7,164	7,523	7,624	101	6
day care	1,873	2,081	1,873	90	0
inpatient care	22,772	23,963	24,260	101	7
Psychiatry	**18,609**	**20,249**	**18,847**	**93**	**1**
outpatient care	5,055	5,429	5,227	96	3
day care	100	128	192	150	92
inpatient care	13,454	14,692	13,428	91	0
Ophthalmology	**15,591**	**16,595**	**16,208**	**98**	**4**
outpatient care	8,049	8,686	8,496	98	6
day care	6,720	6,971	6,694	96	0
inpatient care	822	938	1,018	109	24
Paediatrics	**17,091**	**16,213**	**15,725**	**97**	**–8**
outpatient care	4,073	4,364	4,277	98	5
day care	381	499	445	89	17
inpatient care	12,637	11,350	11,003	97	–13

	2010 actual	2011 budget	2011 actual	Budget execution %	% of change from 2010
Neurology	**12,837**	**13,509**	**14,245**	**105**	**11**
outpatient care	5,895	6,273	6,569	105	11
day care	28	36	67	186	139
inpatient care	6,914	7,200	7,609	106	10
Pulmonology	**11,879**	**12,029**	**13,111**	**109**	**10**
outpatient care	5,630	5,582	6,233	112	11
day care	–	0	2	–	–
inpatient care	6,249	6,447	6,876	107	10
Otorhinolaryngology	**10,186**	**10,334**	**10,493**	**102**	**3**
outpatient care	4,829	4,914	5,078	103	5
day care	1,732	1,900	1,864	98	8
inpatient care	3,625	3,520	3,551	101	–2
Rehabilitation	**8,848**	**9,472**	**9,457**	**100**	**7**
outpatient care	4,367	4,652	4,760	102	9
inpatient care	4,481	4,820	4,697	97	5
Infectious diseases	**5,575**	**6,031**	**6,273**	**104**	**13**
outpatient care	1,799	1,905	2,174	114	21
day care	–	0	1	–	–
inpatient care	3,776	4,126	4,098	99	9
Dermatovenereology	**4,543**	**4,808**	**4,541**	**94**	**0**
outpatient care	3,814	4,028	3,813	95	0
day care	75	88	71	81	–5
inpatient care	654	692	657	95	0
Primary follow-up care	**1,379**	**1,396**	**1,546**	**111**	**12**
inpatient care	1,379	1,396	1,546	111	12
Total specialised health care	**378,798**	**393,378**	**395,025**	**100**	**4**
Total outpatient care	119,383	124,726	130,233	104	9
Total day care	23,398	26,429	24,061	91	3
Total inpatient care	236,017	242,223	240,731	99	2
24/7 preparedness	**8,334**	**8,423**	**8,423**	**100**	**1**
Total	**387,132**	**401,801**	**403,448**	**100**	**4**

Note 2. Note 2. Specialised health care cases

	2010 actual	2011 budget	2011 actual	Budget execution %	% of change from 2010
Internal medicine	**425,654**	**438,249**	**446,374**	**102**	**5**
outpatient care	368,111	380,747	387,808	102	5
day care	4,047	4,239	4,877	115	21
inpatient care	53,496	53,263	53,689	101	0
Surgery	**371,219**	**372,016**	**389,984**	**105**	**5**
outpatient care	316,944	316,391	334,284	106	5
day care	9,796	11,566	11,399	99	16
inpatient care	44,479	44,059	44,301	101	0
Obstetrics and gynaecology	**527,447**	**530,283**	**527,016**	**99**	**0**
outpatient care	477,916	479,010	478,425	100	0
day care	16,196	17,587	17,428	99	8
inpatient care	33,335	33,686	31,163	93	–7
Oncology	**93,633**	**102,537**	**104,250**	**102**	**11**
outpatient care	82,054	89,306	91,570	103	12
day care	1,789	3,339	2,719	81	52
inpatient care	9,790	9,892	9,961	101	2
Orthopaedics	**261,633**	**268,369**	**269,409**	**100**	**3**
outpatient care	243,841	250,066	251,136	100	3
day care	3,933	4,379	4,349	99	11
inpatient care	13,859	13,924	13,924	100	0
Psychiatry	**231,950**	**238,637**	**236,801**	**99**	**2**
outpatient care	220,729	227,221	225,431	99	2
day care	269	307	472	154	75
inpatient care	10,952	11,109	10,898	98	0
Ophthalmology	**364,498**	**374,166**	**377,073**	**101**	**3**
outpatient care	348,971	358,085	361,245	101	4
day care	13,973	14,533	14,147	97	1
inpatient care	1,554	1,548	1,681	109	8
Paediatrics	**146,702**	**146,614**	**151,682**	**103**	**3**
outpatient care	114,476	114,718	120,461	105	5
day care	1,725	1,968	2,076	105	20
inpatient care	30,501	29,928	29,145	97	–4

