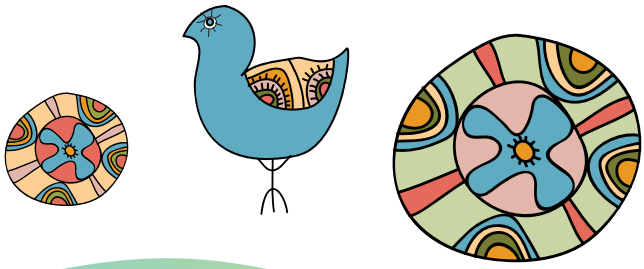
Eesti Haigekassa

# INFORMATION MANUAL 2015



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# Introduction

The Estonian Health Insurance Fund is an institution organizing national health insurance. The purpose of the funds activities is to compensate insured people for the costs of health care, to finance the purchase of medicines and medical appliances and pay for a variety of benefits.

The fund has more than 1.2 million customers. To ensure the availability of health care, subsidized medicines and medical equipment, we work with approximately 3,000 cooperation partners all over Estonia. The management and employees of the fund take our responsibilities to a high sense of responsibility, and we want to ensure that timely and appropriate health care services would be available for all people. An important part of this is each person's awareness of health care facilities and the principles of compensation for services.

You are holding in your hand a manual of the Estonian Health Insurance Fund, which contains information related to the operation of health insurance and the healthcare system and the most significant innovations.

This guide will introduce in detail the health care system in Estonia, including the services offered by the family doctor and the family nurse, the role of the specialist in medical care and the policies for reimbursement of subsidized medicines and medical devices. We will also give information on where to go when expert advice or medical care is needed quickly, and how to behave if you are not satisfied with the quality of the medical care received. Also, the manual will include tips on what to do if there is a need for medical care in another European country.

Health care is an area that affects us all. We hope that you consider it necessary to examine the information contained in the manual. If additional questions emerge after reading, you can receive answers from the Health Insurance Fund information phone 16 363 (from abroad +372 669 6630).

Wishing you happy and healthy reading

Estonian Health Insurance Fund

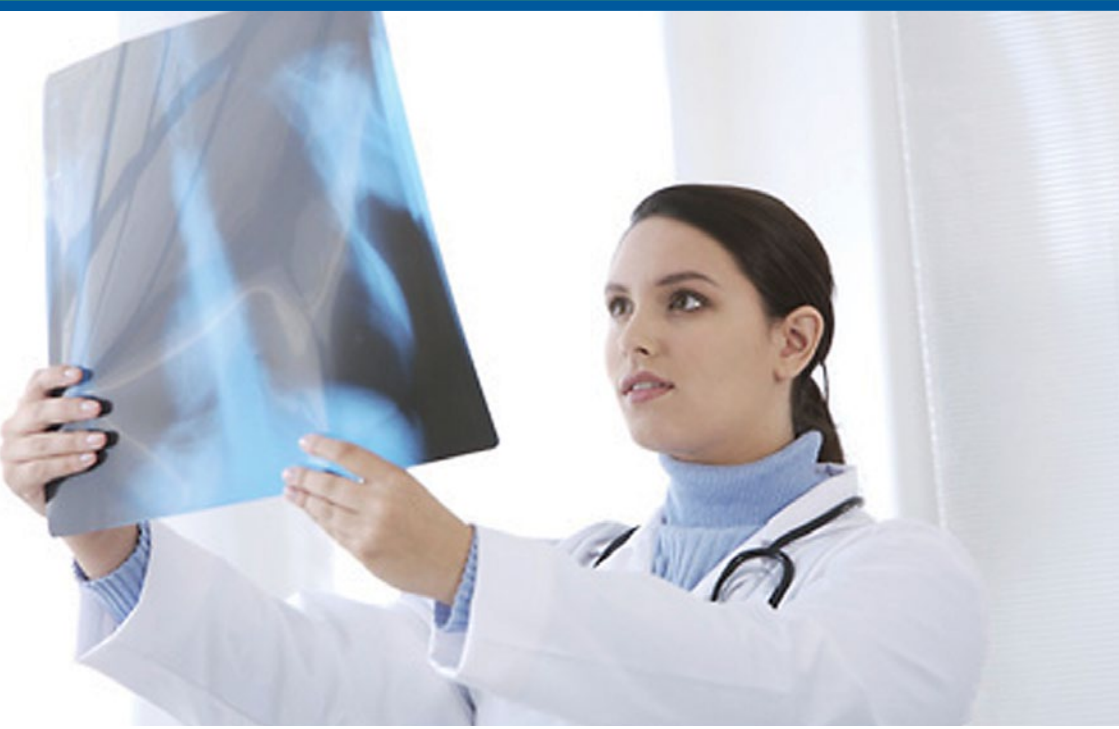
# Health insurance

**In Estonia is in force a solidary health insurance system.** Solidarity in health insurance means that someone's health insurance payments or contribution to the system or access to the necessary assistance does not depend on age, income or health risks. All Estonian health insured persons are entitled to receive the same quality health care, regardless of whether or not they pay a contribution for sickness insurance.

**Health insurance payments** are made by the majority of the working age population, and from the social tax payable from the gross salary of a working person the treatment services also to the population groups in society who currently are not making insurance payments are compensated for. This group includes children, seniors and mothers raising small children at home, also the unemployed and pregnant women. Mutual solidarity includes the young and the old, the rich and the poor and the sicker and the healthier people. Today's working age people use the services relatively little, but health insurance payments paid from their gross wages also cover the health care costs of children and the elderly family members of the taxpayers. Also, today's working-age people will use health care services in the future when they can no longer contribute to the system. The existing funds are used on an ongoing basis to treat all people in need; no one has a personal account.

**By its very nature, health insurance is similar to any other type of insurance.** In the case of home or motor insurance, a person pays the insurance premium, so that in the event of an accident, they would be ensured with the necessary financial support for covering unexpectedly encountered and often considerable amounts of expenditures. Health insurance works similarly, but with the difference that the person's contribution to the system does not depend on his or her assessed health risk but on whether he or she will pay social security contributions and the size of his or her salary income. Health

***A resident of Estonia visits a doctor an average of 6.4 times in a year, in Tallinn the average is 7.8 times. Estonian doctors make more than 9 million appointments a year, i.e., 35 thousand appointments per day. Per any person who does not go to the doctor, there is someone who does this 13 times a year.***



insurance payments are made from the social tax paid by the working person and if the need arises the cost of health care is covered by the insurance. The insurance is required because the probability of illness is quite high, and health care services, medications, etc., are expensive. Even a young and healthy person is not protected from the unexpected. For health problems or a trauma resulting from an accident, the surgical treatment can reach thousands of euro. An illness may ultimately prove to be very costly.

## THE HEALTH INSURANCE FUND REIMBURSES THE SERVICES RENDERED TO THE CONTRACT PARTNER.

**The list of the health care services reimbursed by the Health Insurance Fund is approved by Government Regulation.** The list is updated every year. The Health Insurance Fund covers the vast majority of medically related costs, but to some extent is provided a co-payment from the patient. These include, for example for an appointment and per diem charges. Also, the health insurance budget does not cover all the existing health care services, but only those that are medically justified for the person. **It must also be kept in mind that**

**the Health Insurance Fund reimburses only the health services, in terms of the provision for which, a contract has been entered into with a treatment facility.** On conclusion of an agreement, the right emerges for the health care facility to treat the patients for the insurance money of the health insurance fund, and the corresponding information needs to be in a conspicuous place for all patients. On the other hand, liabilities occur for the health care facility with the health insurance contract to adhere to the agreed length of treatment waiting lists, to provide health services in accordance with international quality standards, etc.

## THE FUND SUPPORTS HEALTH PROMOTION AND THE DEVELOPMENT OF HEALTH INSURANCE.

In addition to necessary health services, compensation for medicines and medical equipment and monetary contributions, the Health Insurance Fund is responsible for designing and the establishment of the prices for health services as well as preparation of the list of health care services. **The fund is also engaged in disease prevention and health promotion, to that end the fund organizes publicity campaigns and funds various health promotion projects.**

***In 2013, there were 1.2 million insured people in Estonia, out of them, the number of people employed was 584 thousand. 797 thousand people made use of specialized medical care, 848 thousand people used the medication compensated by the Health Insurance Fund, every insured person visited the family doctor an average of 4.3 times.***

The purpose of disease prevention is to detect the person's pre-disease condition as early as possible and to contribute to the prevention of the disease. Upon disease prevention, the Health Insurance Fund provides for school health care services, early detection examinations of breast and cervical cancer for women, prenatal diagnosis of hereditary diseases and neonatal hearing tests, as well as sexual health counseling of the youth, and the health checks of young athletes.

