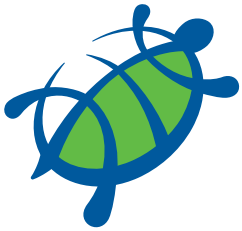
2015



Estonian Health Insurance Fund

Yearbook

The symbol of the Health Insurance Fund is a turtle.

Why does the turtle symbolize health insurance or the Health Insurance Fund?

In many cultures, the turtle is a symbol of the creation of the Earth, which indicates longevity and sustainability in pursuing goals. Turtles are derided for their slowness. Health insurance is a conservative area that needs slow but steady progress. Progress is prudent and consistent, symbolizing the reliability of the Health Insurance Fund and the entire system. The shell protects the turtle against unexpected threats. This is the feeling of protection that the Health Insurance Fund seeks to offer the insured.

Annual Report of the Estonian Health Insurance Fund

Estonian
Health Insurance
Fund

Name	Estonian Health Insurance Fund
Registry Code	74000091
Address	Lembitu 10, 10114 Tallinn
Telephone	+372 620 8430
Fax	+372 620 8449
E-mail	info@haigekassa.ee
The website address	www.haigekassa.ee
The beginning of the fiscal year	January 1, 2015
The end of the fiscal year	December 31, 2015
Main activity	State health insurance
Management Board	Tanel Ross (Chairman) Mari Mathiesen Kuldar Kuremaa
Auditor Association	KPMG Baltics OÜ

Table of Contents

Statement by the Management Board of the Health Insurance Fund 3
Management report 9
The strategic goals and their execution 14
The cooperation between the Health Insurance Fund and the World Bank has helped to identify the development needs of the Estonian health care system. 16
Indicators as an important tool to assess the quality of treatment 18
Quality and availability of the primary medical care in the year 2015 20
New opportunities in the package of specialist medical care and primary health care services 23
The optimal pricing of health care services is based on a strong pricing methodology 26
A methodical and consistent budgeting and planning of agreements is a prerequisite for the sustainability of health insurance 28
The business continuity plans as an important strategy for managing risks 31
Evidence-based treatment options abroad 33
Budget Execution Report 35
The number of the insured 37
Revenues 39
Health insurance costs 42
1. Health care services 43
1.1 Disease prevention 44
1.2 Primary medical care 47
1.3 Specialized medical care 52
1.4 Nursing care 73
1.5 Dentistry 78
2. Health promotion 81
3. The medicinal products compensated for to the insured persons 84
4. Benefits for temporary incapacity to work 90
5. Benefits for medical devices 94
6. The treatment of an Estonian insured person abroad 95
7. Dental care and denture benefits 97
8. Other expenses 99
8.1 Target-financed health insurance costs 99
8.2 Additional benefit for medicinal products 99
8.3 Health care services of a European insured person 100
8.4 Various health insurance benefits 100
Operating expenses of the Health Insurance Fund 101
Capital reserve 103
Risk reserve 104
Retained earnings 104

Annual accounts 105
Balance sheet 106
Profit and loss statement 107
Cash flows 107
Report of changes in net assets 108
Annexes to the annual accounts 108
Annex 1 The accounting policies used for preparing the annual accounts 108
Annex 2 Cash and cash equivalents 112
Annex 3 Receivables and prepayments 112
Annex 4 Inventories 112
Annex 5 Long-term receivables 112
Annex 6 Fixed assets 113
Annex 7 Rental charge 113
Annex 8 Payables and prepayments 114
Annex 9 Reserves 115
Annex 10 Revenue from principal activities 115
Annex 11 Other operating revenues 115
Annex 12 Financial and interest income 116
Annex 13 Health insurance costs 116
Annex 14 General administrative expenses 117
Annex 15 Other operating costs 117
Annex 16 Transactions with related parties 118
Annex 17 Targeted financing 118
Signatures of the annual report 120
Independent sworn auditor's report 121

Estonian Health Insurance Fund is managed on a daily basis by a three-member Management Board: the Members of the Management Board are Kuldar Kuremaa and Mari Mathiesen and the Chairman of the Board is Tanel Ross.

Statement by the Management Board of the Health Insurance Fund

The year 2015 was a busy, successful and innovative year for the Estonian Health Insurance Fund, creating a strong basis for further development of the health insurance system. Our most important priorities continue to be the integrity and evidence-based nature of the insurance package offered to the insured, activities related to ensuring the timely availability of health care services, development of the quality of treatment and ensuring the financial sustainability of health insurance.

The goals of the Health Insurance Fund for the coming years is to develop strategic purchasing to help ensure the comprehensive insurance package designed for the insured for meeting their needs. We want to ensure that the upgrading of the fund is transparent and the quality of the provided services is measurable, taking into account also the people's legitimate expectation of a more inclusive, personalized and holistic approach to health.

In 2015, we started the management for treatment with financing contracts on the basis of new principles, according to which the insured would be covered with an equitable and uniform availability of high-quality health care services.

At the same time, in cooperation with the Ministry of Social Affairs, we started an analysis of the changes in prospective demand for medical care, in order to be better prepared. In 2016, we changed the principles for the development of the structure of the hospital network and for the selection of contract partners of the Health Insurance Fund for the long term.

The health insurance services package and the financial compensation must be evidence-based and cost-effective

An important priority of the Health Insurance Fund is to support a holistic approach to the health of the insured. We continue to strengthen the key role of the family physician and the family nurse in the coordination of health counseling and treatment of the insured, and we support the development of primary health care by the expansion of primary care services.

Disease prevention and early detection will help to increase the quality of human life for many years since diseases detected at the early stages are usually easier to cure, and the person maintains the activity and the capacity for work for a longer period of time. We consider it important to continue the existing cancer screening as well as the inclusion of new evidence-based screening in the package of services. In collaboration with the experts in their field, in 2015, we have developed the conditions and services for colon cancer screening to begin the screening from the second half of the year 2016. This is the first screening, in which the family physician has the coordinating role.

The main task of the Health Insurance Fund is to ensure that the insured have easy access and availability to high-quality and modern health care facilities. For the purpose of the renewal of healthcare services, in 2015 were accepted more than one hundred applications for new services, and on the basis of a justified discretionary decision, 32 applications were upheld in part or in full. As a result of which, from the year 2016, a number of new services were included in the list of health care services and the necessary adjustments were made in the services already on the list, in order to provide patients with better treatment options.

In addition to health care services, it is important for the Health Insurance Fund to provide people with support in the purchase of the necessary medicines and medical equipment. During the year 2015, compensation for nine new active substances was started, and the selection of medicinal products expanded as well. On the basis of the applications for the year 2015, 174 new medical devices were added to the list of medical devices, including four new medical device groups.

In 2015, the conditions for receiving supplementary benefits for medicinal products became more favorable: the threshold, starting from which the benefits would be paid, fell; the rate of benefits grew, and the upper limit for payment of the benefits was abolished.

The year 2015 saw preparations for restoring dental care benefits for adults. During the year, a precise list of reimbursable services was considered, the feasibility for implementation of financial and non-financial compensation was evaluated, and the budget impact was analyzed. The Health Insurance Fund has submitted its proposals to the Ministry of Social Affairs and in 2016, the work for preparation of the processes necessary to expand and implement the benefits package will continue.

The awareness and engagement of the insured are rising

Increasing people's awareness of the health insurance system and its opportunities helps the Health Insurance Fund to ensure the best possible use of health care services and the good health of the insured. Last year, the Estonian population found in their mailboxes, for the first time ever, the Estonian Health Insurance Fund Information Guide introducing national health insurance and the functioning of the health care system including the most important innovations. The feedback from the insured is a sure confirmation that regular in-depth information of the working principles of the entire health care system is essential.

In promoting the health of children and young people, we paid a significant emphasis to the topic of oral health in the course of an awareness campaign as well as by consistent information, and in close collaboration with family physicians, school nurses, and the Estonian Dental Association.

In 2015, we have upgraded the Health Insurance Fund website with a significant card application, which allows insured persons, for the purpose of better access to medical care, to conveniently find Health Insurance Fund contract partners all across Estonia and receive the details about the treatment facilities, such as the contact detail, the location and the services provided.

In 2015, we have made the necessary preparations for the development of the holistic customer communications strategy of the Estonian Health Insurance Fund to help customers feel that the service they are offered is the best possible. We carry out consistent quality of service evaluations. In 2015, in the framework of the Estonian Service Index (ETI), the customer service of the Health Insurance Fund was assessed with the total grade of 3.9 (maximum 4.0) which was the best outcome among the evaluated public sector agencies. In the coming years, we will develop a customer management system together with an

improved feedback collection option, expand the range of e-services and train our staff in order to enhance the person-based, advisory communication between the Health Insurance Fund and the patient.

Access to health care services and their quality

To ensure the sustainability of the health care system, health care services must be accessible to all people, have a very high quality, and be timely. Hereby, the consistent development of e-services, the continued support of the free movement of patients and of the holistic approach to the patient is very important, which simultaneously helps to ensure the most optimal use of the service.

In 2015, on the order of the Estonian Health Insurance Fund, was completed the analysis conducted by the Centre for Applied Social Sciences of the University of Tartu on the experience of other countries in terms of the specialties in which today in Estonia, there is no requirement for a referral. Based on the analysis, the Health Insurance Fund will make proposals for the expansion of the requirement for a referral, after carrying out thorough discussions with each professional association involved.

It is continually important to expand the e-Consultation specialties and increase the network of the service providers offering specialist medical care, which in addition to a faster exchange of information between doctors, also aims to improve the quality of medical care, access to services, and to save time for patients. Today, e-Consultation is available for the vast majority of the main specialties - in addition to the eight specialties already existing in the list of services. From the year 2016, family physicians will be able to consult with the doctors of the specialties of cardiology, gastroenterology, orthopedics, oncology and allergology-immunology.

Development of treatment quality

The development of the treatment quality is one the most important priorities for the Estonian health care system and health insurance. In 2015, we placed emphasis on the strengthening of the monitoring of quality requirements - in co-operation with the Faculty of Medicine of the University of Tartu, and with the professional associations, we started the development of treatment quality indicators, which are planned to be introduced nationwide in the coming years. On the basis of the treatment quality indicators, health care providers will be able to compare themselves with each other, and it also provides the opportunity to compare and monitor quality indicators in each medical institution. There will also emerge the opportunity to compare the figures with other countries. In the autumn of 2015, in the framework of the World Bank Analysis 2015, we published for the first time the indicators to measure the integration of the developed treatment in the context of the Hospital Network Development Plan. Among other things, for example, protracted hospitalization and avoidable medical specialist visits will be measured.

Each year the Estonian Health Insurance Fund commissions five clinical audits, which is a tool to develop the quality of medical care. Clinical audits can be used to improve patient care by assessing systematically against specific criteria. The Clinical audit report also includes general recommendations for professional associations, the Health Board, the Ministry of Social Affairs and other relevant parties. In 2015, the following audits were completed: the quality of treatment of sepsis; treatment of fibrillation patients in Estonian hospitals; cervical and ovarian cancer patients' diagnostics and quality of treatment; treatment of prostatic carcinoma; acute abdominal diagnostics and quality of treatment.

Compilation of clinical and patient guidelines

Since 2011, the Health Insurance Fund has supported completion of clinical and patient guidelines, based on the “Manual for the compilation of clinical guidelines” compiled by the experts of WHO, Faculty of Medicine of the University of Tartu, the Health Insurance Fund and the Ministry of Social Affairs". In August, the delegation of WHO visited Estonia for the purpose of assessing the current clinical guideline-drafting process in Estonia. As a result of the audit, the WHO experts gave a very good evaluation of the drafting and implementation of the Estonian clinical guidelines, in addition, the experts gave recommendations on modernization and supplementing of the approved manual of clinical guidelines. The revised manual is scheduled to be submitted for the clinical guidelines advisory board for approval in the first quarter of 2016.

With the objective of supporting the development of treatment quality and raising awareness of the importance of the development of common standards, and the metrics to evaluate the performance of the treatment process, the Estonian Health Insurance Fund has set a goal and has deemed it feasible to start every year with the funding of the development of three new clinical guidelines, based on the estimates of the clinical guidelines advisory board regarding the importance of the topics.

In 2015, the development of the clinical guidelines for Alzheimer's disease, atrial fibrillation, and tuberculosis was selected as the new topics. For the clinical guidelines already being prepared the compilation of patient guidelines has also been planned. In 2015, 18 clinical and patient guidelines were being developed in the different stages. The Clinical Guidelines Advisory Board approved the patient hypertension guide, a guideline for the use of the surgical safety checklist in the operating room, the guideline for the treatment of bedsores and the guideline for the treatment of the patient with alcohol abuse disorder.

In cooperation with the Ministry of Social Affairs the Estonian Health Insurance Fund initiated a process of unification of patient coordination manuals in the year 2015. The first origin-based cancer patient coordination manuals were completed, and preparations were made for the establishment of methodology for developing coordination manuals.

E-services for the insured and for the development of the health care system

The Health Insurance Fund participates in the preparation of the digital registry and e-referral system managed by the Ministry of Social Affairs. In cooperation with medical institutions and e-Health Foundation, the Health Insurance Fund has contributed to the development of the central nation-wide digital registry, aimed at ensuring the availability of the patient's complete medical information based on common standards to all the entitled parties of the health care system, and the transparent overview of the available appointments in various medical institutions of Estonia, and moreover - to ensure that the cases requiring urgent attention would quickly reach the medical specialists and that such incidents would be reduced in which the patient goes to a medical specialist, when in fact, the support of primary care would be sufficient. The exchange of comprehensive and uniform health information through the system makes it possible to improve the quality of treatment and the access to services, and to increase the analytical capacity to improve the functioning and development of the health care system.

The Health Insurance Fund considers the comprehensive development of the entire e-health information system to be increasingly important. In the course of continuous development of the digital prescription information system, we are preparing the integration of the medicinal product interaction database into the prescription center. The database will enable and give the doctor important information about the interaction of prescribed various pharmaceuticals. At the end of 2015, we started preparations for the clinical decision support platform. Clinical decision support is an application to be integrated on the desktop of the doctor that enables the doctor and the health care worker to receive treatment recommendations based on the treatment and health information of the patient, with evidence-based clinical guidelines, research, and algorithms. As a result, of the implementation of the system, the effective organization of the daily work of doctors and health care workers is ensured. The provision for more efficient and more personalized diagnostic and treatment services, both at the primary level as well as in the specialized medical care, is also ensured. A preliminary analysis of the project and the preparations for an international tender have been planned for the first half of 2016.

From 2015, in respect of the certificates for incapacity to work, only the electronic transmission of data is carried out. We consider it important to continue to contribute to the ongoing development of this service (e-TVL2).

The strategic partners of the Estonian Health Insurance Fund

In 2015, one of the most important items of focus of the Health Insurance Fund has been the development of primary care, therefore, in family medical care, at the beginning of the year 2015, new agreements for financing of modernized treatment were signed and the implementation of a new quality supplement was agreed on for the beginning of 2016. In cooperation with the Estonian Association of Family Doctors, in view of the continuity of care, we have created complementary indicators for the family physician quality system, to measure the effectiveness of treatment.

In 2015, an important priority was to start the development of the financing models of the primary level health care centers, with the aim of creating a network of health care centers to ensure the high quality and uniform availability of primary health care services in Estonia. In doing so, it is important to be based on the optimum action model oriented at the development of the primary level care, which includes all the services that the primary health care should offer. For the compilation of a comprehensive action model, we have commissioned an analysis from the Chair of Family Medicine at the University of Tartu, which will be completed by spring 2016.

When concluding agreements in specialized medical care for the year 2015, in addition to county based demand assessed on a uniform basis, we took into consideration the principles of geographic availability, which aims to ensure high-quality care for each insured as a reasonable distance from their place of residence as possible. From 2015 onwards, in-depth monitoring of compliance with the quality requirements provided in the agreements is carried out.

In nursing care, we have secured the funding for inpatient nursing care under the new requirements, and in home nursing, we are committed to significantly streamline and improve the availability of the service all across Estonia.

For a better and more responsive interaction between the partners, we have continued to work on the development of a single, high-quality partner management system. The aim is to bring together the data and activities for the conclusion, modification, monitoring and exchange of information with partners to be manageable and traceable from one location.

Sustainable development of the organization

For the development of the Health Insurance Fund as an organization, it is necessary to deliver excellent performance with health insurance, in the best possible and passionate way to the insured, to the partners and to the health care system. To this end, we changed the structure of the Health Insurance Fund in such a manner as to ensure a timely and optimal work organization. The new structure approved in 2015, will effectively help to perform the functions assigned to the Health Insurance Fund.

To the Government was submitted a four-year budgetary position, on the basis of which the Government proposed to the State Budget Act, the budgetary position of the Health Insurance Fund for the next fiscal year.

In the autumn of 2015, we renewed the Health Insurance Fund development plan in which we set as a starting point for further work, important objectives for the activities for the years 2016-2019. (a) customer-centeredness, i.e., a more personal approach, (b) ensuring the availability of health insurance benefits, (c) strategic purchasing and development of service quality, and (d) development of the information technology support and infrastructure.

The Health Insurance Fund remains committed to cooperation with the European Union Member States and international organizations, as well as with other countries to share experiences regarding the organization of health insurance and thereby strengthening health insurance. Closer cooperation in 2015 with the World Health Organization and the World Bank was successful. We have continued cooperation with Moldova, in the framework of which the Health Insurance Fund provides the expert competence to Moldova in order to support the development of their health insurance system. In 2015, the Health Insurance Fund was visited by 12 delegations, including China, India, Luxembourg, Georgia, Kazakhstan and elsewhere. Mediating the inputs of various countries, through international cooperation, the Health Insurance Fund is giving its contribution also to the development of the European system of health care.

From 2012, the Health Insurance Fund has been the holder of ISO 9001: 2008 certificate, the continued validity of which is confirmed by the DNV lead auditor this year. In the framework thereof, in the Health Insurance fund was carried out a new comprehensive audit, as a result of which the lead auditor stated in the audit report that the quality management system of the Health Insurance Fund is well functioning, the annual management review on the issues required by ISO 9001 have been addressed and very well covered. The efficiency of the management system of the Health Insurance Fund on the performance of the legislative, regulatory and contractual requirements was assessed as very high.

Management report

Health insurance system

In the central position of the Estonian health system is the current health insurance system. The Estonian Health Insurance Fund pays for the health care services of all the people holding Estonian health insurance, finances medicinal products and medical devices and pays a number of financial benefits. For the provision of health care services, agreements are concluded with family physicians and health care institutions. On the purchasing of services and entering into agreements, the needs of the insured and the rational use of the health insurance funds finances, are taken into account. The Health Insurance Fund does not intervene in the management of the health care institutions; it ensures the impartiality of the financing.

The health insurance system is financed from the social tax. In Estonia, the solidary health insurance system is in use: all the people with medical insurance will receive the same medical care, regardless of the size of their financial contributions, their personal health risk or age.

The Estonian health insurance system complies with internationally accepted principles:

- as a large part of the population as possible must be covered by health insurance;
- the scope of health insurance has to be as large as possible, i.e., the solidarity of health insurance offers the most comprehensive and holistic, modern health services package as possible;
- health insurance should be as deep as possible, i.e., the co-payments of people for the total treatment cost has to be optimized and should not lead to a risk of poverty.

The health insurance system guaranteeing solidarity and equality has been in force since the year 2002 when the new Health Insurance Act was enacted.

The role of the Estonian Health Insurance Fund

The main objective of the Health Insurance Fund is to ensure for the insured parties, timely access to different health insurance benefits, including medical care, medicinal products, and medical devices, as well as temporary incapacity benefits, dental care, and other monetary benefits. In addition, the aim is to promote health and to develop the quality of health care services.

In the provision of the services meeting the needs of the insured persons and ensuring equal access to the services in each county, the Health Insurance Fund is in the buyer's role, assuming the payment obligation of the insured person. Instead of a passive payer, the task of the Health Insurance Fund is to be a strategic buyer.

On the strategic buying, we proceed from the scope of the Health Insurance Act and in terms of health care services, we can talk about the following possibilities:

a) the range of health care services in the so-called service package;
b) price formation of health care services;
c) conditions for the treatment of financing agreements and the provision of legislation;
d) the choice of agreement partners and negotiation of agreement volumes;
e) checking of the justification for financing.

The mission of the Health Insurance Fund is to organize health insurance in such a way as to ensure equal treatment for insured persons and the timely availability of high-quality cost-effective health care services, medical equipment, medicines, and monetary benefits according to need.

The vision of the Health Insurance Fund is to ensure people's sense of security in the emerging and solving of possible health problems.

The core values of the Health Insurance Fund

- **Innovation** - we are aiming at continuous and sustainable development, the prerequisite of which is a competent, loyal staff committed to the outcome;
- **Care** - we are open and friendly. We make decisions taking into consideration all others, and in a transparent manner;
- **Cooperation** - we create an atmosphere of trust within the organization, and in relations with partners and customers.

Organization and management

The highest body of the Health Insurance Fund is the Supervisory Board consisting of 15 members. 5 of them represent the employers' interests, 5 represent the interests of the insured and 5 represent the interests of the state. The Chairman of the Supervisory Board is the Minister of Health and Labor. The Health Insurance Fund is managed by a three-member Board of Directors. As of 31.12.2015, the Health Insurance Fund employed 205 people.

The task of the Health Insurance Fund, for achieving all the health insurance objectives, is to assess both the need for health care, to modernize the health insurance package, to plan the budget and to enter into agreements with health care institutions to ensure the availability of necessary services to the insured. For the best use of resources in the interests of the insured, the Health Insurance Fund will cooperate with all partners in the health care system.

The Health Insurance Fund checks on the basis of the law, the purposeful use of health insurance funds, including the quality and the reasonableness of the purchased services. On a daily basis are operating electronic controls to ensure the accuracy of the data and the invoices. In addition, with the help of health inspectors, we will check the treatment invoices and documents, during the year a total of about 12,000 medical histories and medical records. We support the drafting of clinical guidelines and order clinical audits. We have introduced a system of quality remuneration for family physicians with the aim of ensuring on a uniform basis across Estonia, disease prevention and the quality of monitoring of chronic diseases on the primary care level by family physicians and family nurses.

The Health Insurance Fund finances the promotion of health and prevention of illness on the basis of the Health Insurance Act through projects for specific purposes, being guided by the provisions of the National Health Development Plan approved by the government and by the provisions of the Health Insurance Fund Development Plan. According to the analysis of the years of life lost due to the burden of disease, the greatest loss of health is caused by cardiovascular diseases, malignant tumors, injuries, and poisonings. All these problems also affect the costs of the Health Insurance Fund related to health care services, medical products, and incapacity to work. Some of these can be prevented, or the resulting damage can be reduced by health promotion and prevention.

Table 1 will provide an overview of the major indicators of the period 2011-2015.

Table 1. The most important indicators in 2011-2015

	2011	2012	2013	2014	2015	The change compared to the year 2014
The number of the insured at the end of the year	1,245,469	1,237,104	1,231,203	1,232,819	1,237,336	0%
Revenue (in thousand euros)	735,112	783,131	836,892	900,209	964,353	7%
Health insurance costs (in thousand euros)	718,418	773,575	830,419	908,213	973,609	7%
Health Insurance Fund operating expenses (in thousand euros)	7,080	7,331	7,937	8,502	9,284	9%
The percentage of health insurance expenditure from GDP (%) *	4.3	4.3	4.4	4.5	4.8	5%
The percentage of the total health expenditure from GDP (%) **	5.8	5.7	5.9	6.2	-	-
Indicators of health care services						
The number of insured using specialized medical care	807,875	795,581	796,698	800,326	799,305	0%
Average inpatient hospitalization in days	6.0	6.1	6.0	5.9	5.9	0%
Percentage of emergency specialist medical care from the treatment expenditures (%)						
in outpatient care	18	17	17	17	17	0%
in day care	7	8	8	9	10	1%
in inpatient care	64	66	64	63	63	0%
Average cost of a specialized medical health care treatment cases (euros)						
in outpatient care	45	52	57	63	68	8%
in day care	371	435	456	481	503	5%
in inpatient care	1,008	1,124	1,178	1,289	1,376	7%
Structural appreciation of specialized medical care (%)	2.4	3.1	1.8	0.3	-0.3	-1%
Referrals of an Estonian insured person abroad for treatment and benefits arising from the EU legislation (in thousands of euros)	7,011	5,965	6,648	8,764	8,519	-3%
Indicators of medicinal product benefits						
The number of discount prescriptions	6,945,735	7,438,670	7,625,135	7,883,659	8,046,298	2%
The number of insured using discount prescriptions	841,533	841,387	848,636	850,206	851,627	0%
The average cost of discount prescriptions to the Health Insurance Fund (euros)	13.2	13.3	13.6	13.9	14.0	1%
The average cost of discount prescription to the patient (euros)	7.0	6.6	6.4	6.5	6.7	4%
Indicators of the benefits of incapacity for work						
The number of the days of incapacity for work compensated for by Health Insurance	4,937,836	4,954,761	5,228,586	5,362,002	5,670,910	6%
The cost of the benefit for one day of incapacity for work (euros)	16.4	17.0	18.0	19.4	20.6	6%

* the figures of the years 2011 to 2014 have been amended on the basis of the GDP adjusted by the Statistical Office.

**The data of the year 2015 are published by the NIHD at the end of the year 2016.

The strategic goals and their execution

	Weight	Indicator	Explanation	2014 Objective/actual
INSURED	**63%**			
	10%	Satisfaction of the insured with the health care system	Satisfaction with the health care system identified by the wayof a general survey of the insured	67/**58**
	15%	Satisfaction with the access to medical care	One part of the general survey	55/**43**
	13%	Overall satisfaction with the family physician system	One part of the general survey (taking into account the answers of the persons who have visited their family physician)	88/**79**
	5%	Satisfaction with the quality of the medical care	One part of the general survey	78/**70**
	5%	Satisfaction with the organization for buying medical products in pharmacies	Based on the number of persons who were given the opportunity to choose the most favorable prescription pharmaceuticals in the pharmacy (from the general survey)	65/**61**
	5%	Prevention of children's dental diseases and coverage with treatment	% of the children with the relevant years of birth who have participated in preventive examinations and/or dental treatment	–
	5%	Awareness of the insured persons of their rights	% of the insured persons questioned who are aware of their rights in the following areas: general health care, specialist medical care and benefits for incapacity to work, discount medicines and the scope of health insurance protection	54/**51**
	5%	Coverage of cancer prevention screening	Determination of coverage is based on the health insurance database. The percentage of all women receiving the service out of all the women of the five-year age group, for whom the examination has been performed in the last three years; cervical cancer/breast cancer	Breast cancer 72/**68** cervical cancer 73/**74**
PARTNER	**25%**			
	10%	To involve the insured in activities leading to improved monitoring of the health condition of people with chronic diseases	In the family physician quality system, coverage for hypertension patients with all risk levels on the basis of the results calculated for the previous calendar year	68/**66**
	10%	Structural appreciation of a treatment case (all treatment types together)	The percentage of structural appreciation of the specialized medical care treatment cases compared to the previous period	<2/**0.3**
	5%	Compilation of clinical and patient guidelines	At least three clinical guidelines and three patient guidelines have been confirmed, the topic of which have been approved by the Clinical Guidelines Advisory Board	–
ORGANIZATION	**12%**			
	2%	Employee satisfaction with the management and work organization of the Health Insurance Fund	% of satisfied employees on the basis of the employee survey	93/**93**
	5%	The level of customer service	The index level of customer service is assessed using the *mystery shopping* method in the framework of ETI research	3.6/**3.7**
	5%	Dependability of information systems	Compliance with ISKE criteria in terms of the availability of critical services (insurance verification, prescription center)	K3/**K3**
TOTAL	**100%**			

2015 Objective/actual	Implementation %	Achievement of objectives
	56.29%	
67/**58.9**	8.79%	The satisfaction of the insured with the health care system have risen slightly compared to the previous year's results, but remains still below the target set.
55/**42.5**	11.59%	Satisfaction with the access to the medical care is equal to last year's level
88/**78.3**	11.57%	The level of satisfaction with the family physician system has remained on the same level as last year, although satisfaction with a particular family doctor has risen.
78/**73.3**	4.70%	Despite the fact that the target set was not achieved, satisfaction with the quality of medical care has risen slightly.
65/**64.2**	4.94%	The result of offering the most favorable pharmaceuticals in the pharmacy had reached the closest to the set objective.
70/**70.8**	5.00%	The objective for prevention of children's dental diseases and coverage with treatment was met.
54/**51**	4.72%	Awareness of the insured persons compared to the previous year has improved in terms of raised awareness of finding information on health insurance benefits. However, the awareness had dropped in terms of the knowledge related to various rights in case of obtaining the treatment abroad. In total, the awareness of the insured persons of their rights and obligations remained on the level of the previous year.
Breast cancer 72/**70.3** cervical cancer 73/**74.8**	4.98%	More outreach and improved logistics must be able to be offered among the invitees to breast cancer screening.
	25.00%	
68/**68**	10.00%	In the family physician quality system, coverage for hypertension patients with the activities that help to monitor their state of health has been met.
<2/**-0.3**	10.00%	Compared to last year, there has been a structural depreciation of the average cost of a treatment case.
3/**4**	5.00%	The clinical guidelines approved by the Clinical Guidelines Advisory Board: Treatment of pressure ulcers - prevention and conservative treatment; The use of a surgical safety checklist in operating rooms; Treatment of a patient with alcohol use disorder; The patient hypertension guideline.
	11.98%	
93/**92**	1.98%	Employee satisfaction was 2 percentage points below the target, but given the fact that in the second half of the year, a structural change took place, the aim has been achieved.
3.7/**3.9**	5.00%	The customer service index exceeded the set target value, and in 2015 reached close to the maximum level.
K3/**K3**	5.00%	Critical services were secured throughout the year according to the set target.
	93.27%	

The cooperation with the World Bank is governed by the health care professionals of the Health Insurance Fund.

The cooperation between the Health Insurance Fund and the World Bank has helped to identify the development needs of the Estonian health care system.

In collaboration with the Estonian Health Insurance Fund and the World Bank, in 2015 was carried out a unique study to find out whether today's Estonian health management and strategic purchasing model takes into account the changed needs, or, are changes necessary. As life expectancy has gone increasingly long and there are more and more patients with chronic diseases, the study focused on the aim to ascertain how well today's health system in Estonia follows the principles of integrated treatment in the treatment of patients with chronic illnesses.

To that end, the data available to the Health Insurance Fund was analyzed, and a number of qualitative interviews were carried out with the active partners of the Estonian health care system. The study resulted in a report, "Holistic approach to treatment and cooperation between the parties." The main results of the study showed that Estonian health care is still centered in hospital treatment and specialist medical care. A large part of the acute inpatient treatment is avoidable, and hospitalizations can be significantly reduced if the provision of health care services is taken to a more appropriate level. The survey also showed that a large number of medical specialist visits are preventable. As the main conclusion of the study, we should focus on strengthening the capacity of the primary care level in the health care system. Based on the results of the study were developed indicators to measure the integration of treatment. The indicators can be used to assess what activities can be done optimally and what could be avoided, while not making compromises for the needs of the patient. The developed indicators and their results based on the year 2014 data are published on the website of the Health Insurance Fund[1].

1 Indicators of assessment of integration of the Estonian health care system:
https://www.haigekassa.ee/et/partnerile/tervishoiuteenuste-kvaliteet/ravikvaliteedi-indikaatorid/eesti-tervishoiususteemi

Based on results of the survey conducted by the World Bank, the Health Insurance Fund has planned in their future activities to more precisely evaluate the reasonableness of some services. The analysis pointed out that the lack of primary health care and at times insufficient activity thereof will lead to hospitalizations in internal medicine and cardiology departments and the avoidable appointments to medical specialists. For the more accurate and more substantial identification of the reasons for the results, the Health Insurance Fund is, in the first half of the year 2016, conducting a stratified sampling (analysis of the documents verifying the health insurance benefits by specific treatment cases) in the course of which are assessed the factors related to treatment of patients with hypertension, angina, arrhythmias, and heart failure, the length of stay in the hospital, the justification for the medical services provided and the existence of the surveillance recommendations. In addition, it has been planned to assess the prior and post hospitalization activity of the family physician of the same patients (monitoring and treatment regularity, quality, compliance with the clinical guidelines and good medical practices).

Secondly, it has been planned to review the justification for a referral to the endocrinologist in the case of type II diabetic patients, because the specialty has a long waiting list, and the World Bank analysis showed that there are too many avoidable endocrinology specialist visits. On the basis of the medical records of primary medical care, we evaluate the patient treatment prior to referral to the endocrinologist, the justification of referral to the medical specialist, documentation of the activities (including the contents of the referral). In addition, we will check the existence of a referral on the basis of the treatment document, the need, and justification of the medical services provided by an endocrinologist, treatment of the patient, as well as cooperation with the family physician (provision for feedback and its quality).

The analysis conducted by the World Bank also brought out more clearly the need to describe in greater detail the movement of patients between different levels of health care, to prevent the exclusion of the patients requiring surveillance from the sight of health care professionals. It is necessary to define which types of complaints are made when the family physician refers the patient to a medical specialist, and when must the medical specialist refer the same patient back to the family physician for regular surveillance. To this end, the Health Insurance Fund, in cooperation with the Ministry of Social Affairs, continued the harmonization of the patient treatment guidelines. Within nine months, various opportunities were studied, the first location-based cancer patient treatment guidelines were completed, and a methodology for developing treatment guidelines was elaborated. The agreed methodology has been described in a separate chapter in the new “Manual of a compilation of Estonian clinical guidelines."

We will continue the cooperation with the World Bank, and have agreed on the objectives and activities of the second stage of the collaboration project. Focus is on the prevention of chronic disease, the strengthening of access to health services and the development of the health care system. The more specific goals of stage II of the study is to develop a model that would help to identify the patients, in case of whom the implementation of the preventive, advisory and monitoring activities would most benefit the patient's health and quality of life, and at the same time would also support the optimal use of health insurance resources. The study examines whether and how the waiting times affect the continuity of care across various levels of health care and the plan is to develop the model of differentiation of the waiting times and monitoring of their impact. Also, the price formation of the medicinal products reimbursed by the Health Insurance Fund and ensuring the availability of medicinal products in Estonia will be analyzed. The work has already begun, and the results are expected in the spring of 2017.

The indicators are prepared in collaboration with the Division of Treatment Quality and the Department of Information Technology.

Indicators as an important tool to assess the quality of treatment

The issues for ensuring high quality and a holistic approach to the patient and addressing them are important activities for the Health Insurance Fund. In order to measure the quality of care and to assess the outcomes, there is a need for information collected on the basis of structured, uniform principles. As one means of assessing the quality of treatment, nationally established treatment quality indicators can be applied that allow a transparent and systematic evaluation of the Estonian health care system and the changes in the treatment quality over time; and in the future view to compare Estonia with other developed countries.

At the end of 2013, a cooperation agreement was signed between the Estonian Health Insurance Fund and the Faculty of Medicine of the University of Tartu, on the basis of which the Advisory Board of Treatment Quality Indicators was formed consisting of the acknowledged experts in their field, which is an advisory body to the Board of Directors of the Health Insurance Fund. The objective of the activity of the Advisory Board is to develop a coherent and consistent system for monitoring the quality of the healthcare system in the form of clinical indicators, to help ensure timely health care services to all patients in accordance with the needs and expectations to meet professionally approved requirements and the legislative and ethical principles of the society. To this end, the principles and methodology were developed for the selection of the indicators to characterize treatment quality that supports the development of the quality system for Estonian health care.

After a thorough discussion, the Advisory Board made, to the first five professional associations, a proposal to submit on the basis of the agreed methodology up to ten indicators of the relevant specialty for national deployment. These five specialties were: obstetric and perinatal care, intensive care and anesthesiology, oncology, stroke therapy, and surgery. Professional associations presented their proposals, and the Advisory Board of Treatment Quality Indicators assessed all the presented indicators in detail. First, the preliminary approval of twenty indicators for three specialties was received. In the first half of 2015, the compilation of the technical protocols of the indicators that received the preliminary approval and the mapping of possible data sources in four major medical institutions was carried out. Simultaneously, the continued clarification of the indicators

of the other two specialties was carried out, which were also approved by the Advisory Board and which were developed for deployment in the second half of the year 2015. The Advisory Board has already selected the next three specialties for which will be made the proposal to designate the treatment quality indicators in their field.