	2010 actual	2011 budget	2011 actual	Budget execution %	% of change from 2010
Neurology	**135,929**	**139,891**	**143,678**	**103**	**6**
outpatient care	128,447	132,452	136,023	103	6
day care	77	89	190	213	147
inpatient care	7,405	7,350	7,465	102	1
Pulmonology	**68,686**	**66,571**	**73,665**	**111**	**7**
outpatient care	65,204	63,183	69,733	110	7
day care	–	0	32	–	–
inpatient care	3,482	3,388	3,900	115	12
Otorhinolaryngology	**195,557**	**194,856**	**204,332**	**105**	**4**
outpatient care	179,279	178,298	187,098	105	4
day care	5,641	6,416	6,652	104	18
inpatient care	10,637	10,142	10,582	104	–1
Rehabilitation	**67,514**	**69,340**	**73,653**	**106**	**9**
outpatient care	60,962	62,610	67,122	107	10
inpatient care	6,552	6,730	6,531	97	0
Infectious diseases	**34,373**	**35,340**	**37,559**	**106**	**9**
outpatient care	23,491	23,420	25,527	109	9
day care	–	0	6	–	–
inpatient care	10,882	11,920	12,026	101	11
Dermatovenereology	**174,869**	**178,471**	**169,344**	**95**	**–3**
outpatient care	173,027	176,627	167,517	95	–3
day care	473	469	552	118	17
inpatient care	1,369	1,375	1,275	93	–7
Primary follow-up care	**2,118**	**2,144**	**2,229**	**104**	**5**
inpatient care	2,118	2,144	2,229	104	5
Total specialised health care	**3,101,782**	**3,157,484**	**3,207,049**	**102**	**3**
Total outpatient care	2,803,452	2,852,134	2,903,380	102	4
Total day care	57,919	64,892	64,899	100	12
Total inpatient care	240,411	240,458	238,770	99	–1
24/7 preparedness	**380**	**380**	**380**	**100**	**0**
Total	**3,102,162**	**3,157,864**	**3,207,429**	**102**	**3**

Note 3. Treatment cases and expenses of speciality surgery and internal diseases by sub-speciality

Sub-speciality	Treatment cases	Total
Surgery		
general surgery	273,430	35,778
cardiac surgery	4,035	10,065
urology	57,404	8,674
neurosurgery	13,899	6,682
vascular surgery	11,982	5,569
paediatric surgery	15,672	1,880
thoracic surgery	1,442	1,677
face and jaw surgery	12,058	1,571
organ transplants	62	622
Total surgery	**389,984**	**72,518**
Internal diseases		
cardiology	113,999	41,175
internal medicine	100,485	24,676
haematology	23,021	11,273
nephrology	15,586	9,620
endocrinology	93,858	4,428
gastroenterology	34,763	4,294
rheumatology	62,027	3,294
occupational diseases	2,635	210
Total internal diseases	**446,374**	**98,970**

Note 4. Statistics by age groups

Number of days of incapacity for work for which benefits were paid by EHIF, by reasons for sick leave and age groups	...–19	20–29	30–39	40–49	50–59	60–69	70–...	Total
Illness	8,520	202,571	299,255	485,512	713,024	297,402	40,357	2,046,641
Domestic injury	3,434	65,757	77,768	94,356	117,287	44,951	7,408	410,961
Transfer to another job	2,414	89,451	50,261	2,994	0	0	0	145,120
Occupational accident	1,090	16,903	18,204	22,768	26,065	10,849	883	96,762
Illness or injury during pregnancy	691	36,012	29,463	2,340	0	0	0	68,506
Traffic injury	296	5,529	5,741	5,656	5,460	1,791	153	24,626
Complication arising from occupational accident	14	1,258	1,117	339	704	140	120	3,692
Traffic-related occupational injury	28	187	144	355	370	310	0	1,394
Occupational disease	0	0	130	347	769	91	0	1,337
Complication arising from traffic injury	44	23	254	291	242	106	52	1,012
Injury during protection of national or social interests	0	21	34	0	0	0	0	55
Total	**16,531**	**417,712**	**482,371**	**614,958**	**863,921**	**355,640**	**48,973**	**2,800,106**