The funded health promotion projects of the Health Insurance Fund include training of education and health professionals on children's health, activities related to children's dental health, campaigns and projects of injury prevention

and awareness-raising of people. In addition, the task of the Health Insurance Fund is to help preparation of the treatment standards and treatment guidelines for various health services, to motivate health care facilities to develop the quality of health services, to check the quality and reasonableness of health services, to arrange execution of external agreements pertaining health insurance and the Health Insurance Fund, to participate in the planning of health care, to comment on the legislation and external agreements related to the Health Insurance Fund and health insurance and to advise on the issues related to health insurance.

## Options for obtaining health insurance

**Medical expenses of an insured person are paid by the Health Insurance Fund. Without insurance, people would also not be able to receive a discount on medicinal products, or financial compensation and payment for**

**medical services, which can be very expensive.** Every permanent resident of Estonia as well as all who stay here on the basis of a temporary residence permit or right of residence, if the social is paid for them, have the right for health insurance. In addition, the state guarantees the right to health insurance for children under the age of 19, pupils and students, conscripts, pregnant women, the unemployed, those on parental leave, dependent spouses, pensioners, the caretakers of disabled people and those who have concluded a voluntary insurance agreement with the Health Insurance Fund.

## WORKING ADULTS

**In Estonia, all the insured employees paying the social tax have health insurance.** An employee working under an employment contract, recipient of employment or the service fees under the contract of the Law of Obligations Act, a member of the directing body and the controlling body of a legal person, a sole proprietor and their spouses participating in the activities are entitled to health insurance. **Health insurance is valid for working people, whose social tax is paid for, or who pay social tax for themselves**. These are:

- Employees working under an employment contract;
- Recipients of employment or service fees under the contract of the Law of Obligations Act;
- Members of the directing body and the controlling body of a legal person;
- Sole proprietors and their spouses participating in their activities.

Employees with at least a one-month contract are legally entitled to health insurance. The validity of the employee's health insurance must be cared for by the employer. As of 1 July 2014, an employment register was established by the Tax and Customs Board in which the employer is required to register the working data (the start, pause, and termination of employment) of all of their employees. The data for the health insurance of the employees or for termination of the insurance shall be communicated to the Health Insurance Fund by the Tax and Customs Board. However, it may happen that in the event of exchanging a job, the employer forgets to communicate the information of the employee to the register. The fact that the employer has failed to submit the necessary data to the insurance fund may become evident unexpectedly, for instance at the doctor's office when extending one's usual prescription. Thus, when taking up a new position, **it makes sense after some time of working to check the validity of the insurance on one's own.** This can be done in the state portal at www.eesti.ee or by calling the

Health Insurance Fund information line 16363. Health insurance is valid for two months after the termination of the employment contract.

## CHILDREN

**All children up to 19 years of age, with their principal place of residence in Estonia, according to the population register, have health insurance.** The insurance is valid until the day of their 19th birthday.

## PUPILS AND STUDENTS

**While studying in Estonia, the following persons receive health insurance from the state:**

- Pupils acquiring basic education up to 21 years of age;
- Pupils acquiring general secondary education up to 24 years of age;
- Students acquiring formal vocational education, and higher education students who are permanent residents of Estonia and study in an educational institution in Estonia founded and operated on the basis of legislation or in an equivalent educational institution abroad.
- People without basic education who exceed the age of compulsory school attendance and who are acquiring vocational education or the pupils receiving vocational education on the basis of basic or secondary education;
- Students who are permanent residents of Estonia.

When the schooling is finished and if the young person just stays home, his or her health insurance ends. If, after graduating from secondary school the young person does not continue their studies, does not go into conscript service nor goes to work, he or she should register as unemployed to continue their health insurance.

**For the young person who at the completion of upper secondary school are younger than 19 years of age**, the health insurance is valid up to 19 years of age. For those who at the completion of upper secondary school are at least 19 years of age and a graduate from a secondary school within the standard period of studies, the insurance is valid for a further 3 months after graduation. For the health insurance not to be interrupted, they should continue their education or go to work no later than three months after graduating from secondary school.

**For the young person who immediately after graduating from secondary school continues their studies in a vocational school or at a university**, the state provides health insurance coverage for the entire standard period of

studies, and a further three months after graduation. If a student does not graduate from the school within the standard period of study (except for medical reasons), or he or she will be expelled from school, the health insurance ends one month after the end of the standard period of study or after ex-matriculation.

**During the academic leave** the health insurance stops, except in the case when the leave has been taken for medical reasons. The details of pupils and students shall be submitted to the Health Insurance Fund by the Ministry of Education and Research. **The pupils and the students bound for study abroad** must, in order for the Estonian health insurance to continue, submit to the Health Insurance Fund a document certifying the studies abroad. On the basis thereof, health insurance shall be formalized for up to **12 months**. Therefore, the certificate of the studies shall be delivered to the Health Insurance Fund in **each academic year**.

## THE UNEMPLOYED

**All unemployed people registered in the Unemployment Insurance Fund also have health insurance:**

- Unemployment insurance recipients are covered from the date on which entitlement to the benefit arises;
- Unemployment supports the beneficiaries from the date on which entitlement to the benefit arises;
- Unemployed people who do not receive unemployment support, from the 31st day of registration as unemployed;
- Unemployed people who participate in practical training, work practice, or at least 80 hours in employment training and do not receive the unemployment support from the first day of participation;
- Non-employed persons who have participated in nuclear disaster relief, from the day the application is filed.

A person does not have to submit documents themselves to the Health Insurance Fund for obtaining health insurance. **The data for the start, pause, and stop of the insurance shall be provided by the Unemployment Insurance Fund.**

If the period of registration at the Unemployment Insurance Fund has expired, the health insurance is valid for another month. The exception is the recipients of the unemployment benefit whose health insurance will expire in two months. Information on the registration as unemployed, about unemployment support and benefits and on the applications and the necessary forms can be obtained from the website of the Unemployment Insurance Fund at www.tootukassa.ee or from their offices.

## CONSCRIPTS

For receiving health insurance, the data of the conscript shall be submitted to the Health Insurance Fund by **the Defence Resources Agency**. The health insurance is still valid for **one month** after completing military service.

## PREGNANT WOMEN

If a pregnant woman does not have health insurance, to obtain health insurance she must submit to the customer service office of the Health Insurance Fund a certificate issued by the doctor or midwife about the establishment of pregnancy. The insurance ends **three months** after the expected date of childbirth established by the doctor.

## PARENTS

**The insured is a person on parental leave raising a child who is less than three years of age,** whether it be a mother, father or guardian. Also is insured:

- One non-working parent living in Estonia, who is raising three or more children under the age of 19 living in Estonia, of whom at least one is under 8 years of age;
- One parent, guardian or caregiver residing in Estonia with who has been concluded an agreement for care in the family and who is raising seven or more children under the age of 19 living in Estonia;

The data for receiving health insurance shall be submitted to the Health Insurance Fund by the **National Social Insurance Board**.

## DEPENDENT SPOUSES

*A legally married dependent spouse of the insured person who has less than five years to the pensionable age has the right for state health insurance coverage.*

For receiving the insurance, the person who wishes to obtain the insurance must **submit an application** to the Health Insurance Fund. The insurance ends when the dependent reaches the pensionable age, gets divorced, or the insurance of the maintenance provider ends. If the dependent reaches the pensionable age, generally the insurance continues as the insurance of the old-age pensioner.

*A dependent spouse who is raising children*

A legally married dependent spouse of the insured person has the right for state

health insurance coverage if he or she is raising:

- At least one child under 8 years;
- A child of 8 years of age until the completion of the 1st grade;
- At least three children under 16 years of age.

