Estonian Health Insurance Fund Annual Report 2002

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Beginning of the financial year	1 January 2002
End of the financial year	31 December 2002
Main activity	National health insurance
Management Board	Hannes Danilov (Chairman of the Board) Arvi Vask Andres Rannamäe Rein Parelo
Auditor	KPMG Estonia

The annual report comprises the management report, notes to the implementation of the budget, the annual accounts, the auditor's report and the net surplus distribution proposal.

Annual report 2002

This report is composed of three subdivisions:

I. Management report of the Estonian Health Insurance Fund the Development Plan of the Estonian Health Insurance Fund for 2002 to 2004 and the implementation of the activity plan for 2002 according to the main activities.
II. Analysis of the use of health insurance benefits and notes to the implementation of the budget.
III. Annual accounts as of 31 December 2002.

Summary

In 2002, the Management Board of the Estonian Health Insurance Fund proceeded in the management of the organisation and implementation of the strategy from three documents approved by the Supervisory Board of the Estonian Health Insurance Fund: the Development Plan of the Estonian Health Insurance Fund for 2002 to 2004, Estonian Health Insurance Fund balanced scorecard for 2002 and activity plan for 2002. The scorecard was employed for the first time in the management of the organisation as a whole and the structural units thereof. Therefore, some learning-related difficulties arose during the introduction process, but the adoption of the balanced scorecard has justified itself and has made setting objectives for the organisation and measurement of the performance more effective and objective.
A summary assessment of the Management Board to the implementation of the activity plan and the balanced scorecard in 2002 is given below.

The structure of the Estonian Health Insurance Fund activity plan covered all the strategic development trends specified in the development plan and focused on the attainment of the objectives set on the balanced scorecard. The main outputs of the activity plan for the year 2002 were as follows:

1. Development and introduction of the solutions related to the implementation of the new Health Insurance Act and informing all target groups of the amendments.
2. Systematisation of the analysis, planning, processing and supervision of health insurance benefits and assurance of transparency.
3. Introduction of the selection and holding of competition for the health service providers acting under a contract for health service provision.
4. Development and enhancement of the quality of the Estonian Health Insurance Fund customer service and development of the electronic services and administration environment and improvement of work processes.
5. Introduction of activity-based cost accounting in the management of the Health Insurance Fund and introduction of balanced scorecard throughout the organisation, introduction of new SAP business solutions.
6. Methodical development of the resources of the Estonian Health Insurance Fund – human resources and information technology - for improving work and enhancing performance.

The activity plan goal of introducing of DRG prices and tasks related to the development and recognition of treatment instructions were not completed or completed partially. The main hindrances were the differing perspectives of the Estonian Health Insurance Fund partner organisations and lack of willingness to pursue the topics. The Estonian Health Insurance Fund lacked competent resources and a system in pursuing the goals.

In conclusion, the rating to the implementation of the Estonian Health Insurance Fund activity plan was "good" or "very good" in the extent of 72 %.

The Estonian Health Insurance Fund balanced scorecard was compiled according to the five strategic fields specified in the development plan. For the strategic fields, measurable objectives and success criteria were set up and assigned importance. The results were as follows:

1. Awareness of the insured persons of their rights and obligations.

The results in this field were related to two assessments performed by an independent party: satisfaction of the insured persons with the different aspects of the usage of health insurance benefits and awareness of the insured persons of their rights and obligations. As the implementation of the Act accompanied by informing process took place in the fourth quarter, there was no time for assessing the awareness of the insured persons and this diminishes the attainment of the result by a half.

2. **Availability and quality of health services.** The most important objectives related to the availability of family medical care and specialist medical care were attained. The tasks of developing treatment instructions and performance of medical audits were completed in part or not at all.

3. **Balance between the health insurance benefit (hereinafter HIB) resources and benefits and purposeful use**

All the objectives were attained but for the inclusion of DRG prices in the list of health services. The said prices are applied in the Estonian Health Insurance Fund but not yet introduced under implementation acts. The success criterion "health insurance benefits purchased by way of a competition" could not have been completed, as the new Health Insurance Act does not provide for public competitions for purchasing health services.

4. **Customer service quality of the Estonian Health Insurance Fund (hereinafter EHIF or Health Insurance Fund)**
The customer service objectives were fully attained.

5. **EHIF management and operating effectiveness.** The planned objectives were attained. The activity plan was completed to the extent of 72 % because of the aforesaid reasons.