Note 5. Number of e-forms 2004–2011

	2004			2005			2006			2007		
Form	in	out	total	in	out	total	in	out	total	in	out	total
E 001	4		4	91	7	98	124	17	141	164	18	182
E 101							167		167	210		210
E 104	11		11	215		215	545		545	265	625	890
E 106	13	192	205	26	145	171	38	164	202	51	206	257
E 107	21	20	41	221	48	269	91	98	189	249	33	282
E 108				7	5	12	11	6	17	25	21	46
E 109				10	2	12	11	1	12	7	2	9
E 112	3	10	13		6	6	1	8	9	15	1	16
E 115				3	2	5		2	2		11	11
E 116				3	2	5	1		1		10	10
E 117					2	2					3	3
E 118					2	2					6	6
E 121	65	8	73	108	44	152	91	45	136	103	62	165
E 123							1		1		21	21
E 125				659	1,295	1,954	1,349	2,547	3,896	2,222	3,769	5,991
E 126	11	58	69	136	326	462	115	330	445	121	310	431
E 127							11		11	9		9
Total	**128**	**288**	**416**	**1,479**	**1,886**	**3,365**	**2,556**	**3,218**	**5,774**	**3,441**	**5,098**	**8,539**

	2008			2009			2010			2011		
Form	in	out	total	in	out	total	in	out	total	in	out	total
E 001	169	20	189	126	20	146	209	13	222	230	20	250
E 101	228		228	229		229	1,064		1,064	2,488		2,488
E 104	100	603	703	221	760	981	127	624	751	149	516	665
E 106	124	215	339	115	230	345	123	1,006	1,129	317	2,090	2,407
E 107	273	39	312	243	25	268	488	37	525	695	19	714
E 108	49	62	111	87	27	114	99	105	204	200	87	287
E 109	4	2	6	9	4	13	9	6	15	8	3	11
E 112	58	3	61	35	30	65	15	33	48	59	74	133
E 115	3		3		25	25		36	36	4	54	58
E 116		1	1		11	11		27	27	3	52	55
E 117			0			0		3	3	3		3
E 118			0			0		4	4	5		5
E 121	86	85	171	56	76	132	266	179	445	74	119	193
E 123		53	53	1	41	42		54	54	6	45	51
E 125	2,472	4,622	7,094	3,997	5,261	9,258	3,637	5,950	9,587	5,192	8,072	13,264
E 126	137	363	500	156	475	631	112	344	456	84	435	519
E 127	29	452	481	89	1	90	463	629	1 092	668	349	1 017
Total	**3,732**	**6,520**	**10,252**	**5,364**	**6,986**	**12,350**	**6,612**	**9,050**	**15,662**	**10,185**	**11,935**	**22,120**

2011 Annual Financial Statements

Balance Sheet

Assets

In thousands of euros	31.12.2011	31.12.2010	Note
Current assets			
Cash and equivalents	203,577	68,462	2
Bonds and other securities	0	101,369	3
Receivables and pre-payments	74,107	73,558	4
Inventories	6	5	5
Total current assets	**277,690**	**243,394**	
Fixed assets			
Long-term receivables	501	619	6
Long-term financial investments	0	20,600	6
Tangible assets	806	935	7
Intangible assets	1	37	7
Total fixed assets	**1,308**	**22,191**	
Total assets	**278,998**	**265,585**	

Liabilities and equity

In thousands of euros	31.12.2011	31.12.2010	Note
Liabilities			
Current liabilities			
Loans and pre-payments	49,720	45,921	9
Total current liabilities	**49,720**	**45,921**	
Total liabilities	**49,720**	**45,921**	
Net assets			
Reserves	65,873	65,873	10
Retained earnings of previous periods	153,791	159,618	
Retained earnings during the financial year	9,614	–5,827	
Total net assets	**229,278**	**219,664**	
Total liabilities and equity	**278,998**	**265,585**	

Financial Performance Statement

In thousands of euros	2011	2010	Note
Revenue from the health insurance part of social tax and claims collected from other persons	726,470	686,588	11
Income from targeted financing	1,542	1,180	15
Expenses for targeted financing	–1,486	–2,063	15
Expenditure on health insurance	–716,957	–691,314	12
Gross earnings	**9,569**	**–5,609**	
Administrative expenses	–6,384	–6,176	13
Other operational revenue	4,340	4,224	
Other operating expenditure	–584	–621	
Operating gain/loss	**6,941**	**–8,182**	
Financial income and expenses			
Interest and financial income	2,760	2,446	
Financial expenses	–87	–91	
Total financial income and expenses	**2,673**	**2,355**	
Retained earnings during the financial year	**9,614**	**–5,827**	