In this case the provider of the maintenance must be insured as an employee, a person receiving employment or service fees under the contract of the Law of Obligations Act, a member of a directing or controlling body of a legal person or as a sole proprietor. For receiving health insurance, the documents shall be submitted to the **Estonian Social Insurance Board**, who will communicate the data necessary to formalize insurance coverage to the Health Insurance Fund. More detailed information on the documents can be obtained from the National Social Insurance Board phone 16106 or at the address www.sotsiaalkindlustusamet.ee. If the conditions giving the right for health insurance are no longer met, the National Social Insurance Board shall communicate to the Health Insurance Fund the data for termination of the insurance.

## PENSIONERS

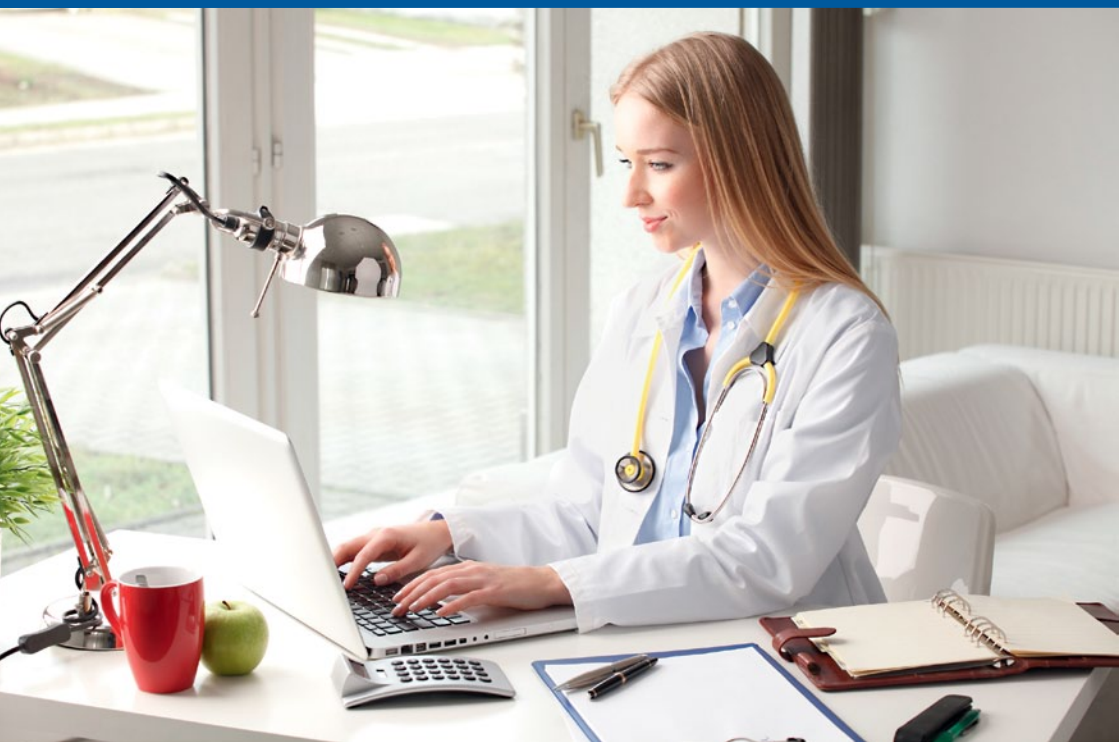
**The people for whom the municipal government or the city government pays the social tax for the support of caring for a disabled person also have the right to state health insurance.** Their data for receiving health insurance is communicated from the local government and shall be submitted to the Health Insurance Fund by the **National Social Insurance Board**.

## CAREGIVERS OF DISABLED PERSONS

**The people for whom the municipal government or the city government pays the social tax for the support of caring for a disabled person also have the right to state health insurance.** Their data for receiving health insurance is communicated from the local government and shall be submitted to the Health Insurance Fund by the **National Social Insurance Board**.

## VOLUNTARY INSURANCE

**If a person does not belong to any of the above groups, it is possible to enter into a voluntary insurance contract with the Health Insurance Fund.** Upon entering into a contract, insurance premiums must be paid to the Health Insurance Fund.



The following persons are entitled to enter into a contract:

- People, who in two months prior to entering into a contract, have been insured at least 12 months through an employer, as a recipient of employment or service fees under a contract of the Law of Obligations Act, a member of a directing or a controlling body of a legal person, a sole proprietor, a pupil or a student;
- A person who has paid for insurance himself or herself, or for whom social tax has been paid while employed under a contract, under the law of obligations with a contract of employment or contract of service, under the law of obligations while under contract of management or a controlling body, as a sole proprietor or a spouse of a sole proprietor in the calendar year preceding conclusion of the contract at least twelve times calculated from the monthly rate

***For information on the validity of your health insurance, you can view in the state portal www.eesti.ee or ask the Health Insurance Fund information line 16363.***

established by the state budget for the fiscal year.

These people may enter into a contract to insure either themselves or their dependents. Typically, a voluntary insurance contract is concluded for one year. Also, information on receipt of health insurance in the Member States of the European Union is on page 28.

***In 2013, the Health Insurance Fund covered medical care services for 500 million euro, family doctor's services for 97 million euro and nursing services for 27 million euro.***

# Health care in Estonia

In Estonia, health care is divided into three levels: **first contact care** or **family doctor care**, **specialized medical care** and **nursing care**. For receiving health care, as a rule, first should be turned to the appointment of the family doctor, by whom patients are guaranteed a quick consultation, the necessary examinations and treatments, and, if necessary, referral to the next level of health care. In case of a need for emergency medical treatment, one can by themselves go to the **accident and emergency medicine department** or call an **ambulance**.

The Health Insurance Fund enters into annual contracts with family physicians and medical institutions, which agree by disciplines to the extent of which amount of medical services are provided to the insured and will be funded by a particular medical institution. Each medical institution shall organize its activities (investment in equipment and material conditions, patient visits, staff costs, proper maintenance of waiting lists and compliance with treatment quality requirements) according to the legislation governing the provision of health services, the commissioning of the Health Insurance Fund and the demand of the insured for the service.

# The family doctor and the family nurse

**The first contact of a person with health concerns in the health care system is his or her family doctor or family nurse**. In situations requiring urgent medical intervention one should indeed turn to the ambulance or the accident

emergency medicine department, but in all other cases, the family doctor with his or her team is the first health consultant. A family doctor is a highly skilled physician who is able to diagnose and treat most diseases. In case of concern needing a medical specialist consultation, the family doctor will refer the patient to the relevant specialist.

***You can check the name of your family doctor in the internet bank at the e-services, in the state portal www.eesti.ee or ask from the Health Insurance Information phone 16 363.***

**A family doctor** in collaboration with a family nurse diagnoses and treats most diseases, monitors the child's progress and persons with chronic conditions, performs minor surgical procedures, refers patients to examinations and analyzes, vaccinates, binds the wounds and removes stitches and, if necessary, makes home visits, gives advice on care, injuries or intoxications, and in terms of preventive measures, advises all persons included on his or her list.

**The family nurse** has independent appointments where he or she teaches, advises and guides people in promoting and maintaining health and preventing disease. The family nurse provides assistance in the event of illness and organizes medical records, in addition, the role of a nurse to monitor people with chronic illnesses. If necessary, the family nurse consults with the family doctor or refers the person to the appointment of the family doctor. Everyone has the right to choose their own family doctor. If he or she fails to do so, the family doctor shall be appointed by the Health Board who will notify the Health Insurance Fund thereof.

**For registration on the list of the family doctor** or for exchanging the family doctor, an application for inclusion in the list must be submitted to the family doctor preferred by the person. The application form can be received from the family doctor or the Health Insurance Fund website. Also, newborns must be registered on the list of the family doctor with an application. If the family doctor has not notified of the refusal of including on the list in writing within seven days, the person

***A person with an acute illness must be received by the family nurse or family doctor on the same day. In the case of a chronic disease and other concerns not requiring such a rapid intervention, the family doctor receives the patient within five working days.***

submitting the application belongs to his or her list the latest as of the first day of the month following the submission of the application. In Estonia, there are approximately 800 family doctors on whom information can be found on the website of the Health Board at: http://www.terviseamet.ee/

The family doctor has the right to refuse to accept a person onto their list if the maximum size limit set for the list of the family doctor has been exceeded. In Estonia, the maximum amount of the list of the family doctor is 2000 people (or 2400, if also an assistant doctor works in the doctor's office).