In the introduction of treatment quality indicators, it is important to bear in mind that substantial information is obtained on the interpretation of the data, so in the case of all the results obtained, in-depth analysis of the causes both by the medical institution and the professional association is necessary. It should be thoroughly thought through which indicators it is feasible to implement target values for and which indicators it is advisable to avoid for specific targets. Only in this way can be obtained an objective overview of the essential indicators of the treatment quality and only in this case, one can obtain the suitable inputs for further improvement activities in the area of treatment quality.

In the near future will follow the preparations for the collection of the data of the approved indicators in the health care institutions nationwide and their regular analysis and publication. At the moment is being developed a system, whereby during the next few years, it would be possible to transmit the consistently collected data for uniform calculation of indicators. At the same time will be continued the inclusion of new specialties to develop new clinical quality indicators.

In addition to the development of treatment quality indicators, we will continue the publication of the indicators calculated on the basis of medical invoices for each hospital of the Hospital Network Development Plan. Hospitals can compare themselves with others, and can take action to improve the results. We have been compiling the Hospital Network Development Plan feedback report already for the fifth year and the results of all the years are displayed on the website of the Health Insurance Fund[2].

Since 2015, the regularly published indicators have been supplemented by the indicators developed in the course of the analysis of the World Bank that describe the integration of treatment in the Estonian health care landscape. The analysis has been based on the most common indicator diseases such as Type II diabetes, asthma, hypertension, the holistic approach of the patients with these diagnoses has been analyzed starting from family physicians and medical specialists all the way to hospitalization. The results of 2014 have been published on the website of the Health Insurance Fund[3] and the publication of the results of the same indicators in the year 2015 is expected this spring, 2016.

2 Hospital Network Development Plan feedback report:
https://www.haigekassa.ee/et/partnerile/raviasutusele/tervishoiuteenuste-kvaliteet/tagasiside-aruanded

3 Treatment Quality Indicators:
https://www.haigekassa.ee/et/partnerile/raviasutusele/tervishoiuteenuste-kvaliteet/ravikvaliteedi-indikaatorite-noukoda

The availability and quality of general health care is a very important area for the Health Insurance Fund, which is managed by the Division of First Level Package Development in close cooperation with the Partner Management Department.

Quality and availability of the primary medical care in the year 2015

On ensuring the quality of health care, one of the important criteria is also the availability of services. The Health Insurance Fund shall ensure that patients who need health care services would be provided them at the right time and in the right place. Since the year 2015, in the primary level, new possibilities were launched, bringing services closer to the patient. In the funding of the family physician, a therapy fund was launched, which increases the role of the family physician as a case manager. Thanks to the therapy fund, there is now an additional option for the referral of the patient to the services of a speech therapist and a psychologist. In addition, in 2015 were developed the requirements for the physical therapy services, the funding of which will begin in 2016.

Development of the family physicians quality system is very important for the Health Insurance Fund. The number of participants in the family physician quality system has increased steadily since 2007, and now the number of participants has increased to 96%. On the basis of the results of the family physician quality system in 2015, the maximum additional remuneration was paid for efficient performance of disease prevention and monitoring of patients with chronic diseases to 447 family physicians, additional remuneration for additional professional competence was paid to 186 family physicians (an increase of 40% compared to the previous period).

In 2015, a survey was conducted which evaluated the satisfaction of the Estonian population with their health care. In the last 12 months, 62% of the Estonian population aged 15-74 have visited the family physician. The survey results reveal that 91% of the visitors were satisfied with the appointment of the family physician and 93% of the visitors were satisfied with the appointment of the family nurse. According to the survey conducted, 78% of the population is satisfied with the family physician system (in 2014 the result was 76%). Out of those who have visited the family physician in the last 12 months, 82% are satisfied with the family physician system.

The Health Insurance Fund analyzes the availability of health care services, taking into consideration the temporal, geographical and financial aspects. The temporal availability of primary medical care is monitored by the Health Insurance Fund in the course of on-the-spot checks. The job description of the family physician and of the health care workers, working together with the doctor, govern the requirements of the availability of primary medical care on the basis of which a patient with an acute health disorder should have access to a family physician's appointment on the day of application, and other patients within five work days.

In the year 2015, 99.6% of the patients with an acute health disorder obtained a family physician's appointment on the day of application. In 99% of the cases checked, patients with non-acute health disorders (i.e., in other cases) were received by the family physician by the deadline, within five work days. 97% of patients obtained an appointment within three work days. On the basis of the first free appointment, the availability of the family physician's care is on the same level compared to the previous year.

The Health Insurance Fund checked, in 2015, the compliance with the financing of general health care by visiting the family physician's centers. The family physician's list is checked at least once every three years, so in one calendar year, there will be visits to approximately one-third of all the family physicians and the conditions for obtaining access to the appointment is examined. The purpose of the visit was to assess whether family physicians allow the patients access to family health care on the conditions provided in the legislation and in the agreement concluded with the Health Insurance Fund.

The availability of family physician's care in the year 2015 was assessed in 270 lists, which accounts for 34% of all the lists. In the same period of the last year were checked 272 lists. The checks revealed that obtaining the appointment on the day of application in 2015 in Estonia was very good. Approximately 2/3 of the patients can obtain an appointment on the day of application or on the following day. The regional differences in access to the appointment are not great, but it can be noticed that in the region of Pärnu the waiting time is slightly longer (38% of the patients waited for three or more days). Nevertheless, obtaining the appointment is ensured within the allowed waiting time. During nine months, among the checked lists, there has been only one practice, where on the basis of the free first appointment, obtaining of an appointment was not ensured within the allowed waiting time. In conclusion, ensuring the availability of family medical care is on a satisfactory level, because as a rule, a patient with an acute illness can access an appointment on the day of application, and in other cases, servicing the person is guaranteed within five working days.

In order to ensure better availability of the primary medical care for the persons with health insurance, the Health Insurance Fund has required the family physicians of long lists (2001 and more persons) to recruit an additional doctor. In 2015, the number of such lists among the samples of the family physicians checked by the Health Insurance Fund was 17%. As regards to compliance with the requirement, positive dynamics has occurred in comparison with the previous calendar year: 28% in the year 2014 and 62% in the year 2015, however, it must be borne in mind that this is a relatively small sample and the result of the calendar years depends specifically on the checked practice. In the future, it should be monitored that working on the list of an additional doctor would be associated with additional medical resources (the doctor's consultation hours longer than the minimum of 20 hours per week required by the contract).

Out of the checked lists, during the year 2015, the organization of work was assessed as very good in 11% of the lists, mostly good deemed to be 73% of the lists, 13% of the lists received a satisfactory assessment and 3% were assessed as poor. In the occurrence of deficiencies, the representatives of the Health Insurance Fund referred to the need to eliminate them. A poor assessment was given to the organization of work of 8 lists. An on-site follow-up check was considered necessary for 16 lists, which accounts for 6% of all the checked lists.

E-Consultation

The possibility of e-Consultation has been created for family physicians since 2013, allowing to receive consultation from a medical specialist. The service saves time and resources for both the patient and the health care worker and has an impact on the waiting lists. On the provision of timely and high-quality health care and advice to the people, the cooperation of family physicians with medical specialists is crucial. e-Consultation improves the quality of the data moving from the family physician to a medical specialist - the family physician consults with the medical specialist electronically, and the entire treatment takes place under the coordination of the family physician.

e-Consultation has been implemented between medical specialists and family physicians since 2013 when the service was launched in the specialties of urology and endocrinology. In 2014, the possibility of e-Consulting was added in the specialties of pulmonology, rheumatology and otorhinolaryngology, and in 2015, in the specialties of pediatrics, neurology, and hematology.

In 2015, e-Consultation services were used by 117 family care health doctors on 2514 occasions. These are mostly the family physicians of the Harju region. For comparison - in 2014, within 12 months, this opportunity was used by 72 family health centers in 1358 occasions. Thus, the use has increased by 85%.

In 2015, conditions were developed for providing e-Consultation services in the specialty of cardiology, and as of 2016, the fee for ECG devices was applied to family physicians in the growth of the capitation fee. Since the year 2015, e-Consultation services have been improved, in addition to the North-Estonian Regional Hospital also by the Ear Nose and Throat Clinic and the Tallinn Children's Hospital. It is also important that consultations on the specialties affiliated with the e-Consultation are provided across Estonia.

An important priority of the Department of Health Insurance Benefits is the continuous development of the health insurance package.

New opportunities in the package of specialist medical care and primary health care services

An important priority of the Health Insurance Fund is the continuous enrichment of the health insurance package with modern, medically evidence-based, cost-effective health care services. All the services reimbursed by the Health Insurance Fund are listed by the Government of the Republic in the annually approved health service list, which includes more than 2,000 different kinds of services, medical products, and complex services. Specialist associations, associations of health care providers and the Health Insurance Fund are able to make proposals for changing the health service list, by submitting a relevant request.

In 2015, in the framework of renewing the health service list, the Health Insurance Fund processed a total of 107 applications from 42 submitters on a uniform basis. The number of medicinal product related proposals was 30, and the number of services related proposals was 77. The materials completed and submitted in the procedural process, including applications, answers to additional questions, compiled evaluations and a summary table complete with the justifications for the decision have been published on the website of the Health Insurance Fund. The purpose of the publication of the material is transparency of the procedural process so that the parties involved would be able to keep up with the process on an ongoing basis and, where appropriate, to express their opinion. On the basis of a justified discretionary decision, 32 applications were upheld in part or in full, as a result of which, as of the year 2016, a number of new services were included in the health service list, and the necessary adjustments were made in the services already existing in the list, in order to provide patients with better treatment opportunities.

New opportunities in specialist medical care

Below are some of the most important new evidence-based services and the changes in the implementing conditions of the services added to the health service list in cooperation with specialist associations. Home physical therapy was added to the list in order to improve the availability of treatment and to improve access to the service for the patients who are unable to go to the health care provider because of a movement or transfer function impairment. On adding a new service, it is possible to

provide the service at home, which is much more convenient for the patient, since he or she does not have to be on inpatient treatment to obtain the service. Also, the psychiatric treatment team's home visit for patients under 19 years of age with severe mental disorders was added to the list. The service is aimed at patients with an acute and severe psychiatric crisis who due to their health condition need the visit of the medical treatment team outside the medical institution.

For the purpose of patient comfort and the availability of treatments, inpatient rehabilitation opportunities were expanded. For that reason, in the case of the rehabilitation service for supporting functions (for persons older than 19 years of age), the requirement according to which a service be paid only in case of a referral by a rehabilitation doctor was abolished. From now on, the patient does not need to make additional visits to the rehabilitation doctor, when the need for treatment has been determined by another medical specialist. In the case of inpatient rehabilitation services, the criterion that previously set the narrow health service list approved for use in rehabilitation was also abolished, and thereby the possibilities of treatment in the course of rehabilitation were expanded.

In order to raise the patients' quality of life, into the list was added a new additional tool to help patients who, following prostate carcinoma surgery and in the case of a residual function of the bladder sphincter, has emerged mild to moderate stress urinary incontinence. The service is indicated for the case where at least 12 months has elapsed from the time of the surgery. The package of services has also been complemented in the high-tech specialties. For example, in radiotherapy are funded modern radiotherapy techniques, which are the safest for other organs and as accurately as possible targeted to the malignant lesion.

A number of new medicines were added to the list. For example, treatment options expanded for patients with advanced Parkinson's disease, for whom treatment with an active substance apomorphine is now available. Unlike the treatment options in the existing health service list, using this does not require surgery. The new active substance pegvisomant was added to the list as an effective treatment option for patients suffering from endocrinological diseases whose disease has not responded to previous treatments. In addition, the availability of the biological treatment for patients with colorectal cancer was improved, which guarantees them better treatment results and a longer life expectancy. The quality of life of urticaria patients, who are not responding to their current treatment, will now be improved by a biological medicine called omalizumab. Moreover, new life-saving opportunity with an active ingredient rituximab is now available for the patients with rare acute neurological conditions. Typical long-acting injectable antipsychotics, which were previously reimbursed on a named patient basis, were also added to the list of services.

In addition to modification of the health service list on the basis of applications, a major achievement of the year 2015 was updating several services as a whole, comprehensive updating of the prices and rules of reimbursement. In this way, services of the specialties of intensive care and anesthesiology, cardiovascular surgery and speech therapy were updated, in order that the funding of health care specialties would meet the modern services provided in the medical institution and thereby motivate the provision for high-quality and efficiently organized treatment.

In the course of the updating of the specialties were also added to the list a number of new evidence-based services, such as new procedures for the intensive care unit, determination of the ankle-brachial index and foam sclerotherapy procedures in vascular surgery and specific research with a voice analyzer and a nasometer in speech therapy. Since 2016, in the health service list have been defined the services provided in the emergency department and their fair and optimal prices. The new emergency medical services will be implemented from 2016 onwards in two regional hospitals. Future plans include expansion of the application of these services on the basis of the analysis of the services.

New opportunities in primary health care

Disease prevention and promotion of their early detection are key priorities of the Health Insurance Fund. In 2015, in cooperation with professional associations, the Institute for Health Development, the E-Health Foundation and the Ministry of Social Affairs has been developed colorectal cancer screening, which will be launched in the second half of the year 2016. Consequently, on the proposal of the Health Insurance Fund, additional remuneration for the prevention of colorectal cancer was added to the health service list, which is paid to the family physician if the occult blood test has been made available to all persons in the list belonging to the target group, and counseling of the patients takes place at various stages of the screening. In connection with the above, colonoscopy screening services, which are carried out in the event of a positive occult blood test for the diagnosis of colorectal cancer, was added to the list.

On the proposal of the Estonian Association of Family Doctors, the family physician quality premium, aiming to motivate family physicians to improve the quality of the activities related to their list and to participate in the quality assessment, was added to the health service list. In addition to the hitherto enabled clinical speech therapy and psychological services, through the patient's therapy fund the family physician is, from the year 2016 on, able to also refer patients to physical therapy services, and through the research fund to the electroneurography service.

A continued priority is to increase the use of e-Consultation, enabling family physicians to refer patients to the consultation of a medical specialist, if necessary.

The service is designed to improve the availability of diagnostics and treatment of the patients. In cooperation with the Estonian Association of Family Doctors and specialist associations, the list of the e-Consultation specialty was expanded. Since 2016, the Health Insurance Fund also pays, on the agreed terms, for the e-Consultation of the specialties of cardiology, gastroenterology, orthopedics, oncology, and immunology-allergology.

Application of risk and cost-sharing principles will ensure the patient more rapid access to new treatments

Expenditures on health care are growing from year to year. New medicinal products are often significantly more expensive than the opportunities of the health insurance for compensation thereof. In order to improve the cost effectiveness and access to medicinal products, to manage excessive financial risks and also to allow for a more personalized approach to the treatment process - the Health Insurance Fund, in cooperation with the marketing authorization holders, is trying to devise ways to make the opportunities for reimbursement of medicinal products more diversified and more flexible. One such solution is the application of a risk and cost sharing scheme.

The difference of risks from pharmaceuticals to pharmaceuticals is rather significant. For example, there may be a risk that the medicinal product does not work or even if it does, it cannot be tolerated by the patient, and the treatment should be discontinued. It is also possible that the medicinal product works well, but in the case of a particular patient, it has to be used much longer than predicted on the basis of research, and it is delivering a significantly greater impact on the budget of health insurance.

Thus, given the nature of the risks and the individual character of the size of the risk in case of each medicinal product, it is not possible to develop fixed schemes to mitigate them. How to most efficiently manage the risk must be evaluated and considered separately in each individual case.

The first risk and cost-sharing schemes, in cooperation with the Health Insurance Fund and the pharmaceutical industry, began in Estonia in 2014 and as of the beginning of 2016, it allows the Health Insurance Fund thereby to compensate for the seven active substances for the treatment of melanoma, lymphoma, osteosarcoma, hepatitis C, prostate, lung and ovarian cancer.

The Estonian Health Insurance Fund, in cooperation with pharmaceutical companies, will continue to develop risk-sharing solutions that would help to enable more medicinal products for the people with health insurance.

The Division of the Specialist Medical Care Package Development is engaged in the price formation methodology of health care services.

The optimal pricing of health care services is based on a strong pricing methodology

For offering health insurance benefits to the insured people, the Health Insurance Fund is required to determine the payment methods, how to pay to medical institutions for treatment of people, and the pricing methodology, meaning how prices are established within the framework of these payment methods. In specialized medical care is used both fee for service and case based payment method. In Estonia, in case-based payment method are used *diagnosis-related groups*, (DRG-s), in the event of which a fixed amount is paid to service providers for the services provided in the course of the treatment case. In the case of fee for service based financing, all the services that were provided to the patient are paid for in accordance with the prices established for the services. The combination of information asymmetry and divergent interests of patients, medical institutions, and insurers has justified the regulation of health care service prices by the state, and in Estonia fee for service and DRG prices are also regulated. As the health care market does not operate under the laws of the market, the key issue is now - what is the right price? To ensure optimum service provisions, to avoid price increases driven by the provider-initiated demand and to motivate hospitals to act more efficiently, the prices must be optimized and insure the provision of high-quality and efficiently organized treatment. The optimal pricing is based on a strong pricing methodology.

Pricing of fee for service prices

Pricing of services, which forms the basis for fee for services funding, is based on the principles of activity-based cost of accounting (ABC methodology). According to this methodology, the activities necessary for the provision of a relevant health care service and the resources necessary for carrying out of those activities (e.g., the time consumed by the doctor and the nurse and the equipment used) must be described. The description of the services is based on the actual practice of the treatment facilities. Already in 2014, the Health Insurance Fund commissioned a pricing methodology analysis from an independent expert to get an assessment of the methodology used. The analysis pointed out that in general terms, the methodology used by the Health Insurance Fund in terms of its concept, is functional and is suitable for compensation of treatment expenses, and

concluded that the system used in Estonia is one of the most detailed and most accurate in compensation of treatment costs. The expert found that the methodology could be further improved and brought out a number of proposals for the development of the existing system.

The expert opinion also highlighted that the prerequisite for finding as objective calculation of the price as possible is high quality and comparable source data in the form of the actual cost data of the health care institutions. To this end, in 2015, in collaboration with health care institutions was developed a clearer and more standardized reporting guideline and a form to make the source data of price calculations of a better quality and to simplify and speed up the work. In addition, the analysis of 2014 pointed out that in order to identify the optimum prices, it is important to agree on the benchmarking method, i.e., on the principle, which level of expenditure will be ultimately taken as a basis for the determination of prices. The important factor is also the simplicity of administration so that it would be possible to keep the price model up to date all the time.

In 2015, a follow-up analysis was commissioned in order to receive practical input. The analysis gave suggestions on how to change the sample used for pricing to be more representative so that it would be easier to apply the results to the entire health care system, and how to change the service pricing methodology, so that prices would be fairly accurate and up to date all the time. Several of the suggestions were added to the year 2016 methodology development action plan. An important activity in 2016, is the collaboration with health care institutions to map overhead costs with a high financial impact in order to bring them to the optimum level, and then to adjust the prices annually according to the Consumer Price Indices. The Health Insurance Fund also wants to introduce the practice of continuously updating the cost of the medical devices with high financial impact. The aim of this activity is to keep prices permanently at an optimum level, relatively accurate and to motivate the efficiency of the system.

Pricing of the DRG-based prices

The basis for DRG-based pricing are the prices of single services provided in the framework of one treatment case, on the basis of which, according to the methodology, a price is calculated for each DRG. The fee for services prices provided during one treatment case (DRG) is formed according to the fee for service costs cost of the medical bills of the patients with a similar clinical picture and clinical course of action, as a result of which the key issue of formation of the optimal DRG prices is formation of homogeneous groups of treatment cases. As in recent years, increasingly the optimality of prices and DRG prices have been paid attention to, and are a very important part of the whole, in 2015 was commissioned a statistical analysis of the DRG pricing methodology. According to the opinion of the external expert, the methodical approach of DRG pricing currently used by the Health Insurance Fund is in compliance with the internationally accepted practices, and DRG cost calculation principles and methods provide a better adaptation to the cost of treatment services and treatment cases provided by medical institutions. The analysis pointed out a number of proposals, the implementation of which would help to examine whether and how the methodology can be used even better. As the Health Insurance Fund desires to obtain practical suggestions for improving the DRG cost calculation methodology, a follow-up analysis will be commissioned in 2016. In formulating the objectives of the analysis, close cooperation has been made with health care institutions, who are the daily users of the system.

it is important for the Health Insurance Fund that all health care prices are optimal, fair and provide the right motivation. To this end, it is important to develop continuously a methodology that would make possible a rapid adaptation to changes in treatment practices in health care institutions and in the economic environment, at the same time bearing in mind the desired goals.

The uniform and optimum distribution of health insurance funds is coordinated by the Department of Financial Management of the Health Insurance Fund in cooperation with the Partner Management Department.

A methodical and consistent budgeting and planning of agreements is a prerequisite for the sustainability of health insurance.

The Estonian Health Insurance Fund shall be the competence center in the field of short, medium and long-term financial planning and analysis of health insurance. Our financial strength, which is a prerequisite for the sustainability of health insurance, lies with adequate reserves, clear purchasing policies and high competence.

The strategic objective of a national social health insurance, and thus also of the Estonian Health Insurance Fund is ensuring equal access to evidence-based and cost-effective health insurance benefits for all insured persons to the extent and in the terms provided by law. The budget of the Health Insurance Fund determines the total order of the Health Insurance Fund, and the volume of the specialties purchased from each specific service provider is planned with contracts. The budget of the Health Insurance Fund shall be approved by the Supervisory Board of the Estonian Health Insurance Fund.

Planning of the budget of the Health Insurance Fund is an iterative process involving the preparation of the long-term forecast for health insurance benefits, planning of the cost and the resources for covering of the cost in the next four years, assessment of demand, drafting of the demand to be financed and implementation of the principles of the geographical availability. The budget of the Health Insurance Fund proceeds from the national health insurance budget position approved by the state budget.

Drafting of projections is a continuous year-round activity in the Health Insurance Fund. The planning is started with a compilation of the long-term prognosis (30+ years) of health insurance benefits which visualize the long-term financial sustainability of health insurance in the event of unchanged policy. This is followed by the shorter and clearer forecasts covering the four upcoming years, the aim of which is to ensure the stability and development of the financing of the health care system, and to enable all parties to understand the financing principles of the health insurance system and the proportions between the types of benefits.

On planning the costs and the sources of covering the cost (i.e., revenue) of the next four years, the change in the age of the population, the current health status and quality of treatment is taken into account, by motivating the use of high-quality and cost-effective treatment methods. The forecast shall be based on the priority areas of the next four-year development plan renewed annually by the Health Insurance Fund, the development forecasts of health insurance benefits (including health care services) and the economic forecasts of the Ministry of Finance. The methodology of the relevant forecasting includes the analysis of the impact of networking at the macro level, takes into account the results of the analysis conducted by the World Bank, the development trends of the primary level and the geographic accessibility principles.

For drawing up the budget, we assess on an annual basis the demand of the insured for the services in the following year, i.e., we forecast the number of treatment cases for each specialty. Demand assessment is carried out in all specialties and treatment types on the county level, based on the place of residence of the insured person. The assessment takes into account the volume of the anticipated need for specialized medical care, nursing care, and dental health care services for the insured persons residing in the county in the following year. The demand for health care services will change over the years, due to the change in age and gender composition of the insured population, the development of medical technologies and changes in the legislation, but is not directly related to the financial constraints of health insurance.

By adjusting the assessed demand with our budgetary funds, the result is the funded demand (the maximum number of the health care budget) - an important input for the planning of contract offers from health care institutions. As the funded demand is based on assessed demand, the contract offers take into consideration the need of the insured patient for treatment by specialty and movement to the treatments in terms of various health care institutions. More details on the assessed demand can be found on the website of the Health Insurance Fund [4].

For more balanced and more optimal use of the health insurance funds, an important role belongs to the application of the geographical availability (GA) principles, which define by types of hospital, in which specialty and in which treatment type the Health Insurance Fund purchases health care services. GA principles are based on the assumption that optimal nature and the quality of the provision of health care services is attainable if the adequate workload is secured for the staff and technology resources in the area of provision of the service. The analysis of the geographical availability of services is carried out on a county-level from the point of view of the insured, by the contract specialties of the Health Insurance Fund and by the service types. We deem sustainable, a doctor's full load in ambulatory medical specialties and in stationary specialties, the need for the service of a treatment unit with at least 20 beds with the occupancy rate of 85%. As a result of such a methodical approach, the places have been identified where purchasing of one or another specialty is optimal and sustainable taking into account the health policy framework and ensures the quality of care for patients.

Implementation of GA principles is crucial for ensuring the equal access to services in Estonia as a whole, helping to relieve the current bottlenecks in the supply of services. Implementation of these principles will ensure the insured persons with a greater certainty and clarity that they are provided with all the needed specialized medical services. For detailed information on GA principles, see the Health Insurance Fund website[5].

In the treatment financing contracts, the purchase order of the Health Insurance Fund is agreed on, and therefore, it is very important that the planning of the contracts is based on the budget, including all the above planning principles. In addition, to the budget inputs, planning of contracts is also based on the capability of each medical institution to provide services, taking into account both the previous provision of the service, as well as the capacity of the medical institution in the coming years. We compare and equalize the average costs of the treatment cases planned into the contracts with the average cost of the treatment cases of the same type of medical institution, thus trying to ensure the best cost-efficiency in the service contract.

We are confident that the budget and contract planning process of the Estonian Health Insurance Fund must be sufficiently comprehensive, clear and transparent. Thus, we guarantee the uniform availability of the high-quality health care services required for the residents of Estonia.

4 The assessment of demand for health care services:
https://www.haigekassa.ee/en/organisation/partner/medical-institutions/assessment-demand-health-care-services-and-planning?highlight=demand

5 The geographic accessibility principles:
https://www.haigekassa.ee/sites/default/files/lep_partnerid/geogr_ks_p6him6tted_eriarstiabis_parandatud.pdf

Preparations for the launch of the interaction registry is starting the final countdown

Due to the demographic situation in Estonia, where the trend is the general aging of the population and the incidence of chronic diseases with younger people, an ever-increasing number of patients consumes a number of different medications at the same time to treat diseases. Polypharmacotherapy increases the risks of undesirable interactions between different pharmaceuticals, as a result of which the expected outcome of treatment deteriorates and emerges an additional burden for health insurance budget.

The researchers of the University of Tartu have estimated that in Estonia, the treatment plans of the about 80 thousand patients could be better thought out if it would be possible to use an electronic tool to detect as many conflicting pharmaceuticals combinations as possible, and avoid them if possible. In Sweden, the data of the prescription center was retrospectively analyzed with the help of an interactions database. It turned out that with the four-month period, 3.8% of the patients came into contact with at least one serious pharmaceuticals interaction, and 38% of the target group was exposed to at least one significant interaction.

In the Nordic countries over the years have been introduced specific pharmaceuticals interaction databases, and developed ways to link these databases on the desktop of the doctor and to the pharmaceuticals prescribing process. The practice of the neighboring countries is supportive, with the help of the databases, the probability of serious interactions has been greatly reduced.

Thus, the Health Insurance Fund reached the decision that the interactions database could improve the quality of care for many patients, improve pharmaceuticals safety and support doctors in making treatment decisions. In May 2015, a public procurement was announced for the purchase of the user's right for pharmaceuticals interaction assessment software. The agreement was signed in the autumn with OÜ Celsius Healthcare through the Health Insurance Fund that will provide, over the next five years to all the pharmaceuticals prescribers, the free possibility of tracking the pharmaceuticals interactions with the help of the database SFINX and its web-based database PHARAO.

In the last months of 2015, the prescription center was further developed, and the interaction list service was completed. During the year 2016, the service will be introduced in all the medical institutions all over Estonia. Agreements with the pharmacies in terms of the extent and details of their interfacing will be reached in the second half of the year 2016.

Information on interactions will, therefore, in the short term, reach all the participants of the treatment process and along with training of the prescribers in terms of the interactions, the prescription of conflicting pairs of medicine to patients will be reduced, and the treatment quality will be improved.

The sustainability and the fault tolerance of the core processes of the Estonian Health Insurance Fund will be ensured by the Business Continuity Working Group.

The business continuity plans as an important strategy for managing risks

The sustainability and the fault tolerance of Estonian Health Insurance will be ensured by an up to date business continuity plan and the continuous testing of the parts thereof. The main objective of business continuity management is to internally implement a management system that will help prepare for possible unforeseen interruptions in the core activities of the Health Insurance Fund and thereby reduce the potential financial and reputational damage. The business continuity plan aims to ensure the capability of the Health Insurance Fund to continue its activities when the usual equipment or the principal operating environment is not available. Business continuity planning takes into account the risks endangering the operation of the Health Insurance Fund, for the management of which, a framework and necessary action plans will be prepared.

The Health Insurance Fund commenced internal business continuity planning in 2011 with the creation of the first workgroup. Process analysis and business continuity management were based on the BSI Standard 100-4 methodology published by German BSI[6], which is also used in state agencies. As a result of the initial workgroup, the first business impact analysis of critical processes was completed and the first business continuity plan was approved in January 2012. The aim of the business impact analysis was, before the creation of the plan, to assess the impact of interruptions on the core processes and certain support processes of the Health Insurance Fund as to identify the associated risks and the possible consequences.

The first business continuity test of the Health Insurance Fund was done In March 2012. Members of the crisis management team played out an emergency scenario where one of the offices of the Health Insurance Fund had been destroyed or was not available. In the course of the test the business continuity plan was implemented. Additionally the restoration of critical IT systems was tested. Both of these tests were completed successfully. Over the course of the next two years the business continuity plan was upgraded, improved and tested. Deeper emphasis was placed on managing internal and external communication. By

6 In German Bundesamt für Sicherheit in der Informationstechnik – Federal Office for Information Security

reviewing the business impact analysis continuously, it was ascertained that cooperation and coordination with other agencies in case of an unexpected incident is essential and as a result, the business continuity plan was updated to reflect critical linkages with other agencies and partners in a crisis situation.

In the second half of 2014 an unexpected testing of the business continuity plan was conducted. The goal of the test was to test the capability of the crisis management team in a real crisis situation. The test allowed to check immediately the efficiency of the updated business continuity plan and to determine whether the changes made and the direction taken corresponds to the expectations of EHIF. As a result of the test and updating the action plan further, a seminar on business continuity was held on in early 2015. During the seminar, it became clear that the Health Insurance Fund must take into account in it's business continuity planning the performance of health care system as a whole in an unexpected situation where a number of regions and agencies are. As a further development of this new direction it was decided to form two business continuity planning work groups. Activities in the field were divided into two sub-topics. The first business continuity planning workgroup (Work Group 1-BC) will continue planning and organizing activities related to the internal business continuity of the Health Insurance Fund. The second workgroup (Work Group 2-BC) is responsible for preparing action plans and a framework for ensuring continuous provisioning of health insurance benefits in unconventional situations, taking into account the external parties (contract partners, other state agencies).

As a result of the 1-BC workgroups activities, a, new version of the plan was approved, also reflecting the structural changes of the Health Insurance Fund that took place during the year 2015. In addition, more business continuity tests around serious failures are planned for 2016 to ensure timely restoration of operational work.

The second workgroup (Work Group 2-BC) analyzed legal framework, that which must govern the activities of the Health Insurance Fund in the case of an unexpected situation. It was agreed that the plans will be prepared for the situations when an emergency has not been declared.

The next step for the second workgroup (Workgroup 2-BC) was the identification of scenarios that may have a significant effect on the activities of the Health Insurance Fund, and the functioning of the health care system. To identify various scenarios, interviews were conducted with the key people and partners of the Health Insurance Fund (contracting partners, various public agencies). The final list with inputs from partners was completed by the beginning of February. Next, the weight of each scenario will be assessed, using the best practices of other countries for assessing risks in the health care system in order to identify critical scenarios, with which further work will be continued.

This year, the Health Insurance Fund will continue developing the list of the activities related to both internal and external business continuity.

The options of the persons insured by the Health Insurance Fund for obtaining treatment abroad is coordinated by the Division of Person-Based and Cross-Border Treatment.

Evidence-based treatment options abroad

Planned medical treatment abroad

The Estonian Health Insurance Fund started to compensate for the costs of cross-border healthcare in the year 2002 when the Health Insurance Act created the opportunity to receive elective medical treatment in another country. For the compensation of the planned treatment costs borne in a foreign country, the prior permit must be applied for from the Health Insurance Fund. For receipt of prior authorization, there are a number of criteria, the compliance of which will be assessed by doctors. The volume of the planned treatment provided in a foreign country to the insured persons and compensated for by the Health Insurance Fund is increasing year by year. In the year 2012, treatment abroad was reimbursed for EUR 2 million, in 2015 foreign elective medical services were purchased for Estonian patients at a total of 3.3 million euros.

In 2015, the major focus was on training major health care providers on the opportunities for treatment abroad, in order to raise doctors' awareness of and creating opportunities for patients to obtain medical treatment abroad if the treatment options in Estonia have been exhausted. We carried out a training day on cross-border treatment in all major hospitals.

We also continued cooperation with the Helsinki University Hospital. With regular meetings held for several years, we have improved the exchange of data and the availability of medical treatments abroad. In the coming years, we plan to develop cooperation with health care institutions of other countries in addition to Finland and to bring to the homepage of the Health Insurance Fund contact information on hospitals where Estonian patients have received the most help.

Although the Health Insurance Act provides an opportunity to receive planned treatment all over the world, in practice, however, the doctors treating the patient refer their patients primarily to EU member states. In 2015, patients went to receive planned treatment mostly in Germany (29 people), in Finland (31 people) and in Sweden (10 people). The most genetic research was conducted in Germany (58 times), Denmark (48 times) Netherlands (22 times) and Belgium (21 times).

Since the end of 2013, people insured by the Estonian Health Insurance Fund may go to another Member State for planned medical treatment, also without prior permission from the Health Insurance Fund - under the Directive on patients' rights - but in this case, the expenses borne by the healthcare services will be paid by the Estonian Health Services according to the prices of the list of health care services. On the basis of the practice of applications reimbursed under a little more than two years old Directive, we see that in the other Member States, health care costs are much more expensive than those of Estonia, and on average, we can compensate for only 30% of the costs incurred by the patient. Surely this is one of the reasons why on the basis of the Directive so few patients are able to go to another country for targeted therapy. For better planning of the expenses of the insured, the Health Insurance Fund can provide a price estimate on the basis of a relevant query of the person seeking treatment (query on the European Union's health care cost reimbursement) - 8 applications for such price queries were submitted to the Health Insurance Fund last year.

For better processing of the requests for benefits submitted under the Directive on patients' rights and for sharing experiences, representatives of the Estonian Health Insurance Fund last autumn visited colleagues of Latvia and Finland to become acquainted with the implementation of the Directive. The aim of cooperation with neighboring countries, in addition to sharing the various practices, is to become acquainted with the health care systems of other countries, in order to better advise the insured of EHIF in practical issues related to receiving cross-border healthcare services.

The needed medical care on the basis of the European health insurance card

Estonia joined the European Union in 2004 and since then, for the insured persons of the Health Insurance Fund, a possibility emerged, during a temporary stay in another Member State, to obtain the necessary medical care on the basis of the European Health Insurance Card. If the insured does not have a European Health Insurance Card with them, they will first have to pay for the provided medical care and then submit the request for compensation to the Health Insurance Fund. As the amounts can be quite large, it is important to obtain the European Health Insurance Card before going on a trip. On the basis of a valid European Health Insurance Card, the necessary medical care is provided to the insured person on equal terms with the insured persons of that country; the person must pay only the deductible fees. In order to raise awareness, in the spring and summer period of the year 2015, we carried out a campaign of the importance of the European Health Insurance Card. The campaign resulted in a significant increase in ordering the Cards last year, compared to the year 2014. When in the year 2014 were ordered 77 741 cards, then in the year 2015 were ordered 94 992 cards (22% more).