The Management Board rates the implementation of the activity plan for 2002 and the scorecard as "good"

We completed all the major tasks planned with regard to the health insurance scheme and the organisational development of the Health Insurance Fund. The use of benefit funds was kept in the framework of the budget and the health insurance administration costs were 8.4 % lower than planned. As to the deadlines of the activity plan, some delays occurred in performing tasks arising from both internal reasons (complexity of the tasks and a large concentration of development projects with a limited number of specialists and over-optimistic planning) and external reasons (delay in the implementation of the Health Insurance Act, differing perspectives of parties outside the Health Insurance Fund).

Management report
2002

Goal 1.
Satisfaction of the insured persons and awareness of their rights and obligations

Activity

1.1. **Campaign for the introduction of the new Health Insurance Act has been completed, deadline a month before the entry into force of the act**

Introduction of the new Health Insurance Act was rather intensive – use of public channels (media), holding of briefing days for the representatives of the employers and in health care institutions, public presentations and distribution of special publications. National newspapers dedicated special report pages for the introduction of the new act during the first half of October. Leaflet Health Insurance in Estonia was published in 100, 000 copies in the Estonian language, the circulation number of leaflets in the Russian and English languages was smaller. The leaflet was distributed through the regional departments to all the contractual partners of the Health Insurance Fund - medical institutions, health centres, and via Estonian embassies and consulates also in foreign states.

The same distribution methods were used for another booklet describing in more detail voluntary health insurance. The Health Insurance Act was also introduced in the format of a supplement to the national newspapers Eesti Päevaleht, SL Õhtuleht and Molodjoz Estonii (Russian-speaking target audience). The circulation rates amounted to tens of thousands. Numerous relevant articles were published in county newspapers and the local radio stations covered the topic rather extensively. All the materials introducing the new act were constantly updated on the Health Insurance Fund web page.

1.2. **Individual health insurance reminder for the insured has been developed, deadline 1 June 2002**

The individual health insurance reminder for the insured was developed by October.

1.3. **Health insurance information campaign for employers has been carried out, deadline 1 August 2002**

The information campaign for the employers was completed later than scheduled – by 11 October 2003. Altogether 68 briefing seminars were held nation-wide with 5,661 representatives of employers present (15 % of the employers registered with the Health Insurance Fund). During the briefing days 10,000 booklets in Estonian and 4,000 booklets in Russian on health insurance for the employers were distributed.

The Health Insurance Fund organised briefing seminars to such an extent for the first time.

A telephone poll conducted on the order of the Health Insurance Fund among 500 employers revealed that 75 % of the respondents were satisfied with the information provided by the Health Insurance Fund.

1.4. **Materials for health care institutions for informing the insured of their rights, obligations and opportunities in health care have been developed and the informing campaign held, deadline 1 September 2002**

Press releases, shorter and longer articles in specialised medical publications – Meditsiiniuudised, Lege Artis, Hippokrates and Eesti Arst. Amendments to the Health Insurance Act were communicated to physicians also by direct mail. In addition, lawyers and health services department and medicinal products department shared information with physicians in professional societies and health care institutions.

The informing objectives in clauses 1.1-1.4 were attained according to the nature of the task but completed after the deadline as for the delayed adoption and entry into force of the Health Insurance Act.

1.5. Survey of the satisfaction of the insured, deadline 13 December 2002

The objective was attained by deadline.

Marketing research and consulting company EMOR polled in the framework of Omnibus survey from 13 to 20 November 2002 and 27 November to 4 December 2002 a total of 999 Estonian residents aged between 15-74.

The aim of the survey was to provide information about the satisfaction of the residents with the Health Insurance Fund, availability and quality of health services in the field of general medical care, outpatient specialised medical care and inpatient specialised medical care. Another aim was to find out the attitudes of the population regarding the ongoing health care reforms.

2/3 of the respondents rated the quality of medical care in Estonia as "good" or "rather good". 50 % of the respondents found the availability of medical care as "good" or "rather good". The survey revealed that the satisfaction of people with different institutions has risen substantially. People are more or less equally satisfied with family physicians (87 %), specialist doctors (86 %) and dentists (92 %). The frequency of family physician visits has gone up. 60 % of the patients were received upon the day of contacting the physician. Family medicine poses yet problems in Tallinn where the waiting lists for family physician consultation are too long. Ever more health problems are solved with the aid of family physicians.

Satisfaction with inpatient care and Health Insurance Fund customer service has also increased.

Goal 2
Availability and quality of health services

Activity

2.1. **Monitoring of the availability criteria set in the contract has been established and, upon necessity, the contracts will be amended, deadline 1 May 2002**
Objective attained by deadline.