***A family doctor's visit is free of charge for the insured. For home visits, the family doctor may charge up to € 5, regardless of how many patients she or he checks during the visit. Home visits for pregnant women and children under two years of age are free of charge.***

**Development of the family doctor system and increasing the role of the family doctor and the family nurse in our health care system is an important strategic objective of the Health Insurance Fund.**

## E-CONSULTATION - A FASTER HELP FOR A PATIENT

On the provision of timely and high-quality health care and advice to people, the cooperation of family doctors with medical specialists is crucial. To ensure more efficient co-operation, in 2013, for family doctors, was established the possibility through a health information system to consult with a medical specialists for adjustment of the diagnosis of their patients and for determining the treatment. The e-consultation service saves the time of the patients, because one does not always have to go to a medical specialist themselves - the family doctor consults the medical specialist electronically, and **the entire treatment takes place in coordination by the family doctor.** However, if during the e-consultation the medical specialist decides that the patient still needs specialized medical assistance or further examination, the medical specialist is able to invite the patient to the appointment. E-consultancy also improves the speed of the information moving from the family doctor to the medical specialist and allows us to decide better on the basis thereof of how quickly the patient requires specialized medical care.

In 2013, the Health Insurance Fund began funding the e-consultancy services

in the specialties of **urology** and **endocrinology**. By 2014, requirements for a referral and the response were agreed upon, and funding was begun in the specialty of lung diseases, rheumatology, and ear-nose-throat diseases. The Health Insurance Fund expanded the range of specialties of e-consultancy in 2015, in collaboration with family doctors, and specialty associations have been developed requirements for a referral in pediatrics, neurology, and hematology.

Joining the service is voluntary for the doctor.

## Medical specialist

**If, in the opinion of the family doctor, the patient's health concern needs the intervention of a specialist of a narrower specialty, he or she shall issue a respective referral.** Without a referral, a person can turn to a doctor of eye and skin and venereal diseases, gynecologist, and a psychiatrist. The insured have the right to choose an appropriate medical specialist and the time of appointment in any medical institution who has a contract with the Health Insurance Fund. The list of the contractual partners of the specialist medical care of the Health Insurance Fund can be found at the homepage www.haigekassa.ee - people - medical and nursing care - medical specialist - contract partners.

https://www.haigekassa.ee/et/inimesele/arsti-ja-oendusabi/eriarstiabi/lepingupartnerid

A resident of Tallinn may, if desired, visit a doctor in Tartu, a resident of Saaremaa can seek medical care in a medical institution in Pärnu, etc.

**Specialized medical care** is divided into three parts - outpatient, inpatient, and day treatment. Outpatient care means a doctor's appointment during which the patient is examined; some procedure is performed (blood test, cardiogram, etc.) on the spot and, if necessary, further treatment is prescribed. The patient will not stay in the hospital for a longer period of time.

**In case of day care** a patient stays in the medical institution for no longer than just the appointment, but will not stay overnight in the hospital. **Inpatient care** is provided in a hospital, and the patient has to stay there overnight or longer. The Supervisory Board of the Health Insurance Fund has set the times during which a person must have access to the doctor or the maximum rates of waiting lists. Setting the maximum rate of waiting lists is based on the principle that **a person must receive adequate health care service at a time when his or her health condition does not deteriorate significantly.**

***For a medical specialist visit, a medical institution shall be entitled to charge the patient a per visit fee up to five (5) euro, excluding pregnant women, children under 2 years of age and in cases where a person is referred to another doctor of the same medical institution or on provision of emergency medical care if it is followed by hospitalization. During the hospital, the patient may be charged a bed-day fee of 2.50 euro per day, to a maximum of 25 euro per stay in the hospital.***

***The maximum waiting period of an outpatient visit is six weeks, for a planned hospital admission and day surgery procedures up to eight months. The waiting time may be extended if a person prefers a certain doctor or a medical institution, the medical institution has few doctors or other resources (equipment, facilities), a patient is waiting for re-appointment, etc.***

Those in need of specialized medical care are placed on the waiting list according to the severity of the health problem. In the event of a serious problem, the

medical specialists can be accessed faster.

From 2014, the Health Insurance Fund has entered into an agreement with the medical institutions, according to which **the institutions must keep the waiting lists of the specialties with referral open at least four months, and the specialties without a referral (dermatology doctor, eye doctor, gynecologist, psychiatrists) for at least three months.** This agreement is designed to reduce the situations where a person is calling a medical institution and is told that there are no available appointment times, and he or she should call again after some period of time. We check compliance with the requirement on a regular basis.

# Nursing care

Nursing care service is provided to the patient in need of help either in the nursing hospital (with the former name of a long-term care hospital), at his or her home, or in a place where he or she is cared for. A patient is referred to the **nursing hospital** by the family doctor or a medical specialist with their referral - from the home, from the hospital, as well as from a care institution.

A patient can be referred to **home nursing services** by a family doctor or a medical specialist (neurologist, surgeon, oncologist, etc.), formalizing a referral for that care. A social worker or caregiver can also inform of the customer's nursing care need to the family doctor who will assess the situation and arranges the help accordingly.

***Inpatient nursing care patients pay 15% of the per diem fees, or up to 9.20 euro per day. The Health Insurance Fund pays the medical institution for one-day nursing care, which is about 52 euro to 1560 euro per month. In the nursing care, similarly to the medical specialist care, the patient may be charged a bed-day fee of 2.50 euro per day, to a maximum of 25 euro per stay in the hospital. Outpatient nursing care services, including home nursing services are free of charge.***

## NURSING CARE IN THE HOSPITAL AND AT HOME

The issues relating to care for people are handled both by the health care system

and the social welfare system. The goal of the nursing care service is the maintenance and possible improvement of the established health and functional condition of the patient, short-term or long-term care and support of patients in a stable condition, and, if necessary, alleviation of discomfort, also preparation of a person for referral to a nursing home or a care home.

**The Health Insurance Fund finances both the in-patient nursing care provided in a hospital as well as home nursing services where a nurse will visit the patient at home.** More information on social welfare services (nursing homes, etc.) is available in the local municipality.

The need for referral of a patient to a nursing hospital is decided by the family doctor either by himself/herself or together with the nurse. The doctor will issue a referral indicating the patient's health problems and the necessary treatment, and the nurse will indicate the need for nursing care.

Home nursing service is intended for patients who cope in the home environment, either alone or with the help of their family members with their everyday operation, but whose medical condition requires expert follow-up or support. Home nursing services are provided in the patient's home, and it includes patient counseling regarding health maintenance and lifestyle, upon the doctor orders performance of certain medical procedures (oxygen therapy, wound care, injections and drip-making, bladder flush etc.).

Skin condition assessment and prevention of and care for pressure ulcers are also included in home care nursing activities. In addition a home nurse measures blood glucose levels using a glucometer, performs urine analysis with a test strip, carries out repositioning and applies physical therapy elements for increasing the joint mobility and physical activity of the patient. One type of home care nursing is the supportive home care of cancer patients which is provided for cancer patients in a serious condition - in most cases with the aim of alleviating the patient's discomfort and includes psychosocial counseling of the patient and his or her loved ones, taking into account the specificities of the cancer patient. The service includes home visits of a specialist doctor and nurse. Home nursing services are provided by the home nurses who have received the necessary training. The information about nursing service providers who have a contract with the Health Insurance Fund can be obtained at the Health Insurance Fund website.

# Medical devices

A medical device is an appliance or other product necessary for the treatment, monitoring or alleviating of a disease that a person can use independently. **The Health Insurance Fund compensates for the purchase of a medical device necessary for home treatment and/or monitoring of a disease.** The list of medical devices shall be established by the Minister of Social Affairs with his or her regulation and the valid list can be found at the Health Insurance Fund website as well as in the electronic State Gazette. The medical devices to be compensated for include, for example, supplies needed by diabetics (insulin pens, test strips to measure blood glucose, etc.), orthoses, catheters, for certain medical reasons, also dressings and patches, a positive airways pressure device and masks etc.

**The devices should also be partly paid for by the patients themselves. Cost sharing forms, depending on the medical device, either 10% or 50% of the device price.**

**The doctor providing treatment establishes the need for a medical device and prepares the digital card of the medical device for acquisition thereof on favorable terms.** For purchase of the device, the patient must turn to the pharmacy or a seller who has entered into a contract with the Health Insurance Fund and presents an identity document. If you buy the device for someone else, then it is necessary that the identification code of the person for who you buy the device is included.