Cash-Flow Statement

In thousands of euros	2011	2010	Note
Cash flow from operating activities			
Social tax received	725,633	685,313	
Payments to suppliers	–717,139	–697,005	
Personnel expenses paid	–3,244	–3,584	
Paid taxes on labour costs	–1,041	–1,303	
Other revenue received	7,429	6,723	
Total cash-flow from operating activities	**11,638**	**–9,856**	
Cash-flow from investments			
Payments for fixed assets	–251	–632	
Proceeds from financial investments	264,127	139,664	
Payments for financial investments	–140,399	–146,224	
Total cash-flow from investments	**123,477**	**–7,192**	
Net increase/decrease in cash in hand and in the bank	**135,115**	**–17,048**	
Cash in the bank and cash equivalents at the beginning of the period	68,462	85,510	2
Change in cash	135,115	–17,048	
Cash in the bank and cash equivalents at the end of the period	203,577	68,462	2

Changes in Net Assets Statement

In thousands of euros	2011	2010	Note
Reserves			
Reserves at the beginning of the year	**65,873**	**64,442**	
Increase in reserves	0	3,216	
Decrease in reserves	0	–1,785	
Reserves at the end of the year	**65,873**	**65,873**	10
Retained earnings of previous periods			
At the beginning of the year	**153,791**	**161,049**	
Decrease in reserves	0	1,785	
Increase in reserves	0	–3,216	
Retained earnings during the financial year	9,614	–5,827	
At the end of the year	**163,405**	**153,791**	
Net assets at the beginning of the year	**219,664**	**225,491**	
Net assets at the end of the year	**229,278**	**219,664**	

Notes to the Annual Financial Statements

Note 1. Accounting principles used when preparing the Annual Accounts

General principles

The 2011 Annual Accounts of the Estonian Health Insurance Fund (EHIF) have been prepared in compliance with Estonia's good accounting practice. This is based on internationally recognised accounting and reporting principles, the main requirements of which have been established by the Accounting Act of the Republic of Estonia and supplemented by guidelines issued by the Accounting Standards Board. The general rules for state accounting have also been considered in the preparation of these Annual Accounts.

The financial year began on 1 January 2011 and ended on 31 December 2011. The figures in the Annual Accounts are shown in thousands of euros.

Functional and reporting currency

In connection with the change in the official currency of the Republic of Estonia, as of 1 January 2011 the functional and reporting currency of the Estonian Health Insurance Fund is the euro instead of the Estonian kroon. Financial data for previous periods which was submitted in Estonian kroons is recalculated into euros in accordance with an exchange rate of 15.6466, which was confirmed in the regulation of the Council of the European Union. Based on the fact that the exchange rate between the Estonian kroon and the euro has been previously fixed at the same level, the change in functional and reporting currency did not impact upon the Estonian Health Insurance Fund's financial standing, its total net gain (or loss) for the accounting period, or upon cash flows.

Financial statement formats

For Statement of Financial Performance purposes, the income statement format number two which is set out in the Accounting Act is used, with the structure of entries having been adjusted according to specific types of EHIF activity.

Financial assets and liabilities

Financial assets include cash, short-term financial investments, trade receivables and other current and long-term receivables. Financial liabilities include supplier payables, accruals and other short- and long-term loan commitments.

Financial assets and liabilities are initially registered at their acquisition value, which is the fair value of the payment made or received for particular financial assets or liabilities. The initial acquisition value includes all transaction expenses directly associated with the financial asset or liability in question.

Purchases and sales of financial assets are recorded consistently on the value date, ie. on the date when EHIF either becomes the owner of financial assets which have been purchased or loses the right of ownership to financial assets which have been sold.

Financial liabilities are recorded on the balance sheet at their adjusted acquisition value. Financial assets are removed from the balance sheet when EHIF loses the right to cash-flows arising from the financial asset, or when it grants a third party the cash-flows arising from the financial asset, together with most of the risks and benefits associated with the financial asset. Financial liability is removed from the balance sheet when it has been discharged, terminated, or expired.

Cash and equivalents

Cash and equivalents include cash in the bank, deposits on hand, and short-term bank deposits (ie. those with a redemption period of less than three months) without a significant risk of change in market value. The Cash-Flow Statement is prepared using the direct method.

Foreign currency transaction recording

Foreign currency transactions are recorded using European Central Bank official exchange rates available on the day of transaction. Monetary and non-monetary financial assets and liabilities denominated in foreign currencies and recorded at fair value are re-translated into euros on the date of the balance sheet using the official exchange rates of the European Central Bank. Gains and losses from foreign currency transactions are recorded on the Financial Performance Statement as income and expenses for the accounting period.

Financial investment accounts

Financial investments in shares and bonds are recorded on the balance sheet based on their fair value. The assessment of fair value is based on the market value of the financial investment on the date of the balance sheet.