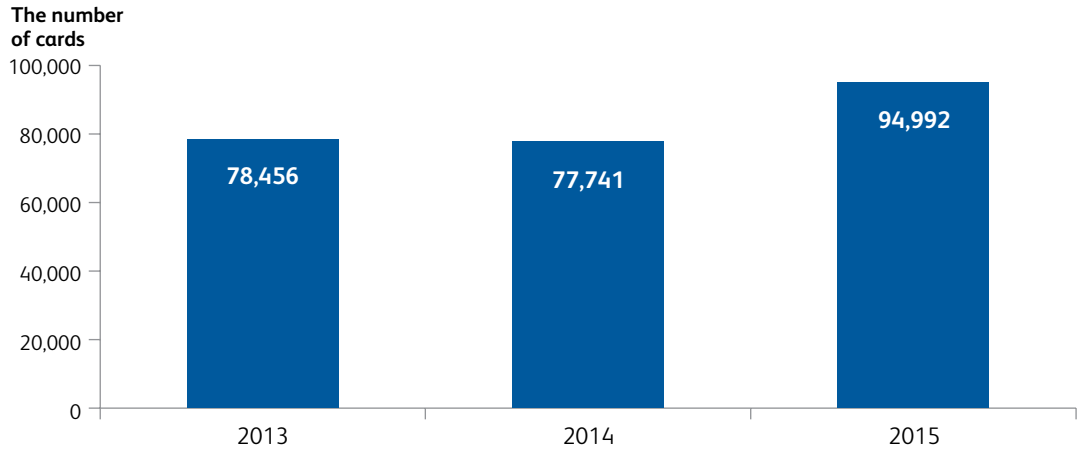


Figure 1. Orders of the European Health Insurance Card in the years 2013-2015

Budget Execution Report

Table 2. Budget execution in thousands of euros

	2014 actual	2015 budget	2015 actual	Budget execution	The change compared to the year 2014
REVENUE OF THE ESTONIAN HEALTH INSURANCE FUND					
Health insurance part of the social security tax	893,759	945,390	958,599	101%	7%
Revenue from insurance contracts	1,195	1,500	1,317	88%	10%
Recoveries and revenues from health insurance benefits	1,062	1,050	1,026	98%	-3%
Financial revenue	652	940	262	28%	-60%
Other revenue	3,541	3,790	3,149	83%	-11%
TOTAL BUDGET REVENUE	**900,209**	**952,670**	**964,353**	**101%**	**7%**
HEALTH INSURANCE COSTS					
Costs of health care services	**664,070**	**698,399**	**712,692**	**102%**	**7%**
Disease prevention costs	7,591	7,850	7,650	97%	1%
Costs of primary medical care	82,248	92,067	92,460	100%	12%
Costs of specialized medical care	529,044	548,830	561,533	102%	6%
Costs of nursing care	24,537	27,030	28,450	105%	16%
Costs of dental care	20,650	22,622	22,599	100%	9%
Health promotion costs	**857**	**1,100**	**1,088**	**99%**	**27%**
The costs of the medicinal products compensated for to the insured persons	**109,753**	**111,600**	**112,801**	**101%**	**3%**
Costs of the benefits for temporary incapacity for work	**103,902**	**102,590**	**116,977**	**114%**	**13%**
Costs of the benefits of medical devices	**8,770**	**9,430**	**9,076**	**96%**	**3%**
The treatment of an Estonian insured person abroad	**8,764**	**7,210**	**8,519**	**118%**	**-3%**
Costs of dental care and denture benefit	**9,159**	**9,920**	**9,362**	**94%**	**2%**
Other expenses	**2,938**	**3,351**	**3,094**	**92%**	**5%**
Total health insurance costs	**908,213**	**943,600**	**973,609**	**103%**	**7%**
OPERATING EXPENSES OF THE HEALTH INSURANCE FUND					
Labor costs	5,261	5,672	5,554	98%	6%
Management costs	1,450	1,642	1,579	96%	9%
Information technology costs	962	938	932	99%	-3%
Development costs	278	225	277	123%	0%
Other operating costs	551	593	942	159%	71%
Total operating expenses of the Health Insurance Fund	**8,502**	**9,070**	**9,284**	**102%**	**9%**
TOTAL BUDGET COSTS	**916,715**	**952,670**	**982,893**	**103%**	**7%**
Budget year net gain	**-16,506**	**0**	**-18,540**	**-**	**-**
RESERV					
Change in reserve capital	3,239	2,774	2,774	-	-
Change in risk reserve	1,289	921	921	-	-
Change in the retained earnings	-21,034	-3,695	-22,235	-	-
Total change in reserves	**-16,506**	**0**	**-18,540**	**-**	**-**

The number of the insured

Permanent residents of Estonia, people living in Estonia under a temporary residence permit or right of residence for whom is paid or who pay their own social insurance tax, as well as the people considered equal to those people on the basis of Health Insurance Act or a relevant agreement are entitled to health insurance.

Reflecting the health insurance statistics, persons insured on different grounds have been divided into five groups:

- working insured - persons insured by the employer, sole proprietors (including their spouses participating in their activities), governance body members, persons entered into contract under the law of obligations;
- persons considered equal to the insured - pensioners, children, students, pregnant women, dependent spouses;
- insured by the state - unemployed, persons on parental leave, care givers for disabled persons, conscripts;
- persons insured under a foreign contract - pensioners from European Union (EU) Member State settling in Estonia, employees posted in Estonia from another EU Member State, Estonian pensioners leaving for another EU Member State, military pensioners of the Russian Federation;
- people considered equal to the insured under a voluntary contract - persons insured on the basis of the contract are considering equal to insured persons pursuant to the Health Insurance Act.

Statistically is essential the category of the employed, insured persons. This means that if a person has more than one valid insurance, the health insurance statistics do not show double data. Therefore, for example, the data of the persons insured as pensioners as well as a working person are reflected only as the employed, insured persons.

Table 3. The number of the insured

	31.12.2013	31.12.2014	31.12.2015	The change compared to the year 2014 (persons)	The change compared to the year 2014
Employed insured persons	584,094	600,998	615,333	14,335	2%
Persons considered equal to insured persons	594,408	583,101	587,459	4,358	1%
Other insured persons	52,701	48,720	34,544	-14,176	-29%
Persons insured by the state	50,391	46,275	31,918	-14,357	-31%
Persons insured under a foreign contract	1,903	1,993	2,100	107	5%
Persons considered equal to the insured persons under a voluntary contract	407	452	526	74	16%
Total	**1,231,203**	**1,232,819**	**1,237,336**	**4,517**	**0%**

In the year 2015, the proportion of employed persons among the persons with health insurance has increased, accounting for as much as 49.7% of the total number of the insured persons. According to Statistical Office data, in 2015, the rate of employment was 65.2%, which is the highest figure in recent years. As the possible causes of the improved labor market indicators in the year 2015, compared to the previous year, may be highlighted the impact of the employment register on the employment and the employment growth in the previous year.

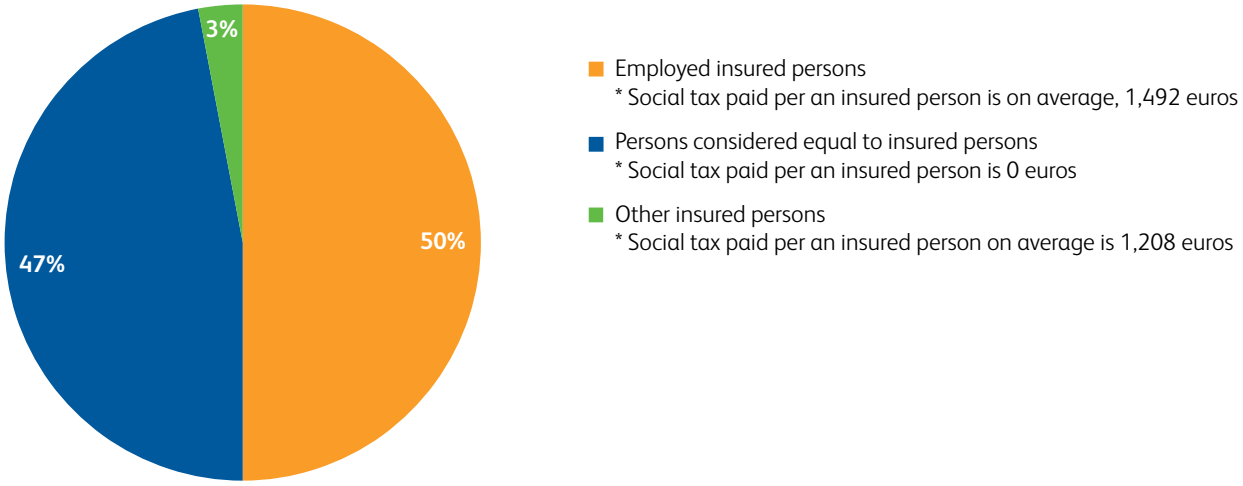


Figure 2. The proportion of the insured persons of their total number and the contribution of the social tax

Revenues

Table 4 provides an overview of the revenues of the Health Insurance fund in the year 2015.

Table 4. Revenue budget execution in thousands of euros

	2014 actual	2015 budget	2015 actual	Budget execution
Health insurance part of the social security tax	893,759	945,390	958,599	101%
Revenue from insurance contracts	1,195	1,500	1,317	88%
Recoveries and revenues from health insurance benefits	1,062	1,050	1,026	98%
Financial revenue	652	940	262	28%
Other revenue	3,541	3,790	3,149	83%
Total	**900,209**	**952,670**	**964,353**	**101%**

Health insurance part of the social security tax

The execution of the revenue budget of the Health Insurance Fund is most affected by the revenue of the health insurance part of the social tax. In the year 2015, the revenue of the health insurance part of the social tax was EUR 958.6 million, which exceeded the budget planned for the year 2015 by 13.2 million euros (budget execution 101.4%). Compared to the year 2014, the revenue of the health insurance part of the social tax has increased by 7.2%.

An overview of the revenue of the health insurance part of the social tax and on the growth and the shrinkage is provided in figure 3.

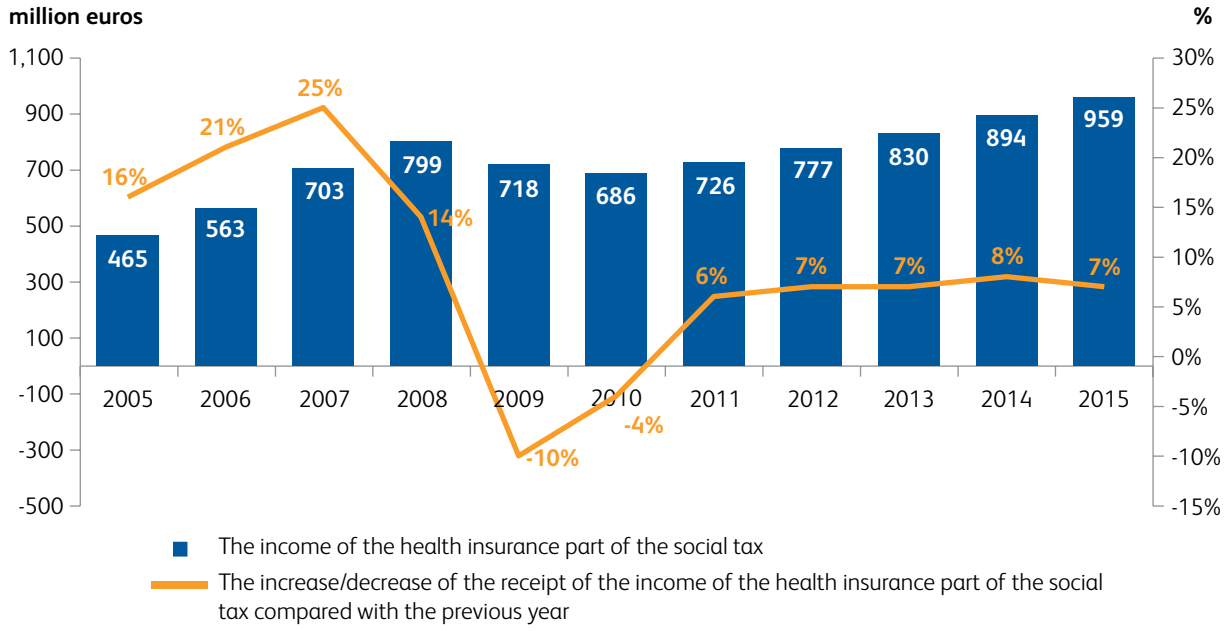


Figure 3. The revenue of the health insurance part of the social tax and the growth and shrinkage in the years 2005-2015

95.8% of the social tax is paid by employers, the state pays the remaining 4.2% of the unemployed and recipients of social benefits (see Figure 4).

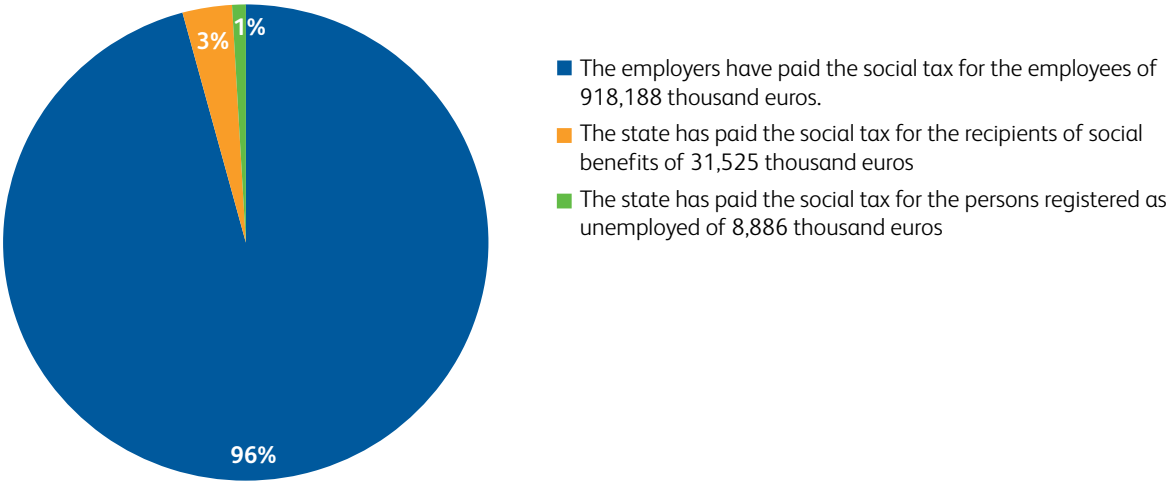


Figure 4. Participation in payment of the social tax

Revenue from insurance contracts

Until 2015, the budget row named revenue received on the basis of a contract and was considering equal to the insured person.

Revenues under the insurance contract are the revenues received from the voluntary insurance contract and revenue from insuring military pensioners of the Russian Federation living in Estonia.

Pursuant to the Health Insurance Act §22, a person without insurance can obtain insurance for himself or herself by entering into the contract with the Health Insurance Fund and paying the monthly premiums. The premium amount per calendar month in the year 2015 was 123 euros. As of December 31, under the contract of considering equal with an insured person were insured 526 persons and during the year revenues were yielded in the amount of EUR 787 thousand.

In 2015, insurance of the non-working pensioners of the Armed Forces of the Russian Federation yielded revenues of 530 thousand euros. As of December 31, under the foreign contract were insured 398 persons. In 2015, the Russian Federation paid 106 euros per month for each military pensioner. The health insurance payment monthly fee is calculated on the basis of the average annual cost of treatment for the year 2014 for the age group of 70-79 years.

Recoveries and revenues from health insurance benefits

Until 2015, the name of the budget line was 'claims of payments from other persons'.

As recoveries are recorded the claims for payment of health insurance benefits paid as a result of the road traffic injury submitted to the insurance company, claims for payment of the damages caused to the Health Insurance Fund with unfounded insurance claims submitted to the employers and claims for payment submitted by the health care service providers, pharmacists, the insured persons and employers as a result of the inspection.

In 2015, claims were submitted for payment for nearly one million euros. 56% of the execution of the budget for claims for payment for the year 2015 accounts for the claims for payment of traffic damages submitted to the insurance companies.

Financial revenue

The Health Insurance Fund will receive interest from the balance of the cash held on the national group account on the basis of the deposit contract concluded with the Ministry of Finance, the amount of which is equal to the return of national cash reserve. The return of the year depends on the events influencing the price of movements of the bond market and the interest rates on short-term deposits.

In the financial year, the Health Insurance Fund received financial revenue of 262 thousand euros. The annual results of the liquidity reserve amounted to 0.17%. In June, due to the decline in bond prices, the liquidity reserve of the month resulted in zero, because the negative interest is not taken into account (see Figure 5).

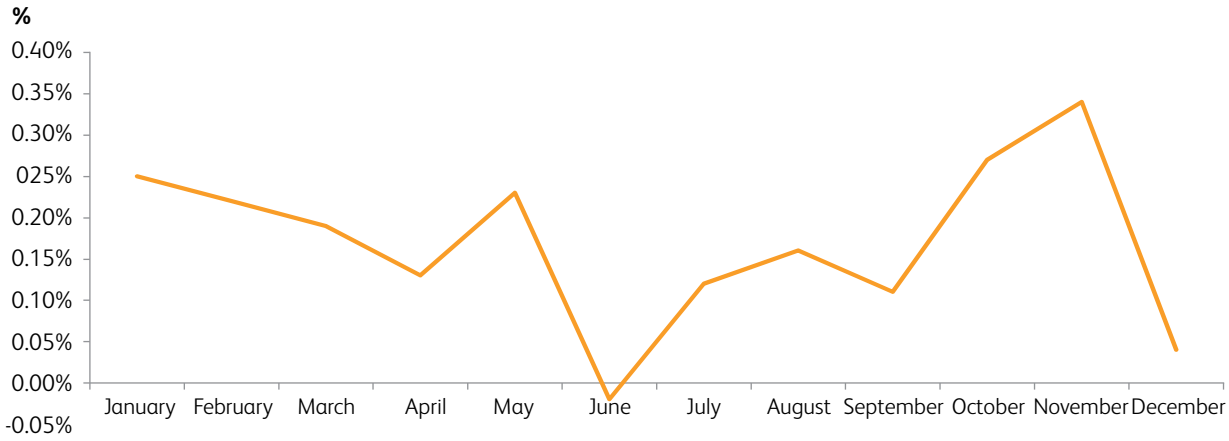


Figure 5. The year 2015 return by month

Other revenue

In other revenues, the most important types of revenue are revenue from government grants and claims submitted to the competent authorities of other Member States by the Health Insurance Fund for the medical services provided in Estonia to the insured persons of the EU Member States. In other revenues is recognized the revenue from the processing of medical invoices and the foreign exchange gains related to the operating cost and health insurance costs.

In 2015, the Health Insurance Fund received the targeted financing revenue of 1.6 million euros. For the health insurance costs were obtained 1.5 million euros from the state budget to cover the costs of medicines and health care under the Artificial Insemination and Embryo Protection Act. The Health Insurance Fund received the revenue from the NIHD of 12 thousand euros to cover the expenditure incurred in the framework of the national cancer prevention strategy. For the operating expenses, targeted financing was received from the Government of the Republic regulation for canceling of student loans, for the health insurance system development project in Moldova, and from the Estonian Research Council for the development of the project revenue quality indicators.

In 2015, the Health Insurance Fund submitted claims for 1.5 million euros to the competent authorities of the other Member States for the medical services provided in Estonia to the insured persons of the EU Member States.

Health insurance costs

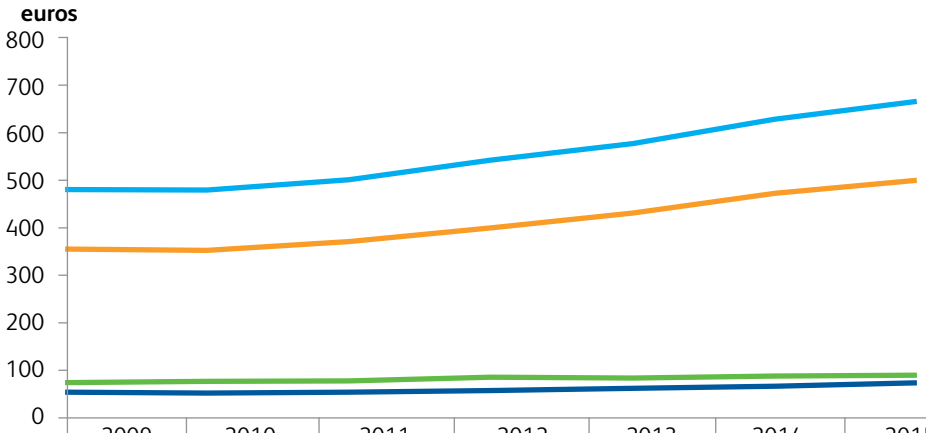
An overview of the average expenditure of the health insurance per insured person by age groups is shown in Table 5.

Table 5. In 2015, the average cost per insured person in euros

Age of insured persons	Number of insured persons as of 31.12.2015	Primary medical care Expenditures	Other health care costs *	The medicinal products medical products compensated for	Costs total
0–9	148,324	79	298	26	403
10-19	125,991	57	286	22	365
20-29	146,613	59	304	38	401
30-39	161,655	61	344	53	458
40-49	158,310	65	346	63	474
50-59	162,734	83	499	110	692
60-69	156,267	86	725	171	982
70-79	109,505	102	1,039	229	1,370
80-89	59,086	96	1,140	192	1,428
90-99	8,706	86	1,011	115	1,212
100-109	145	84	1,186	66	1,336
Total	**1,237,336**	**75**	**501**	**91**	**667**

* Other health care costs include benefits in cash for specialized health care, nursing care, dental care and dental benefits.

Average expenditure per person in 2015 increased by a total of 188 euros, compared with the year 2009 (see Figure 6). By the age of the insured persons, the average costs have increased the most in the age group 70-79 years of age.



	2009	2010	2011	2012	2013	2014	2015
Primary medical care	53	51	53	57	62	67	75
Other health care services*	354	351	370	399	431	473	501
Medicinal products	73	76	77	86	84	89	91
Total expenditures	479	478	500	542	577	629	667

* Other health care costs include benefits in cash for specialized health care, nursing care, dental care and dental benefits.

Figure 6. The average cost per insured person for the years 2009-2015, in EUR

1. Health care services

For 2015, the health care budget was planned in the amount of 698.4 million euros. The budget was exceeded in specialized medical care and nursing care (see Table 6).

Table 6. Execution of the medical services budgets in thousands of euros

	2014 actual	2015 budget	2015 actual	Budget execution
Disease prevention costs	7,591	7,850	7,650	97%
Costs of primary medical care	82,248	92,067	92,460	100%
Costs of specialized medical care	529,044	548,830	561,533	102%
Costs of nursing care	24,537	27,030	28,450	105%
Costs of dental care	20,650	22,622	22,599	100%
Total	**664,070**	**698,399**	**712,692**	**102%**

In 2015, the funding of health care services increased in comparison with the previous year by 48.6 million euros - including funding for specialist medical care of 32.5 million euros, funding of primary medical care of 10.2 million euros, funding of nursing care of 3.9 million euros, funding of dental care of 1.9 million euros and funding of disease prevention of 59 thousand euros.

The execution of the budget of the health care services of the accounting year was affected by the general rise in prices of health services and the need to ensure access to health services for insured persons.

In the budget for primary medical care, compared to last the funding, the Fee For Services Fund has increased. Appointments held during non-working hours have improved access to family health care for the insured persons just in the evening hours, which was also the expectation of the insured persons.

Specialist medical care was funded more than planned in order to ensure the availability of the services, the budget was filled both in terms of the amount and of the treatment cases. Compared to the budget, outpatient treatment and day care were funded on a larger scale than planned.

The percentage of the medical services in excess of the contract volume in the financing[7] of the specialized medical care was 3.6% as regards the treatment cases, 2.1% as regards the amount. 118 thousand treatment cases were remunerated by a factor, with a total cost of 11.4 million euros. In outpatient treatment, 6 million euros were paid for 105 thousand treatment cases as treatment services provided in excess of the contract volume, in the day treatment, 1.1 million euros for four thousand treatment cases and in inpatient treatment, 4.3 million euros for nearly nine thousand treatment cases. Hospital Network Development Plan hospitals submitted treatment invoices for 10.8 million euros for the treatment cases exceeding the contractual volume, the selection partners for 0.6 million euros.

In dental care selection procedure of the Health Insurance Fund partners was carried out in the year 2015. To ensure consistent treatment of patients, the funding of the ongoing treatment and of the treatment of the patients registered in the treatment waiting lists was agreed upon with health care institutions with whom the contract for the new period was not entered.

In nursing care overfilling is affected by the need for implementation of the price coefficient of the inpatient nursing bed days to a greater extent and the growth of the number of home nursing visits.

7 For ensuring the availability of the services to the insured persons, the Health Insurance Fund assumes biannually the obligation for payment of the fee in case the treatment cases agreed on the basis of Annex 3 of the treatment financing agreement have been performed in the outpatient treatment:

- by a factor of 0.3 inpatient treatment invoice amount;
- by a factor of 0.7 outpatient and day-care treatment invoice amount, whereas the amount to which the factor 0.7 is applied is up to 5% of the total amount of the outpatient and day treatment obligations agreed upon in Annex 3 of the Agreement;
- by a factor of 0.3 outpatient and day-care treatment invoice amount, if the monetary volume of the overtime work of the outpatient and day-care treatment exceeds 5% of the total amount of the outpatient and day treatment obligations agreed upon in the Agreement;

1.1 Disease prevention

In an evidence-based manner, a significant part of the loss of health can be reduced by prevention and early detection of diseases. Disease prevention is an important part of health care services aimed at the involvement of healthy people in health examinations, population-based screening or preventive health services, in order to prevent or lower the incidence of preventable diseases and to reduce the need for medical treatment. Disease prevention and early detection will help to increase the quality of human life for many years since the disease detected at the early stages is usually curable and the person maintains the activity and the capacity for work. The Health Insurance Fund deems important the program-based resuming of the evidence-based cancer screening, including the application of new screening, considering the evidence-based nature, cost-effectiveness, as well as international experience and the health care organization in Estonia.

In the case of screening and other preventive services, we assess on a regular basis the feasibility of the project-based approach and the capabilities and justification of the integration as part of the system. The Health Insurance Fund contributes consistently towards raising people's awareness, influencing health behavior and inclusion in the treatment process. Almost every health care worker is engaged in disease prevention in the framework of their daily work in family health care, specialized medical care and nursing care. The Health Insurance Fund provides further support for disease prevention with project-based work, in which the inclusion of a specific target group and coordinated management is important.

Table 7. Disease prevention budget execution in thousands of euros and the number of participants in the projects

	2014 actual		2015 budget		2015 actual		Budget execution	
	The amount	Number of participants	The amount	Number of participants	The amount	Number of participants	The amount	Number of participants
School health care	4,039	150,499	4,319	150,215	4,338	152,081	100%	101%
Counseling of youth about reproductive health and prevention of sexually transmitted diseases	1,049	31,871	1,126	34,000	1,043	29,361	93%	86%
Early detection of breast cancer	954	35,239	1,086	35,000	1,045	38,269	96%	109%
Early detection of cervical cancer	238	14,702	324	18,000	269	15,475	83%	86%
Young athletes' health check	621	8,984	758	10,000	706	9,400	93%	94%
Early detection of colorectal cancer	0	0	37	0	37	0	100%	-
Analysis to improve disease prevention and development of the health care system	198	0	200	0	200	0	100%	-
Other prevention	28	0	0	0	12	0	-	-
Phenylketonuria and hypothyroidism examination *	192	13,559	0	0	0	0	-	-
Newborn hearing examination*	272	14,273	0	0	0	0	-	-
Total	**7,591**	**269,127**	**7,850**	**247,215**	**7,650**	**244,586**	**97%**	**99%**

* The activities of the phenylketonuria and hypothyroidism and newborn hearing examination project have from the year 2015 onwards, been integrated into the primary medical care.

School health care service is the health care sector, which engages in students' health promotion, disease prevention, health surveillance and provision of first aid and the development of self-help skills, forming the largest part of the budget for the prevention of diseases. The assessment of the need for school health services is based on the statistics of the number of students provided by the Ministry of Education and Research. The primary goal of the school health care service is to ensure the welfare of the students and to support their normal development and growth, but the service does not include the treatment of diseases. The Health Insurance Fund finances the school health care service on the common grounds in all day schools. As the students' health issues are very complex, the school health care team is interdisciplinary. The school health care team collaborates with the school management, the board of trustees, the student councils, and the local governments. Within the next four years, the main activities of the Health Insurance Fund are related to coordination of development work, particularly keeping in mind the modernization of the guidelines, better monitoring of data acquisition and the transfer of reporting to the Health Information System. In 2015, school health care services were provided in 536 schools by 173 service providers. In 2015, services were provided to 3070 students in the schools for students with special needs.

The target group of the screening of early detection of breast cancer includes women of 50–62 years of age. In 2015, were invited for screening the women born in the years 1953, 1954, 1955, 1957, 1959, 1961, 1963 and 1965 who had health insurance. The Health Insurance Fund has commissioned from the Health Care Institute of the University of Tartu a Health Technology Assessment Follow-Up Report and plans potential development in the coming years, according to these results, involving the relevant professional associations and organizations.

The target group of the screening of early detection of cervical cancer includes women of 30–55 years of age. In 2015, were invited for screening the women born in the years 1960, 1965, 1970, 1975, 1980 and 1985 who had health insurance. The main preventive action for cervical cancer is outreach work and the regular participation of the target group in the well-organized screening.

The volumes of the projects of early detection of breast and cervical cancer are related to the goal to achieve in the breast and cervical cancer screening the target value of at least 70% participation rate of the women invited because this level begins to reveal the evidence-based positive effect on total mortality.

From the second quarter of 2015, the invitation of women to the screening is organized by Cancer Screening Registry. The Health Insurance Fund costs for both projects are primarily related to the financing of the provision of the service, which is supported by the outreach necessary for the achievement of the coverage of the target groups and the feedback to family physicians. Outreach activities are carried out in the framework of the Health Promotion Action Plan, a brief overview of which is provided in Chapter 2.

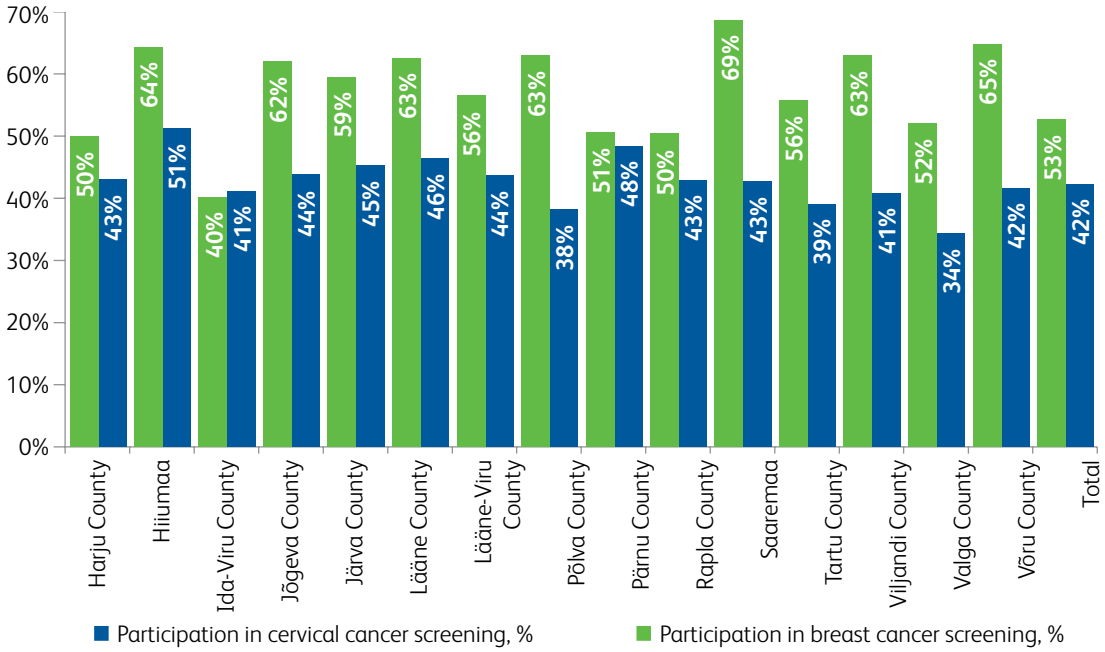


Figure 7. Participation of women receiving invitations in the year 2015 for breast and cervical cancer screening on the basis of the lists of family physicians across counties

The aim of the project of youth counseling about reproductive health and prevention of sexually transmitted infections is through services designed for children and young people to motivate and raise awareness of the behavior reducing health, as a result of which we will achieve a good reproductive health of Estonian youth, reflected in the decline in the fertility rate of the 15-19-year-olds and in the decline of the abortion rate of the legally induced abortions in the age group of 15-24 years. The volume of services provided in the youth counseling offices is related to the use of the centers by the youth, in addition, additional activities will take place to enhance the involvement of young men continually.

The young athletes' health check is aimed at the young people of 9-19 years of age who are engaged in sports on a regular basis for at least 6 hours, in addition to the physical education classes at school. For young athletes is performed the complex of initial checks according to the sports area and the training load, and if necessary additional checks are added. Additional checks or services will be implemented only for medical purposes. On the basis of the guidelines for carrying out nationwide health checks of the young athletes, heath checks are ensured for 10 000 young athletes, including directing the checks in particular to young people who train more than 8 hours per week (at least 50%). One goal is enhancing the project management activities on empowering of the partners in and improving cooperation between family physicians and the sports doctors providing the project service. The Health Insurance Fund plans the development activities in accordance with the results of the projects operational audit conducted in the second half of the year 2015.

Early detection screening of colon cancer is launched in stages from the second half of 2016, the launch of which is preceded by thorough analysis and interdisciplinary development. The created screening is registry-based and for the first time largely coordinated through the primary level. The target group of colon cancer screening in the year 2016 are the men and women born in the year 1956. The initial size of the target group is 16,674 persons, and the expected coverage of the target group for the initial period is 30% or 5,000 persons. Starting from 2017 will follow the primary analysis of the implementation of the new screening and planning of the possible follow-up actions.

The Management Board of the Health Insurance Fund has conducted negotiations with the World Bank for carrying out analysis for the purpose of development of the financing of the Estonian health care system *(„Estonia – Toward Integrated Health Care")* - in the year 2014 and as a follow-up in the year 2015 (feedback to the initial analysis result from the Estonian partners, where appropriate, specification of the analysis and drafting of the final analysis report). The completion of the analysis was scheduled for the year 2015 (completed by December 2015); the feedback to the primary analysis result from the Estonian partners where appropriate, the specification of the analysis and drafting of the final analysis report will remain for the year 2016.

1.2 Primary medical care

The Health Insurance Fund considers the strengthening of primary care to be most essential, which ensures the role of the family physician as the case manager in the treatment process. The significant change that took place in the financing of family health care in the year 2015 was the implementation of the therapy fund in the specialties of speech therapy and psychology. New specialties were also added to the e-Consultation services.

The growth of the actual use of the budget for the year 2015 was most affected by the increase of the wage component. In addition, as a new opportunity has been established for the use of the therapy fund for the family physicians for referring patients to speech therapy and psychological services.

In 2015, family health care was funded at 92.4 million euros. Compared to the year 2014, the increase in funding was 10.2 million. The funding was increased due to the increase in the wage component. The second family nurse allowance and the non-working time allowance have also risen. The Fee For Services fund and the operations fund have also increased. In the first year, the use of the therapy fund was less than expected.

Table 8. Execution of the primary health care budget in thousands of euros

	2014 actual	2015 budget	2015 actual	Budget execution
Basic allowance	9,497	9,718	9,722	100%
Distance allowance	467	472	474	100%
Second family nurse allowance	2,994	3,762	4,072	108%
Capitation fee	50,455	56,091	55,667	99%
The capitation fee for the insured of up to 3 years of age	2,778	3,176	3,057	96%
The capitation fee for the insured between 3 to 6 years of age	3,289	3,655	3,563	97%
The capitation fee for the insured between 7 to 49 years of age	21,049	23,254	23,047	99%
The capitation fee for the insured between 50 to 69 years of age	13,746	15,316	15,419	101%
The capitation fee for the insured of over 70 years of age	9,593	10,690	10,581	99%
Fee for Services fund	16,419	18,250	19,458	107%
Operations fund	358	400	430	108%
Therapy fund	0	946	208	22%
Performance pay	1,389	1,676	1,666	99%
Allowance for appointments outside of working hours	137	158	209	132%
Family physician advice line	532	594	554	93%
Total	**82,248**	**92,067**	**92,460**	**100%**

Financing of primary health care has become more differentiated: the largest share still accounts for the capitation fee (60%), but its share of the financing of the total primary health care compared to the year 2014 has decreased by 1%. The share of the Fee for Services fund of the total budget is 21%, and the share of the basic allowance is 11%.