Your pharmacist may sell medical devices at favorable terms to the extent of the maximum allowed amount. However, the entire limit provided for the entire period does not need to be purchased at one time; the residue limit is calculated automatically. If by the end of the term part of the medical devices allowed for this period have been left unpurchased, the residue will not carry over to the next period.

The list of medical devices is updated annually on the basis of the proposals

of manufacturers and professional associations, and the price agreements concluded with the manufacturers. For a current list of medical devices, **see the Health Insurance Fund website.**

# Medicines

**Since medicines are very expensive nowadays, part of the cost thereof is helped to be covered by the Health Insurance Fund.** Discounting of medicines or full or partial payment for medicines is one of the means to ensure access to affordable medicines for people and helps to avoid the situation where the patient does not start the necessary treatment due to excessively high price of the medicine.

The Health Insurance Fund pays, to a certain extent, for the medicine the value of which has been previously thoroughly assessed and, consequently, it has been decided to enter into the discount medicines list. On these medicines applies the 50, 75, 90, or 100% discount rate. Higher rates apply to essential medicines necessary for treatment of serious and chronic illnesses, and larger discounts also apply to certain groups of the population (old-age and disability pensioners).

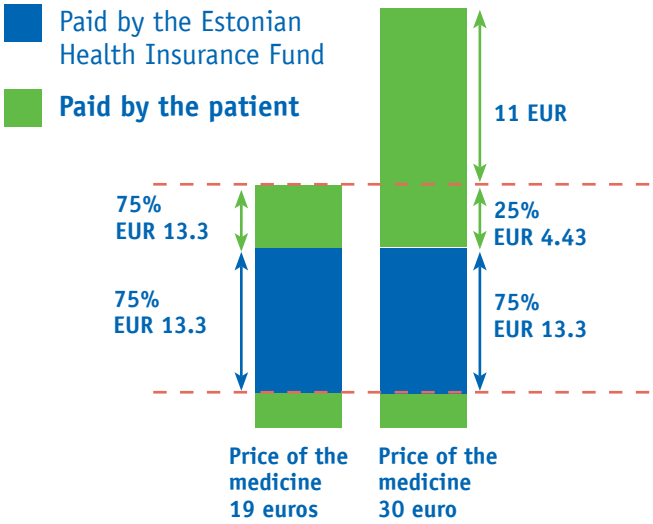
**For any prescription, the person purchasing the medicine should always pay the base rate of co-payment which depending on the prescription discount per cent is approximately 1-3 euro.** For the remaining part of the cost of the

***What is the price limit?***

***The price limit is set on the basis of the most favorable price of the medicine with the same active substance available in pharmacies. The calculation of the health insurance benefits starts from the limit price. In case if the sales price of the packaging exceeds the price limit, the difference between the prices shall be paid by the patient. The price limit of a medicine will change if a new preparation formulation containing the same active ingredient will be available or any of the manufacturers lowers the price. Correctives in the limit prices of medicines and in the list of discounted medicines are made by the Ministry of Social Affairs on a regular basis every quarter.***

medicine applies the discount of the Health Insurance Fund according to the set percentages and the patient shall pay as compulsory co-payments the excess remaining from the discount. If a price limit has been set for the medicine and the price of the medicine purchased exceeds the price limit, then in addition to the base rate and the mandatory co-payment, in the pharmacy must be paid the part exceeding the price limit. It can be called avoidable cost sharing, and a choice of the person buying the medicine sometimes allows here a significant financial saving.

*An example of two medicines with the same active ingredient with the 75% discount on the cost in case of the existence of the limit price (19 euro).*




## WHAT IS THE ACTIVE INGREDIENT (AKA INTERNATIONAL NON-PROPRIETARY NAME) BASED RECIPE?

**All doctors have a duty to prescribe active ingredient based prescriptions.** On the prescription, the doctor writes the name of the active ingredient, not the trade name of the medicine. It gives people in the pharmacy the opportunity to choose the medicine with the most suitable price among the medicines with

the same active ingredient.

The doctor can write on the prescription the trade name of a specific medicine only if there is a medical need for that. In this case, the patient does not have options in the pharmacy, he or she must buy the medicine, the name of which is written on the prescription.

***The data of all your prescriptions can be verified in the state portal www.eesti.ee in the service Prescriptions.***

## WHAT IS THE ORIGINAL MEDICINE AND WHAT IS THE GENERIC MEDICINE?

The journey of a medicine from its inception until it reaches the pharmacy counter is an expensive and lengthy process. Therefore, the company who invented the medicine and brought it to the market has the right for a patent period or exclusivity of sales of the medicine to get benefits from the so-called original medicine invented by it and to maintain the motivation to continue to develop new medicines. After the end of the patent period, other companies may start to produce the medicine which contains exactly the same active ingredient as the original medicine and is designed for the treatment of exactly the same diseases. They are called generic medicines; sometimes the names of copy medicines or the generics are also used.

***Diseases are cured and relieved by the active ingredient, not the trademark! A medicine consists of active ingredients and the excipients. The active ingredient is the one that has an impact. Excipients keep the medicine together, provide a suitable form, the color, shape, taste and the like.***

**A generic medicine is as effective as the original medicine** because it contains exactly the same active ingredient in the same amount as the original medicine.

In addition to the discount medicine obtained in the pharmacy, the Health Insurance Fund will also pay for the medicines used in the hospital.

# If help is needed urgently!

**People needing help often turn to the emergency call number 112 with health concerns that do not really need a quick and lifesaving intervention.** Also, there are a lot of those situations where people turn to the emergency room of the hospital with a health concern in terms of which useful advice could be obtained by telephone, and without leaving home.

***The number of calls to the family doctor consultation phone +372 634 66 30 has increased year by year. In 2013, the average number of calls per day was 650.***

**The family doctor advisory phone +372 634 66 30** has been designed to simplify obtaining advice and help during the time when the family doctor is not available, or if a person is not sure, how they should begin addressing their health concerns.

On the advisory line experienced family doctors and family nurse's respond and counseling takes place 24h in both Estonian and Russian, and also on public

***If there is any doubt about whether to dial +372 634 66 30 in case of a health problem or to go to the emergency room of the hospital or dial 112, always first dial +372 634 66 30. Together with the counselor, you can decide what would be the most appropriate thing to do in case of a specific health problem.***

***If when calling +372 634 66 30 it turns out during the call that the caller's medical condition requires emergency medical care, the call will be directed to the emergency center number 112 to dispatch an ambulance. Call the emergency number 112 if someone's life, health, property or the environment is at risk or there is a reason to believe that something like this is about to happen.***

***Calling from abroad, dial +372 630 4107***

holidays and weekends. Calling can also be useful when you are away from home or need medical advice for a person close to you.

Before dialling +372 634 66 30, it is good to recall **what medicines are regularly taken, it would be good if possible, also to measure one's blood pressure and body temperature**, so the counselor gets a clearer picture of the health status of the person needing help and is able to give better advice. A counselor with medical education can help assess the criticality of the situation and provide operational guidance for initial help, in simpler situations, also for home treatment.

## Emergency medical care

**Anyone who, outside office hours, develops a serious health concern that needs a quick solution, can contact the emergency medicine departments, located at hospitals.** All the seekers for help are assisted in accordance with the seriousness of the problem and the need for the speed of the help. Another variant in case of a problem requiring urgent assistance is

***In the emergency medicine department, a patient may be charged up to 5 euro per visit unless the doctor will evaluate the patient's health problem as falling into the category of emergency. In this case, the visit will not be charged for.***

to call an ambulance on the phone 112. Emergency treatment is not funded by the Health Insurance Fund, but directly from the state budget.

# Medical care and treatment opportunities in a foreign country

## THE REQUIRED MEDICAL TREATMENT WHILE STAYING TEMPORARILY IN ANOTHER EU COUNTRY.

When planning a trip to another European Union Member States it makes sense to think in advance about what you need to know, and what to take with you to reduce costs, which may be associated with an unexpected health disorder.