Gains and losses from changes in value are recorded in the statement of financial performance for the accounting period.

Receivables accounts

Trade receivables include receivables for goods sold, services provided, and claims for payment regarding health insurance benefits, which will be due in the following financial year. Receivables with a term of more than one year, including postponed tax claims against the Tax and Customs Board, are recorded as long-term receivables.

Receivables for goods sold and services provided include receivables for prescription forms sold to medical institutions and family physicians, claims to the Ministry of Social Affairs for the service of processing invoices for medical treatment, and claims which need to be submitted to competent authorities of the EU for health services provided. The probability of collecting receivables is assessed at least once a year as at the date of the balance sheet. Receivables are assessed individually, and are recorded on the balance sheet on a conservative basis in view of the amounts which are collectable. Doubtful receivables are recorded as expenses for the accounting period. Receivables, which have been collected during the accounting period and have been recorded as expenses, are recorded as reductions of the expenses of doubtful receivables.

Receivables which do not justify any recovery measures, for practical or economic reasons, are deemed to be irrecoverable and have been excluded from the balance sheet.

Inventories

Inventories are recorded at acquisition value and expensed using the FIFO method. Inventories are appraised on the balance sheet based on their acquisition value or net realisation value, whichever is lower.

Tangible assets

Tangible assets include assets with a useful life of more than one year and an acquisition value of more than 2,000 euros. Assets with a shorter period of useful life and lower acquisition value are recorded as expenses at the time of acquisition.

Tangible assets are recorded at acquisition value and depreciated on the basis of their useful life using the linear method. Land is not subject to depreciation. The following depreciation periods (in years) are applied:

- ➜ buildings and structures 10–20 years
- ➜ inventories 2–4 years
- ➜ machinery and equipment 3–5 years

Intangible assets

Intangible assets include identifiable assets which have no physical substance, with a usage period of more than one year in EHIF operations, and an acquisition value of more than 2,000 euros. Intangible assets are recorded at their acquisition value and depreciated over two to five years using the linear method.

Expenditure on tangible and intangible assets incurred after acquisition is generally recorded under expenses for the accounting period. Additional expenditure is added to the cost of intangible assets if it is likely that this expenditure allows the asset to generate more future economic benefits than expected, and if this expenditure can be reliably assessed and associated with the asset.

Targeted financing

Targeted financing means targeted grants, given and received on certain conditions, subject to verification of targeted use of the grant by the provider of targeted financing. Targeted financing is recorded as revenue or expenditure only when there is sufficient evidence that the beneficiary meets the requirements for targeted financing and the grants have actually been paid. Targeted financing is recorded on the basis of the gross price method. It is recorded as income in those periods when expenses were incurred for which the targeted financing compensation was intended.

Revenue and expenditure accounts

Revenue and expenditure are recorded according to the accrual method of accounting. Interest income is recorded using the accrual method.

The most important sources of income for the Estonian Health Insurance Fund include the health insurance portion of the social tax and claims for payment from other persons. The health insurance portion of the social tax is received in the form of weekly transfers from the Estonian Tax and Customs Board. Once a month, the Estonian Tax and Customs Board forwards a transfer notice regarding tax balances to the Estonian Health Insurance Fund, on the basis of which an entry is prepared in the accounts regarding any increase or decrease in revenues. Claims for payment from other persons are reflected in the submission of a claim against legal entities or private individuals, pursuant to the law or relevant contract, for the compensation of material damage incurred by the Estonian Health Insurance Fund.

Operating and financial lease accounts

Financial lease is defined as a lease relationship in which all material risks and benefits related to asset ownership are transferred to the lessee. Any other lease contracts are deemed to be operating leases. When classifying leases into operating and financial leases, public sector units also regard cases which are described in Section 15 of the IPSAS 13 (Leases) Standard as being financial leases, meaning that the leased assets cannot easily be replaced by another asset.

Assets leased under a financial lease are recorded on the balance sheet as assets and liabilities according to the total fair value of leased assets. Lease payments are divided into financial costs and the downward adjustment of liabilities. Financial costs are recorded during the lease period.

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

Appropriations and contingency liabilities

EHIF sets up appropriations for liabilities with uncertain timings or amounts. The amount and timing of appropriations is based on the estimates of managers or other experts in the field.

An appropriation is recorded if EHIF has, prior to the date of the balance sheet, incurred a legal or operational liability, the probability of realisation of the appropriation in the form of outgoing resources is greater than 50%, and the amount of appropriation can be determined with sufficient reliability.

Risk reserve

EHIF's risk reserve budget is governed by Section 39[1] of the Estonian Health Insurance Fund Act as follows:

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

EHIF had an obligation to establish a risk reserve as from 1 October 2002 in connection with the new Health Insurance Act coming into force. This Act amended the Estonian Health Insurance Fund Act by adding Section 39[1].