The number of lists receiving the second family nurse allowance has grown by 20% compared to the year 2014. The share of performance pay (2%) has remained at the same level as the year 2014. The family physician advice line 1220 and the distance allowance make up 1% of the execution of the primary health care budget.

The operations fund was launched in 2014 and in the second year of operation, its use amounted to 0.5% of the total budget. The allowance for appointments outside of working hours also applied in the year 2014, and in 2015, their use increased by 53%. The first year of use of the therapy fund was more modest than expected.

The total number of the lists in the year 2015 was 801. The number on the lists decreased compared to last year by three and the number of insured persons on the list decreased by 2015 persons (see Table 9). The total number of primary medical care providers is 467, of which 26% are group practices with several lists and 74% are single lists.

The amount of lists below the limit size, where the population in the area of service is less than 1,200 people and in which case the Health Insurance Fund pays the capitation fee for 1,200 persons, has remained unchanged (19 lists) compared with the previous year. The additional capitation fee is paid for a total of 11,000 persons.

The basic allowance is the monthly fee paid to family physicians, which is intended to cover the rental of the premises, utilities and transportation costs of the family physicians. During the year, the basic allowance with a factor of 1.5 was paid to 56 lists with multiple reception offices.

The increase in the capitation fee by 9%, compared to the previous year, is due to a limit price of the capitation fee related to the medical workers' wage agreement.

The Fee for Services fund is used for funding the examinations and procedures provided to the patients by family physicians. The financing of the Fee for Services fund increased compared to the year 2014 by 19%; budget execution is increased by 107%. The planned financial volume of the Fee for Services fund was increased by both the limit price of the Fee for Services fund as well as the increase in the limit price of the capitation fee. The average execution of the Fee for Services fund among the family physicians remained on the same level as in the year 2014 (the average execution rate 91%). Underspending of the Fee for Services fund results from a different practice of family physicians in referring patients to examinations and may also depend on the age composition of the list since the examination requirements may vary by age group. As of the end of the year, the Fee for Services fund had been exceeded by 7% of the contractual partners, while in the case of 21% of the contractual partners, the execution of the Fee for Services fund remained under 80%. In 2014, invoices were submitted to the Health Insurance Fund for the excess work of the Fee for Services fund by 27 service providers in the total amount of 22 thousand euros.

The aim of the Operations fund is to support the remaining activities within the competence of the family physician on the primary level. Consequently, the activities that are performed by family physicians themselves (services related to surgical manipulations and gynecology) has been transferred from the Fee for Services fund to the Operations fund. Thus, all family physicians who wish and have enough competence to perform surgical manipulations and gynecological procedures can do so without being limited by the financial capacity of the Fee for Services fund. The Operations fund is financed on a service basis, and consequently, the costs of the action fund reflect also the e-Consultation service, and the autopsies ordered by the family physician.

In 2015, most services of the Operations fund per list were used by the family physicians in the Pärnu region - both the volume of services per list, as well as the expenditure of the Operations fund was highest in the Pärnu area.

Out of the services, the dressing of burn patients and other surgical procedures were used most.

E-Consultation has been implemented between medical specialists and family physicians since 2013 when the service was launched in the specialties of urology and endocrinology. In 2014, the possibility of e-Consultation was added in the specialties of pulmonology, rheumatology and otorhinolaryngology, and in 2015, in the specialties of pediatrics, neurology, and hematology.

E-Consultation services were used by 117 family care health centers on 2514 occasions. These are mostly the family physicians of the Harju region. For comparison - in 2014, within 12 months, this opportunity was used by 72 family health centers in 1358 occasions. Thus, the use has increased by 85%.

The Health Insurance Fund financed the e-Consultation services to the total extent of 31 thousand euros.

In 2015, conditions were developed for providing e-Consultation services in the specialty of cardiology, and as of 2016, the fee for use of an ECG device was applied to family physicians in the growth of the capitation fee. Since the year 2015, e-Consultation services have been provided, in addition to the North-Estonian Regional Hospital, also by the Ear Nose and Throat Clinic and the Tallinn Children's Hospital. It is also essential for the South-Estonian hospitals to start consultations on specialties affiliated with the e-Consultation.

The total number of lists receiving distance allowance is 188, of which 129 are located 20–40 km away from the nearest hospital, and 57 further than 40 kilometers from the nearest hospital. The number of recipients of distance allowance has grown by two lists compared to the same period last year.

Since the year 2013, 283 lists have added the second family nurse. it is important for the Health Insurance Fund that the number of lists who have hired a second family nurse for better servicing of the list would continue to grow. According to the feedback of family physicians, on the application of the second family nurse allowance, the biggest obstacle is non-compliance to the space requirements.

Table 9. The number of the lists of family physicians, the number of the financed insured persons in the list and the number of non-working time appointments.

	2014 actual	2015 actual	The change compared to the year 2014
The number of lists			
The number of lists	804	801	0%
The number of lists receiving distance allowance	186	188	1%
The number of lists receiving the second family nurse allowance	236	283	20%
The average size of the list (the number of insured persons in the list)	1,540	1,671	9%
The number of persons			
The total number of persons for whom the capitation fee has been paid	1,237,832	1,235,817	0%
insured persons under 3 years of age (limit of the capitation fee 6.51 euros per month)	39,639	39,130	-1%
insured persons from 3 to 6 years of age (limit of the capitation fee 4.85 euros per month)	62,726	61,225	-2%
insured persons from 7 to 49 years of age (limit of the capitation fee 2.99 euros per month)	644,886	642,354	0%
insured persons from 50 to 69 years of age (limit of the capitation fee 4.07 euros per month)	312,133	315,698	1%
insured persons over 70 years of age (limit of the capitation fee 4.97 euros per month)	178,448	177,410	-1%
The number of non-working time appointments			
The number of non-working time appointments of the family physician	4,462	5,014	12%
The number of non-working time appointments of the family nurse	4,960	6,307	27%
The number of calls to the advice line			
The number of calls	246,526	233,638	-5%

The number of participants in the family physician quality system has increased steadily since 2007, while in the last year, the number of participants has decreased by 1%. The results of the family physician quality system are summarized once a year on the basis of last year's activities. On the basis of the results of the family physician quality system in 2015, the maximum additional remuneration was paid for efficient performance of disease prevention and monitoring of patients with chronic diseases to 447 family physicians, additional remuneration for additional professional competence was paid to 186 family physicians (an increase of 40 compared to the previous period).

Figure 8 shows the proportions of the participants in the quality system and who achieved the results and who did not achieve the results for the years 2006-2014.

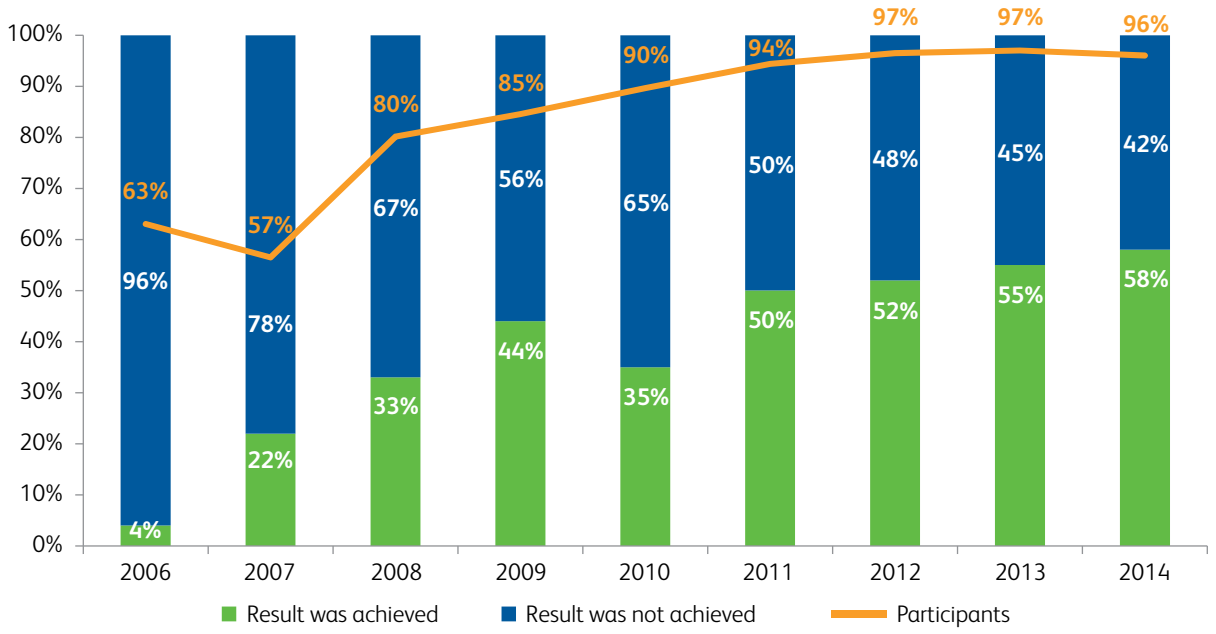


Figure 8. The proportions of the participants in the quality system who achieved the results for the years 2006-2014

Non-working time appointments were introduced as of the year 2014. The population satisfaction survey commissioned by the Health Insurance Fund has revealed that people have the expectation of getting access to the doctor's appointment also in the evening time. Consequently, in the list of the health care services of the Estonian Health Insurance Fund were added new services, allowing to pay the family physician and family nurse for the appointments performed during non-working hours. Compared to the year 2014, the service has grown in terms of the family physician appointments by 12% and in terms of family nurse appointments by 27%.

The aggregate number of visits to primary health care has grown in comparison with the figures for the year 2014. The upward trend of the appointments of the family nurse can be seen; one reason is the implementation of the additional remuneration of the second family nurse as of the year 2013. Also, the number of visits to the family physicians has increased compared to the year 2014. The proportion of the insured persons visiting family physicians has in recent years been between 75% and 81% respectively (see Table 10).

Table 10. The number of the appointments of the family physician and the family nurse in the period 2009-2015

	2009	2010	2011	2012	2013	2014	2015
Appointments of the family physician	4,182,361	3,994,334	4,411,214	4,523,318	4,425,781	4,472,867	4,559,726
Appointments of the family nurse	418,305	480,269	535,240	592,690	892,307	1,077,126	1,180,296
Prophylactic appointments	387,782	394,360	363,182	326,747	301,812	297,241	343,737
Total appointments	**4,988,448**	**4,868,963**	**5,309,636**	**5,442,755**	**5,619,900**	**5,847,234**	**6,083,759**
Persons going to the appointments	973,129	957,090	981,575	973,882	986,213	987,635	1,006,406
The number of persons in family physician lists	1,280,795	1,271,082	1,255,971	1,247,223	1,251,810	1,237,832	1,235,817
The proportion of persons going to the family physician appointments out of the persons in the family physician lists	76%	75%	78%	78%	79%	80%	81%

Family physician advice line 1220

The budget for the year 2015 compared to the year 2014 has increased slightly, due to the change in the wage component. The number of calls compared to the year 2014 has decreased by 5%, the average monthly number of calls was

19,470. In the autumn, a public outreach campaign was carried out; the positive trend can be seen in the growth of the calls in November and December. In Figure 9 has been outlined the annual service volume by months in the year 2015.

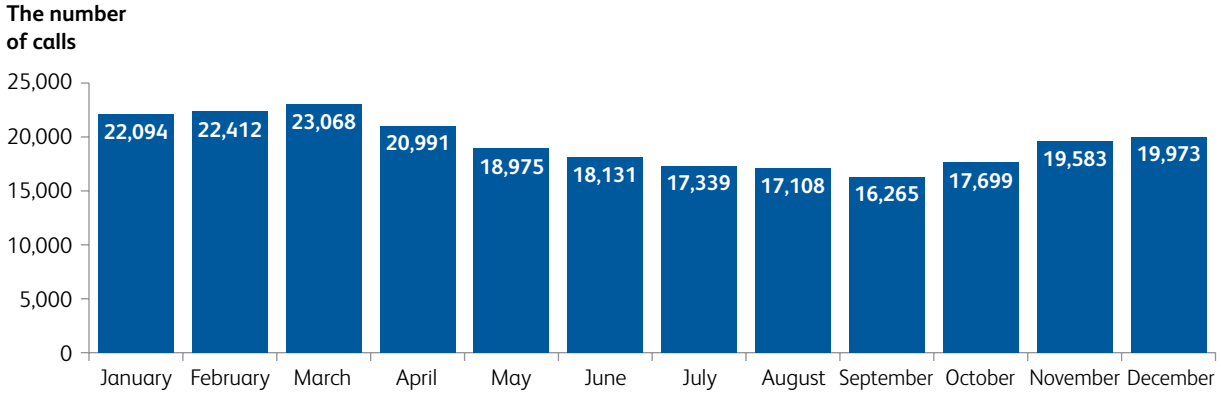


Figure 9. The number of advice line calls by month in the year 2015

Availability of primary medical care

The Health Insurance Fund checks the availability of primary medical care periodically on the basis of the job description of the family physician, according to which a patient with an acute health condition should have an appointment on the day of contacting the doctor while other patients should have the appointment within five working days. The purpose of the checks is also to assess whether family physicians allow the patients access to primary health care on the conditions provided in the legislation and in the agreement concluded with the Health Insurance Fund.

In the year 2015, the availability of the primary health care was assessed in 270 lists, which accounts for 34% of all the lists. In the same period of the last year, 272 lists were checked. The number of the lists to be visited depends on the work organization of the regional departments of the Health Insurance Fund, but the objective of checking a third of the lists within a year is guaranteed.

An acute health condition is a condition in the case of which postponement of the provision of primary health care can lead to the deterioration of the patient's health or exacerbation of the disease. A patient with an acute health condition should have an appointment on the day of the application while other patients should have the appointment within five working days.[8]

All patients with an acute disorder had access to the family physician's appointment on the day of application. In 99% of the cases checked, patients with non-acute health disorders were received by the family doctor within 5 working days. 97% of patients obtained an appointment within three working days. Thus, it can be said that the availability of the primary health care has remained on the same level compared to the previous year. The overall assessment is that the availability of primary health care in Estonia is very good.

Out of the checked lists, the work organization was assessed as very good in 11% of the lists, mostly good deemed to be 73% of the lists, 13% of the lists received a satisfactory assessment and 3% were assessed as poor (8 checked lists). In the occurrence of shortcomings, the need for rectification thereof was acknowledged.

Most of the shortcomings could be eliminated as early as during the visit. A follow-up check by the Health Insurance Fund was considered necessary in the case of 16 lists.

8 The Health Insurance Fund checks access to the family physician's appointment according to the Regulation of the Minister of Social Affairs "The work instruction of the family physician and the health care professionals working with them" § 5 paragraph 4 providing the obligation to enable the patient an appointment in case of an acute disorder on the day of application, and in other cases within five working days.

1.3 Specialized medical care

In the budget of the specialized medical growth of the financing, as compared to same period last year, was planned at 19.8 million euros. The planning of the budget took into account the list of health services entered into force on 01.01.2015 complete with the changes, including the salary increase resulting from the collective agreement, concluded between the Estonian Medical Association, the Union of Estonian Healthcare Professionals, the Estonian Nurses Association, the Estonian Ambulance Association and the Estonian Hospitals Association.

The budget was filled in terms of amount and in terms of treatment cases by 102%. Compared with the previous year, funding for specialized medical care rose to 32.5 million euros and the number of treatment cases by 16.8 thousand (see Table 11).

Table 11. Execution of the specialized health care budget in thousands of euros and the number of treatment cases by types of treatment

	2014 actual		2015 budget		2015 actual		Budget execution	
	The amount	Number of treatment cases	The amount	Number of treatment cases	The amount	Number of treatment cases	The amount	Number of treatment cases
Specialized medical care total	**518,764**	**3,272,491**	**537,160**	**3,215,844**	**549,854**	**3,289,241**	**102%**	**102%**
outpatient treatment total	188,659	2,971,371	196,416	2,922,264	202,596	2,988,966	103%	102%
day treatment total	34,600	71,912	35,289	70,837	37,960	75,490	108%	107%
inpatient treatment total	295,505	229,208	305,455	222,743	309,298	224,785	101%	101%
Preparedness fee	**10,280**	**380**	**11,670**	**380**	**11,679**	**380**	**100%**	**100%**
Total	**529,044**	**3,272,871**	**548,830**	**3,216,224**	**561,533**	**3,289,621**	**102%**	**102%**

Tructural appreciation of the treatment cases of specialized medical care S (the change of the use of services provided by the framework of one treatment case which will be assessed in comparable prices) in the specialized medical care was the total of 0.3%, i.e., structural depreciation treatment cases occurred, including the structural appreciation of treatment cases, occurred in the outpatient treatment by 1.0% and in the inpatient treatment by 1.2%, the structural depreciation in the day treatment 0.3%. The structural appreciation of treatment cases was affected by the movement of treatment between types of treatment, and the number of treatment cases submitted per one person. In the year 2015, per one person who received treatment have been in the specialized medical care submitted treatment invoices by 0.6% more than last year.

Taking over of the obligation of the payment for the provided medical services which exceed the contract volume. Since 2014, the Health Insurance Fund takes over the obligation to pay for the treatment services exceeding the contract volume for the Hospital Network Development Plan (HVA) hospitals and the selection partners twice a year. Payment coefficient in outpatient and day treatment has increased - in terms of the amount which does not exceed 5% of the total financial volume, the treatment invoices submitted for the treatment services exceeding the contract volume will be paid by the factor of 0.7 instead of the current factor 0.3.

The percentage of the medical services in excess of the contract volume in the financing of the specialist medical care in 2015 was 3.6% as regards the treatment cases, 2.1% as regards to the amount. 118 thousand treatment cases were remunerated by a factor, with a total cost of 11.4 million euros. In outpatient treatment, 6 million euros were paid for 105 thousand treatment cases as treatment services provided in excess of the contract volume, in the day treatment, 1.1 million euros for four thousand treatment cases and in inpatient treatment 4.3 million euros for nearly nine thousand treatment cases. Hospital Network Development Plan hospitals submitted treatment invoices for 10.8 million euros for the treatment cases exceeding the contractual volume, the selection partners for 0.6 million euros.

Financing of the persons registered on the waiting lists after the selection contest. In March of 2014, in addition to the HVA hospitals, also the contracts of the selection partners in specialized medical care were terminated. Health Insurance Fund conducted a selection competition. The funding of the ongoing treatment and of the treatment of the patients registered in the treatment waiting lists was agreed upon with health care institutions with whom the contract for the new period was not entered. For purchasing of the waiting lists on the basis of the contracts entered into in the year 2014, in the year 2015 were paid 265 thousand euros for 546 treatment cases.

Availability of specialized medical care

Medical institutions submit reports on waiting lists for specialized medical care, nursing care and dental care to the Health Insurance Fund on a regular basis. The hospitals of the Hospital Network Development Plan (HVA) submit a monthly overview of the actual waiting time of the scheduled outpatient visits of[9] specialized medical care in the previous month (retrospective report of waiting lists), and the projection report of waiting lists - the number patients in the waiting list as of the first day of the month and the waiting time to the available time of appointment. The selection partners provide a quarterly projection report of the waiting lists. In addition, the waiting lists are also checked with on-site visits and on a case by case basis.

As of 01.01.2016, the number of appointments registered in the specialized medical care waiting lists (on the basis of projection reports) has increased by 1.5% in all types of treatment - 0.2% in outpatient treatment, 8.6% in day treatment and 10.4% in inpatient treatment.

Table 12. Appointments registered in specialized medical care waiting lists

	01.01.2015		01.01.2016		The change compared to the year 2015
	The number of appointments in waiting lists	Within the maximum waiting time limits	The number of appointments in waiting lists	Within the maximum waiting time limits	The number of appointments in waiting lists
Outpatient	157,801	49%	158,134	52%	333
Day treatment	7,319	91%	7,951	93%	632
Inpatient	15,977	89%	17,642	88%	1,665
Total	**181,097**	**54%**	**183,727**	**57%**	**2,630**

Compared to the same period last year, the total number of appointments registered on the waiting list has increased (by 2,630 appointments), and also the proportion of visits taking place during the allowed waiting period has increased (to 57%). The number of appointments in the maximum allowable length of waiting lists[10] has increased by 6.8 thousand (including outpatient treatments by 4.8 thousand). The number of appointments exceeding the maximum permitted length of waiting lists has decreased by 4.2 thousand, and particularly in the outpatient settings.

9 The waiting list reports define the primary appointment as follows: The scheduled primary appointment is the patient's primary appointment in case of a primary illness, exacerbation of a disease or for a follow-up check of diseases monitored by a medical specialist beyond one treatment episode. A treatment episode is a provision of outpatient health care services from the first appointment until resolving of the health problem, in the case of chronic diseases, provision of outpatient health care services generally within 3 months from the first appointment. The waiting list report provides information only on scheduled treatment; emergency assistance is not reflected in this report. In the case of chronic diseases, e.g., once a year routine follow-up examinations held annually are considered the primary appointment.

10 In outpatient treatment, the permitted length of the waiting list is 6 weeks, in day treatment and in inpatient treatment it is generally 8 months.

Table 13. The actual waiting time of the scheduled visits of specialized medical care in an outpatient setting in the Hospital Network Development Plan hospitals.

	2014		2015		The change compared to the year 2014
	The number of appointments	Within the maximum waiting time limits	The number of appointments	Within the maximum waiting time limits	The number of appointments
Total regional hospitals	312,062	61%	314,261	60%	2,199
Total central hospitals	458,423	71%	446,350	70%	-12,073
Total general hospitals	268,084	87%	271,909	86%	3,825
Total HNDP hospitals	**1,038,569**	**72%**	**1,032,520**	**71%**	**-6,049**

Based on the backward reports, during the year of 2015, 71% of the scheduled first contact outpatient specialist medical care appointments of the Hospital Network Development Plan took place during the maximum allowed length of waiting list (up to 42 calendar days). The proportion of the appointments within the limit of the permitted length of the waiting lists has decreased compared to the same period last year - during the year 2014, 72% of the HNDP outpatient appointments were provided within the permitted maximum length of the waiting list.

The different proportion of the appointments within the maximum permitted length of the waiting list in the outpatient waiting lists of HNDP hospitals (45% according to the reports submitted on the 1st day of the month) and of the actual data (71% according to the data of the already held appointments) is due to appointments with a very short waiting period, which are not reflected in the reports submitted on the waiting lists as of the 1st day of the reporting month. The data of various reports, however, indicate similar problems.

For the comparison of the data of various reports, the Figure 10 provides the information on the HNDP waiting lists and on the actual waiting period of the appointments.

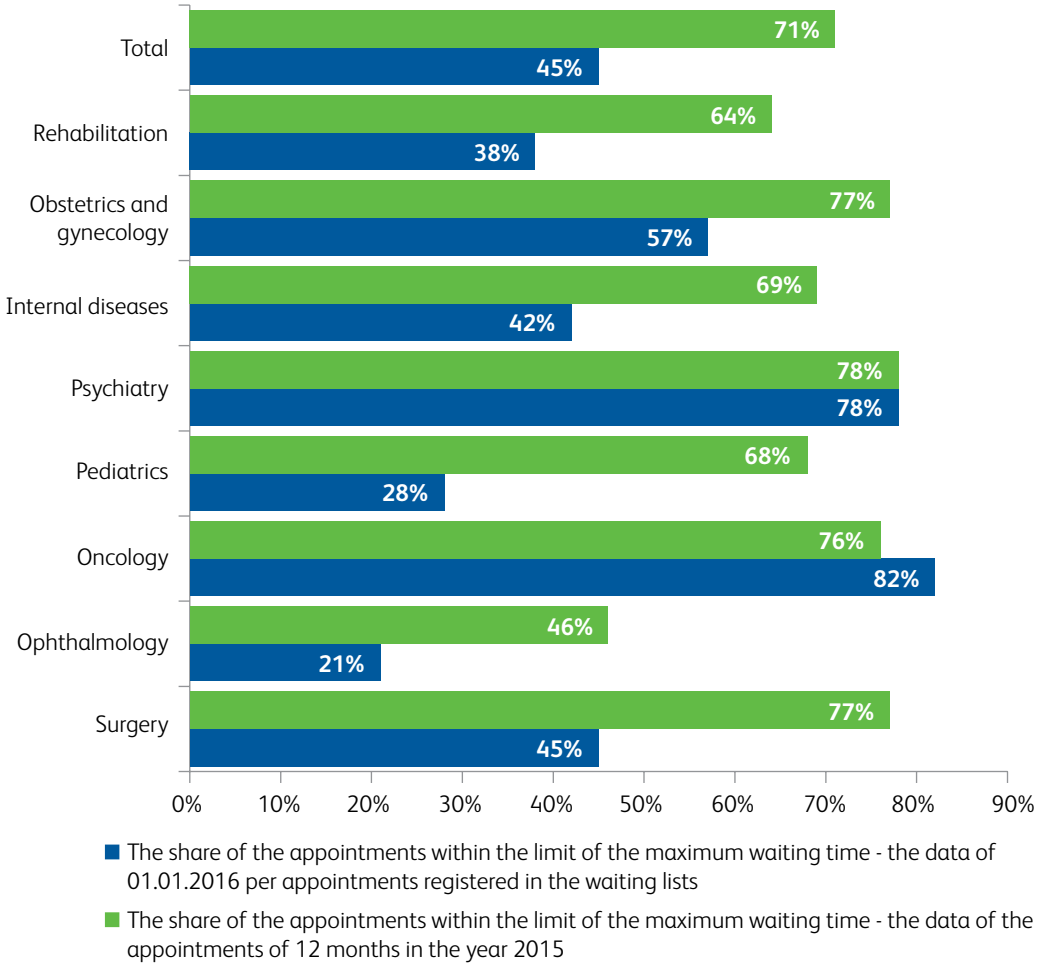


Figure 10. The outpatient waiting lists of specialized medical care and the actual waiting period in the Hospital Network Development Plan hospitals.

An assessment of the availability of basic specialties of the specialized medical care is given in the chapter in the subdivision "Budget execution and treatment cases by specialties." A more detailed overview of the availability of health care services has been published on the website of the Health Insurance Fund.[11]

11 Access to health care services: https://www.haigekassa.ee/sites/default/files/ravijarjekorrad/2015_koondaruanne.pdf

The main use indicators of specialized medical care

An overview of the main use indicators of specialized medical care in 2015, including comparison with previous years, is provided in Table 14.

Table 14. The most important indicators of the use of specialized medical care in the years 2012–2015

					Change		
	2012 actual	2013 actual	2014 actual	2015 actual	2013/ 2012	2014/ 2013	2015/ 2014
Average cost of a treatment case in euros	138	147	158	167	7%	7%	6%
Outpatient	52	57	63	68	10%	11%	8%
Day treatment	435	456	481	503	5%	5%	5%
Inpatient	1,124	1,178	1,289	1376	5%	9%	7%
Structural appreciation (%)	3.1	1.8	0.3	-0.3	-1%	-2%	-1%
The number of inpatient bed days	1,412,328	1,385,260	1,356,592	1,330,068	-2%	-2%	-2%
Average inpatient hospitalization in days	6.1	6.0	5.9	5.9	-2%	-2%	0%
The number of outpatients appointments	3,785,111	3,796,893	3,888,729	4,055,968	0%	2%	4%
Outpatient appointments per treatment case	1.29	1.29	1.31	1.36	0%	2%	4%
The number of persons using the services of specialized medical care	795,581	796,698	800,326	799,305	0%	0%	0%
Outpatient	774,661	775,566	780,302	779,593	0%	1%	0%
Day treatment	51,549	52,554	54,870	56,901	2%	4%	4%
Inpatient	155,653	155,982	153,032	150,154	0%	-2%	-2%
The number of treatment cases per treated person	3.97	3.99	4.08	4.12	1%	2%	1%
Outpatient	3.70	3.72	3.81	3.83	1%	2%	1%
Day treatment	1.26	1.29	1.31	1.33	2%	2%	2%
Inpatient	1.49	1.48	1.50	1.50	-1%	1%	0%
The number of treatment cases per an insured person	2.56	2.58	2.65	2.66	1%	3%	0%
Outpatient	2.32	2.34	2.41	2.42	1%	3%	0%
Day treatment	0.05	0.06	0.06	0.06	20%	0%	0%
Inpatient	0.19	0.19	0.19	0.18	0%	0%	-5%
Percentage of emergency medical care from the treatment expenditure (%)							
Outpatient	17	17	17	17	0%	0%	0%
Day treatment	8	8	9	10	0%	1%	1%
Inpatient	66	64	63	63	-2%	-1%	0%
Percentage of emergency medical care from the treatment cases (%)							
Outpatient	17	17	17	17	0%	0%	0%
Day treatment	10	10	11	11	0%	1%	0%
Inpatient	64	63	61	60	-1%	-2%	-1%
Number of surgeries:	154,969	155,289	157,691	159,261	0%	2%	1%
Outpatient	18,345	17,719	18,459	18,674	-3%	4%	1%
Day treatment	50,479	51,609	53,926	55,358	2%	4%	3%
Inpatient	86,145	85,961	85,306	85,229	0%	-1%	0%

In the year 2015, the number of insured did not change significantly - at the beginning of the year, the number of insured was 1,232,819, at the end of the year the number was 1,237,336 (0.4% change). The total number of persons who used specialized medical care services decreased in 2015 by 1,000 persons - 3,000 persons requiring fewer days of hospitalization, and 2,000 more persons using day treatment services, which can be considered an encouraging trend.

The number of treatment cases per insured person in day treatment did not change compared to the previous year, in inpatient treatment, it decreased by 5%. The number of outpatient consultations is increased by 4%, the number of inpatient-bed-days decreased by 2% and the number of surgeries increased by 1%. The increase in the number of surgeries occurred mainly in day treatment, whereas the number of inpatient surgeries did not decrease. The proportion of the emergency in care inpatient treatment cases has fallen by 1%. Thus, the decrease in the need for hospital treatment in 2015 was mainly due to the decrease in the emergency care and non-surgical hospital treatment.

The average cost of a treatment case has grown in all treatment types. One reason for the growth of the average cost of a treatment case is the list of health care services entered into force since January 1, 2015, which also includes a general increase in prices resulting from the wage agreement of health care workers.

Despite the increase in the average cost of a treatment case, the average structural cost of a treatment case has dropped in specialized medical care by 1%.

The number of treatment cases in the specialized medical care per treated person grows by 1%.

The number of persons receiving treatment in an outpatient setting has remained on the level of the previous year, the number of outpatient appointments has increased (4%), and so has the number of medical invoices submitted for one person who received (1%).

In inpatient treatment, the number of persons who received treatment has reduced, the average number of days of inpatient hospitalizations has remained on the same level as the previous year. The average cost of treatment cases has increased both as a result of the rise in prices of health care services, as well as due to the fact that the treatment of lighter conditions is moving over to outpatient and day treatment. In addition, compared to last year, the number of exorbitant treatment cases has increased - exorbitant treatment cases are mostly in the inpatient type of treatment.

As a summary of the year 2015, the Health Insurance Fund as a strategic buyer has been able to control the structural appreciation of specialized medical care. More services than before are provided in outpatient and day treatment. The use of inpatient treatment is reduced, more and more health care services (including surgeries) are performed in an outpatient setting or in day treatment instead of an inpatient setting.

Exorbitant specialized medical care treatment cases

An exorbitant treatment case is deemed the treatment invoice, the cost of which is, at least, EUR 65 000. Planning of exorbitant treatment cases is based on the exorbitant treatment cases of the previous contract period. In 2015, the Health Insurance Fund financed 58 exorbitant treatment cases with the total cost of 5.2 million euros. Funding for exorbitant treatment cases has increased from year to year.

The exorbitant treatment cases affect the most the inpatient specialized health care - in inpatient treatment there are 55 treatment cases amounting to 4.9 million euros and in outpatient treatment three treatment cases in the amount of 315 thousand euros.

By specialties, the effect of exorbitant treatment cases was most important in the pediatric specialties, accounting for 9% of the execution of the inpatient treatment budget.

Table 15. Exorbitant treatment cases in thousands of euros and the number of treatment cases

	2014 actual		2015 actual		The change compared to the year 2014	
	The amount	Number of treatment cases	The amount	Number of treatment cases	The amount	Number of treatment cases
Surgery	1,434	15	1,801	22	26%	47%
Oncology	312	3	945	10	203%	233%
Pediatrics	979	10	1,219	13	25%	30%
Internal diseases	1,668	17	1,153	12	-31%	-29%
Obstetrics and gynecology	84	1	66	1	-21%	0%
Total	**4,477**	**46**	**5,184**	**58**	**16%**	**26%**

Most exorbitant cases occurred in the North Estonian Regional Hospital (20 treatment cases), in the Tartu University Clinic (20 treatment cases) and in the Tallinn Children's Hospital (12 treatment cases).

Budget execution and treatment cases by specialties.

In the budget for the specialized medical care of the Health Insurance Fund in 2015, was the primary follow-up treatment, surgery, ophthalmology, oncology, pediatrics, psychiatry, internal medicine, obstetrics and gynecology, and rehabilitation. An overview of the performance of the basic specialties is presented below in alphabetical order.

Primary follow-up treatment

Table 16. Execution of the primary follow-up treatment budget in thousands of euros and the number of treatment cases.

	2014 actual		2015 budget		2015 actual		Budget execution	
	The amount	Number of treatment cases	The amount	Number of treatment cases	The amount	Number of treatment cases	The amount	Number of treatment cases
Primary follow-up treatment	2,163	2,606	2,424	2,503	2,432	2,850	100%	114%
Inpatient	2,163	2,606	2,424	2,503	2,432	2,850	100%	114%

Primary follow-up treatment is not a medical specialty, but rather an organizational treatment provider, based on special cases of funding. The patients are referred to the primary inpatient follow-up treatment when at the end of the active inpatient treatment, the outpatient treatment is not yet possible. In the context of primary follow-up treatment at general hospitals and the selection partners, it generally means a situation in which patients are hospitalized in higher stage hospitals are sent to the medical institution of their place of residence for follow-up treatment.

In 2015, were provided more than planned and cheaper primary follow-up treatment cases. In the specialty, the structural depreciation was 3.9%. In 2015, a total of 2,700 persons received follow-up care, compared with the previous year, the number of persons who received primary follow-up treatment grew by 8% (200 people).

The availability of primary follow-up treatment

The availability of the primary follow-up treatment is good, and there are no waiting lists. A patient is directed to the primary follow-up treatment from the acute treatment department, as appropriate, on the agreement between the providers of acute and follow-up treatment.

Surgery

Table 17. Execution of the surgery budget in thousands of euros and the number of treatment cases

	2014 actual		2015 budget		2015 actual		Budget execution	
	The amount	Number of treatment cases	The amount	Number of treatment cases	The amount	Number of treatment cases	The amount	Number of treatment cases
Surgery	142,377	878,488	145,774	868,084	149,300	894,534	102%	103%
Outpatient	37,521	788,861	39,612	780,769	40,871	805,499	103%	103%
Day treatment	8,749	24,295	9,414	24,400	9,715	25,582	103%	105%
Inpatient	96,107	65,332	96,748	62,915	98,714	63,453	102%	101%

The specialty of surgery aggregates the treatment services of cardiac surgery, pediatric surgery, neurosurgery, face and jaw surgery, orthopedics, otorhinolaryngology, thoracic surgery, urology, vascular surgery and general surgery. The contracts recognize the service based special cases of surgery for the endoprosthetic of joints, installation of hearing implants and organ transfers.

In the specialty of surgery, the planned increase of financing compared to the previous year was 3.4 million euros, and the number of treatment was planned to be in decline by 10 thousand cases. When planning the budget, the continued movement of the treatment from inpatient treatment to day treatment and to outpatient treatment was expected.