The most important help that must be in the wallet is the European Health Insurance Card. On this basis, the people insured by the Estonian Health Insurance Fund can receive the medical treatment during a temporary stay in another Member State and receive treatment on equal terms with the insured people living in that country. For this, the need for health care has to be incurred during the stay in the other country,

- ***The European Health Insurance Card is easy to order via the Internet from the portal www.eesti.ee or in customer service offices. The card can be ordered to your home address, and it is free.***
- ***The European Health Insurance Card cannot be used when the health insurance has ended. If the health insurance is not valid and the card is still used, pursuant to the Health Insurance Act and the Law of Obligations Act, the Health Insurance Fund has the right to demand compensation for damages.***
- ***The European Health Insurance Card is valid for three (3) years and can only be used with an identity document.***
- ***If you are traveling outside the European Union, it is advisable to take out travel insurance.***
- ***Calling from abroad, the Health Insurance Fund information phone is +372669 6630.***

and the need for health care must be medically justified. Whether the medical care is needed, will be decided by the doctor.

**The European Health Insurance Card gives the right to the necessary medical care during a stay within the European Union and the European Economic Area and Switzerland.** The required medical care is not free - the patient's deductible expenses (visit, hospital charges, etc.) must be paid for according to the tariffs in the country of location. Deductible expenses shall not be compensated for the patient. Also, the card does not cover the transport costs between countries. Therefore, when traveling to a foreign country we also recommend always to obtain travel insurance with health risks protection. Taking this into account, the hospital should issue invoices only on the deductible expenses, which in turn can be submitted to private insurance companies. **Definitely for obtaining health care service, a state medical institution should be turned to, not to private doctors** because the insurance card will be accepted only by the health care institutions within the state system.

## WHAT IS THE NECESSARY MEDICAL CARE?

**Whether it is the necessary medical care or not, is determined by the doctor treating the patient,** but as a general rule the necessary medical care means treatment of a sudden-onset health problem emerging for a person during their stay in another Member State. A health problem, for example, may be a high fever, abdominal pain, heart attack, injury caused by an accident, etc. There is no list that shows what is exactly included in the needed medical care.

Only in terms of individual services it has been agreed upon, what definitely needs to be considered the necessary medical care - these are oxygen and dialysis therapy, and chemotherapy. The need for these services is known to the person before going to another Member State, but without these services the person could not travel at all.

For obtaining such services, a person should prior to going to another country, agree with a hospital there that this hospital would be able to provide this service at an appropriate time.

In addition, giving birth at the due time shall be considered necessary medical care, but only if a woman wants to give birth in another Member State for family reasons, such as the spouse living and working in another country.

For example, if you did not have your European Health Insurance Card with you

and you had to pay for the medical services incurred in another member State you can apply for the reimbursement later in Estonia. The application form is available on the website of the Health Insurance Fund, or in customer service offices. You have to provide original invoices of the treatment and payment records. The reimbursement is made in accordance with the rates of the state that provided the treatment. The Health Insurance Fund makes an inquiry to the state where you were treated, and according to information received, shall transfer the reimbursable amount to your bank account.

## SCHEDULED MEDICAL TREATMENT ABROAD

Unlike necessary health care the prerequisite for which is the emergence of the need for treatment during the stay abroad, **scheduled treatment represents a situation where a person goes to another country in order to receive treatment there.** For reimbursement of scheduled treatment abroad by the Health Insurance Fund, there are two options. The first option is to apply to the Health Insurance Fund for the authorization to cover the necessary medical expenses in a foreign medical institution (see www.haigekassa.ee for the authorization criteria). This option is designed for those insured persons who are medically indicated for a health service that cannot be provided to them in Estonia or cannot be provided within a time-limit which is medically justifiable, taking into account their current state of health and the probable course of their illness. The health care service must have proven medical effectiveness and the average probability of achieving the expected outcome must be at least 50%. The Health Insurance Fund shall decide on the basis of the medical council's decision composed of at least two Estonian medical specialists, one of whom is the doctor providing treatment to the patient.

***For compensation for medical services received abroad, funded by the Health Insurance Fund, there are three possibilities:***

- ***On the basis of the European Health Insurance Card;***
- ***On the basis of prior authorization from the Health Insurance Fund (scheduled medical treatment abroad);***
- ***On the basis of the European Union's Directive on the free movement of patients.***

In the cases where the criteria are fulfilled, the Health Insurance Fund grants authorization and issues a document confirming takeover of the payment and covers the medical expenses incurred abroad. The patient has to pay for non-medical expenses like co-payment fees, travel expenses, etc.

Another option for scheduled medical treatment abroad is on the basis of the European Union's 'Directive on the free movement of patients.' This means that a patient holding a referral from the medical specialist may choose any of the medical institutions or a doctor of the state system or a private service provider within the European Union, and after receiving treatment to apply for compensation from the Health Insurance Fund. An important difference between recourse to a medical specialist on the basis of a referral in Estonia and abroad lies in the fact that while abroad the entire medical treatment must be paid for by the patient first, and then upon returning home to apply for reimbursement of the cost from the Health Insurance Fund. It must be kept in mind that the Health Insurance Fund pays only for the health services that the patient would be entitled to receive at the expense of Health Insurance Fund also in Estonia. The reimbursement is not possible in case of health care services that are not provided in or recoverable in Estonia (e.g., dental care for adults) or the services medically not indicated for the person. If the price of the service received from abroad is higher than the price in our list of health care of the Health Insurance Fund, the patient must pay the difference in price themselves. **Also, the patient has to pay for the visit, co-payment fees, and travel expenses.**

For receiving the compensation, an application must be submitted, the form of which is available on the website of the Health Insurance Fund or in the customer service offices, as well as to provide original invoices of the treatment, payment records, referral of the medical specialist and the summary of the treatment protocol.

# Financial compensation

In addition to payment for the health services provided to people, funding of medicines and medical devices, **the Health Insurance Fund also pays a number of monetary benefits**. These include different benefits for incapacity for work, a supplementary benefit for medicinal products and dental care benefits and benefits for artificial insemination.

***Information related to payment of the benefit for incapacity for work can be viewed on the state portal www.eesti.ee. Also, you can view there the data transmitted by the doctor, your bank account number on which shall be transferred the benefit of incapacity for work by the Health Insurance Fund and the data based on which the benefit is calculated. Additional information can also be obtained from the Health Insurance Fund information line 16363 or by e-mail at info@haigekassa.ee***

## BENEFITS OF TEMPORARY INCAPACITY FOR WORK

Benefits for incapacity to work is calculated based on the data on the social tax calculated or paid for by the recipient of the benefit for the previous calendar year received from the Tax and Customs Board. The employer calculates the sickness benefit of the employee on the basis of the average wage of the last six months.

When calculating benefits, the average income per calendar day in the calendar year preceding the beginning date of the leave indicated in the certificate of incapacity for work equals the quotient of the income calculated for the person on the basis of the calculated or paid social tax and the number 365.

For obtaining the amount of the benefit, the benefits rate percentage is calculated from the daily income that is multiplied by the number of days subject to reimbursement. Due to different reasons for leave the benefit rates also differ. From the benefit, income tax is withheld.

**From 2015 onwards, the full transition to an electronic certificate for incapacity to work will take place (E-TVL).** E-TVL is an electronic certificate for incapacity to work, which replaces the previously used paper certificate

for incapacity to work. E-TVL allows for faster disbursement of benefits. If the employer transmits the data electronically, the doctor does not need to issue to people paper certificates for the incapacity to work.

At the end of the leave period, the doctor will finalize the electronic certificate for incapacity to work on his or her computer and transmits it to the Health Insurance Fund database. The employee should inform the employer of the termination of the certificate for incapacity to work, and then the employer will be able to enter from his or her part the information necessary for the certificate in the system.

If the employer transmits the data of the certificate through the state portal www.eesti.ee, the benefit will arrive at the employee's bank account within a few days after transmission of the employer's data.

## Dental care benefit

*Who is eligible?*

Persons covered by health insurance, at least 63 years of age, the old-age and disability pensioners, pregnant women, mothers of a child less than one-year-old and people with an increased need for dental care.

*How much is paid?*

People at least 63 years of age, the old-age and disability pensioners up to 19.18 euro per year, pregnant women, mothers of a child less than one year old and people with increased need for dental care up to 28,77 euros per year. Submit an application to the Health Insurance Fund complete with a document proving the payment for the service provided by the dentist. The service may be provided both in Estonia and abroad. Pregnant women and people with an increased need for dental care must attach a medical certificate.