An appropriation for the risk reserve will be established by a decision of the Supervisory Board following approval of the audited Annual Accounts.

Legal reserve

The establishment of EHIF's legal reserve is governed by Section 38 of the Estonian Health Insurance Fund Act as follows:

- ➜ The legal reserve of the Health Insurance Fund means the reserve formed from EHIF's budget funds for the reduction of 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 half of EHIF's total budget 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 legal reserve provided by this Act is reached or restored.
- ➜ The legal reserve may only be used as an exception by order of the Government of the Republic following a proposal by the Minister of Social Affairs. Prior to submitting that proposal, the Minister shall listen to the opinion of EHIF's Supervisory Board.

An appropriation for the legal reserve will be established by a decision of the Supervisory Board following approval of the audited Annual Accounts.

Events occurring after the date on the balance sheet

The Annual Accounts reflect important circumstances affecting the assessment of assets and liabilities which have appeared between the dates shown on the balance sheet, ie., 31 December 2011 and the date when the Accounts were compiled, but which are related to the transactions for the accounting period or earlier periods.

Events after the date on the balance sheet, which have not been included in the assessment of assets and liabilities but have a significant impact on the result of the next financial year, are published in the notes to the Annual Accounts.

Note 2. Cash and equivalents

In thousands of euros	31.12.2011	31.12.2010
Deposits at call	164,404	1,656
Fixed-term deposits	39,173	66,806
Total cash in hand and in the bank	**203,577**	**68,462**
Fixed-term deposits		
Due within 1 month	29,264	35,560
Due within 1 to 3 months	9,909	31,246
Total	**39,173**	**66,806**
Interest income on cash and equivalents	954	1,028

Note 3. Bonds and other securities

In thousands of euros	31.12.2011	31.12.2010
Volume of fund at acquisition cost	0	101,022
Volume of fund at market value	0	101,369

According to a deposit contract between EHIF and the Republic of Estonia, which was used in order to consolidate EHIF's bank accounts into the group account at the State Treasury, all bonds and other securities were sold as at 30 December 2011. The revenue obtained from the sale of bonds and other securities is reflected in the row of the accounts which shows the total net gain (or loss) as interest and financial income.

Note 4. Receivables and prepayments

In thousands of euros	31.12.2011	31.12.2010
Trade receivables	1,430	1,020
Claims for targeted financing*	55	40
Claims for reimbursement of operating expenses	3	4
Contractual claims against insured persons	19	14
Interest receivables	75	43
Social tax receivables	72,454	72,391
Pre-paid expenses	71	46
Total	**74,107**	**73,558**

* The claims for targeted financing were made to the Ministry of Social Affairs for the financing of external in-vitro fertilisation.

Social tax receivable to the amount of 72,454 thousand euros comprises short-term claims to the Tax and Customs Board for the health insurance part of social tax.

Note 5. Inventories

As at 31 December 2011, EHIF had unused prescription forms worth 6,000 euros (against 5,000 euros as at 31 December 2010). Inventories belonging to EHIF are deposited in storage with liability resting with other persons and with a balance sheet value of 3,000 euros (against 1,000 euros as at 31 December 2010).

Note 6. Long-term financial investments and long-term receivables

6.1. EHIF has acquired shares with the following nominal values

Shares of AS Viimsi Haigla (at cost)

In thousands of euros	31.12.2011	31.12.2010
Balance at the beginning of the year	6	6
Balance at the end of the year	0	6

EHIF owned 900 shares in AS Viimsi Haigla, which were sold in 2011. The sales price for the shares was EUR 112,000.

6.2. EHIF has acquired long maturity bonds as follows

In thousands of euros	31.12.2011	31.12.2010
Volume of fund at acquisition cost	0	20,310
Volume of fund at market value	0	20,594

All long maturity bonds were sold as at 30 December 2011 (see Note 3).