The budget was filled by 102% in terms of the amount and by 103% in terms of treatment cases, i.e., treatment cases were slightly more expensive than planned. Compared to last year, the financing of the specialty grew by 6.9 million euros (including 0.4 million euros from the increase in the volume of exorbitant treatment cases), and by 16 thousand treatment cases. In the specialty took place structural depreciation by 2.9%, including the structural depreciation of the outpatient treatment was by 2.0% and in the day treatment by 0.7%, and in inpatient treatment, structural appreciation of treatment cases was by 1.2%.

In 2015, in the surgical specialty, the Health Insurance Fund financed the treatment of 408 thousand people. The number of people receiving treatment increased compared to the previous year by 1%. For one treated person, 1.4% more treatment invoices were submitted compared to the previous year.

Availability of the specialty of surgery

In some surgical specialties, the availability is good (the share of the appointments within the limit of the maximum waiting time is higher than the average). In narrower surgical specialties (e.g., vascular surgery, neurosurgery, cardiac surgery, lastekirurgia, urology), however, the proportion of the appointments exceeding the maximum waiting time was significantly higher than the average - moreover, the waiting times for the appointment of these specialists (waiting time until the 4th free appointment time) are often longer than the average.

Ophthalmology (eye diseases)

Table 18. Execution of the ophthalmology budget in thousands of euros and the number of treatment cases

	2014 actual		2015 budget		2015 actual		Budget execution	
	The amount	Number of treatment cases	The amount	Number of treatment cases	The amount	Number of treatment cases	The amount	Number of treatment cases
Ophthalmology	21,346	378,238	20,798	371,298	21,691	371,815	104%	100%
Outpatient	11,532	360,869	11,774	355,157	12,371	355,097	105%	100%
Day treatment	8,087	15,545	7,273	14,442	7,508	14,857	103%	103%
Inpatient	1,727	1,824	1,751	1,699	1,812	1,861	103%	110%

The budget was exceeded in terms of the amount in all the treatment types, in terms of treatment cases it was exceeded in inpatient treatment and day treatment. The outpatient and day treatment cases were more expensive than planned; inpatient treatment cases were less expensive than planned.

In the specialty of ophthalmology, the Health Insurance Fund financed in the year 2015, the treatment of 178 thousand insured persons - the number of persons receiving treatment decreased by 2.3%, or by 4,200 people.

In the specialty of ophthalmology took place structural depreciation of treatment cases by 0.8%, including the structural appreciation of treatment cases in outpatient treatment was by 1.2% and in the day treatment by 0.3%, and in inpatient treatment, they depreciated by 1.7%.

The number of persons receiving treatment in outpatient settings has declined in the comparison of two periods by 0.6% (by 1,100 people).

In the day treatment of ophthalmology, cataract surgery amounts for an important part (96% in the amount, 95% of the treatment cases). The budget of cataract surgeries (and the related total budget of day treatment in ophthalmology) was also impacted by the contracts concluded for the purchase of waiting lists caused by the change in the contractual partners, on this basis, 254 thousand euros were paid for 499 cataract surgeries.

In the inpatient treatment, more than planned, but cheaper treatment cases were provided.

Availability of the specialty of ophthalmology

The availability of the specialty of ophthalmology is not good and the waiting times of this specialty are the longest. Despite the growth in financing, the waiting periods in this specialty in HNDP hospitals are long; the demand exceeds the facilities of the health care institutions for the provision of the service. For contacting an ophthalmologist, no family physician's referral is required, the establishment of the requirement for a referral could contribute to the shortening of the waiting times - it is important to ensure the availability of specialized medical care to the patients who need it quicker for medical reasons. The waiting time for the selection partners is shorter than at the HNDP hospitals. The insured have the right to turn to any of the Health Insurance Fund contract partners all over Estonia; the contract partner data are published on the website of the Health Insurance Fund.[12]

Oncology

Table 19. Execution of the oncology budget in thousands of euros and the number of treatment cases

	2014 actual		2015 budget		2015 actual		Budget execution	
	The amount	Number of treatment cases	The amount	Number of treatment cases	The amount	Number of treatment cases	The amount	Number of treatment cases
Oncology	70,539	145,567	76,443	149,697	76,172	152,406	100%	102%
Outpatient	36,101	126,059	37,036	129,588	38,482	131,605	104%	102%
Day treatment	2,060	3,782	2,434	4,017	2,640	4,620	108%	115%
Inpatient	32,378	15,726	36,973	16,092	35,050	16,181	95%	101%

In the main specialty of oncology is also reflected the use of the treatment services of hematology and the treatment services related to bone marrow transplantation.

In the specialty of oncology, a faster than the average growth was planned for funding of the budget, in relation to the need to keep the availability of the treatment stable, at the rise of the incidents of the disease. The increase of the need for treatment of oncological diseases is linked both to the aging of the population, as well as to the development of the treatment and diagnostic opportunities. In the budget was planned the growth in the amount of 5.9 million compared to the previous year, the growth of treatment cases was by 4100. Unlike the general budget for specialist medical care, in the specialty of oncology, the increase of inpatient treatment cases was also planned.

The budget was filled by 102% in terms of treatment cases and by 100% in terms of the amount. Compared to the previous year, funding increased by 5.6 million euros, the number of treatment cases increased by 6,800. The amount planned for inpatient treatment was used more for outpatient and day treatment, including the volume of exorbitant treatment cases increased by 0.6 million euros. The movement between the types of treatment was faster than planned.

In the specialty of oncology, in the year 2015, treatments were received by a total of 49 thousand insured individuals, the number of persons receiving the treatment has grown by 4.6% compared to last year.

In the outpatient and day treatment, the treatment cases were more expensive than planned, in the inpatient treatment, they were cheaper than planned. Treatment cases in outpatient and day treatment have become more expensive in particular due to the use of increased use of blood / blood products and medicinal products.

The structural depreciation of an oncological treatment case in 2015 was 0.6%, including the structural appreciation of the outpatient treatment by 0.4% and the structural depreciation in day treatment by 3.2%, and in inpatient treatment by 0.4%.

12 The Health Insurance Fund contract partners: https://www.haigekassa.ee/et/inimesele/arsti-ja-oendusabi/haigekassa-lepingupartnerid

Availability of the specialty of oncology

Availability of the specialty of oncology is a priority. The provision of health care services is primarily concentrated in the North-Estonian Regional Hospital and in the Tartu University Hospital. In a smaller volume, oncology treatment services are also provided in the Tallinn Children's Hospital and in the East Tallinn Central Hospital. The share of the appointments within the limit of the maximum waiting time is higher than the average for specialized medical care. Generally, the waiting times are within the maximum allowable length of the waiting lists. In the case of oncology, when assessing the appointments within the maximum waiting time, the routine follow-up examinations held even just once a year qualify as the primary appointment under the definition and must be further considered. The oncology outpatient waiting time as of 01.01.2016 complied with the two weeks described as the Estonian cancer treatment quality assurance purposes in all hospitals providing oncology services. The availability of the treatment services of the specialty is guaranteed.

Pediatrics

Table 20. Execution of the pediatric budget in thousands of euros and the number of treatment cases

	2014 actual		2015 budget		2015 actual		Budget execution	
	The amount	Number of treatment cases	The amount	Number of treatment cases	The amount	Number of treatment cases	The amount	Number of treatment cases
Pediatrics	21,984	155,474	22,911	152,200	22,548	150,553	98%	99%
Outpatient	7,136	125,238	7,675	123,486	7,322	120,411	95%	98%
Day treatment	1,159	2,840	1,146	2,690	1,226	3,024	107%	112%
Inpatient	13,689	27,396	14,090	26,024	14,000	27,118	99%	104%

In the pediatric specialty, the increase in financing of the budget by EUR 1 million was planned compared to the previous year; in respect to treatment cases, a decrease in the number of treatment cases by 3300 was planned due to the decrease in the number of children. On the planning of the average cost of a treatment case, additional financial means for using of biological therapy were added to the outpatient treatment budget. On the planning of the average cost of a day treatment case, the addition of hematology treatment courses in the budget of the specialization was taken into account. In the inpatient treatment, the reason for the increase in the cost of a treatment case planned into the budget was due to the planning of a greater number of expensive treatments than in the past.

The budget was executed by 98% in terms of finance and by 99% in terms of the number of treatment cases. Compared to the previous year, funding increased by 0.6 million euros, the number of treatment cases decreased by 4900. The average cost of a treatment case was cheaper than planned in all types of treatment.

The structural appreciation of an oncological treatment case in 2015 was 0.6%, including the structural appreciation of the outpatient treatment by 0.4% and the structural depreciation in day treatment by 2.2%, and in inpatient treatment by 1.6%. In day treatment, the use of medicinal products declined compared with expectations. In inpatient treatment, the treatment cases were shorter than planned and on a case-based manner cheaper (DRG), the average cost of a treatment case was also affected by exorbitant treatment cases. In 2015, in the specialty of pediatrics, the Health Insurance Fund financed 13 exorbitant treatment cases with the total cost of 1.2 million euros.

In 2015, in the pediatric specialty, the Health Insurance Fund financed the treatment of 74 thousand children. Compared to the previous year, the number of persons receiving treatment declined by 2.5%, or by 1,900 persons. For one treated person, 3.2% less (4900 treatment cases) treatment invoices were submitted compared to the previous year.

Availability of the specialty of pediatrics

The longer than average waiting times of the pediatric specialty are mainly related to the Tallinn Children's Hospital and Tartu University Hospital. The longer waiting periods of more specialized professionals, such as children's cardiologist, have not been separately highlighted in the reports of these health care facilities. The waiting time of general pediatrics in these hospitals is within the permitted limits.

Psychiatry

Table 21. Execution of the budget of psychiatry in thousands of euros and the number of treatment cases

	2014 actual		2015 budget		2015 actual		Budget execution	
	The amount	Number of treatment cases	The amount	Number of treatment cases	The amount	Number of treatment cases	The amount	Number of treatment cases
Psychiatry	26,790	240,417	28,255	237,829	29,157	246,390	103%	104%
Outpatient	7,699	229,317	8,321	227,632	8,334	235,570	100%	103%
Day treatment	452	623	648	618	669	741	103%	120%
Inpatient	18,639	10,477	19,286	9,579	20,154	10,079	105%	105%

In the specialty of psychiatry, the increase of financing of the budget by EUR 1.5 million was planned compared to the previous year; in respect of treatment cases, a decrease in the number of treatment cases by 2600 was planned. The higher than the average budget increase was related to the modernization of the part of psychiatric services of the list of health care services- the limit price was harmonized with the standard price, the service descriptions were updated, and several new services were added.

The budget was executed by 103% in terms of finance and by 104% in terms of the number of treatment cases. Compared to the previous year, funding of the specialty of psychiatry increased by 2.4 million euros, the number of treatment cases increased by 6000. The average cost of a treatment case was cheaper than planned. In the specialty took place structural depreciation by 1.9%, including the structural depreciation of the outpatient treatment by 2.1% and in the day structural appreciation by 20.5%, and in inpatient treatment, structural appreciation by 3.5% took place.

In 2015, in the specialty of psychiatry, the Health Insurance Fund financed the treatment of 65 thousand people - the number of people receiving treatment has remained on the level of the year 2014, For one treated person, 2.6% more treatment invoices were submitted compared to the previous year.

Availability of the specialty of psychiatry

The availability of the specialty of psychiatry is good, all over Estonia the average waiting times are within the maximum allowable length of the waiting list. Longer waiting times are in the North Estonian Regional Hospital and in Western Tallinn Central Hospital.

Internal diseases

Table 22. Execution of the budget of internal diseases in thousands of euros and the number of treatment cases

	2014 actual		2015 budget		2015 actual		Budget execution	
	The amount	Number of treatment cases	The amount	Number of treatment cases	The amount	Number of treatment cases	The amount	Number of treatment cases
Internal diseases	172,715	873,998	176,361	844,814	183,850	886,727	104%	105%
Outpatient	57,949	796,102	59,772	768,725	62,866	810,036	105%	105%
Day treatment	11,258	8,107	11,507	8,075	13,097	9,299	114%	115%
Inpatient	103,508	69,789	105,082	68,014	107,887	67,392	103%	99%

The specialty of internal medicine aggregates the treatment services of dermatovenerology (skin diseases), endocrinology, gastroenterology, infectious diseases, cardiology, occupational diseases, nephrology (kidney and urinary tract diseases), neurology, pulmonology (lung diseases), rheumatology and internal medicine. As service-based special cases in the specialty of internal medicine, the dialyzes is recognized (hemodialysis and peritoneal dialysis).

The budget was exceeded by both the amount and by the number of treatment cases. Contract volumes were exceeded by many service providers, the share of the work in excess of the contract volume in financing medical services of the specialty, in the year 2015, in terms of treatment cases and the amount was 2%. Compared to the previous year, funding of the specialty of internal diseases increased by 11.1 million euros, the number of treatment cases increased by 13 thousand.

The number of treatment cases increased compared to what was planned to the actual use in the preceding year in outpatient and day treatment. The number of inpatient treatment cases in the specialty of internal medicine decreased by 3% compared to the previous year - presumably, far more inpatient services will be provided in day treatment and the outpatient setting.

In 2015, in the specialty of internal medicine, the Health Insurance Fund financed the treatment of 366 thousand people. The number of people receiving treatment increased compared to the previous year by 0.5%, or by 1800 people. For one treated person, 1% more treatment invoices were submitted compared to the previous year.

In the specialty took place structural depreciation of 1.0%, including the structural depreciation of the outpatient treatment by 1.2% and in the day treatment structural appreciation was by 1.8%, and in inpatient treatment, structural appreciation by 2.6% took place. The absolute number of inpatient treatment cases compared to both what was planned in the budget as well as with the use of the previous year was lower. In the inpatient setting are treated, in comparison to the previous year, an average of more complex conditions requiring a longer duration of treatment and milder cases have at least partly moved to outpatient and day treatment.

In terms of the services marked on treatment invoices, has increased, in particular, the share of financing of laboratory examinations, tests and treatments, and the medicinal products in internal medicine specialty.

Availability of the specialty of internal medicine

The availability of the specialty of internal medicine is variable and outpatient waiting times that are longer than average are in particular in regional and central hospitals, where patients' demand for a particular medical institution and / or the attending physician exceeds the possibilities of the medical institution for the provision of service. In general hospitals, there are problems with waiting times in the specialties where doctors are few or where the treatment is provided a couple of times a month by the doctors of regional and central hospitals providing appointments in the general hospital.

Obstetrics and gynecology

Table 23. Execution of the budget of obstetrics and gynecology in thousands of euros and the number of treatment cases

	2014 actual		2015 budget		2015 actual		Budget execution	
	The amount	Number of treatment cases	The amount	Number of treatment cases	The amount	Number of treatment cases	The amount	Number of treatment cases
Obstetrical care and gynecology	47,080	511,634	50,657	506,237	50,611	501,454	100%	99%
Outpatient	23,929	466,155	25,712	460,791	25,538	455,738	99%	99%
Day treatment	2,835	16,720	2,867	16,595	3,105	17,367	108%	105%
Inpatient	20,316	28,759	22,078	28,851	21,968	28,349	100%	98%

In the specialty of obstetrics and gynecology are also recorded births and treatment cases related to artificial insemination.

In the specialty of gynecology, the increase of financing of the budget by EUR 3.6 million was planned compared to the previous year; in respect of treatment cases, a decrease in the number of treatment cases by 5400 was planned.

Compared to the previous year, the funding of gynecology increased by 3.5 million euros, the number of treatment cases decreased by 10.2 thousand. More day treatment was provided than planned, the use of outpatient and inpatient treatment (including the number of births) was lower than expected in the budget. The average cost of a treatment case was slightly higher than planned in all types of treatment.

In 2015, in the specialty of gynecology, the Health Insurance Fund financed the treatment of 194 thousand people. The number of people receiving treatment decreased compared to the previous year by 0.7% of 1500 people.

The structural appreciation of an oncological treatment case in 2015 was 1.8%, including the structural appreciation of the outpatient treatment by 2.2% and the structural depreciation in day treatment by 2.3%, and in inpatient treatment by 0.8%.

Availability of the specialty of obstetrics and gynecology

The availability of the specialty of gynecology is good, as the share of the appointments within the limit of the maximum waiting time is higher than the average.

Rehabilitation

Table 24. Execution of the budget for rehabilitation in thousands of euros and the number of treatment cases

	2014 actual		2015 budget		2015 actual		Budget execution	
	The amount	Number of treatment cases	The amount	Number of treatment cases	The amount	Number of treatment cases	The amount	Number of treatment cases
Rehabilitation	13,770	86,069	13,537	83,182	14,093	82,512	104%	99%
Outpatient	6,792	78,770	6,514	76,116	6,812	75,010	105%	99%
Inpatient	6,978	7,299	7,023	7,066	7,281	7,502	104%	106%

In rehabilitation, a decrease in the financing of the budget by EUR 233 thousand was planned compared to the previous year; in respect of treatment cases, a decrease in the number of treatment cases by 2900 was planned. In terms of the average cost of an outpatient treatment case, an increase was planned in the budget in order to enable the patient more procedures and examination in the framework of one rehabilitation case and to reflect them on a single treatment invoice.

The budget was executed by 104% in terms of finance and by 99% in terms of the number of treatment cases. Compared to the previous year, funding of rehabilitation increased by 323 thousand euros, the number of treatment cases decreased by 3600. The average cost of a treatment case in the outpatient treatment was more expensive than planned and in the inpatient setting, it was cheaper than planned.

The structural appreciation of the specialty in 2015 was 3.5%, including in the outpatient treatment by 2.8% and the structural depreciation in inpatient treatment was by 2.3%.

In the specialty of rehabilitation, the Health Insurance Fund financed in the year 2015 the treatment of 53 thousand people - a decrease compared to the previous year by 5.9% of by 3300 people.

Availability of the specialty of rehabilitation

In the availability of the specialty of rehabilitation, there is still room for development, the growth of financing was not accompanied by a shortening of waiting times. In summary of the two periods, the number of primary scheduled appointments has increased, but especially on the expense of the appointments exceeding the maximum permitted length of the waiting list.

Execution of the contracts of specialized medical care

Table 25. Execution of the contracts of specialized medical care in thousands of euros

	The contract of the first half of 2015		Execution of the contract of the first half of 2015		The contract of the second half of 2015		Execution of the contract of the second half of 2015		Execution of the contract of the second half of the year	
	The amount	The number of treatment cases	The amount	The number of treatment cases	The amount	The number of treatment cases	The amount	The number of treatment cases	The amount	The number of treatment cases
HNDP hospitals	**262,359**	**1,330,014**	**266,984**	**1,376,093**	**251,157**	**1,258,699**	**255,872**	**1,306,055**	**102%**	**104%**
Regional hospitals	146,231	517,147	148,675	537,384	140,120	487,471	142,632	501,191	102%	103%
Central hospitals	82,047	559,132	84,088	583,382	78,482	531,050	80,746	561,035	103%	106%
General hospitals and local hospitals	34,081	253,735	34,221	255,327	32,555	240,178	32,494	243,829	100%	102%
Selection partners	**19,914**	**308,494**	**19,800**	**302,158**	**19,564**	**296,466**	**19,506**	**304,769**	**100%**	**103%**
Total contracts for financing of treatment	**282,273**	**1,638,508**	**286,784**	**1,678,251**	**270,721**	**1,555,165**	**275,378**	**1,610,824**	**102%**	**104%**
Buyout of treatment waiting lists *	288	649	157	345	0	0	108	201	-	-
Total	**282,561**	**1,639,157**	**286,941**	**1,678,596**	**270,721**	**1,555,165**	**275,486**	**1,611,025**	**102%**	**104%**

* The volume of the contracts entered into for buyout of the treatment waiting lists is the volume of the year - the contract was concluded for the period 01.01-31.12.2015 without making a distinction between half years.

Compared with the year 2014, the amount paid to HNDP hospitals increased by 6%, in the case of selection partners (together with the execution of the contracts entered into by buying out of the waiting lists) by 4%. The number of treatment cases referred to remained the same in the HNDP hospitals compared to the year 2014, the number of treatment cases provided by the selection partners increased by 2% compared with the previous year.

The amounts paid toRegional hospitals (North-Estonian Regional Hospital, Tallinn Children's Hospital and the Hospital of the University of Tartu) increased by 7% in 2015 compared to the previous year, 2% more treatment cases than in 2014 were provided in regional hospitals. The treatment cases of regional hospitals amounted to 32% in 2015, and the amount was 52% of the total performance of specialized medical care contracts.

Regional hospitals provided both in the 1st and the 2nd half of the year more treatment cases than had been agreed on. As overtime work, 2871 thousand euros was paid to the North Estonian Regional Hospital for 12,865 treatment cases, 2766 thousand euros were paid to Tartu University Hospital for 21,488 treatment cases, 16 thousand euros to the Tallinn Children's Hospital for 717 treatment cases.

The amounts paid to central hospitals (East Tallinn Central Hospital, Ida-Viru Central Hospital, West-Tallinn Central Hospital, Pärnu Hospital), in 2015 increased by 7% compared to the previous year, the number of treatment cases provided in central hospitals was the same as in 2014. The treatment cases of central hospitals amounted to 35% in 2015, and the amount was 29% of the total performance of specialized medical care contracts.

All central hospitals provided outpatient treatment cases both in the 1st and the 2nd half of the year at least to the extent agreed upon in the contract. In both halves of the year, all central hospitals submitted treatment invoices for payment of

overtime work. In 2015, in total, 1865 thousand euros were paid to East Tallinn Central Hospital for overtime work for 16,291 treatment cases, 1,141 thousand euros were paid to Ida-Viru Central Hospital for 9426 treatment cases, 856 thousand euros were paid to West Tallinn Central Hospital for 13,552 treatment cases; 598 thousand euros were paid to Pärnu Hospital for 16,117 treatment cases.

General hospitals and local hospital (Hiiumaa Hospital, Järvamaa Hospital, Kuressaare Hospital, South Estonian Hospital, Läänemaa Hospital, Narva Hospital, Põlva Hospital, Rakvere Hospital, Raplamaa Hospital, Valga Hospital, Viljandi Hospital and Jõgeva Hospital) provided in the year 2015, by 1% less treatment cases than in the year 2014. The amount paid to those health care institutions increased by 4% compared to the previous year. The proportion of general hospitals and local hospitals in the execution of the budget in 2015 was in 15% in terms of treatment cases and 12% in terms of the amount. In both half years, all general hospitals fulfilled the number of the agreed outpatient treatment cases and submitted part of the invoices as overtime work - those hospitals were paid a total of 742 thousand euros for 6432 treatment cases.

In 2015,selection partners provided by 2%, more treatment cases than in 2014. The amount paid to those health care institutions increased by 4% compared to the previous year. For purchasing of the waiting lists on the basis of the contracts entered into in the year 2014, in the year 2015 were paid 264 thousand euros for 546 treatment cases.

The table below provides information on the fulfillment of specialized medical care contracts by HNDP hospitals in 2015 by health care institutions.

Table 26. Execution of the contracts of specialized medical care of Hospital Network Development Plan hospitals in thousands of euros

	The contract of the first half of 2015		Execution of the contract of the first half of 2015		The contract of the second half of 2015		Execution of the contract of the second half of 2015	
	The amount	The number of treatment cases	The amount	The number of treatment cases	The amount	The number of treatment cases	The amount	The number of treatment cases
Regional hospitals								
Foundation Tallinn Children's Hospital	**11,020**	**88,698**	**11,006**	**88,595**	**10,493**	**81,885**	**10,486**	**83,302**
Outpatient	4,169	77,710	4,171	76,289	3,759	71,776	3,759	72,288
Day treatment	950	2,056	934	2,192	842	1,863	819	1,952
Inpatient	5,900	8,932	5,901	10,114	5,893	8,246	5,909	9,062
Foundation Tartu University Hospital	**65,908**	**251,817**	**66,816**	**264,498**	**62,725**	**235,909**	**64,131**	**243,949**
Outpatient	21,159	222,624	21,853	234,090	19,816	208,304	20,804	215,963
Day treatment	3,144	6,698	3,329	7,232	2,987	6,215	3,046	6,483
Inpatient	41,605	22,495	41,634	23,176	39,923	21,390	40,281	21,503
Foundation North Estonian Regional Hospital	**69,303**	**176,632**	**70,852**	**184,291**	**66,902**	**169,677**	**68,014**	**173,940**
Outpatient	20,135	155,116	20,933	162,322	19,687	149,046	20,784	153,487
Day treatment	2,997	3,858	3,067	4,036	2,856	3,690	2,750	3,561
Inpatient	46,172	17,658	46,852	17,933	44,359	16,941	44,481	16,892
Central hospitals								
East Tallinn Central Hospital	**36,450**	**232,474**	**37,226**	**239,412**	**34,567**	**219,110**	**35,585**	**226,975**
Outpatient	14,733	210,493	15,155	217,451	13,897	198,218	14,311	205,019
Day treatment	3,659	7,868	3,702	7,760	3,424	7,426	3,698	8,162
Inpatient	18,058	14,113	18,368	14,201	17,246	13,466	17,575	13,794
West Tallinn Central Hospital	**19,856**	**152,713**	**20,264**	**158,058**	**19,450**	**146,227**	**19,881**	**154,083**
Outpatient	7,964	139,838	8,175	144,667	7,711	133,888	8,004	141,857
Day treatment	1,872	2,739	1,921	2,826	1,942	2,681	2,006	2,804
Inpatient	10,020	10,136	10,169	10,565	9,797	9,658	9,870	9,422
Foundation Ida-Viru Central Hospital	**12,787**	**81,197**	**13,391**	**85,818**	**12,341**	**78,097**	**12,869**	**82,823**
Outpatient	4,255	73,170	4,408	76,765	4,088	70,307	4,297	74,541
Day treatment	957	1,796	1,048	1,967	1,005	1,758	1,067	1,946
Inpatient	7,575	6,231	7,936	7,086	7,248	6,032	7,504	6,336
Foundation Pärnu Hospital	**12,953**	**92,748**	**13,207**	**100,094**	**12,124**	**87,616**	**12,412**	**97,154**
Outpatient	4,398	83,190	4,551	90,335	4,129	78,482	4,340	87,971
Day treatment	801	2,628	842	2,795	801	2,666	825	2,814
Inpatient	7,753	6,930	7,814	6,964	7,194	6,468	7,247	6,369

	The contract of the first half of 2015		Execution of the contract of the first half of 2015		The contract of the second half of 2015		Execution of the contract of the second half of 2015	
	The amount	The number of treatment cases	The amount	The number of treatment cases	The amount	The number of treatment cases	The amount	The number of treatment cases
General hospitals and local hospitals								
Järvamaa Hospital	**2,512**	**21,836**	**2,495**	**22,088**	**2,333**	**20,162**	**2,339**	**21,074**
Outpatient	1,134	20,043	1,134	20,267	1,047	18,503	1,047	19,352
Day treatment	119	385	120	392	110	356	109	353
Inpatient	1,259	1,408	1,241	1,429	1,176	1,303	1,183	1,369
Foundation Kuressaare Hospital	**3,361**	**24,786**	**3,326**	**25,394**	**3,211**	**23,095**	**3,201**	**23,788**
Outpatient	1,043	22,329	1,072	22,911	972	20,736	1,007	21,424
Day treatment	175	348	178	326	193	353	189	324
Inpatient	2,144	2,109	2,076	2,157	2,047	2,006	2,005	2,040
Foundation Läänemaa Hospital*	**1,904**	**16,502**	**1,907**	**16,813**	**1,806**	**15,670**	**1,815**	**16,174**
Outpatient	655	15,009	644	15,344	620	14,278	635	14,829
Day treatment	73	294	73	315	65	261	65	289
Inpatient	1,177	1,199	1,191	1,154	1,121	1,131	1,115	1,056
Rakvere Hospital	**3,773**	**24,787**	**3,874**	**26,678**	**3,863**	**25,520**	**3,808**	**25,406**
Outpatient	1,247	21,454	1,295	23,290	1,311	22,169	1,294	22,402
Day treatment	147	587	167	785	147	586	154	606
Inpatient	2,379	2,746	2,412	2,603	2,405	2,765	2,360	2,398
South Estonian Hospital	**2,842**	**19,003**	**2,988**	**19,366**	**2,851**	**19,007**	**2,946**	**19,349**
Outpatient	879	16,427	879	16,444	878	16,423	878	16,563
Day treatment	206	630	228	714	206	630	229	743
Inpatient	1,758	1,946	1,882	2,208	1,767	1,954	1,839	2,043
Foundation Narva Hospital:	**6,645**	**51,085**	**6,492**	**47,021**	**5,888**	**44,286**	**5,797**	**44,000**
Outpatient	2,189	44,738	2,121	40,733	1,969	38,681	1,953	38,596
Day treatment	239	559	235	570	248	547	237	500
Inpatient	4,216	5,788	4,135	5,718	3,671	5,058	3,606	4,904
Foundation Viljandi Hospital:	**5,370**	**33,715**	**5,370**	**34,916**	**5,067**	**31,201**	**5,075**	**31,567**
Outpatient	1,516	30,251	1,542	31,405	1,399	27,926	1,407	28,294
Day treatment	213	600	173	570	203	566	203	623
Inpatient	3,642	2,864	3,655	2,941	3,466	2,709	3,464	2,650
Valga Hospital	**1,830**	**15,975**	**1,866**	**16,089**	**1,821**	**15,955**	**1,826**	**15,961**
Outpatient	654	14,421	651	14,421	654	14,416	652	14,449
Day treatment	152	463	160	501	152	461	155	470
Inpatient	1,024	1,091	1,054	1,167	1,015	1,078	1,019	1,042

	The contract of the first half of 2015		Execution of the contract of the first half of 2015		The contract of the second half of 2015		Execution of the contract of the second half of 2015	
	The amount	The number of treatment cases	The amount	The number of treatment cases	The amount	The number of treatment cases	The amount	The number of treatment cases
Foundation Hiiumaa Hospital:	**734**	**5,747**	**718**	**5,554**	**702**	**5,733**	**670**	**5,501**
Outpatient	207	5,108	189	4,927	195	5,129	180	4,979
Day treatment	37	161	35	149	35	152	27	108
Inpatient	490	478	494	478	472	452	464	414
Põlva Hospital	**1,930**	**14,491**	**1,958**	**14,648**	**1,931**	**14,486**	**1,923**	**14,655**
Outpatient	643	12,694	629	12,699	642	12,689	632	12,852
Day treatment	130	549	127	571	129	547	124	564
Inpatient	1,157	1,248	1,203	1,378	1,160	1,250	1,167	1,239
Foundation Raplamaa Hospital*	**1,893**	**16,753**	**1,942**	**18,162**	**1,796**	**15,531**	**1,825**	**17,468**
Outpatient	798	15,322	824	16,709	738	14,178	777	16,194
Day treatment	113	298	113	257	147	332	127	282
Inpatient	982	1,133	1,006	1,196	911	1,021	921	992
Foundation Jõgeva Hospital:	**1,285**	**9,055**	**1,285**	**8,598**	**1,284**	**9,532**	**1,270**	**8,886**
Outpatient	436	8,121	437	7,630	466	8,633	461	7,993
Day treatment	30	100	30	100	30	99	30	97
Inpatient	818	834	818	868	787	800	779	796
Total HNDP hospitals	**262,359**	**1,330,014**	**266,984**	**1,376,093**	**251,157**	**1,258,699**	**255,872**	**1,306,055**
Outpatient	88,214	1,188,058	90,662	1,228,699	83,977	1,123,782	87,223	1,169,053
Day treatment	16,015	32,617	16,483	34,058	15,520	31,189	15,859	32,681
Inpatient	158,130	109,339	159,839	113,336	151,660	103,728	152,790	104,321

* Up to March 2015, Foundation Läänemaa Hospital

* Up to March 2015, Foundation Rapla County Hospital

Health care services indicated in specialized medical care invoices

In 2015, the Health Insurance Fund financed health care services (except for the preparedness fee) for 549.9 million euros.

The most important part in the specialized medical services invoices in 2015 constituted tests and procedures (See Figure 11). Financing of tests and procedures increased the fastest in the financial volume - financing grew as much as the overall financing of specialized medical care. The number of users is increased by 2%. In the case of laboratory tests the number of financed uses has increased by 3% and the funding has increased by 9%. The increase of the proportion of tests and procedures and laboratory tests in funding reflects the technological development. However, it is important to ensure that the tests and procedures carried out are needed, avoidance of repeat tests, in addition to ensuring the safety of the patient, is also essential for the rational use of health insurance.

The number of uses of bed days has declined, but the funding has increased by 4%.

Funding of outpatient appointments increased by 9%, the number of uses increased by 7%. The proportion of the salary component in the limit price of an outpatient appointment is relatively high (for example, 80% of the price of the primary appointment of doctor accounts for labor cost). The increase in the prices resulting from the health care workers' wage agreement had the most significant impact in case of outpatient visits.

Funding of medical products out of the specialized medical care budget, covers mainly the chemical treatment in hematology and oncology, biological treatment, and other use of specific expensive medicinal products (e.g., medicinal products used in organ transfer). In the case of medicinal products (as an exception of other service groups) the number of users increases more quickly than the costs. A comprehensive overview of the using of medicinal products in the budget of healthcare services will be provided in Chapter 3 of this report.

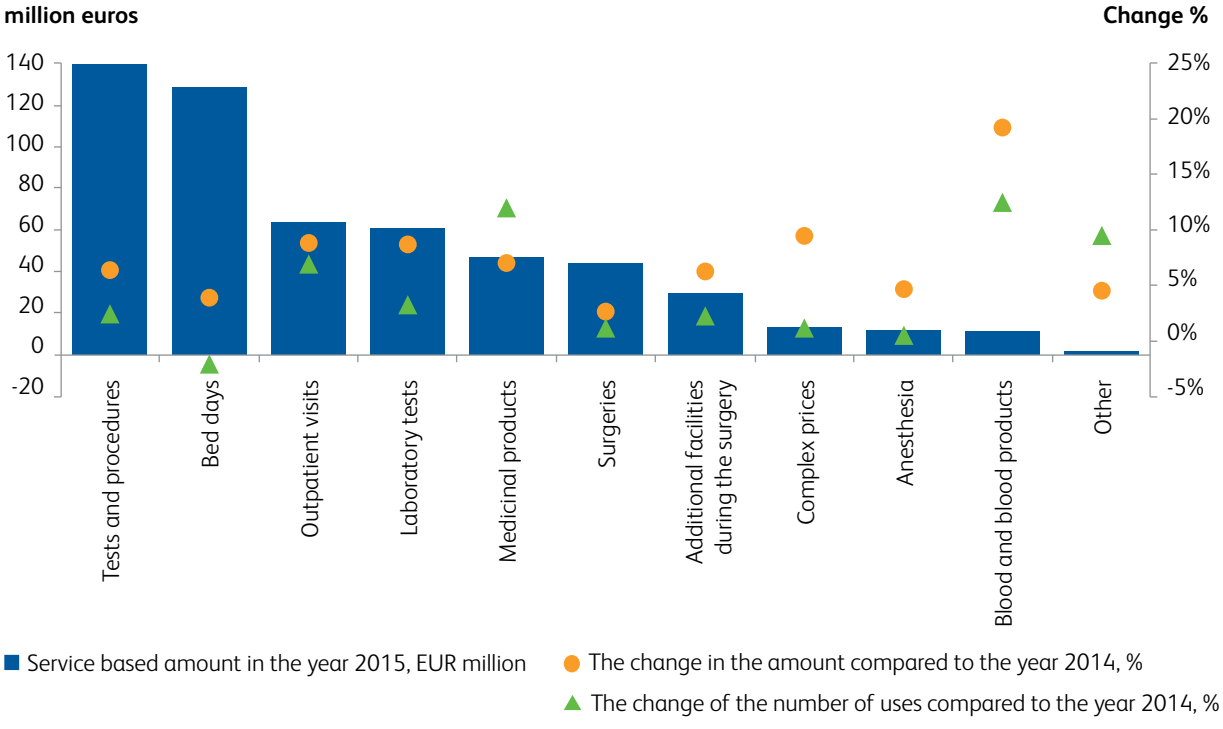


Figure 11. The services reflected in the treatment invoices of specialized medical care in 2015, reflected by the types of service

1.4 Nursing care

In the year 2015, the estimated financial volume of nursing care was 27.0 million euros, which was 10.2% higher than the funding of the nursing care services in the year 2014 (see Table 27).