*When is the money received?*
Not later than six months after the arrival of the properly prepared documents at the Health Insurance Fund.
**N.B.:** *Compensation can be claimed only by the people covered by health insurance for whom has emerged the need for increased dental care as a result of the following health care services (e.g., surgery and radiation therapy of tumors in the head and neck region, surgical treatment of facial skull bone traumas, a procedure during which a trauma has occurred, tissue and organ transplants, etc.). For the exact list, see www.haigekassa.ee

***The dental care of less than 19-year-old children and youth is financed by the Health Insurance Fund. For receiving the free dental care, you must turn to the contract partner of the Health Insurance Fund.***

## Denture benefits

*Who is eligible?*
Persons covered by health insurance at least 63 years of age, the old-age and disability pensioners.

*How much is paid?*
Up to 255.65 euro within a three-year period.

*How do I apply?*
There are two possibilities:
a) Submit an application for the maker of dentures, in which you apply for compensation for the cost directly to the maker of the denture to the extent of the benefit.
b) Submit an application along with a document certifying the payment to the Health Insurance Fund.

*When is the money received?*
In the event of submission of an application to the Health Insurance Fund within 90 days after the arrival of the application and the invoice at the Health Insurance Fund.

# Supplementary benefit for medicinal products

*Who is eligible?*
The insured person who pays for the discounted prescriptions at least 300 euro in a calendar year.

*How much is paid?*
…depends on the amount spent on medicinal products.

*How do I apply?*
Submit an application to the Health Insurance Fund at the customer service office or the state portal www.eesti.ee. Applications must be submitted only once. This can be done even before spending 300 euro. The Health Insurance Fund itself keeps an account of the amount spent on prescription medicines.

*When is the money received?*
The benefit is payable in January, April, July and October. After submitting your application the Health Insurance Fund verifies whether the applicant has the right for the benefit for the previous two years. If so, the insured person can receive the benefit also for these years. For detailed information about the calculation of the benefit see he state portal www.eesti.ee section "Benefits for medicinal products". NB! Discount prescriptions that were purchased before 01.01.15 are subject to the old procedure of calculation of the benefit which is available on the website of the Health Insurance Fund at www.haigekassa.ee.

# Benefit of the medicines related to in vitro fertilization

*Who is eligible?*
Women covered by health insurance up to 40 years of age (including) who have a medical indication for in vitro fertilization or embryo transfer, who have undergone the procedure and who have within 90 days before the date of the procedure purchased in the pharmacies the medicines entered

***More detailed information on the benefits is available on the Health Insurance Fund website at www.haigekassa.ee, the state portal at www.eesti.ee, or the Health Insurance Fund information phone 16363.***

on the list of the Estonian Health Insurance Fund necessary for performing the procedure.
A person is eligible for the benefit an unlimited number of times. For the purchased discount, medicines can also be requested for the supplementary benefit for medicines.

*How much is paid?*
Up to 639.12 euros per procedure. For one prescription, a benefit can be received only once. In calculating the benefit, the patient's co-payment of the discount prescription is not taken into account. (In case of 50% discount on a prescription euro 3.19, 75% -100% discount prescription euro 1.27.)

*How do I apply?*
Submit the application to the Health Insurance Fund by registered mail or electronically, digitally signed. Information on the medicinal product is available in the database of the Health Insurance Fund.
**NB!** After each in vitro fertilization and embryo transfer procedure, a new application must be submitted to the Health Insurance Fund.

*When is the money received?*
Payouts are on a quarterly basis, on the 20th day of February, May, August, and November. If the patient pays for the procedure herself, or the procedure is performed in a foreign country, for receiving the benefit, in addition to the application, a medical case summary containing information on the medical institution, the need for the service and the time of provision of the procedure must also be submitted in the form of the medical institution.

# If there is suspicion of an expediency or the quality of the health care service

When it comes to your own health or the health of those close to you and the concern is serious, then uncertainty and hesitation are easy to emerge. Also, there are occasional situations in which a person feels the need to consult another specialist regarding their health issues to get a second opinion, or he or she has been dissatisfied with the received service.

Dissatisfaction with medical care can have a number of reasons, particularly in situations where the doctor's decision regarding the treatment of the patient or

the result thereof is not as expected. If a person doubts the **doctor's decision** and would like to ask for a second opinion, he or she is entitled to turn to another doctor free of charge. One can turn to another medical specialist on the basis of a referral on the basis of the general waiting list.

If there is doubt as to the **quality of medical service received**, there are a number of options to resolve the situation.

- **First, you should always contact the management of the specific medical institution.** The responsibility for the high quality of medical care lies with the service provider, and he or she has the obligation to ensure proper service. Analysis of patient dissatisfaction helps the medical institution to prevent similar incidents in the future and to introduce the necessary improvement measures either in the customer service or in treatment.
- **Definitely, also the Health Insurance Fund should be informed.** The Health Insurance Fund as the financier also has the obligation to monitor the quality of health services provided to the insured persons. To this end, consistent and versatile operations are going on - from the examination of the treatment documents up to commissioning clinical audits from professionals in the field and to the development of treatment guidelines of Estonia. Also, we take our customers' dissatisfaction very seriously, and we work closely with the medical institution to clarify the circumstances of each individual case.
- **The Supervisory Department of the Health Board** examines and evaluates the conformity, i.e., compliance with the legislation for the provision of health care services, so in some cases it is useful also to turn to them.
- The patient or those close to him or her can also contact the **Expert Committee on the Quality of Health Care** operating at the Ministry of Social Affairs. For monetary compensation, the patient can go to court.
- Patients receive advice and assistance also from the Estonian Patient Advocacy Association on any topics pertaining to medicine. The Association has offices in Tallinn.

## WHAT CAN THE EXPERT COMMITTEE DO?

The Expert Committee can, with the help of experts, examine the situation in detail and develop its position in this matter. It can also make suggestions to the relevant medical institution based on the particular case. The Expert Committee cannot, for example, suspend the right of practicing as a doctor or punish the doctor otherwise. However, the Committee can, if necessary, make proposals to this effect.

The Expert Committee has considerable opportunity to find a pre-trial outcome. It is always possible to turn to the courts. However, the first move should be made with the medical institution.

## People with chronic diseases

With age, there is also the increasing likelihood of developing chronic diseases that require regular monitoring by a health care professional. More and more people both in the world and in Estonia develop chronic diseases (e.g., cardiovascular diseases, diabetes, respiratory diseases, diseases of the joints, kidney diseases). **The family doctor and the family nurse the first point of contact for all health problems, they are also involved in the early detection and the treatment of the disease and prevention of complications.** If necessary, the family doctor refers the person to the appointment of the medical specialist for the diagnosis and determination of treatment or uses the e-consultation service. In monitoring of chronic disease, the first contact care or the family doctor system plays an important role. As a result, the monitoring of chronic diseases is one of the quality criteria of the family doctors which the Health Insurance Fund monitors in the work of family doctors. This criterion aims to early detection chronic illnesses and effective treatment thereof in order to reduce disease complications and mortality. In order to ensure high quality of treatment by family doctors, in interdisciplinary collaboration have been prepared a number of guidelines for diagnosis and treatment of illnesses (the guidelines can be found at www.ravijuhend.ee).

**The family nurse expects people with chronic diseases to schedule an appointment at least once a year,** then he or she can check the key indicators of health, discuss with the patient his or her ability to cope with the disease and the everyday life and the behavior affecting the progression of the disease. For some chronic diseases, it

is possible to improve a person's quality of life and to postpone the development of complications due to the progression of the disease also by making small changes in the daily life (such as a healthy diet, increasing physical activity, adjustments in the daily schedule). If a person has any new health complaints, the analysis results are not too good or there is a need to make changes to the treatment, the family nurse refers the person with a chronic disease to the appointment of the family doctor. If a person suffering from a chronic illness has not come to the family doctor for a checkup on a regular basis, the family doctor or the family nurse herself or himself may contact the patient. In this case, the patient should always come to the appointment, so it is possible to control better the chronic disease.