6.3. Other long-term receivables

In thousands of euros	31.12.2011	31.12.2010
Postponed long-term claim against the Tax and Customs Board	145	261
Long-term part of the amount paid to the Social Insurance Board for renovating premises at the Pärnu Department and Rapla Office	356	358
Total	**501**	**619**

Note 7. Fixed assets

7.1. Tangible assets

In thousands of euros			
Acquisition value	**Land and buildings**	**Other inventories**	**Total**
31.12.2009	384	1,483	1,867
Purchase of fixed assets	0	672	672
Written off	0	–299	–299
31.12.2010	384	1,856	2,240
Purchase of fixed assets	0	204	204
Written off	0	–237	–237
31.12.2011	384	1,823	2,207
Accumulated depreciation			
31.12.2009	196	1,085	1,281
Calculated depreciation	21	302	323
Written off	0	–299	–299
31.12.2010	217	1,088	1,305
Calculated depreciation	21	312	333
Written off	0	–237	–237
31.12.2011	238	1,163	1,401
Residual value			
31.12.2010	167	768	935
31.12.2011	146	660	806

7.2. Intangible assets

In thousands of euros	
Acquisition value	**Purchased licenses**
31.12.2009	427
Purchase of fixed assets	0
Written off	–31
31.12.2010	396
Purchase of fixed assets	0
Written off	–19
31.12.2011	377
Accumulated depreciation	
31.12.2009	336
Calculated depreciation	54
Written off	–31
31.12.2010	359
Calculated depreciation	36
Written off	–19
31.12.2011	376
Residual value	
31.12.2010	37
31.12.2011	1

Note 8. Leased assets

Operating lease

The Financial Performance Statement includes operating lease payments in the amount of 326,000 euros. Of this, 26,000 euros were paid for the lease of various means of transport and 300,000 euros were paid pursuant to commercial lease contracts of premises.

The amount of operating lease payments in 2010 was 329,000 euros. Of this, 31,000 euros were paid for the lease of means of transport and 298,000 euros were paid pursuant to commercial lease contracts of premises.

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

In thousands of euros	
Less than 1 year	131
1–5 years	42
Total minimum lease payments	**173**

Note 9. Debts and prepayments

9.1. Supplier payables

In thousands of euros	31.12.2011	31.12.2010
Accounts payable for medical care services	35,467	35,981
Accounts payable for medicinal products subject to discount	5,361	6,461
Other supplier payables for health insurance benefits	5,928	2,155
Other supplier payables	429	359
Total	**47,185**	**44,956**

9.2. Tax liabilities

In thousands of euros	31.12.2011	31.12.2010
Individual income tax	1,797	363
Social tax	225	132
Income tax on fringe benefits	4	0
Unemployment insurance premium	15	5
Mandatory funded pension premium	3	0
Value added tax	0	7
Total	**2,044**	**507**

The individual income tax liability includes an individual income tax of 1,747,000 euros deducted from the benefits for incapacity for work paid by EHIF to insured persons. The social tax liability includes a social tax of 49,000 euros (51,000 euros as at 31 December 2010) calculated on the holiday pay which had not been disbursed to employees.

9.3. Other debts

In thousands of euros	31.12.2011	31.12.2010
Payables to employees	400	400
Other debts	80	58
Pre-payments received	11	0
Total	**491**	**458**

Pre-payments received reflect the balance of the Moldova project which was financed by the Ministry of Foreign Affairs.

Note 10. Reserve

In thousands of euros	31.12.2011	31.12.2010
Legal reserve	51,147	51,147
Risk reserve	14,726	14,726
Total reserves	**65,873**	**65,873**

Note 11. Revenue from operating activity

In thousands of euros	2011	2010
Revenue from the health insurance part of social tax	725,580	685,882
Amounts due from other persons	890	706
Total	**726,470**	**686,588**

Note 12. Expenditure on health insurance

In thousands of euros	2011	2010
Health service benefits, including	522,525	500,952
disease prevention	6,528	6,938
general medical care	66,108	64,507
specialised medical care	417,017	397,450
nursing care	14,816	14,255
dental care	18,056	17,802
Health promotion expenditure	806	786
Expenditure on benefits for medicinal products	91,465	90,737
Expenses on benefits for temporary incapacity for work	80,770	81,436
Other cash benefits	8,295	8,964
Other expenditure on health insurance benefits, including*	13,096	8,439
health service benefits arising from international agreements	8,210	3,810
benefits for medical devices	4,886	4,507
benefits to doctors for vaccinations	0	122
Total expenditure on health insurance	**716,957**	**691,314**

* Expenditure in 2010 differs from the corresponding expenditure shown in the budget implementation statement, as the budget expenditure includes targeted financing from the state budget to the amount of 2,063,000 euros (see Note 15). For 2011, the difference in expenditure, which amounts to 1,461,000 euros, is shown under health insurance benefits.

Note 13. Administrative expenditure

In thousands of euros	2011	2010
Personnel and administrative expenditure	4,380	4,343
Remuneration	3,262	3,235
including remuneration of the Management Board members	139	133
Unemployment insurance premium	44	43
Social tax	1,074	1,065
Management costs	1,011	1,052
Information technology costs	834	653
Development costs	159	128
Total administrative expenditure	**6,384**	**6,176**

Remuneration of members of the Management Board in 2011 includes 18,000 euros for performance related pay, which will be disbursed in 2012 after the decision of the Supervisory Board.