Over execution of the budget of inpatient nursing care is mainly due to the need for implementation of the price coefficient of nursing inpatient bed days to a lesser extent than planned. The requirement for implementation of the inpatient price coefficient 0.89 arises from the list of health care services of the Health Insurance Fund in those instances where the service provider has no appropriate personnel for the provision of the inpatient nursing care service. The questionnaire-based survey conducted by the Health Insurance Fund at the end of the year 2014 showed that a significant proportion of nursing care partners lacked the requisite number of nursing staff. The results of the survey were taken into account in budget planning. At the end of the year 2014, and during the first half and 2015, the majority of the inpatient nursing care partners settled the personnel-related issues and by the end of the year, the coefficient of bed days will be implemented only in the contracts of fewer partners.

The ever execution of the home nursing budget is related to the improvement of the availability of home nursing services.

Since 2015, geriatric assessment is no more planned and monitored as a separate component - as a collaboration of the Estonian Society of Geriatrics and the Estonian Health Insurance Fund, this service has been integrated into the specialized inpatient treatment and it is financed primarily in the framework in the specialty of inpatient internal medicine.

Table 27. Execution of the budget of nursing care in thousands of euros and the number of treatment cases

	2014 actual		2015 budget		2015 actual		Budget execution	
	The amount	Number of treatment cases	The amount	Number of treatment cases	The amount	Number of treatment cases	The amount	Number of treatment cases
Inpatient nursing care	19,493	19,055	21,717	19,156	22,395	18,078	103%	94%
Home nursing	4,946	36,844	5,313	33,650	6,055	36,945	114%	110%
Geriatric assessment *	98	1,400	0	0	0	0	-	-
Total	**24,537**	**57,299**	**27,030**	**52,806**	**28,450**	**55,023**	**105%**	**104%**

*Since 2015, geriatric assessment is no more planned and monitored as a separate component - as a collaboration of the Estonian Society of Geriatrics and the Estonian Health Insurance Fund, this service has been integrated into the specialized inpatient treatment.

Compared to the same period last year, funding for home nursing visits has increased by 4%. The number of people receiving the service has been reduced, while the average number of visits per person has increased by 9% compared to the previous year (see Table 28).

Table 28. The nursing care visits and the number of persons receiving the service

	2014 actual		2015 actual		The change compared to the year 2014	
	Visits	Persons	Visits	Persons	Visits	Persons
The number of visits and persons	252,490	8,461	262,339	8,060	4%	-5%

The availability of nursing care

As of 01.01.2016, a total of 1700 appointments have been registered in the nursing care waiting lists. Compared to the same period last year, the number of accesses to services registered in the treatment waiting lists both in home nursing and inpatient nursing care has grown. 95% of the appointments registered in the nursing care waiting lists takes place within the maximum permitted length of the waiting list [13] - waiting times are generally within the maximum permitted length of the waiting list.

Table 29. The number of appointments registered in nursing care waiting lists

	01.01.2015		01.01.2016		The change compared to the year 2015
	The number of appointments in waiting lists	Within the maximum waiting time limits	The number of appointments in waiting lists	Within the maximum waiting time limits	The number of appointments in waiting lists
Geriatric assessment	16	100%	-	-	-
Home nursing	420	95%	530	91%	110
Inpatient nursing care	1,047	96%	1,184	97%	137
Total	**1,483**	**96%**	**1,714**	**95%**	**231**

Estonian Society of Geriatrics in cooperation with the Estonian Health Insurance Fund decided as of 2015, to plan the future of geriatric assessment service integrated into the inpatient specialized medical care services in order to increase the possibilities for more flexible provisions of services. The service is primarily financed within the framework of inpatient internal medicine specialty.

13 In inpatient nursing care the maximum permitted length of the waiting list is 3 months, in home nursing 2 weeks.

Execution of the contracts of nursing care

In 2015, the Health Insurance Fund paid the medical institutions 28.5 million euros for 55 thousand treatment cases. The treatment cases of the Hospital Network Development Plan amounted to 40% in 2015, and the amount was 57% of the total performance of nursing care contracts.

The table below provides information on the performance of nursing care contracts in the first and the second half of the year 2015. The first half-year contracts have been fulfilled 100%, fulfillment of treatment cases is 103%. The fulfillment of the second half-year is 99% and the fulfillment of treatment cases if 100%. The depreciation of the average cost of a treatment case is due to the larger than expected proportion of provision of the outpatient nursing care cases. The result is as expected, since the objective of the Health Insurance Fund is to improve the accessibility of the home nursing care.

Table 30. Execution of the contracts of nursing care in thousands of euros

	The contract of the first half of 2015		Execution of the contract of the first half of 2015		The contract of the second half of 2015		Execution of the contract of the second half of 2015		Execution of the contract of the second half of the year	
	The amount	The number of treatment cases	The amount	The number of treatment cases	The amount	The number of treatment cases	The amount	The number of treatment cases	The amount	The number of treatment cases
HNDP hospitals	8,288	11,102	8,260	11,237	8,082	10,693	8,037	10,508	99%	98%
Regional hospitals	840	1,074	840	1,016	893	1,078	886	1,105	99%	103%
Central hospitals	3,729	4,048	3,726	4,032	3,614	3,901	3,614	3,621	100%	93%
General hospitals and local hospitals	3,719	5,980	3,694	6,189	3,575	5,714	3,537	5,782	99%	101%
Selection partners	6,328	16,217	6,306	16,907	5,844	15,971	5,811	16,112	99%	101%
Buyout of treatment waiting lists *	40	252	33	240	0	0	3	19	-	-
Total	**14,656**	**27,571**	**14,599**	**28,384**	**13,926**	**26,664**	**13,851**	**26,639**	**99%**	**100%**

* The volume of the contracts entered into for buyout of the treatment waiting lists is the volume of the year - the contract was concluded for the period 01.01-31.12.2015 without making a distinction between half years.

Table 31 provides information on the performance of nursing care contracts of the Hospital Network Development Plan hospitals concluded for the first and the second half of the year 2015.

Table 31. Execution of the contracts of the Hospital Network Development Plan hospitals in thousands of euros

	The contract of the first half of 2015		Execution of the contract of the first half of 2015		The contract of the second half of 2015		Execution of the contract of the second half of the year		Execution of the contract of the second half of the year	
	The amount	The number of treatment cases	The amount	The number of treatment cases	The amount	The number of treatment cases	The amount	The number of treatment cases	The amount	The number of treatment cases
Regional hospitals										
Foundation Tartu University Hospital	579	861	579	819	632	865	625	873	99%	101%
Foundation North Estonian Regional Hospital	261	213	261	197	261	213	261	232	100%	109%
Central hospitals										
East Tallinn Central Hospital	1,354	1,805	1,355	1,746	1,301	1,733	1,301	1,610	100%	93%
West Tallinn Central Hospital	1,276	912	1,276	793	1,227	884	1,227	667	100%	75%
Foundation Ida-Viru Central Hospital	416	656	412	770	429	636	429	668	100%	105%
Foundation Pärnu Hospital	684	675	684	723	657	648	657	676	100%	104%
General hospitals and local hospitals										
Järvamaa Hospital	272	476	272	478	252	440	252	443	100%	101%
Foundation Kuressaare Hospital	377	685	377	697	363	658	363	660	100%	100%
Foundation Läänemaa Hospital*	239	383	222	378	226	348	226	354	100%	102%
Rakvere Hospital	389	1,010	389	1,057	358	932	358	976	100%	105%
South Estonian Hospital	435	635	435	642	434	634	434	623	100%	98%
Foundation Narva Hospital:	682	957	682	977	630	884	630	896	100%	101%
Foundation Viljandi Hospital:	396	736	396	807	394	733	394	730	100%	100%
Valga Hospital	244	337	244	357	244	336	244	337	100%	100%
Foundation Hiiumaa Hospital:	79	71	79	73	76	68	76	69	100%	101%
Põlva Hospital	246	314	246	338	246	313	246	309	100%	99%
Foundation Raplamaa Hospital*	186	164	185	155	178	157	170	172	95%	110%
Foundation Jõgeva Hospital:	174	212	166	230	173	211	145	213	84%	101%
Total HNDP hospitals	**8,288**	**11,102**	**8,260**	**11,237**	**8,082**	**10,693**	**8,037**	**10,508**	**99%**	**98%**

* Up to March 2015, Foundation Läänemaa Hospital

* Up to March 2015, Foundation Rapla County Hospital

The nursing care contracts were filled in terms of the amount by 99% and in terms of treatment cases by 101%. Financial execution in inpatient nursing care was 100%, execution of treatment cases 98%, in home nursing the financial execution was 99%, and the execution of treatment cases was 103%. Compared with the year 2014, the amount paid to HNDP hospitals increased by 15%, in the case of selection partners (together with the execution of the contracts entered into by buying out of the waiting lists) by 17%. The number of treatment cases provided in nursing care decreased by 10% in the HNDP hospitals that at the selection of partners remained at the same level.

The amounts paid to Regional hospital (North-Estonian Regional Hospital, Tallinn Children's Hospital and the Hospital of the University of Tartu) increased by 21% in 2015 compared to the previous year, 5% less treatment cases in nursing than in 2014 were provided in regional hospitals. The contracts were executed in terms of financial volume by 100% and in terms of treatment cases by 99%. The North Estonian Regional Hospital provides inpatient nursing care, in both half-years, the medical institution executed the amount of the contract at 100%, and the average cost of a treatment case was 1% lower than in agreed for the whole year. Tartu University Hospital provides both inpatient nursing care and home nursing services. Execution of the contract amount was 99%, execution of the treatment cases was 98%. In Tallinn Children's Hospital nursing care services are not provided.

The amounts paid to central hospitals (East Tallinn Central Hospital, Ida-Viru Central Hospital, West Tallinn Central Hospital, Pärnu Hospital), in 2015 increased by 15% compared to the previous year, the number of treatment cases provided in central hospitals was less by 13% than in 2014. The contracts were executed in terms of financial volume by 100% and in terms of treatment cases by 96%.

General hospitals and local hospitals (Hiiumaa Hospital, Järvamaa Hospital, Kuressaare Hospital, South Estonian Hospital, Läänemaa Hospital, Narva Hospital, Põlva Hospital, Rakvere Hospital, Raplamaa Hospital, Valga Hospital, Viljandi Hospital and Jõgeva Hospital) provided in the year 2015, 8% less treatment cases than in the year 2014. The amount paid to general hospitals for nursing care services increased by 15% compared to the previous year. The contracts were executed in terms of financial volume by 99% and in terms of treatment cases by 102%.

Compared to the year 2014, the provision for nursing care services has grown at the most significant rate, financially by 23% in the Raplamaa Hospital.

The number of treatment cases in nursing care at the selection partners in the year 2015 remained at the same level compared to the year 2014. The amount paid to selection partners for nursing care services increased by 17% compared to the previous year. On the basis of the contract entered into for funding waiting lists, 36 thousand euros were paid for 259 cases.

An overview of execution of nursing care contracts by health care institutions has been published on the website[14] of the Health Insurance Fund.

14 Execution of the contracts of nursing care:
https://www.haigekassa.ee/et/partnerile/raviasutusele/ravi-rahastamise-lepingud

1.5 Dentistry

The largest part of the dental services financed by the Health Insurance Fund is made up of the dental care for children up to 19 years of age. The obligation of payment for adult dental services is assumed by the Health Insurance Fund to the health care institution only in case of provision of emergency care services. The financial benefits for dental care (denture benefits, dental care benefits) is viewed separately in the report - an overview of the financial benefits will be provided by Chapter 7 of this report.

Table 32. Execution of the budget of dental care in thousands of euros and the number of treatment cases

	2014 actual		2015 budget		2015 actual		Budget execution	
	The amount	Number of treatment cases	The amount	Number of treatment cases	The amount	Number of treatment cases	The amount	Number of treatment cases
Prevention and treatment of children's dental diseases	16,035	327,876	17,832	375,810	17,534	377,403	98%	100%
Orthodontics	3,689	45,905	3,872	50,500	4,047	50,139	105%	99%
Adult emergency dental care	926	19,976	918	19,860	1,018	22,581	111%	114%
Total	**20,650**	**393,757**	**22,622**	**446,170**	**22,599**	**450,123**	**100%**	**101%**

* From 2015, prevention of children's dental diseases and children's dental care is reflected in the budget of the Health Insurance Fund on one line - the target group of the services coincides to a large extent, the distinction between prevention and treatment is not needed in their present form.

On drawing up a dental care budget for the year 2015, an increase for the financing was planned compared to the previous year. The dental care budget was executed by 101% in terms of treatment cases and by 100% in terms of the amount. Compared to the previous year, funding of dental care increased by 1.9 million euros and the number of treatment cases increased by 56.4 thousand. The number of treatment cases compared to last year has increased due to the fact that, from 2015 onwards, the dental care invoices are submitted on an appointment basis, previously, on the treatment invoice may have been reflected a treatment continued over several appointments.

For the continued provision of dental treatment services in all counties in Estonia, in 2015, the Health Insurance Fund conducted a public competition for contracting partners. Since 01.07.2015, new treatment financing agreements for the insured for the provision of dental services are in force for the next four years.

Prevention and treatment of children's dental diseases

From 2015, prevention of children's dental diseases and children's dental care is planned as one line - the target group of the services coincides to a large extent, the distinction between prevention and treatment is not needed in their present form. In 2015, the Health Insurance Fund financed the provision of dental care to 149 thousand children (except for orthidontics). The number of children whose dental care and preventive dental services were funded by the Health Insurance Fund, has grown by 2000 the children in comparison with the previous year.

The target group of prevention of children's dental diseases in 2015 were the children who were born in 2003, 2006, 2008 and 2009. The responsibility of recommending appointments for dental disease prevention lies on the family nurses and school nurses - it has been regulated in the work instructions of both family physician and of health care professionals who work with them as well as in the regulation governing the work of the school nurse.

The coverage of 3 to 19 year-old children with dental services across counties compared to the same period of the previous year is shown in figure 12.

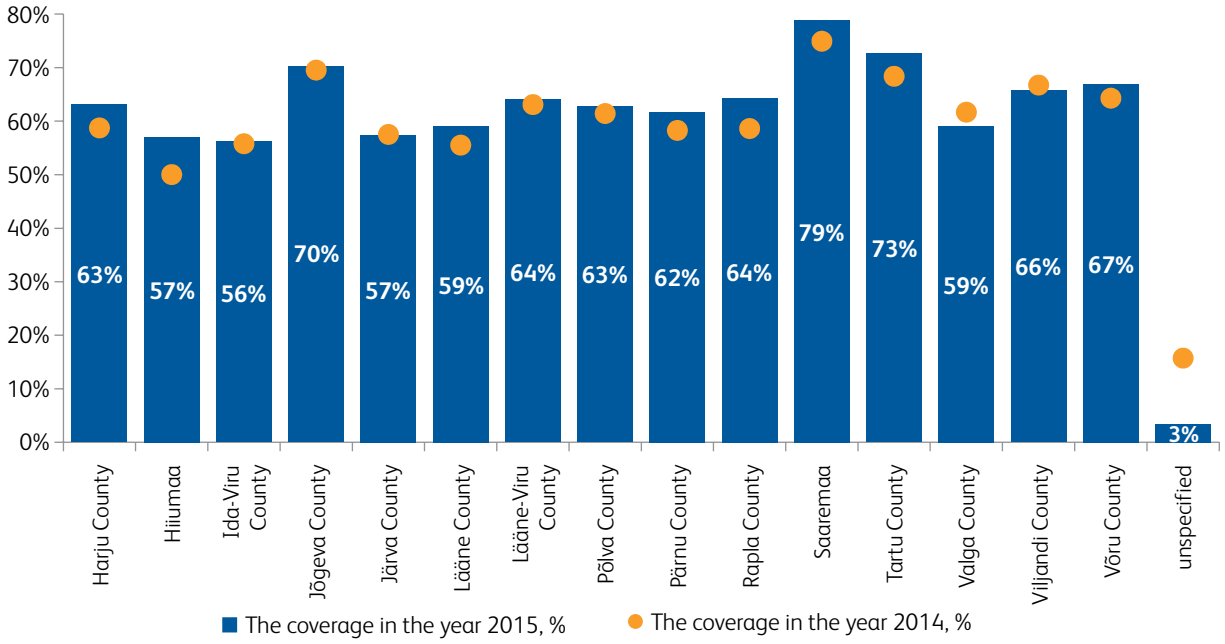


Figure 12. The coverage with children's dental services by counties for the years 2014-2015

At this age, the average coverage of children with the service is 62%, however, the coverage of the children of Saare and Tartu counties with the dental services is significantly higher, and it was also higher than in other counties in the same period of the previous year.

Lower than the average coverage is in Ida-Viru County, Hiiu County and Järva County. Compared to the year 2014, coverage of children with dental services has risen the most in Hiiu County and fallen the most in Valga County.

The coverage of 3 to 19 year-old children with dental services by ages is shown in figure 13. Coverage for dental service is higher than average among children aged 6-12 years. The coverage for dental services was the highest for the age group of 7 year-olds. The coverage for the services was the lowest among the 3-year-old children. The coverage for dental services falls in the ages 13-18. The coverage of children with dental services by age is similar to the year 2014.

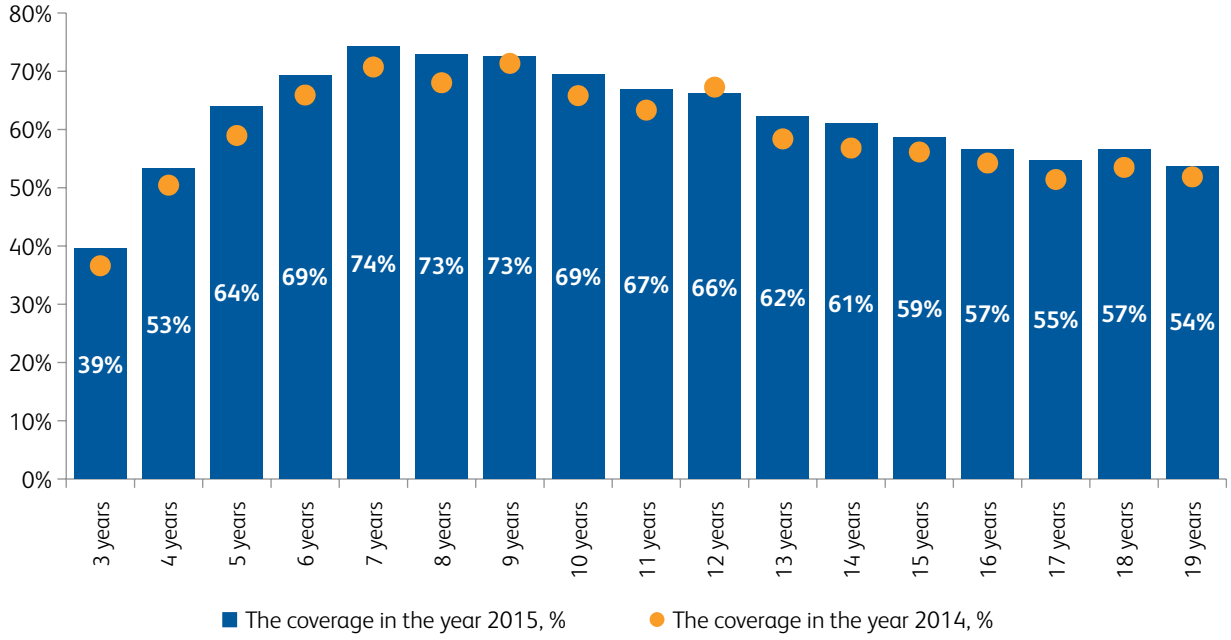


Figure 13. The coverage with children's dental services by ages for the years 2014–2015

The coverage of children with dental services was affected by the outreach activities conducted in 2015 and by the selection process of providers of dental services, which resulted in the change of service providers in counties, and some parents had to find a new dental care provider for their child.

Orthodontics

In orthodontics, the planned increase of financing was 0.2 million euros and the planned increase of the number of treatments was 4600 thousand cases. The budget was executed by 105% in terms of finance and by 99% in terms of the number of treatment cases. Compared to the previous year, funding of orthodontics increased by 0.4 million euros, the number of treatment cases increased by 4200. The number of people receiving treatment increased compared to the previous year by 3.5% of by 670 children, which can be considered positive.

Adult emergency dental care

The funding of adult emergency dental care was planned to stay at the last year's level of use. The budget was executed by 111% in terms of finance and by 114% in terms of the number of treatment cases. Compared to the previous year, funding of adult emergency dental care increased by 92 thousand euros, the number of treatment cases increased by 2600. In 2015, funding for adult emergency dental care compared to last year has increased in terms of treatment cases as well as in terms of persons receiving treatment. Over execution of the budget is due to the fact that decline in usage was expected when drawing up the budget.

Availability of dental care

As of 01.01.2016, a total of 19 700 appointments have been registered in the dental care waiting lists. The total number of appointments registered in the waiting lists in children's dentistry and orthodontics compared to the same period last year has increased significantly (11%). 95% of the appointments registered in the dental care waiting lists takes place within the maximum permitted length of the waiting list [15] - waiting times are generally within the maximum permitted length of the waiting list (see Table 33).

Table 33. The number of appointments registered on the children's dental care waiting lists

	01.01.2015		01.01.2016		The change compared to the year 2015
	The number of appointments in waiting lists	Within the maximum waiting time limits	The number of appointments in waiting lists	Within the maximum waiting time limits	The number of appointments in waiting lists
Children's dental care	15,159	96%	15,976	95%	817
Orthodontics	2,611	97%	3,710	99%	1,099
Total	**17,770**	**96%**	**19,686**	**95%**	**1,916**

15 In case of insured persons under 19 years of age, the maximum permitted length of the waiting list, in the case of a chronic pulpitis, is one week, in the case of simple caries and chronic periodontitis, two months,; in the case of orthodontic services nine months.

2. Health promotion

Being guided by the Health Insurance Fund Development Plan, the Health Insurance Fund finances the health promotion in order to achieve the objectives set out in the National Health Plan. Promotion of people's health and welfare will be more effective if it is subject to an active contribution to a number of institutions who collaborate to achieve a single goal. Health promotion activities are financed, in addition to the Estonian Health Insurance Fund, also by the Ministry of Social Affairs and the Health Development Institute.

By the year 2015, in the budget of the Health Insurance Fund 1.1 million euros is planned for health promotion. 99% of the budget planned for the year 2015 has been used (see Table 34). The under execution of the budget was affected by economically more favorable tenders of the public procurements.

Table 34. Execution of the health promotion budget in thousands of euros

	2014 actual	2015 budget	2015 actual	Budget execution
Activities aimed at children's health development	189	400	359	90%
Activities aimed at the patient awareness	418	330	435	132%
Empowering of the primary level	0	185	26	14%
Development of health system	0	185	268	145%
Prevention of home and leisure injuries and poisoning	250	0	0	-
Total	**857**	**1,100**	**1,088**	**99%**

In health promotion activities, in the year 2015 were a total of 16 projects, which were mainly aimed at the development of children's health, increasing public awareness and educating the patient.

To improve people's awareness, in the 1st and the 2nd half year a campaign of "Reasonable use of pharmaceuticals" reached the population with a renewed message and visuals, aimed at raising awareness about the choice of prescription pharmaceuticals and to enhance the number of people using the service of prescription view of the state portal eesti.ee and thereby directing people to make reasonable choices to reduce people's expenses on purchases of prescription pharmaceuticals , thus improving patient compliance. The visibility of the campaign among the population was 85%, and as a result of the campaign, the number of viewers of prescriptions in the state portal increased.

Communication of screening for cervical cancer in terms of early detection took place in January and in October, and the communication of early detection of breast cancer in May and in October. For raising public awareness, press releases and stories of the importance of screenings were published in major daily newspapers. As the examination coverage is lower in the larger cities, we displayed posters with the birth years of the invitees in outdoor media and used radio channels for notifications of screenings.

The information recalling and presenting the family physician helpline options reached the population through the radio, outdoor media and newspapers in the second half of the year. We informed the public of the European Health Insurance Card both in the first and the second half of the year, which resulted in the increase of issuing of the cards by 17 000 cards.

The health pages reflecting the topics of the Health Insurance Fund were published in the sixth largest daily and weekly newspapers, extra attention was on the Russian-speaking readers of Ida-Viru region', cooperation takes place with the newspaper Põhjarannik.

The largest of the activities targeted at children's healthy development was the children's healthy teeth project in the framework of which were completed television clips on oral health that reached the viewers both in the first and the second half of the year. The television clips were broadcast on the most popular TV3 series. The key messages of the clips were "Thirst drink is water", "Visit the dentist once a year," "Dental care for children under 19 years of age is free to the contractual partners of the Health Insurance Fund". A focus group study has been conducted on the availability of dental care for children in selected regions, whose aim was to find out the main obstacles in the availability of dental care for children and the main reasons why children

do not reach the dentist. Articles have been published in major daily newspapers on the children's oral health and dental care. A reprint “The mouth of the child is the mirror of the family” was completed which was distributed in maternity hospitals, in dental offices and at the receptions of family physicians. Souvenirs of toothbrushes and sand clocks were manufactured, which were distributed to children in cooperation with the Estonian Dental Association. The topic of dental health was integrated into the formula booklets where topics were divided into three age groups.

In cooperation with the Estonian Dental Association, outreach activities took place for the target groups and stakeholders, where 260 kindergartens and primary school teachers have the awareness of oral health problems and the willingness to intervene. There have also been outreach activities to the target group. Counseling has been conducted in kindergartens and schools, where direct contact has been achieved with 13,322 children. For improving the oral health knowledge of the population, participation in different fairs, sporting events and information days has taken place. The children's dental health project also works closely with KEAT (Defend Yourself and Help Others) safety youth camp and the Rescue youth camp that was attended in the framework of the health related topic point. Study videos have been completed for stakeholders, and pregnant women, which are available on the website kiku.hambaarst.ee. The web portal kiku.hambaarst.ee has received an important supplement and the target and stakeholder groups have been made more user-friendly. Also, a survey plan has been completed with the aim in 2016, to map the dental health status of the 3, 6, and 12-year-old children.

In the framework of the project "Health promotion in kindergarten and school” has been carried out a variety of health-related training courses with the aim to deepen health-promoting way of thinking and application of health information into practice. In the project training has been involved a total of 10%, i.e., 120 representatives of educational institutions, a total of 240 employees. Teaching materials have been compiled from educational institutions with a view to promoting children's health and well-being. The training materials have been prepared based on evidence-based nature and the study of mapping of the needs performed in Estonia. The support structure has been extended for training and counseling of educational institutions in collaboration with diabetes and school nurses, and with the Estonian Children and Youth Diabetes Association. The coping of diabetic children has been increased in educational institutions through the development of a support network, wherein 25 different educational institutions training and counseling of the staff have been conducted in order to increase the coping of children suffering from diabetes.

Out of children's health-related publications was completed an updated booklet “Child's mouth is the mirror of the family" and "Child Health Diary", which was distributed to family physicians. Ready to print was also the reprint of “Acute respiratory infections in children and their treatments at home."

Projects aimed at children KEAT safety related youth camps took place in all 15 counties, and a total of 2766 students of 6th to 8th grades participated in the camps. The aim of the project is to teach young people the safety knowledge essential for life, regarding how to foresee the risks and how to cope with various emergencies. The main project partners are: County health promoters, the Rescue Board, the Police and Border Guard Board, the Red Cross, the National Defense League and the Road Administration. In the framework KEAT camps were held training which was attended by 8402 children.

The aim of the promotional project “Pregnancy crisis counseling” is to ensure the availability of the appropriate advisory services for pregnant woman and a person close to her, to help them make informed decisions about pregnancy-related issues, raising awareness of the potential risks and to become informed about state-backed support services and assistance. In 2015, on the basis of referrals and with the support of the Health Insurance Fund were counseled 2200 different persons in 4500 different events, which makes an average of two contacts per customer.

In the framework of the activities of first level empowerment we informed the population of the family physician helpline number 1220 by way of outdoor media, radio and articles.

For promotion of the health system on 4-5. June took place a Health Promotion Conference "Child welfare - our common responsibility." For the first time, the conference was held on two days, the first day of which was international with the cooperation of the Tallinn School Health Foundation and EUSUHM *(the European Union for School and University Health and Medicine)* . The two days of the conference brought together a total of 650 people, including 250 foreign guests. The conference satisfaction survey showed that 66% of participants in the conference were very satisfied, 30% assessed the conference as "good", and 4% gave an assessment of "neutral." No assessments “bad" and "very bad" were given.

In 10-12 June in Pärnu was held the fourth training of evidence-based clinical guidelines, which was intended for introducing the methodology to the people drafting new clinical guidelines and the members of the working group. The training involved a total of 54 health care workers. In the training, workshops were held for becoming familiarized with the various technical means facilitating the work of the clinical guidelines working group. An overview of the analytical methods of research was provided, and a theoretical, and practical approach to quality assessment of the clinical guidelines with the tool AGREE took place. The training that was held in summer resumed in the fall with a two-day follow-up training in Tallinn, where the trainer was Professor Holger Schünemann from McMaster University in Canada. In the training, interpretation of proof on the preparation of clinical guidelines and the formulation of recommendations was acquired.

In August, WHO experts were in Estonia and conducted an upgraded assessment of the clinical guideline-drafting process whose purpose was to obtain recommendations on the opportunities of improvement of the clinical guidelines development process in Estonia. As a result, a report was prepared, which gave an assessment to the process currently in force, and recommendations on how to enhance the development of clinical guidelines.

In 2015, four new ready clinical guidelines were completed, all of which are aimed at raising awareness of health care workers with evidence-based treatment techniques. The completed clinical guidelines “Using of a surgical safety checklist in the operating room," "Treatment of pressure sores - prevention and conservative treatment", “Treatment of patients with alcohol use disorder" and “Treatment of perioperative acute pain" are available electronically on the clinical guideline website www.ravijuhend.ee

To complement the clinical guidelines one patient guideline was completed , and three different ones made it to the final phase of the preparation, which will reach the target audiences in the form of publications through healthcare workers. The patient guidelines are electronically available on the website of the clinical guidelines.

3. The medicinal products compensated for to the insured persons

The medicinal products compensated by the Health Insurance Fund that the patient can use independently, are issued from the pharmacy on the basis of a prescription of a health care professional. Part of the cost of the prescription will be paid by the Health Insurance Fund, and the appropriate amount will be deducted in the pharmacy. Thus, the patient can immediately buy discount medications and need not apply for reimbursement afterward. With a certain periodicity, the pharmacy, in turn, presents invoices for payment to the Health Insurance Fund. With regard to various diseases and medical products, different discount rates apply that are established by the Government, Minister of Social Affairs and Health and the Minister of Labor regulations, which in turn are based on the Health Insurance Act.

Reimbursement of the medicinal products meant for ambulatory use to patients is an open commitment to the Health Insurance Fund. This means that the Health Insurance Fund is obliged to compensate for need-based medicinal products to the extent determined by law and cannot refuse to refer to the lack of funds. In 2015, discount medicines were compensated for to the insured in the total amount of 112.8 million euros, 101% of the budget planned for the year 2015 has been used (see Table 35).

Table 35. Execution of the budget of medicinal products compensated to the insured in thousands of euros

	2014 actual	2015 budget	2015 actual	Budget execution
100% compensated medicinal products	53,630	54,440	55,168	101%
90% compensated medicinal products	32,796	33,400	34,050	102%
75% compensated medicinal products	5,973	6,120	5,849	96%
50% compensated medicinal products	17,354	17,640	17,734	101%
Total	**109,753**	**111,600**	**112,801**	**101%**

Funding of pharmaceuticals benefits grew by 2.8% compared to the year 2014. The growth is relatively evenly distributed throughout the different discount types, excluding the medicinal products compensated for at the 75% discount rate, for which the use has remained below budget. The difference between execution of the budget in terms of medicinal products compensated for to the extent of 75% and 90% is mainly resulted from the new anticoagulants, the compensating of which by the Health Insurance Fund began in the middle of the year 2014, and the users of which are mostly over 63 years old and, therefore, receive preparations at a higher discount rate. The general growth of the budget, on the one hand, is affected by the number of discount prescriptions purchased, and on the other hand, the average cost of a discount prescription. The number of discount prescriptions has increased by 2% compared to last year; this reflects an increase in pharmaceuticals use, which is pronounced more or less equally in terms of all discount rates. The cost of an average discount prescription has increased for the Health Insurance Fund by 1%. Nevertheless, the increase in the average cost of a discount prescription has been relatively modest compared with the regular, and in terms of medicinal products compensated for with a 75% rate, it has even declined (see Table 36).

Table 36. The number of discount prescriptions and their average cost for the Health Insurance Fund

	2014 actual		2015 actual		The change compared to the year 2014	
	The number of discount prescriptions	The average cost of discount prescription for the Health Insurance Fund	The number of discount prescriptions	The average cost of discount prescription for the Health Insurance Fund	The number of discount prescriptions	The average cost of discount prescription for the Health Insurance Fund
100% compensated medicinal products	900,451	59.56	919,389	60.01	2%	1%
90% compensated medicinal products	2,858,018	11.48	2,916,353	11.68	2%	2%
75% compensated medicinal products	565,074	10.57	572,052	10.22	1%	-3%
50% compensated medicinal products	3,560,116	4.87	3,638,504	4.87	2%	0%
Total	**7,883,659**	**13.92**	**8,046,298**	**14.02**	**2%**	**1%**

In summary, the Health Insurance Fund financed discount medicines per insured patient in 2015, an average of 99 euros and this amount has increased by 11% compared to the previous year (see figure 14).

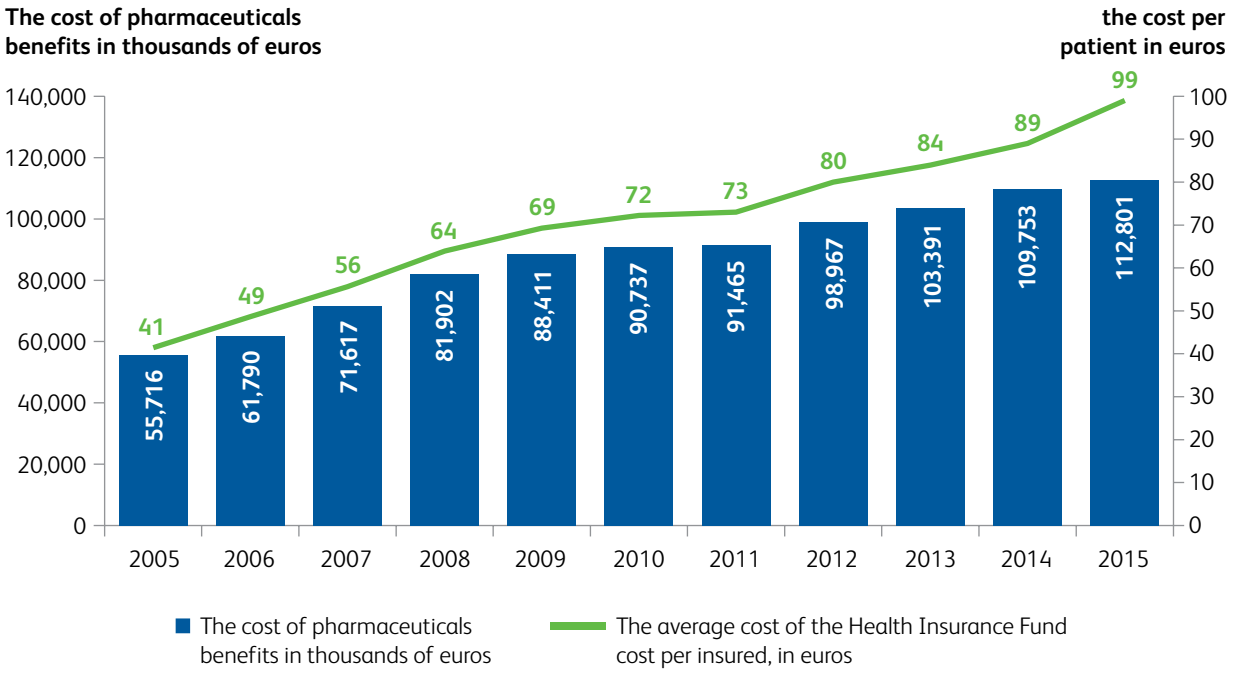


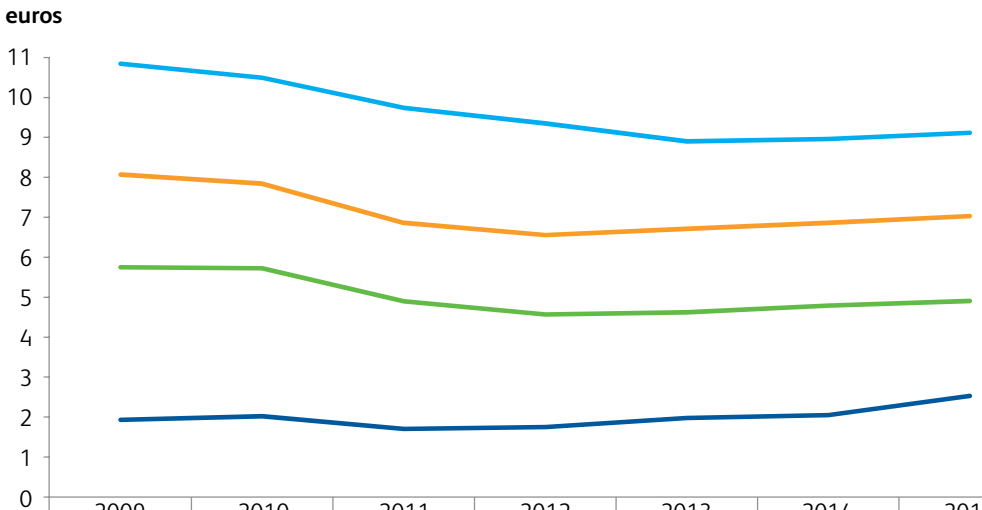
Figure 14. The total cost of the pharmaceuticals benefit and the cost per insured in 2005-2015

The cost sharing of the insured in purchasing of prescription pharmaceuticals has increased in the past year from 31.7% to 32.31%, the average cost of a prescription for the patient was 6.69 euros. The increase of the cost-sharing of the insured is largely due to a slightly renewed pharmaceuticals policy, in the case of which the limit price has, due to the pharmaceuticals prices in the reference countries, been also established for pharmaceuticals (conditions: thrombosis and thromboembolic disease, hypothyroid-

ism, glaucoma) with no generic preparations. In addition, there has been an impact of some significant decline in the limit price in the groups of widely used active substances: pharmaceuticals with a 100% discount (epilepsy, glaucoma) and pharmaceuticals with a 75/90% discount (hypertension, asthma). Changing of the use of an accustomed packaging in such a case takes time.