# Supporting child health development

**To support the development of children's health and to ensure continuous monitoring of the health of children, the pediatricians, family doctors, family nurses and medical specialists have agreed in the regulation of the Minister of Social Affairs to regular health checks of children.** Subject to monitoring is the child's growth and development, hearing, vision and speech. Information can be obtained about infectious diseases and vaccination. In addition, assistance for developing healthy dietary, exercise habits and family counseling is provided.

**The recommended times for child health checks under the Regulation of the Minister of Social Affairs**

| Age/grade of the child | Doctor | Nurse* | Dentist | Ophthal-mologist | Vaccinations |
|---|---|---|---|---|---|
| 12 hours | | | | | Viral hepatitis B vaccine (1) |
| 1-5 days | | | | | Tuberculosis vaccine |
| 1 week (home visit) | X | X | | | |
| 2 weeks | X | | | | |
| 1 month | X | | | | Viral hepatitis B vaccine (2) |
| 2 months | | X | | | Rotavirus vaccine |
| 3 months | X | | | | inactivated polio vaccine (1), diphtheria, tetanus and acellular pertussis vaccine (1), Haemophilus influenza type b vaccine (1), rotavirus vaccine |

| | | | | | |
|---|---|---|---|---|---|
| 4,5 months | | X | | | inactivated polio vaccine (2), diphtheria, tetanus and acellular pertussis vaccine (2), Haemophilus influenza type b vaccine (1), rotavirus vaccine |
| **Age/grade of the child** | **Doctor** | **Nurse*** | **Dentist** | **Ophthal-mologist** | **Vaccinations** |
| 6 months | X | | | | inactivated polio vaccine (3), diphtheria, tetanus and acellular pertussis vaccine (3), Haemophilus influenza type b vaccine (3), viral hepatitis B vaccine (3) |
| 7 months | | X | | | |
| 9 months | X | | | | |
| 12 months | X | | | | measles, mumps, and rubella vaccine (1) |
| 18 months | X | | | | |
| 2 years | | X | | | inactivated polio vaccine (4), diphtheria, tetanus and acellular pertussis vaccine (4), Haemophilus influenza type b vaccine (4) |
| 3 years | X | | X | x | |
| 4 years | | X | | | |
| 5 years | X | | | | |
| 6-7 years | X | | x | | inactivated polio vaccine (5), diphtheria, tetanus and acellular pertussis vaccine (5) |
| 7-8 years/ 1st grade | | X | x (7 years) | | |
| 8–9 years/ 2nd grade | X | | | | |
| 9–10 years/ 3rd grade | | X | x (9 a) | | |
| 11–12 years/ 5th grade | X | | X (12 years) | | Viral hepatitis B vaccine (1,2,3 - with 1-month interval) |
| 13-14 years /7th grade, 10th grade | | X | X (14 years) | | measles, mumps, and rubella vaccine (2) |
| 15–16 years/9th grade | X | | X (15 years) | | diphtheria, tetanus and acellular pertussis vaccine (6) |
| 17–18 years/11th grade | | X | | | diphtheria, tetanus and acellular pertussis vaccine (7) |

## THE FIRST SEVEN YEARS AT THE FAMILY DOCTOR

**A healthy infant is monitored during the first year of life prophylactically on a monthly basis.** Three visits must be made to the family nurse. In these visits, children are weighed and measured. In addition, the nurse's job is to advise the parents on child nutrition, hygiene, care, prevention of accidents and the like. Visits to a pediatrician of healthy infants have not been provided for. If necessary, the family doctor will refer the child to the appointment of a medical specialist such as a neurologist or orthopedist.

**With a 6-7-year-old child, pre-school health checks should be passed by the family doctor.** The doctor will evaluate the development and school readiness of the child. Among other things, the child's vision and auditory acuity and speech development is checked. In case of discrepancies, the doctor may refer the child for additional examination to a speech therapist, or to an ophthalmologist. **Medical examinations should be passed well before the beginning of school, as early as in the spring.** Then there will be time to solve the problems. For example, if necessary to acquire glasses or if a child needs extra help or any special conditions, it is possible to arrange for that

in a good time. The project of integration of children with diabetes in school, in which the disease is detected before the school and specialists provide the school staff with the necessary training and support.

## DENTAL HEALTH CARE

The best means for the prevention of dental care is particularly domestic hygiene. **It is advisable to visit the dentist at least at three years of age**. Constant checkups should begin as early as the first signs of teething. The most important thing is to create a good start for regular dental checks and build the child's trust in the doctor. The children who are already familiar with the dentist and have positive experiences will feel more comfortable at the dentist later.

***Studies have shown that when at the end of adolescence the teeth are strong and healthy, no treatment is needed for several more decades. Thus, with the right hygiene habits of children and with preventive checks, situations can be avoided where in the adult age a large part of savings is absorbed by dental care.***

Also, school nurses cooperate with dentists in the referral of children to **preventive screening at 7, 9 and 12 years of age.** If a child needs dental treatment, it must surely take place with the knowledge and on the approval of the family. It should, however, be observed **if the dentist has a contract with the Health Insurance Fund.** Only then, the service is free for parents.

## INDEPENDENCE OF SCHOOL-AGE CHILDREN ON THE CONSENT OF THE FAMILY

**For admission to the school, the officially certified transcript of the pupil's health record must be submitted.** It must include earlier vaccinations, chronic illnesses, regularly used medications, as well as drug or food allergies. The information is essential for monitoring the health of the child at school, but also for adjustment of the study load and the way of life.

When coming to school, parental consent is asked for the provision of school health care services, in general, including for medical examinations in the 1st, 3rd, 7th and 9th grade.

The concept of consent arises from the Law of Obligations Act. On this basis, the patient can be examined, and healthcare can be provided to him or her only on his or her consent. Equally valid with a written consent is verbal consent. Parental consent is important in situations such as when a student asks for help from the school nurse during the break.

***The Health Insurance Fund finances the dental care of less than 19-year-old children and youth. Therefore, the latest at 18 years of age, teeth must be checked. Free treatment can be obtained from the contractual partners of the Health Insurance Fund. For more detailed information see: www.haigekassa.ee***

**Before each vaccination, the school nurse must ask for a written consent from the parent of the child even if it has already been granted for the child's admission to the school.** Parental consent will help to rule out any contraindications. If the family does not want to vaccinate their children, this must be confirmed in writing.

## WHAT KIND OF HEALTH ASSISTANCE CAN BE RECEIVED FROM SCHOOL?

**No treatment takes place at school. The treatment of the sick child is determined and coordinated by a family doctor or a medical specialist.** If a child has fallen ill at school or a trauma has occurred, the school nurse must give him or her first aid and inform the parents. A school nurse does not designate examinations or treatment, nor can he or she issue a medical excuse for absence. In case of illness, a family doctor should be contacted.

The school nurse can help if for health reasons a pupil needs differences in the organization of study, such as in the period after an illness. The nurse needs to know about the child's allergies or chronic diseases. Only then, it will be possible to provide quick and appropriate assistance. In small schools, the nurse is not always present, but his or her office hours and the phone number must be available.

# HEALTH INSURANCE FUND INFORMATION PHONE 16363

On workdays 8.30 to 16.30, from abroad +372 669 6630
E-mail: info@haigekassa.ee
www.haigekassa.ee

## Family doctor advisory phone +372 634 66 30

Medical advice around the clock in Estonian and Russian

## CUSTOMER SERVICE OFFICES OF THE ESTONIAN HEALTH INSURANCE FUND:

**Harju Department**
Tallinn and Harju County
Lastekodu 48, 10144 Tallinn
Mon, Tue, Thu, Fri 8:30 to 16:30
Wed 8.30–18.00

**Pärnu Department**
Pärnu County, Lääne County,
Saare County,
Hiiu County and Rapla County
Rüütli 40a, 80010 Pärnu
Mon, Tue, Thu, Fri 8:30 to 16:30
Wed 8.30–18.00

**Viru Department**
Ida-Viru County and Lääne-Viru
County, Järva County
Nooruse 5, 41597 Jõhvi
Mon, Tue, Thu, Fri 8:30 to 16:30
Wed 8.30–18.00

**Tartu Department**
Tartu County, Viljandi County,
Jõgeva County
Võru County, Põlva County, and
Valga County
Põllu 1a, 50303 Tartu
Mon, Tue, Wed, Fri 8:30 to 16:30
Thu 8.30–18.00

Eesti Haigekassa