Number of EHIF employees

	2011	2010
Members of the Management Board	3	3
Managers	15	18
Professionals	36	33
Associate professionals	154	157
Auxiliary staff	5	5
Total number of employees calculated in full-time equivalents	**213**	**216**

Note 14. Transactions with related parties

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

During the accounting year, transactions were made with the following related parties: E-Tervise Sihtasutus (transactions to the amount of 2,000 euros), SA Põhja-Eesti Regionaalhaigla (100,161,000 euros), and OÜ Eesti Diabeedikeskus (265,000 euros). The amount of transactions with MTÜ Eesti Standardikeskus and AS Papiniidu Projekt was under 500 euros.

As of 31 December 2011, the Estonian Health Insurance Fund's obligation to the North Estonia Medical Centre Foundation amounted to EUR 7,693,000, while OÜ Eesti Diabeedikeskus accounted for a further EUR 57,000.

In 2010, transactions between related parties took place with AS Helmes (whose total value of transactions was EUR 58,000), the Estonian E-Health Foundation (with a total value of transactions of EUR 2,000), the North Estonia Medical Centre Foundation (reaching EUR 93,365,000), and OÜ Eesti Diabeedikeskus (reaching EUR 18,000).

Once the contract of service for management board members has expired, these members shall be paid compensation equivalent to the value of three months' remuneration.

The remuneration paid to members of the Management Board is shown in Note 13.

Note 15. Targeted financing

The Ministry of Social Affairs is the provider of targeted financing pursuant to Section 35[1] (5) of the Artificial Insemination and Embryo Protection Act, reimbursing expenditure on medicinal products for external in-vitro fertilisation and making payments to insured persons for infertility treatment based on agreements with the providers of health services.

Based on the Government of the Republic Regulation No. 8, of 21 January 2010, on "The Conditions and Procedure for Granting Development Assistance and Humanitarian Aid", the Ministry of Foreign Affairs has concluded a contract with EHIF for supporting the development of the health insurance system in Moldova.

Expenses of targeted financing

In thousands of euros	2011	2010
Reimbursing the expenditure on medicinal products for external in-vitro fertilisation	883	679
Reimbursement of infertility treatment according to health services	578	457
Influenza vaccine Pandermix	0	927
Moldova project	25	0
Total	**1,486**	**2,063**

Revenue from targeted financing

In thousands of euros	2011	2010
Reimbursing the expenditure on medicinal products for external in-vitro fertilisation	883	679
Reimbursement of infertility treatment according to health services	578	457
Funds for the national cancer prevention strategy	23	29
Funds for the changeover to the euro project	33	15
Moldova project	25	0
Total	**1,542**	**1,180**

Expenses related to targeted financing for the national cancer prevention strategy are recorded under health promotion expenditure, and expenses for the changeover to the euro and for the Moldova project are recorded under EHIF's operating expenses.

KPMG Baltics OÜ
Narva mnt 5
Tallinn 10117
Estonia

Telephone +372 6 268 700
Fax +372 6 268 777
Internet www.kpmg.ee

INDEPENDENT AUDITORS' REPORT

(Translation from the Estonian original)

To the Supervisory Board of Eesti Haigekassa

We have audited the accompanying financial statements of Eesti Haigekassa ("the Company"), which comprise the balance sheet as at 31 December 2011, the statement of financial performance, changes in equity and cash flows for the year then ended, and notes, comprising a summary of significant accounting policies and other explanatory information, as set out on pages 91 to 105.

Management's Responsibility for the Financial Statements

Management is responsible for the preparation and fair presentation of these financial statements in accordance with accounting principles generally accepted in Estonia, and for such internal control as management determines is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error.

Auditors' Responsibility

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

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

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

Opinion

In our opinion, the financial statements present fairly, in all material respects the financial position of the Company as at 31 December 2011, and its financial performance and its cash flows for the year then ended in accordance with the accounting principles generally accepted in Estonia.

Tallinn, 28 March 2012

/signature/

Taivo Epner
Authorized Public Accountant No 167

KPMG Baltics OÜ
Licence No 17
Narva mnt 5, Tallinn 10117

Signatures to the Annual Report

The Management Board of the Estonian Health Insurance Fund has prepared the 2011 annual report.

The annual report is comprised of the management report and the annual accounts, to which the independent auditor's report has been appended.

The Management Board
28.03.2012

Hannes Danilov
Chairman of the Management Board

Mari Mathiesen
Member of the Management Board

Kersti Reinsalu
Member of the Management Board

Estonian
Health Insurance
Fund

Annual Report 2011