Table 37. Cost-sharing of the insured in a percentage

	2014 actual	2015 actual	The change compared to the year 2014
100% discount prescriptions	3.30	4.04	0.7%
90% discount prescriptions	28.80	29.60	0.8%
75% discount prescriptions	39.40	40.76	1.4%
50% discount prescriptions	64.80	65.17	0.4%
Total	**31.70**	**32.31**	**0.6%**



	2009	2010	2011	2012	2013	2014	2015
50% discount rate	10.85	10.50	9.74	9.36	8.91	8.97	9.12
75% discount rate	8.07	7.85	6.86	6.56	6.71	6.86	7.03
90% discount rate	5.75	5.72	4.90	4.57	4.62	4.79	4.91
100% discount rate	1.93	2.02	1.70	1.75	1.98	2.05	2.53

Figure 15. The average cost of the prescription for the patient in the period 2009-2015, in EUR

During the year 2015, compensation of nine new active substances was started. Selection of pharmaceuticals expanded in case of chronic obstructive pulmonary disease, hepatitis C virus, type 2 diabetes, multiple sclerosis, and pulmonary hypertension. Few new cost-effective and useful pharmaceuticals were added because the addition of the pharmaceuticals giving added value to the health was scarce. It also explains the modest increase in the budget.

In some cases, the Health Insurance Fund exceptionally compensates for medicinal products also on patient's individual request. Such an arrangement is applied mostly in cases where in Estonia there is no marketing authorization for the medicinal products needed for the patient and used on an outpatient basis, and, therefore, the medicinal products cannot be included in the pharmaceuticals list of the Health Insurance Fund. Compensation by way of exception allows the pharmaceuticals made available also in the case of a number of rare diseases. In 2015, 2436 persons received compensation by way of exception totaling 1.1 million euros.

Most health insurance funds are required by compensated preferential pharmaceuticals used for the treatment of diabetes, which is mainly due to insulin preparations, the amount spent on the latter has declined due to the widespread use of insulin (glargine), due to the addition of generics and the application of the limit price. During the year, the amount spent on oral dia-

betes preparations has risen, whereas this is mainly due to the increase in the number of patients. The volume of compensation for cancer pharmaceuticals from the budget of preferential pharmaceuticals has increased by 2%; the latter is primarily due to new active substances compensated for by the Health Insurance Fund (abiraterone, axitinib). In the third place has fallen the cost of hypertension pharmaceuticals, which has been reduced due to the addition of new generic preparations into the groups of widely used active substances (telmisartan, telmisartan + HCTZ, ramipril). The cost of asthma medicines has decreased due to adding of generic preparations to combination preparations (salmeterol + fluticasone, beclomethasone + formoterol) and application to the limit price. In chronic hepatitis C, the cost has fallen due to the good treatment results of the medicinal products the compensation of which starting at the beginning of 2014, leading to a decreased number of patients needing treatment.

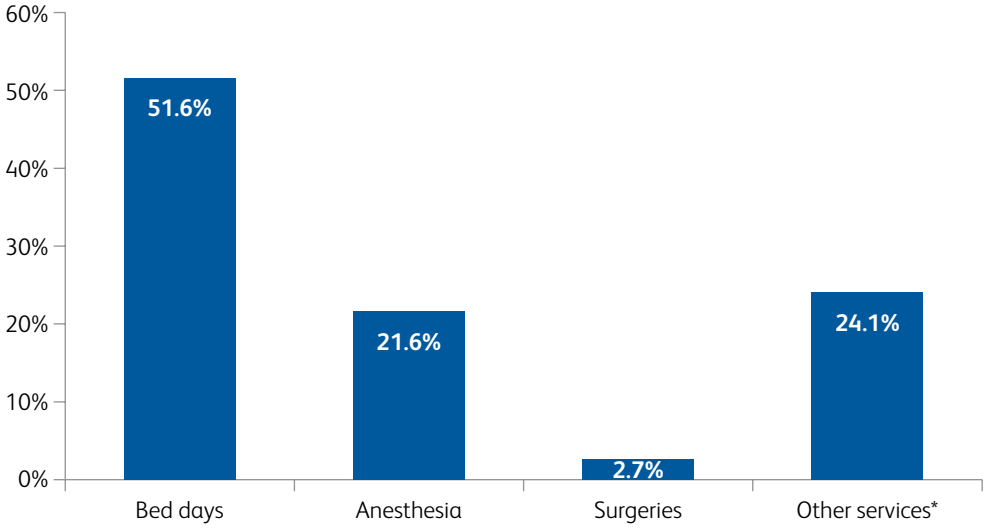
An overview of the diagnoses related to major pharmaceuticals benefits is provided in Table 38.

Table 38. The diagnoses related to major pharmaceuticals benefits in thousands of euros

Diagnosis	2014 actual		2015 actual	
	Compensated for by the Health Insurance Fund	% The total cost of the pharmaceuticals benefit	Compensated for by the Health Insurance Fund	% The total cost of the pharmaceuticals benefit
Diabetes in total, including	17,609	16	18,285	16
Insulin	11,455	10	10,845	10
Oral preparations	6,154	6	7,440	7
Cancer	12,253	11	14,285	13
Hypertension	14,913	14	13,853	12
Bronchial asthma	6,343	6	5,654	5
Glaucoma	4,359	4	4,055	4
Chronic hepatitis C virus infection	3,681	3	3,015	3
Mental disorders	2,938	3	2,612	2
Hypercholesterolemia	2,343	2	2,298	2
Total	**64,439**	**59**	**64,057**	**57**

Compensation for hospital medication in the budget of health care services

In addition to the discount pharmaceuticals compensated for in an outpatient setting, the health insurance means are also used for the payment of the pharmaceuticals used in hospitals. In 2015, the amount of the pharmaceuticals component within the health care services was 15.7 million euros, which is 3% less than the year before. The change in the proportion is due to a decrease in the volume of inpatient care and the growth of the wage component of health care workers. Pharmaceutical costs are accounted for in the cost of various bed days, as well as in the limit prices of surgeries and in anesthesia services (see Figure 16).



* Other services are hemodialysis or peritoneal dialyzer, bone marrow transplantation-related services, various endoscopic procedures, some dental services for children, etc.

Figure 16. Distribution of medicinal products in health care services

In addition, the Health Insurance Fund assumes the payment obligation also for the so-called pharmaceutical services referred to separately in the list of services (services with R-codes). It mainly means chemotherapy in hematology and oncology, biological treatment, and other use of specific expensive medicinal products (e.g., antibiotics used in the treatment of sepsis or medicinal products used in organ transfer) (see figure 17).

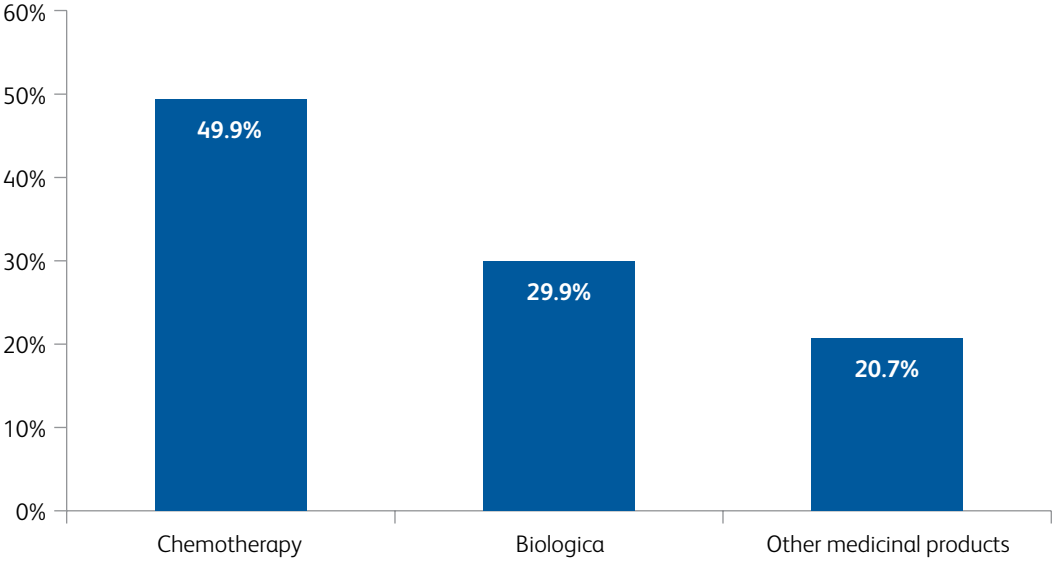


Figure 17. The share of medicinal products funded through the list of health services

In 2015, the share of pharmaceutical services in the list of health services was 46.6 million euros, which compared to last year has increased by 8.7%. Most of the growth of the cost have been caused by the biological treatment, as well as the chemotherapy used for the treatment of cancer, in the case of which new active substances have been started to compensate within the framework of the services.

In total, the Health Insurance Fund financed medicinal products for EUR 175.5 million from the budget of the health care services and from the budget of the outpatient pharmaceutical benefit and the supplementary benefit for medicinal products, which accounted for 18% of health insurance costs (see Table 39).

Table 39. Funding of medicinal products from the budget of the Health Insurance Fund in thousands of euros

	2014 actual	2015 actual	The change compared to the year 2014
The medicinal products compensated for to the insured persons	109,753	112,801	3%
The use of the pharmaceutical codes in the list of health care services*	42,878	46,592	9%
The cost of medicinal products in health care services	16,204	15,723	-3%
Additional benefit for medicinal products	199	349	75%
Total cost of medicinal products	**169,034**	**175,465**	**4%**

* The figures of the year 2014 have been adjusted.

4. Benefits for temporary incapacity to work

Benefits for temporary incapacity to work is a financial compensation paid on the basis of a certificate of incapacity for work to an employed person who due to a temporary leave from work loses the income subject to social tax.

Benefits for temporary incapacity for work in 2015 were 117 million euros, which is 13.1 million more than in the previous year (see Table 40).

Table 40. Execution of benefits for incapacity for work in thousands of euros

	2014 actual	2015 budget	2015 actual	Budget execution
Sickness benefits	46,403	45,400	52,743	116%
Care allowances	16,465	15,900	18,367	116%
Maternity benefits	37,890	38,330	42,264	110%
Occupational accident benefits	3,144	2,960	3,603	122%
Total	**103,902**	**102,590**	**116,977**	**114%**

The benefit of temporary incapacity for work is based on the income of the person for the previous calendar year, subject to social tax. The source documents for the payment of benefits are for sick leave certificates, care leave certificates, maternity leave certificates and adoption leave certificates.

The procedure for payment of the benefit for temporary incapacity for work depends on the type of the certificate of incapacity for work and on the cause of incapacity for work (see the Health Insurance Fund website[16]).

16 Benefits for temporary incapacity to work
https://www.haigekassa.ee/en/people/benefits/benefits-temporary-incapacity-work

Table 41. Comparison of the benefits of incapacity for work

	2014 actual	2015 actual	The change compared to the year 2014
Sickness benefits			
The number of the leaves compensated for by the Health Insurance Fund	217,582	229,201	5%
The number of days compensated for by the Health Insurance Fund	2,997,073	3,193,910	7%
The amount of benefit paid by the Health Insurance Fund (EUR thousand)	46,403	52,743	14%
Average benefit per one day (EUR)	15.5	16.5	6%
Care allowances			
The number of the leaves compensated for by the Health Insurance Fund	106,419	112,963	6%
The number of days compensated for by the Health Insurance Fund	855,143	895,948	5%
The amount of benefit paid by the Health Insurance Fund (EUR thousand)	16,465	18,367	12%
Average benefit per one day (EUR)	19.3	20.5	6%
Average length of the leave	8.0	7.8	-3%
Maternity benefits			
The number of the leaves compensated for by the Health Insurance Fund	9,969	10,383	4%
The number of days compensated for by the Health Insurance Fund	1,385,026	1,443,956	4%
The amount of benefit paid by the Health Insurance Fund (EUR thousand)	37,890	42,264	12%
Average benefit per one day (EUR)	27.4	29.3	7%
Average length of the leave	138.9	139.1	0%
Occupational accident benefits			
The number of the leaves compensated for by the Health Insurance Fund	5,752	6,158	7%
The number of days compensated for by the Health Insurance Fund	124,760	137,096	10%
The amount of benefit paid by the Health Insurance Fund (EUR thousand)	3,144	3,603	15%
Average benefit per one day (EUR)	25.2	26.3	4%
Average length of the leave	21.7	22.3	3%
Total benefits			
The number of the leaves compensated for by the Health Insurance Fund	**339,722**	**358,705**	**6%**
The number of days compensated for by the Health Insurance Fund	**5,362,002**	**5,670,910**	**6%**
The benefits paid by the Health Insurance Fund (EUR thousand)	**103,902**	**116,977**	**13%**
Average benefit per one day (EUR)	**19.4**	**20.6**	**6%**

In the last year has risen both the number of the compensated sick leave certificates as well as the number of days of incapacity for work together with the average rate of benefit per one day. The numerical growth of these indicators is explained by the increase in the number of the employed and insured persons who are entitled to a temporary benefit of incapacity for work. In 2015 compared to the previous year the number of persons employed and insured increased by 2.4%, accounting for 49.7% of the total number of the insured. However, the number of sick leave certificates issued has remained stable per person employed and insured in 2014, 0.36 and in 2015, 0.37 sick leave certificates issued for one employed and insured person. The number of compensated days has increased in proportion to the growth of the number of the certificates of incapacity for work, whereas the number of reimbursable days remained stable. The benefit for an average day is linked to the increase in the average wage. On the calculation of the benefit, the Health Insurance Fund is based on the previous year's income tax with social tax. In 2014, the average salary increased by 6%, and in the same magnitude has also increased the average benefit paid out in the year 2015.

The growth of benefits is also influenced by the introduction of electronic certificates of incapacity for work as of 01.01.2015 that has become obligatory - certificates of incapacity for work reach the Health Insurance Fund immediately after termination of the certificate of incapacity for work, and the speed of arrival of the payment of the certificates of incapacity for work has also picked up. Now, all the steps necessary for calculation and payment of the benefit can be carried out in two days. The introduction of the e-certificate of incapacity for work has allowed shortening the waiting time from thirty days to two, or nearly 20 times. With regard to the e-certificate of incapacity for work, in January 2015 were paid 200 thousand more days of benefits for incapacity for work than in previous years (amounting to an estimated EUR 4.5 million).

Sickness benefits

Sickness benefits are the benefits that are paid to the person with health insurance during the period of his or her temporary incapacity for work in order to partially compensate the employee for the unpaid wages at the time of illness. In doing so, during the period of incapacity for work caused by illness, domestic injury, traffic injury and quarantine no benefits are paid during 1-3 days, the benefit for days 4-8 is paid by the employer , and from the 9th day, the payment of the benefit is assumed by the Health Insurance Fund. For other reasons, the Health Insurance Fund will pay the benefit from the second day of illness.

Sick leave certificates were used in 2015 mostly for the reasons of illness and domestic injury, 77% and 14%, respectively. Compared to the previous year, the use of sick leave certificates by reasons remained unchanged.

Table 42. The number of employed insured persons and the use of sick leave days by age group*

	The number of employed insured persons on 31.12.2014	Sick leave days per an employed, insured person	The number of employed insured persons on 31.12.2015	Sick leave days per an employed, insured person	Change in the number of employed insured persons	Change in the number of sick leave days
...–29	115,178	6.12	116,168	6.10	1%	0%
30-39	134,610	5.23	142,271	5.20	6%	-1%
40-49	137,814	6.44	140,016	6.80	2%	6%
50-59	133,618	9.45	132,662	10.10	-1%	7%
60	79,778	9.11	84,216	9.70	6%	6%

* Recorded are days of incapacity for work with all the reasons for leave of sick leave certificates (including occupational accidents).

To compare the length of sick leave, the Health Insurance Fund compensates the most for the eight-day sick-leaves, followed by 5 and 7-day sick leaves. Most sick leaves were compensated for in March and less from June to September. This figure is particularly affected by the spread of viral diseases. The average length of sick leaves compensated for by the Health Insurance Fund has remained at the same level, in 2014, it was 13.8 days and in 2015 it was 13.9 days. Also, the number of sick leave certificates issued has remained stable per person employed and insured, in 2014, 0.36 and in 2015, 0.37 sick leave certificates issued for one employed and insured person.

Care allowances

Care allowances are benefits paid to the person with health insurance who takes care of a sick child or family member.

The use of care allowances by reasons has not changed significantly compared to the previous year. The care allowance for taking care of an under 12-year-old child accounted for 97% of all the care allowances. The care allowances of taking care of a child less than three years of age or a disabled child under 16 years of age are accounting for a total of 3% of all the care allowances.

As of 01.07.2015, an insured person is entitled, under the certificate for care leave, to receive care allowance for nursing of a child under 12 years of age up to 60 calendar days if the illness is caused by a malignant tumor and the child's treatment begins in the hospital. In 2015, 28 such cases were compensated for in the total amount of EUR 6 thousand.

Maternity benefits

Maternity benefits are benefits paid to the employed person with health insurance during pregnancy and maternity leave.

In the year 2015, the number of maternity leaves increased by 4% compared to the same period in the previous year.

Table 43. The use of maternity benefits usage by age groups

Age group	Persons	The number of maternity leaves	Days compensated for	The amount of benefit	The average cost of the day	Average length of the leave
10-19	81	81	11,338	153,383	13.5	140.0
20-29	4,824	4,825	674,165	17 108,523	25.4	139.8
30-39	4,957	4,958	692,270	22 628,047	32.7	139.7
40-49	479	479	66,183	2 374,492	35.8	138.3

In comparison to other benefits of incapacity for work, the maternity benefit paid by the Health Insurance Fund had a faster rise, which is justified by the higher reproductive age of women and the higher average wages of this age group.

Occupational accident benefits

Occupational accident benefits are paid from the second day of the sick leave.

Breakdown of the certificates of incapacity for work issued due to occupational accidents by reasons has not significantly changed compared to the previous year. In the sick leave certificates submitted to the Health Insurance Fund due to occupational accidents in 2015, the reasons were divided as follows: accidents at work 95%, a complication resulting from an accident at work 3% and occupational injury in traffic 2%.

Benefits paid on the basis of a foreign medical certificate

The Health Insurance Fund pays the insured person a benefit for temporary incapacity for work also on the basis of a document certifying illness issued by a doctor in a foreign country. In 2015, doctors issued to Estonian insured people, 569 primary certificates of sick leave. Compared to the previous year, the number of certificates remained at the same level, but benefits were paid by 11% more. The increase in the paid compensation is probably due to an increase in the proportion of the insured with a higher wage because the benefits are calculated on a uniform basis for both foreign and domestic certificates of incapacity for work. With a foreign medical certificate was applied 90% for sickness benefits, 6% for care allowance, 3% for occupational accident benefits and 1% for maternity benefits. The percentages of the benefits have changed significantly by the types of certificate of incapacity for work. Figure 18 shows that compared to the year 2014, issuing of certificates of incapacity for work by age group has changed. Most of the year 2015 certificates of incapacity for work were used by the group of the people 30-49 years of age.

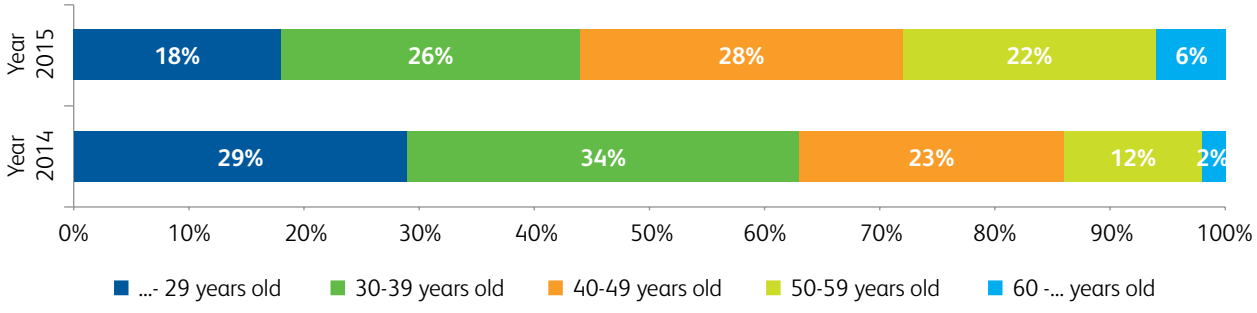


Figure 18. Foreign medical certificates by age groups in the years 2014-2015

5. Benefits for medical devices

The Health Insurance Fund will reimburse the insured persons with the necessary medical device, with the help of which is possible to treat illnesses and injuries, or the use of which prevents the progression of the disease. The exact list of reimbursable medical devices and reimbursement conditions are established by the Regulation of the Minister of Health and Labour.

The benefit of a medical device is an open commitment to the Health Insurance Fund similarly to the medicinal products to be compensated for. The Health Insurance Fund compensates for the medical devices to all the insured persons to whom the doctor has prescribed its use, taking into account the conditions provided in the list of medical devices.

Compared to the year 2014, the volume of the benefits of medical devices has increased by nearly 3.5%, the number of users of medical devices has increased by almost 9%. The result was to be expected and is caused in particular by the limit price system implemented in 2014 regarding the diabetic glucometer test strips, which significantly reduced the amounts to be compensated in this group, despite the rapid growth in the number of users of the test strips (see Table 44).

Table 44. Execution of the budget of the medical device benefits in thousands of euros and the number of persons

	2014 actual		2015 budget	2015 actual		Budget execution
	The amount	The number of persons	The amount	The amount	The number of persons	The amount
Primary early prostheses and orthoses	2,058	16,179	2,175	1,911	19,465	88%
Blood glucose meter test strips	3,751	40,998	4,273	3,838	42,828	90%
Stoma care devices	1,221	1,762	1,140	1,343	1,824	118%
Insulin pumps and insulin pump supplies	494	341	438	537	315	123%
Wound dressings and patches	49	1 571	72	59	1,713	82%
Permanent positive pressure apparatus and masks	814	2,689	853	960	2,425	113%
Disposable needles for insulin pens	292	10,600	332	308	10,604	93%
Lancets	50	5,505	77	78	7,562	101%
Other medical devices	41	271	70	42	228	60%
Total	**8,770**	**79,916**	**9,430**	**9,076**	**86,964**	**96%**

At the beginning of the year 2015, to the list of medical devices were added a number of new medical devicesand compensation conditions for the medical devices already on the list were expanded. When doing so, the amounts of the compensated glucometer test strips and lancets for diabetics in half a year were considerably increased. In spite of the above, compensation of blood glucose meter test strips increased compared with the previous year only by 2.3% while the number of users of the test strips grew by nearly 4.5%. The result is related to the implementation of the above-cited limit price system with respect to the blood glucose meter test strips.

Compared to the plan, the biggest change has taken place in the group of insulin pumps and pump accessories, </15984> stoma care means and automatic permanent positive pressure apparatus and masks . The latter reflects the rapid growth of the number of patients using the devices.

Compared to what was planned for the budget, compensation for wound dressings necessary for the treatment of various wounds and ulcers has decreased . However, compared to the year 2014, the compensation of wound dressings has increased by nearly 20%, and the number of users thereof has increased by almost 9%.

In 2015, 114 proposals were presented for supplementing or changing of the list of medical devices of the Health Insurance Fund, 59 of them found a positive solution. In total, on the list of medical devices were added 174 new medical devices, including four new medical device groups. Also, the compensation conditions for the medical devices were expanded significantly for patients with various stomas and patients suffering from *Epidermolysis Bullosa* . Thus, since 2016, a number of new opportunities were added to the list for the insured.

6. The treatment of an Estonian insured person abroad

The treatment of the insured abroad consists of scheduled treatment abroad under the Health Insurance Act and of the benefits in relation to European Union legislation, where the recipient of the benefit is the insured of the Estonian Health Insurance Fund. The provision of health services and payment, therefore, is regulated by the European Parliament and Council Regulation is coordinating the social security systems of the EU countries, pursuant to which the health care benefits are an open commitment to the Health Insurance Fund.

At the end of the year 2013, Estonia started to implement the Directive, "European Parliament and Council Directive on the application of patients' rights in cross-border healthcare." Under the Directive, patients may go to another Member State in order to receive, in addition to the necessary treatment, also scheduled treatments. Reimbursement of the cost from the Health Insurance Fund budget will take place on the basis of the limit prices of health care services currently existing in Estonia.

Table 45. The treatment of an Estonian insured person abroad in thousands of euros

	2011 actual	2012 actual	2013 actual	2014 actual	2015 budget	2015 actual	Budget execution
Planned treatment abroad	1,745	2,035	2,168	3,882	2,350	3,303	141%
The cost of the health care benefit of an Estonian insured person in another Member State	5,266	3,930	4,480	4,781	4,700	5,118	109%
The costs on the basis of the European Parliament and the Council Directive	0	0	0	101	160	98	61%
Total	**7,011**	**5,965**	**6,648**	**8,764**	**7,210**	**8,519**	**118%**

Planned treatment abroad

The free cross-border movement of the insured is regulated by European Union legislation and the Estonian Health Insurance Fund and the Finnish Red Cross agreement on finding bone marrow nonrelated donors. The insured will be referred to a planned treatment or examination in a foreign country if the health care service applied for and its alternatives are not provided in Estonia. The health care services must be indicated for the patient, and it must have a proven medical efficacy, and the average probability of achieving its goal must be at least 50%. An assessment of compliance with the criteria will be provided by a medical council consisting of at least two medical specialists.

Compared to the year 2014, the number of treatment cases has increased, but the average cost of the treatment case has decreased. In 2015, the average cost of a treatment case was 12 thousand euros, which is 14% lower compared to the previous year.

During the year 2015, with the decision of the Management Board, the Health Insurance Fund has taken over the obligation payment for a planned healthcare service provided abroad in 282 cases. Of these, 94 decisions were made on planned treatment abroad, 161 for examinations, and in the case of 27 insured persons, the bone marrow non-related donor was sought by the Finnish Red Cross Blood Service (see Table 46). Refusing decisions were made in 5 cases during the reporting period (three less than in the previous year).

Table 46. Countries where the insured went for planned treatment or examination in 2015 *

Country	Total	Treatment	Examination
Germany	87	29	58
Denmark	41	0	41
Finland	37	31	6
Netherlands	22	0	22
Belgium	21	0	21
Sweden	19	10	9
Latvia	8	8	0
Russia	5	5	0
United Kingdom	4	2	2
Spain	4	3	1
Italy	3	3	0
Switzerland	3	3	0
Israel	1	0	1
Total	**255**	**94**	**161**

* The number of positive decisions taken in the same year does not match the number of people who went to a foreign country as in terms of some people, several decisions of treatment or examination were taken.

Treatment invoices do not always arrive in the year of submission of an application, as the treatment or examination can take place later. Therefore, the number of treatment invoices is different from the number of applications and the decisions of the Health Insurance Fund during the corresponding year.

In 2015, treatment invoices were received from other countries for 283 persons. Of these, 105 insured went to the treatment abroad, 137 went to examinations and 41 persons had bone marrow donor search related expenses.

In 2014, treatment invoices were received from other countries for 272 persons. Of these, 85 insured went to the treatment abroad, 153 went to examinations and 33 persons had bone marrow donor search related expenses.

The cost of the health care benefit of an Estonian insured person in another Member State

The insured of the Estonian Health Insurance Fund have the right to the European Parliament and the Council Regulation:

- while staying temporarily in another Member State to receive necessary health care;
- to receive any medical care while living in another Member State.

For the year 2015 were planned 4.7 million euros, but the execution of the budget was 109%. The Health Insurance Fund paid to the other Member States, 5.1 million euros for the health care services provided to people staying temporarily in the other EU Member States, and to posted workers and retirees living there. Compared to the year 2014, the compensated amount decreased by 7%.

The majority of the 4.2 million euros of the cost of the health care benefit of an Estonian insured in another Member State accounted for the cost of the health care provided to people living or staying in another Member State. 843 thousand euros was paid to the other Member States as a capitation fee for the pensioners receiving pension from Estonia and back payments were made for 59 thousand euros to persons who, when staying in another Member State, did not carry the European Health Insurance Card, which is why an invoice was submitted to the person.

In 2015, a total of 94 aggregate invoices were received by the Health Insurance Funds from the other Member States; the individual invoices totaled 6833. Most of the invoices were filed by Germany - 2623 invoices totaling 1.7 million euros, followed

by Finland (1303 invoices totaling 1.3 million euros), Sweden - 393 invoices (440 thousand euros), Austria - 177 invoices (197 thousand euros) and a Swiss competent authority submitted 114 invoices (147 thousand euros) for the Estonian insured who received medical care there. Fewer invoices were received from the remaining countries and amounts were also lower.

Benefits of the Patients' Rights Directive

According to the Patients' Rights Directive 2011/24 / EU (hereinafter the Directive), patients can go to another EU Member State in order to receive treatment and after receiving the health care services to seek financial compensation from the Health Insurance Fund for the services, which they are entitled to at the expense of the Health Insurance Fund, also in Estonia, in accordance with the prices provided in the list of health care services of the Health Insurance Fund. In 2015, 54 applications were granted, and 98 thousand euros were compensated to the persons for the health care services provided in foreign countries.

The most common health problems, due to which a person insured in Estonia has gone to another EU Member State to receive health care service under the Directive, are linked to the oncological, cardiological, neurological or gynecological diseases.

In 2015, under the Directive, most patients visited Germany -12 people, Finland - 11, Latvia - 6, Spain - 6, Lithuania -4 and Poland, -4 people.

7. Dental care and denture benefits

The dental care benefit is a monetary compensation to be paid to the target groups provided by the Minister of Social Affairs regulation to improve the availability of dental care.

Monetary benefits of dental care are divided into:

- denture benefits;
- dental care benefits.

The monetary benefits of dental care were, in 2015, 9,4 million euros, which is 203 thousand euros more than in the previous year, whereas the budget remained under executed (see Table 47). Denture benefits were paid, as compared to the previous year, by 169 thousand euros more, the average benefit was 188.64 euros, which is 5 euros higher than the average denture benefit of the previous year. Dental care benefits were paid by 34 thousand euros more than in the previous year. The average payment for dental treatment was 19.93 euros, an increase of 0.53 euros compared with the previous year.

Table 47. Execution of the budget of dental care in thousands of euros and the number of applications

	2014 actual		2015 budget		2015 actual		Budget execution	
	The amount	The number of applications	The amount	The number of applications	The amount	The number of applications	The amount	The number of applications
Denture benefit	7,275	39,633	7,855	44,680	7,444	39,461	95%	88%
Dental care benefit	1,884	97,138	2,065	96,250	1,918	96,251	93%	100%
Total	**9,159**	**136,771**	**9,920**	**140,930**	**9,362**	**135,712**	**94%**	**96%**

The Health Insurance Fund compensates for an insured person per year as follows:

- for a pregnant woman, for a person with an increased need for dental care, and for a mother of a child less than one-year-old 28.77 euros;
- for an insured person at least 63 years of age, an old-age pensioner or person receiving a pension for incapacity for work under the State Pension Insurance Act 19.18 euros.

Denture services are compensated for to an insured person receiving an old-age pension or a pension for incapacity for work under the State Pension Insurance Act and an insured person over 63 years of age up to 255,65 EUR over 3 years.

For receiving dental care benefits, the insured must submit an application and a document certifying payment for the service to the Health Insurance Fund.

Denture benefits can be applied for in the Health Insurance Fund ex-post facto. By submitting an application directly to the doctor, a person can apply for the service immediately for a price more favorable to the amount of the benefit. The insured then pays to the service provider for the denture only the part in excess of the benefit; the Health Insurance Fund will pay the rest. Pensioners prefer an application for the benefit through the health care institutions, because they do not need to pay separately to the Health Insurance Fund, and the invoice to be paid is smaller by the amount of the benefit.

Table 48. The number of applications for dental care benefits by types

	2014 actual	2015 actual	The change compared to the year 2014
A pregnant woman	4,985	4,755	-5%
A mother of a child less than 1-year-old	5,432	5,266	-3%
A person with an increased need for dental care	126	143	13%
Old age pensioner or a person receiving pension for incapacity for work	86,595	86,087	-1%
Total	**97,138**	**96,251**	**-1%**

The use of dental benefits in the year 2015 decreased by types among pregnant women, mothers of children less than 1-year-old and old age pensioner or a person receiving a pension for incapacity for work. The total number of submitted applications was less by 887 applications compared to the year 2014 (see Table 48).

8. Other expenses

Other expenses reflect

- target-financed health insurance costs;
- Additional benefits for medicinal products
- Health care services of a European insured person
- Various health insurance benefits.

Table 49. Budget execution of other expenditures in thousands of euros

	2014 actual	2015 budget	2015 actual	Budget execution
Target-financed health insurance costs	1,446	1,681	1,491	89%
Additional benefit for medicinal products	199	220	349	159%
Health care services of a European Union insured person	1,258	1,450	1,249	86%
Various health insurance benefits	35	0	5	-
Total	**2,938**	**3,351**	**3,094**	**92%**

8.1 Target-financed health insurance costs

The target-financed health insurance costs are the medicinal products and health care services financed under the Artificial Insemination and Embryo Protection Act. Artificial insemination services and pharmaceuticals compensation can be applied to up to 40 years old (including) woman with health insurance who has a medical indication for the artificial insemination and/or embryo transfer.

In total from the state budget was financed 1.5 million, of which medicinal products for 596 thousand euros and health care services for 895 thousand euros.

The targeted financing received for health insurance costs is recognized in the structure of the Health Insurance Fund budget, among other revenues (see Chapter Revenues).

8.2 Additional benefit for medicinal products

At the beginning of the year 2015, the conditions for payment of supplementary benefits for medicinal products changed: the threshold starting from which the benefits would be paid, fell to the rate of benefits grew, and the upper limit of payment of the benefits was abolished.

The insured person will receive an additional benefit for medicinal products if his or her expenses on the medicinal products of the pharmaceutical list exceed 300 euros per calendar year (not considering the statutory co-payment or the prescription fee, and the amount in excess of the limit price).

In 2015 has grown both the number of persons receiving benefits, as well as the average amount of the benefit. In 2015, the budget for supplementary benefits for medicinal products has been executed to the extent of 159%.

8.3 Health care services of a European insured person

The persons insured in the other EU Member States are entitled to:

- the necessary healthcare during a temporary stay in Estonia;
- any medical assistance while living in Estonia.

The necessary health care of the insured person of the EU Member States will be paid for by the Health Insurance Fund, but the final cost of health care services will be borne by the state providing insurance to the person.

For the health care services of the patients from other Member States who received treatment in Estonia EUR 1.2 million was paid to the health care providers, including 42 thousand euros were paid to the pharmacies for the discount pharmaceuticals of the patients from other EU countries. In 2014, a total of 1.3 million euros of benefits were paid to the hospitals and pharmacies for the health care services provided to the insured from the other Member States and for the issued discount medicinal products.

8.4 Various health insurance benefits

As of the year 2015, into the Government Regulation "List of health services of the Estonian Health Insurance Fund " was added the service of corneal crosslinking with riboflavin. In January, before the conclusion of the financial annex of 2015 of the treatment funding agreement with the health care institution providing the service, surgery was performed on a patient with a serious medical condition as a paid service. Guided by the health status of the insured receiving the service and by the principle of equal treatment of insured persons, 12 insured persons who paid themselves for their treatment were reimbursed exceptionally for the cost of the health care service in the amount of 5 thousand euros.

Operating expenses of the Health Insurance Fund

The operating expenses of administration of the health insurance benefits of the Health Insurance Fund, for the year 2015 were planned 9.1 million euros. In fact, 0.2 million euros more than planned, a total of EUR 9.3 million (see Table 50) were spent on the administration activities. Budget overruns are due to higher than planned VAT costs and the claims written off.

The Health Insurance Fund proceeds in the planning of its activities and operating costs from the development plan approved by the Supervisory Board and the scorecard objectives for the current year. The Health Insurance Fund uses activity-based planning, during which the processes/functions necessary for achieving the aims of the organization are reviewed, and the resource required for the performance of these functions is planned.

Table 50. Execution of the operating costs budget of the Health Insurance Fund in thousands of euros

	2014 actual	2015 budget	2015 actual	Budget execution
Labor costs	5,261	5,672	5,554	98%
Management costs	1,450	1,642	1,579	96%
Information technology costs	962	938	932	99%
Development costs	278	225	277	123%
Other operating costs	551	593	942	159%
Total	**8,502**	**9,070**	**9,284**	**102%**

Labor costs

The resource requirements planning of the staff of the Health Insurance Fund is based on activity-based necessity matrix where through measurable activities, based on statistical key figures and estimated activities, which are based on estimates, is determined the number of posts necessary to meet the objectives during the budget period. In 2015, on drafting the budget, 216.8 posts were assessed to be the activity-based budgeting resource requirements. In the third quarter of 2015 was completed a comprehensive structural reform of the Health Insurance Fund, as a result of which was approved on 15 September the resource requirement of the Health Insurance Fund in the capacity of 215.6 posts, of which as of 31 December have filled 205 posts. Under execution of labor costs results from unfilled vacant posts. Under execution of the labor costs is lower than expected in relation to the redundancy payments paid out in September. As a result of the structural reform, nine employees were made redundant, for whom in the new structure, a result of changes in the tasks of a number of positions, no longer positions could be offered. To these were added three staff members who did not agree with the changes in the employment contract.

Management costs

In the management expenses are recorded daily operating expenses, health insurance personnel training costs, consultancy (including auditing) and research costs and internal communication costs.

The total management costs were executed in 2015 at 96%. Under execution of management, costs have affected the under execution of the consultancy and research costs (execution 65%) resulting from the postponing of the audit of IT testing planned for 2015 to the first half of the year 2016.

In the first half of 2015, the Health Insurance Fund in cooperation with PricewaterhouseCoopers Advisor carried out an analysis of the structure of the Estonian Health Insurance Fund. The aim of the analysis was to analyze the existing structure and work organization of the Health Insurance Fund and to provide opportunities for the restructuring and for making the work organization of the Health Insurance Fund more efficient and more flexible. As a result of the analysis was initiated structural reform, as a result of which by 15 September, structure, composition and distribution of tasks of the Health Insurance Fund were changed.

In cooperation with the Ministry of Social Affairs and AS Emor, a study aimed at measuring the assessment of the population of Estonia of their health and of the health care and the health care organization provided in Estonia was carried out. The study revealed that on the estimate of the population, the quality of health care in Estonia remains to be good, and most people are satisfied with Estonia's dental service.

In the fourth quarter of the year 2015, the Health Insurance Fund participated in a study conducted by TNS Emor "Estonian Customer Service Index (ETI) in the public sector in 2015", which was designed to provide an objective intersectoral overview of the level of service among providers of public services in Estonia. The survey assessed the level of service of the agencies in three service channels: direct service, telephone service and email service. As a result of the study, the Estonian Health Insurance Fund is in the comparison of the five mapped public sector bodies the most highly rated in all three channels.

In 2015, in cooperation with Turu-uuringute AS, the conducting of quarterly image research continued, to which starting from the fourth quarter were added questions related to e-services. According to the latest image research, the Health Insurance Fund is in the 6th-7th place among the public sector authorities (73% of the population trusts the Health Insurance Fund), while the research pointed out that a third of the Estonian people are not quite sure what the Estonian Health Insurance Fund deals with.

Since 2012, the Health Insurance Fund holds an ISO 9001: 2008 management system certificate. The management system certificate audit carried out at the beginning of 2016 assessed the effectiveness of the management system of the Health Insurance Fund on performance of the legislative, regulatory and contractual requirements as very high, and confirmed that the management of the Health Insurance Fund is clearly oriented to continuous improvement of the enterprise and the processes.

Information technology costs

IT expenses reflect the costs related to the acquisition of information technology equipment and software and the development and maintenance of information technology systems of the Health Insurance Fund.

IT expenditures have been executed to the total of 99%. Out of the information technology costs of the year 2015 the costs of IT equipment and software acquisition make up the 450 thousand euros (including depreciation of IT fixed assets 169 thousand euros), central systems maintenance costs 352 thousand euros, and the central systems development costs 130 thousand euros.

The most important IT developments in 2015 were the development of unauthorized prescriptions, the transition to x-road version 6, SAP systems upgrades, acquisition of licenses of SAP Lumíra and SAP Portal and preparations for the transition to SAP HANA servers. Continued development work with the pharmaceutical interactions registry, quality indicator registry and digital registry.

Development costs

Under the development costs are recorded the costs of auditing and consultancy of the health insurance benefits and the costs related to informing the public (including the development of the Health Insurance Fund website).

The total development costs were executed in 2015 at 123%. In 2015, the development costs represent health insurance benefits consultancy 103 thousand euros, informing the public 84 thousand euros and the auditing of the health insurance benefits 90 thousand euros.

In 2015, five clinical audits were completed: the quality of treatment of sepsis; treatment of fibrillation patients in Estonian hospitals; cervical and ovarian cancer patients' diagnostics and quality of treatment; treatment of prostatic carcinoma; acute abdominal diagnostics and quality of treatment. In 2015, were also launched five new clinical audits - depression diagnosis and treatment in primary level; quality of independent inpatient nursing care and justification; treatment of low back pain at the primary level; Type 2 diabetes diagnosis and treatment, and the quality of independent antenatal midwifery.

In 2015, the most important health benefits consultations were the health services pricing model analysis commissioned from the AS PricewaterhouseCoopers and the analysis "Areas of responsibility of primary level and specialized medical care in selected countries and referral to a medical specialist" commissioned from the University of Tartu.

For informing the public, articles and special information pages introducing the Health Insurance Fund were published in the most common and medicine related journalistic publications. In collaboration with web agency Web Expert, the Health Insurance Fund website underwent an in-depth development last year, with the aim of enhancing simple, understandable and convenient access to the information to the insured. As a result of the development, the Health Insurance Fund website received a significant upgrade in the form of a card application, which allows people conveniently find Health Insurance Fund contract partners over Estonia and to receive the information related to treatment facilities, such as the contact details, the location, and the services provided.

Other operating costs

Under other operating expenses are recorded VAT costs, targeted financing of operating costs and other operating expenses (foreign exchange losses, claims are written off and other payments).

Other operating expenses in total in 2015 were executed at 159%, all sub-lines of the other operating expenses were over-executed. Out of other operating costs in 2015, the VAT cost accounts for EUR 591 thousand, other operating expenses EUR 258 thousand and targeted financed operating costs 93 thousand euros.

Overexecution of the VAT costs results from increased VAT expenses associated with IT investments.

Overexecution of other operating costs results from higher claims written off more than projected. In 2015, 148 thousand euros of doubtful receivables were written off. Despite book write off of the claims, they will continue to be dealt with. Off-balance sheet accounting is held of the written off claims and in the care of receipt of the claims the received revenue shall be reflected as a reduction of costs for the current calendar year.

Last year there were also more target-financed operating expenses than originally planned. In addition to the Moldovan project funded by the Ministry of Foreign Affairs, the Health Insurance Fund carried out last year a quality indicators project funded by the Estonian Research Council.

Capital reserve

Formation of capital reserve is governed by the Estonian Health Insurance Fund Act § 38 as follows:

- The capital reserve of the Health Insurance Fund means the reserve formed of the budget funds for the health insurance fund for the reduction of the risk which macroeconomic changes may cause to the health insurance system.
- The capital reserve amounts to 6% of the budget.
- The capital reserve may only be used exceptionally on a Government Order on the proposal of the Minister responsible for the field. Before submitting the proposal to the Government, the Minister responsible for the field shall hear the opinion of the Supervisory Board of the Health Insurance Fund.

By the end of the year 2014, the capital reserve of the Health Insurance Fund was EUR 54.4 million. According to the Estonian Health Insurance Act, § 38, the required amount of the capital reserves in 2015 was 57.2 million euros. In order to meet the legally required level, the reserve capital was increased in 2015 by 2.8 million euros.

In 2016, the required amount of the capital reserve was 60.8 million euros. In order to meet the legally required level, in 2016, the reserve capital has to be increased by 3.7 million euros.

Risk reserve

Formation of risk reserve is governed by the Estonian Health Insurance Fund Act § 39[1] as follows:

- The risk reserve of the Health Insurance Fund is the reserve formed of the budget funds of the Health Insurance Fund for the reduction of the risks caused by the taken obligations to the health insurance system.
- The capital reserve amounts to 2% of the volume of the Health Insurance Fund budget.
- The risk reserve can be introduced by the decision of the Supervisory Board of the Health Insurance Board.

By the end of the year 2014, the amount of the risk reserve of the Health Insurance Fund was EUR 18.0 million. According to the Estonian Health Insurance Act, § 39[1], the required amount of the risk reserve in 2015 was 18.9 million euros. In order to meet the legally required level, the risk reserve was increased in 2015 by 0.9 million euros.

In 2016, the required amount of the capital reserve was 20.1 million euros. In order to meet the legally required level, in 2016, the reserve capital has to be increased by 1.2 million euros.

Retained earnings

The introduction of the retained earnings of the Estonian Health Insurance Fund from the previous periods is governed by the Health Insurance Fund Act §36[1] as follows

- The retained earnings of the Estonian Health Insurance Fund from the previous periods has been permitted to be introduced during a financial year to the extent of up to 30%, but not more than 7% of the health care costs provided in the Heath Insurance Fund Budget in the previous calendar year.
- The introduction of the retained earnings of the Estonian Health Insurance Fund from the previous period is decided by the Supervisory Board on the basis of a proposal of the Management Board.

At the beginning of the year 2015, the retained earnings of the Estonian Health Insurance Fund from the previous period was EUR 141.2 million.

In 2015, EUR 2.8 million was transferred from the retained earnings of the previous period to the capital reserve and EUR 0.9 million to the risk reserve, to bring the reserves to the level required by law.

The budget was planned to be balanced by the year 2015. As in the reporting year, funding of health care benefits exceeding the planned amount, the total net gain of the year 2015 was minus 18.5 million euros.

As of 31 December 2015, the total retained earnings were EUR 119.0 million euros.

The Management Board of the Health Insurance Fund will make a proposal to the Supervisory Board to transfer EUR 3.7 million from the retained earnings of the previous period to the capital reserve and EUR 1.2 million to the risk reserve, to bring the reserves to the level required by law.

Annual accounts

Balance sheet

Assets

In thousands of euros	31.12.2015	31.12.2014	Annex
Current assets			
Cash and cash equivalents	152,881	176,346	2
Receivables and prepayments	96,549	90,504	3
Inventories	4	5	4
Total current assets	**249,434**	**266,855**	
Fixed assets			
Long-term receivables	345	348	5
Tangible assets	897	309	6
Intangible assets	39	119	6
Total fixed assets	**1,281**	**776**	
Total assets	**250,715**	**267,631**	

Liabilities

In thousands of euros	31.12.2015	31.12.2014	Annex
Obligations			
Short-term obligations			
Payables and prepayments	55,722	54,098	8
Total short-term obligations	55,722	54,098	
Total obligations	**55,722**	**54,098**	
Net assets			
Reserves	76,032	72,337	9
Earnings from previous periods	137,501	157,702	
Earnings from the accounting period	-18,540	-16,506	
Total net assets	**194,993**	**213,533**	
Total liabilities	**250,715**	**267,631**	

Profit and loss statement

In thousands of euros	2015	2014	Annex
Health insurance part of the social security tax and recoveries from other parties	959,625	894,821	10
Revenues from targeted financing	1,560	1,503	17
Expenses of targeted financing	-1,585	-1,475	17
Health insurance costs	-972,118	-906,767	13
Gross result	**-12,518**	**-11,918**	
General administrative expenses	-8,342	-7,951	14
Other operating revenues	2,906	3,233	11
Other operating costs	-848	-522	15
Operating profit	**-18,802**	**-17,158**	
Financial and interest income	262	652	12
Earnings from the accounting period	**-18,540**	**-16,506**	

Cash flows

In thousands of euros	2015	2014	Annex
Cash flows from the principal activity			
Proceeds from social tax	952,146	887,167	
Invoices paid to suppliers	-975,399	-911,088	
Fees paid to employees	-4,314	-4,234	
Taxes paid on labor costs	-1,448	-1,420	
Other revenues	6,168	6,313	
Total cash flows from the principal activity	**-22,847**	**-23,262**	
Cash flow from investing activities			
Paid for fixed assets	-618	-33	
Total cash flows from investing activities	**-618**	**-33**	
Net change in cash and bank accounts	**-23,465**	**-23,295**	
Bank accounts and cash equivalents at the beginning of the period	176,346	199,641	2
The change in cash	-23,465	-23,295	
Bank accounts and cash equivalents at the end of the period	152,881	176,346	2

Report of changes in net assets

In thousands of euros	2015	2014	Annex
Reserves			
Reserves at the beginning of the year	**72,337**	**67,808**	
Separation of reserves	3,695	4,529	
Reserves at the end of the year	**76,032**	**72,337**	9
Earnings from previous periods			
At the beginning of the year	**141,196**	**162,231**	
Separation of reserves	-3,695	-4,529	
Earnings from the accounting period	-18,540	-16,506	
At the end of the year	**118,961**	**141,196**	
Net assets at the beginning of the year	**213,533**	**230,039**	
Net assets at the end of the year	**194,993**	**213,533**	

Annexes to the annual accounts

Annex 1 The accounting policies used for preparing the annual accounts

The annual accounts of the Estonian Health Insurance Fund (hereinafter the Health Insurance Fund) for the year 2015 has been prepared in accordance with generally accepted accounting policies in Estonia. Generally accepted accounting policies of Estonia is the accounting policies based on internationally accepted accounting and reporting principles, the basic requirements of which have been established by the Estonian Accounting Act and supplemented by the guidelines of the Accounting Standards Board. The annual accounts have been prepared under the general rules of state accounting.

The financial year started on 1 January 2015 and ended on 31 December 2015. The figures of the annual accounts are presented in thousands of euros.

Reporting formats

As a profit report, the statutory income statement format 2 is used, the structure of the records of which are modified on the basis of the specific nature of the activities of the Health Insurance Fund.

Financial assets and liabilities

Financial assets include cash, accounts receivable and other short-term and long-term receivables. Financial liabilities include trade and other payables, accrued expenses and other short and long-term debt obligations.

Financial assets and liabilities are initially recognized at acquisition cost, being the fair value paid or received for the financial asset or liability. Initial acquisition costs include all the related transaction costs directly related to all financial assets and liabilities.

Purchases and sales of financial assets are consistently recognized at the value date, i.e., at the date when the Health Insurance Fund becomes the owner of the purchased financial assets or loses its ownership of the sold financial asset.

Financial liabilities are recognized on the balance sheet at amortized acquisition cost.

Financial assets are removed from the balance sheet when the Heath Insurance Fund loses the right to receive cash flows from the financial asset or transfers the cash flows from the financial assets and the majority of the risks and rewards associated with financial assets to a third party. A financial liability is derecognised in the balance sheet when it is discharged, canceled or expired.

Cash and cash equivalents

Cash and cash equivalents include cash in the bank. The cash flow statement has been prepared using the direct method.

Recognition of foreign currency transactions

Recognition of foreign currency transactions is based on the European Central Bank's currency exchange rates at the transaction date. The monetary assets and liabilities and non-monetary assets and liabilities that are recorded in foreign currency measured at fair value option are translated into euros at the balance sheet date at the exchange rates of the European Central Bank at the balance sheet date. Gains and losses from foreign exchange transactions are recognized in the income statement as income or expense in the period.

Accounting for receivables

Trade receivables include claims for goods sold and services rendered, and the requirements in respect of health insurance benefits, which are due within the next financial year. Receivables, whose due date is longer than one year, including the rescheduled tax claims of the Tax and Customs Board and, are recorded as long-term receivables.

Requirements for sales of goods and services include requirements for prescription forms sold to medical care institutions and family physicians, the requirements to the Ministry of Social Affairs for the services of processing medical invoices and the requirements to the competent authority of the insuring Member State for health care services of the patients from the other EU Member States treated in Estonia.

The probability of collecting receivables is assessed at least once a year at the balance sheet date. Receivables are individually assessed and recognized in the balance sheet on the basis of conservative principle in view of the amounts collectible. Receivables whose collection is improbable are expensed for the accounting period. Previously expensed receivables that have been received during the accounting period are reflected as a reduction of the cost of improbable claims.

Receivables whose collection is not possible or economically justified, are considered uncollectible and written off.

Inventory accounting

Inventories are recorded at acquisition cost and expensed using the FIFO method. Inventories are measured on the balance sheet, based on whichever is lower - the acquisition cost or net realizable value.

Tangible assets

Tangible fixed assets are the assets of a more than a one-year useful life whose acquisition cost exceeds EUR 2,000. The assets with a shorter useful life and lower acquisition cost are expensed on the acquisition of assets.

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

The used depreciation periods (in years) are as follows:

- Buildings 10-20
- Inventory 2-4
- Machinery and equipment 3-5

The expenses made on the tangible assets after the acquisition are generally expensed as incurred. Additional expenses are added to the cost of tangible fixed assets when it is probable that this expenditure allows the asset to generate more economic benefits than the initial estimate, and these costs can be reliably estimated and attributed to the asset.

Intangible assets

Intangible assets are identifiable assets with no physical substance, that have more than one year of useful life and that are used in the operations and whose acquisition cost exceeds EUR 2,000.

Intangible fixed assets are recorded at acquisition cost and depreciated on a straight-line basis within 2 to 5 years.

The expenses made on the intangible assets after the acquisition are generally expensed in the period. Additional expenses are added to the cost of intangible fixed assets when it is probable that this expenditure allows the asset to generate more economic benefits than the initial estimate, and these costs can be reliably estimated and attributed to the asset.

Targeted financing

The targeted financing is the grants provided and received for an intended purposes, subject to certain conditions in which case the grantor supervises the targeted use of the grant. Targeted financing is not recognized as revenue or expenses until the conditions related to targeted financing are met.

Accounting of revenues and expenditures

Revenues and expenses are recognized on an accrual basis. Interest income is recognized on an accrual basis.

The most important types of revenue of the Health Insurance Fund are the health insurance part of the social tax and recoveries from other parties. The health insurance part of the social tax is received by the Tax and Customs Board in the form of weekly transfers. On a monthly basis, the Tax and Customs Board forwards to the Health Insurance Fund the notification of forwarding of tax balances under which revenue is recognized in the accounts. Amounts due from other parties are recognized on submitting a claim to legal persons for compensation for financial damages caused to the Health Insurance Fund under the law or the contract. The claims submitted to natural persons are taken up at the receipt of the claim.

Accounting for operating and finance lease

A financial lease is a lease, in the case of which all substantially risks and rewards related to ownership are transferred to the lessee. The remaining lease contracts are treated as operating leases. On the classification of leases into financial and operating leases, the public sector entities consider a criterion is referring to the financial lease also the situations provided in IPSAS 13 (Leases) section 15, where leased assets cannot easily be replaced by another asset.

The assets leased under the financial lease are recognized on the balance sheet as assets and liabilities at fair value of the leased property. The lease payments to be paid are divided into financial costs and reduction of liabilities. Financial costs are recognized during the lease period.

Operating lease payments are recognized during the lease period as linear expenses.

Provisions and contingent liabilities

The Health Insurance Fund establishes provisions for liabilities with uncertain due dates or amounts. Determining the amount and the due date of the provisions takes place on the basis of the assessment of the management or the experts of the relevant field.

A provision is recognized when a legal or constructive obligation has emerged for the Health Insurance Fund before the balance sheet date, the likelihood of realization of the provision in the form of expenses of the resources is more than 50%, and the amount of the provision can be reliably determined.

Risk reserve

Formation of risk reserve of the Health Insurance Fund is governed by the Estonian Health Insurance Fund Act § 39[1] as follows:

- The risk reserve of the Health Insurance Fund is the reserve formed of the budget funds of the Health Insurance Fund for the reduction of the risks caused by the taken obligations to the health insurance system.
- The capital reserve amounts to 2% of the volume of the Health Insurance Fund budget.
- The risk reserve can be introduced by the decision of the Supervisory Board of the Health Insurance Board.

The Health Insurance Fund has an obligation to establish a risk reserve as of 1 October 2002, relating to the entering into force of the Health Insurance Act. With the said Act, the Estonian Health Insurance Act was amended by supplementing of that Act by section 39[1].

A provision to the risk reserve is formed by a decision of the Supervisory Board after the approval of the audited annual report.

Capital reserve

Formation of the capital reserves of the Health Insurance Fund is governed by the Estonian Health Insurance Fund Act § 38 as follows:

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

A provision to the capital reserve is formed by a decision of the Supervisory Board after the approval of the audited annual report.

Post-balance-sheet date events

The annual accounts reflect the significant facts affecting the assessment of assets and liabilities which occurred between the balance sheet date, December 31, 2015, and the date of preparing the annual accounts, but is related to the transactions taking place in the accounting period or prior periods.

The post-balance sheet events that have not been taken into account in the assessment of the assets and liabilities, but which significantly affect the outcome of the next financial year, are disclosed in the annexes of the annual accounts.

Annex 2 Cash and cash equivalents

In thousands of euros	31.12.2015	31.12.2014
Cash in the bank	152,881	176,346

The means of the Health Insurance Fund are held on the current account belonging to the composition of the group account of the Treasury of the Ministry of Finance. According to the deposit agreement concluded between the Estonian Health Insurance Fund and the Republic of Estonia, the Health Insurance Fund has unrestricted access to the money on the group account with a weeks' notice. The Republic of Estonia has the right to determine the usage limit to the deposited amount, but as of 31.12.2015, this has not been done.

Annex 3 Receivables and prepayments

In thousands of euros	31.12.2015	31.12.2014
Trade receivables	2,665	3,159
Uncollectible receivables	-144	-91
Targeted financing requirements*	22	57
Operating expenses reimbursement receivables**	26	1
The requirements to the policyholders under the contract	24	28
Interest receivables	5	17
The social tax requirement ***	93,539	87,086
Prepaid future expenses	412	247
Total	**96,549**	**90,504**

* Targeted financing requirement is to the Ministry of Social Affairs for funding of artificial insemination treatments.

** Operating expenses repayment requirement includes the quality indicators project right of recourse in the amount of 25 thousand euros.

*** The social tax requirement in the amount of 93,539 thousand euros consists of short-term requirement against the Tax and Customs Board for the calculated health care insurance part o the social tax.

Annex 4 Inventories

The Health Insurance Fund as at 31.12.2015 in its inventory unused prescription forms for an amount of EUR 4 thousand (as at 31.12.2014 5 thousand euros).

Annex 5 Long-term receivables

Various long-term receivables

Under long-term receivables is recorded the long-term part of the amount paid to the Estonian National Social Insurance Board for the renovation of Pärnu Department and the former Rapla office. As at 31.12.2015, it is 345 thousand euros (as at 31.12.2014, 348 thousand euros).

Annex 6 Fixed assets

6.1. Tangible assets

In thousands of euros				
Acquisition cost	**Land**	**Buildings**	**Other inventory**	**Total tangible fixed assets**
31.12.2014	**1**	**411**	**1,465**	**1,877**
Acquired fixed assets	0	0	750	750
Written-off	0	0	-318	-318
31.12.2015	**1**	**411**	**1,897**	**2,309**
Accumulated depreciation				
31.12.2014	**0**	**297**	**1,271**	**1,568**
Calculated depreciation	0	22	139	161
Written-off	0	0	-317	-317
31.12.2015	**0**	**319**	**1,093**	**1,412**
Residual value				
31.12.2014	**1**	**114**	**194**	**309**
31.12.2015	**1**	**92**	**804**	**897**

6.2. Intangible assets

In thousands of euros	
Acquisition cost	**Purchased licenses**
31.12.2014	**616**
Acquired fixed assets	0
Written-off	0
31.12.2015	**616**
Accumulated depreciation	
31.12.2014	**497**
Calculated depreciation	80
Written-off	0
31.12.2015	**577**
Residual value	
31.12.2014	**119**
31.12.2015	**39**

Annex 7 Rental charge

Operating lease

The accounting entity as the lessee

The year 2015 income statement reflects the operating lease payments in a total amount of 365 thousand euros. Of this amount, 29 thousand euros were recognized for the lease of vehicles and under the rental contracts premises are recognized 336 thousand euros.

The operating lease payments were recognized in 2014 in a total amount of 329 thousand euros. Of this amount, 26 thousand euros were for the lease of vehicles and under the rental contracts premises were 303 thousand euros.

There are no contingent liabilities related to lease payments. The lease contracts of premises can be terminated with the prior notification term of two months to one year, depending on the contract.

Operating lease expenses are recognized in Annex 14.

Annex 8 Payables and prepayments

8.1. Payables to suppliers

In thousands of euros	31.12.2015	31.12.2014
Unpaid invoices for services to medical institutions	40,437	41,314
Unpaid invoices for the medicinal products issued to pharmacies on preferential terms	6,648	6,229
Unpaid invoices for the health insurance benefits to other suppliers	5,535	3,724
Other payables to suppliers	316	206
Total	**52,936**	**51,473**

Payables to suppliers include transactions with related parties in the amount of 2,882 thousand euros (as at 31.12.2014, 2,899 thousand euros), see Annex 16

8.2. Tax arrears

In thousands of euros	31.12.2015	31.12.2014
Personal income tax	2,030	1,903
Social tax	235	216
Fringe benefit tax	5	5
Unemployment insurance tax	11	11
Compulsory pension payments	7	5
Value added tax	1	1
Total	**2,289**	**2,141**

Personal income tax arrears include the personal income tax withheld from the benefit for incapacity to work calculated for the insured by the Health Insurance Fund in the amount of 1,952 thousand euros (as at 31.12.2014, 1,840 thousand EUR).

The social tax arrears include the social tax calculated from the holiday pay not paid to the employees in the amount of 57 thousand euros (55 thousand euros as at 31.12.2014).

8.3. Other debts

In thousands of euros	31.12.2015	31.12.2014
Payables to employees	315	290
Other debts	182	150
Advance payments received	0	44
Total	**497**	**484**

Total payables and prepayments in 2015 are 55,722 thousand euros and in 2014 54,098 thousand euros.

Annex 9 Reserves

In thousands of euros	31.12.2015	31.12.2014
Capital reserve	57,160	54,386
Risk reserve	18,872	17,951
Total reserves	**76,032**	**72,337**

At of the end of 2014, the capital reserve of the Health Insurance Fund amounted to 54,386 thousand euros. According to the Estonian Health Insurance Act, § 38, the required amount of the capital reserves in 2015 was 59,160 thousand euros. In order to meet the statutory level, the reserve capital was increased in 2015 to 2,774 thousand euros.

By the end of the year 2014, the amount of the risk reserve of the Health Insurance Fund was EUR 17,951 thousand. According to the Estonian Health Insurance Act, § 39[1], the required amount of the risk reserve in 2015 was 18,872 thousand euros. In order to meet the statutory level, the risk reserve was increased in 2015 to 921 thousand euros.

Annex 10 Revenue from principal activities

In thousands of euros	2015	2014
Health insurance part of the social security tax	958,599	893,759
Amounts due from other parties	1,026	1,062
Total	**959,625**	**894,821**

Amounts due from other parties includes requirements to related parties in the amount of eight thousand euros (12 thousand euros in 2014), see Annex 16.

Annex 11 Other operating revenues

In thousands of euros	2015	2014
Voluntary insurance contracts	787	628
Transnational insurance contracts	530	568
Services rendered to the European Union citizens	1,519	1,974
Medical invoices processing fees	45	55
Foreign exchange gains	25	8
Total other operating revenues	**2,906**	**3,233**

Annex 12 Financial and interest income

The Ministry of Finance calculates for the Health Insurance Fund interest from the cash deposited in the current accounts belonging to the group account of the state, the amount of which is equal to the return of national cash reserve.

Interest on cash balance in 2015 is 262 thousand euros (in 2014, 652 thousand euros).

Annex 13 Health insurance costs

In thousands of euros	2015	2014
Health care services benefits	712,692	664,070
including disease prevention	7,650	7,591
Primary medical care	92,460	82,248
Specialized medical care	561,533	529,044
Nursing care	28,450	24,537
Dental care	22,599	20,650
Health promotion costs	1,088	857
Expenses for pharmaceutical benefits	112,801	109,753
Costs of the benefits for temporary incapacity for work	116,977	103,902
Other cash benefits	9,711	9,358
Other health insurance benefits costs *	18,849	18,827
including health care benefits arising from international agreements	9,768	10,022
Medical device benefits	9,076	8,805
Various health insurance costs	5	0
Total health insurance costs	**972,118**	**906,767**

*The cost of the year 2015 differs from the expenditure shown in the corresponding line of the budget execution report, as the budget reflects, among the expenses, the targeted financing from the state budget in the amount of 1,491 thousand euros (the difference of the year 2014 1,446 thousand euros).

Within the health insurance costs are recognized transactions with related parties in the amount of 43,827 thousand euros (39,000 thousand euros in 2014), see Annex 16.

Annex 14 General administrative expenses

In thousands of euros	2015	2014
Personnel and administrative expenses	5,554	5,261
Wages	4,154	3,929
including the remuneration of the members of the Management Board	147	162
Unemployment insurance	31	37
Social tax	1,369	1,295
Management costs	1,579	1,450
including operating lease payments*	365	329
Information technology costs	932	962
Development costs	277	278
Total general administrative expenses	**8,342**	**7,951**

*See annex 7

Within the economic expenses are recognized transactions with related parties in the amount of 4 thousand euros (one thousand euros in 2014), see Annex 16.

Among the remuneration of the Management Board members of the year 2015 have been recognized EUR 11 thousand of performance pay, the payment of which shall be decided by the Supervisory Board after the approval of the annual report.

Annex 15 Other operating costs

In thousands of euros	2015	2014
Foreign exchange losses	44	18
Requirements are written off	148	95
VAT cost from the operating expenses	591	352
Health insurance forms	52	46
State fees	1	1
Notary fees, bailiff fees and court fees	11	0
Compensation of health services by way of exception	1	10
Total other operating expenses	**848**	**522**

Annex 16 Transactions with related parties

Related parties are the members of the Management Board and the Supervisory Board of the Health Insurance Fund and companies, and health care providers with whom the Health Insurance Fund is linked to a Management Board or Supervisory Board member.

Transactions with related parties in the year 2015

In thousands of euros	The amount	Annex
Purchase of services	43,831	13, 14
Sale of services	8	10
Obligation 31.12.2015	2,882	8
Claim 31.12.2015	0	

In 2015, discounts of claims were not made with related parties.

As purchases of services are mainly reflected the treatment services purchased from health care providers, where the related person of the institution is a member of the Supervisory Board.

Transactions with related parties in the year 2014

In thousands of euros	The amount	Annex
Purchase of services	39,001	13, 14
Sale of services	12	10
Obligation 31.12.2014	2,899	8
Claim 31.12.2014	0	

On the expiration of the contract of service of the Management Board members, compensation paid to them to the extent of three months' remuneration.

The remuneration calculated for the members of the Management Board are shown in Annex 14.

Annex 17 Targeted financing

Under the Artificial Insemination and Embryo Protection Act, § 35[1] paragraph 5, compensation for medicinal product expenses related to the IVF procedure and payment for the infertility treatment to the health care providers for the insured persons takes place on the basis of a contract subject to targeted financing by the Ministry of Social Affairs.

Ministry of Foreign Affairs has on the basis of the Government Regulation No. 21 of January 8, 2010 “Conditions and procedures for the provision of development and humanitarian aid " § 25. paragraph 8 entered into a contract with the Health Insurance Board to support the health insurance system of Moldova.

On the basis of the partnership agreement of sub-activity of the activity 3 of the health promotion research program TerVE, a project “Mapping of the data for measuring the values of the quality indicators of four specialties and assessment of the development needs for supplementing thereof (KVAL_INDIK)” was carried out.

On 24.11.2015 was signed a one-year cooperation agreement with the Health Insurance Fund and the Software Technology and Applications Development Center. This cooperation agreement has been concluded for the conducting of the project EU48684 subprojects 4.1 „Technologies for Information Extraction, data integration and management (Health-IE)“ and 4.2 „Health Data Analysis“ funded by EAS. With this target-financed project (STACC project) it is possible through the Software Technology and Applications Development Center to use the means of the Enterprise Estonia for solving analytical challenges significant for the Health Insurance Fund.

Expenses of targeted financing:

In thousands of euros	2015	2014
Artificial insemination pharmaceutical benefits to insured persons	596	621
Infertility treatment in accordance with the health care services	895	825
The Moldova project	47	23
Student loan reimbursement	4	6
Quality Indicators Project	36	0
STACC project	7	0
Total	**1,585**	**1,475**

Targeted financing expenses of national cancer prevention means are recognized within the prevention of diseases. The expenses of the Moldova project, the quality indicators and STACC project and reimbursement of student loans are recognized in the operating expenses of the Health Insurance Fund.

Revenues from targeted financing:

In thousands of euros	2015	2014
Artificial insemination pharmaceutical benefits to insured persons	596	621
Infertility treatment in accordance with the health care services	895	825
Means for national strategy for cancer prevention	12	28
The Moldova project	19	23
Student loan reimbursement	4	6
Quality Indicators Project	34	0
Total	**1,560**	**1,503**

Signatures of the annual report

The Management Board of the Estonian Health Insurance Fund has prepared the annual report of the year 2015.

The annual report consists of the management report and the annual accounts, accompanied by the independent sworn auditor's report.

Management Board
30. March 2016

Tanel Ross
Chairman of the
Management Board

Mari Mathiesen
Member of the
Management Board

Kuldar Kuremaa
Member of the
Management Board

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, which comprise the balance sheet as at 31 December 2015, the statements of financial performance, changes in net assets 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 106 to 119.

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 2015, and its financial performance and its cash flows for the year then ended in accordance with the accounting principles generally accepted in Estonia.

Tallinn, 01.04.2016

/signed/

Andris Jegers
Authorized Public Accountant No 171

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

KPMG Baltics OÜ, an Estonian limited liability company and a member firm of the KPMG network of independent member firms affiliated with KPMG International Cooperative ("KPMG International"), a Swiss entity. Reg no 10096082.

Estonian Health Insurance Fund Yearbook 2015