The criteria for availability of medical care for the year 2002 were approved by the Supervisory Board of the Health Insurance Fund on 30 November 2001 and entered into a contract concluded between the Health Insurance Fund and the health care institutions. The availability is monitored quarterly in three ways – family physician availability will be monitored by the Health Insurance Fund by way of questionnaires ensuring sufficient reliability, the specialist medical care by way of regular reports from health care institutions and the problem waiting lists (cataract surgery, endoprosthesis) via central monitoring software. Monitoring of the family medical care and specialist medical care availability has been introduced. As of the end of the second quarter, the problem waiting lists were included into the central monitoring system.

2.2. **Reporting on the accessibility of family health services has been introduced, deadline 1 May 2002**
The objective has been attained by deadline.

According to the contract concluded between a family physician and the Health Insurance Fund, a family physician shall be available in one working day for patients with acute diseases and in three working days for patients with chronic diseases.

Table 1. Availability of family physician in 2002 (percentage of the insured who received medical care in due time)

	Acute disease				Chronic disease			
Department	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Harju	100 %	100 %	100 %	100 %	84 %	100 %	100 %	100 %
Ida-Viru	100 %	100 %	100 %	100 %	92 %	100 %	97 %	100 %
Kagu	100 %	100 %	100 %	100 %	100 %	100 %	95 %	100 %
Lääne	100 %	100 %	100 %	100 %	100 %	100 %	100 %	100 %
Pärnu	100 %	100 %	100 %	100 %	91 %	100 %	100 %	100 %
Rakvere	100 %	100 %	100 %	100 %	100 %	100 %	100 %	100 %
Tartu	100 %	100 %	100 %	100 %	83 %	100 %	98 %	100 %
TOTAL	100 %	100 %	100 %	100 %	89 %	100 %	99 %	100 %

In the year 2002, family physician was available for 100 % of patients with acute diseases and 97 % of patients with chronic diseases. The average annual availability of family physician was 99 %.

2.3. **Reporting on the availability of health services with specialist doctors has been introduced, deadline 1 May 2002**
The objective has been attained by deadline.

Pursuant to the reporting procedure for monitoring the waiting lists and waiting periods approved by the Estonian Hospitals Association in the first quarter of 2002 and the contract for financing medical treatment concluded with health care providers, the health care providers have submitted an electronic report on the availability of specialist medical care to the Health Insurance Fund as of the end of each quarter. A specialist doctor shall be available immediately in the case of emergency care, in four weeks in the case of regular outpatient medical care and in six month in the case of regular inpatient care. The endoprosthesis and cataract surgery waiting periods have been agreed upon separately in the contract.

The table below describes the availability of specialised medical care in the quarters 1-4 of the year 2002. The make the data comparable, it has been standardised per 100,000 insured persons.

Table 2. Availability of specialised medical care (patients who wait longer than the maximum length of waiting period per 100,000 insured persons*)

	Outpatient				Inpatient			
Department	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Harju	226	56	892	361	146	303	129	140
Ida-Viru	95	125	337	148	70	60	60	40
Kagu	182	366	342	281	3	140	158	150
Lääne	156	37	62	44	27	20	0	9
Pärnu	8	8	81	17	0	2	7	11
Rakvere	38	82	243	0	4	78	34	8
Tartu	1,611	772	1,542	1,165	760	697	745	760
Estonian average	416	214	500	395	204	269	161	210

* According to the new Health Insurance Act, the maximum length of a waiting list shall be approved by the Supervisory Board of the Health Insurance Fund and, in the case of patients waiting longer than the maximum length of the waiting list, the Health Insurance Fund shall submit the Supervisory Board a grounded application for amending the maximum length of the waiting list.

2.4. Waiting list monitoring software has been introduced, deadline 1 June 2002.
The objective was attained after the deadline

For monitoring the central waiting list operatively and ensuring equal availability, an Internet-based IT solution was applied as of 1 July 2002.

2.5 **Contracts for performing medical audits have been concluded, deadline 1 May 2002**
The objective was attained after the deadline

The topics for medical audits for the year 2002 was the treatment of myocardial infarction in different Estonian hospitals, comparison of cancer patient chemotherapy in oncology centres and analysis of cases exceeding the maximum number of profile-specific bed days in internal medicine department. The Health Insurance Fund was unable to conclude the contracts for performing medical audits by deadline. The reasons behind this were the complexity of preparatory work (definition of the task and negotiations with area specialists) in a situation where there is no previous practice in Estonia and the health service bureau vacant positions could not be fulfilled despite repeated competitions.

For the purposes of the medical audit, contracts were concluded with the Estonian Cardiac Society for the audit of myocardial infarction treatment and with professor emeritus Vello Salupere for the justification of the length of treatment in internal medicine departments in October 2002. The terms and conditions for audit contract were sent to the Estonian Cancer Society but the negotiations on the performance of an audit were not concluded successfully by the end of the year 2002.

2.6. **Three medical audits have been performed, deadline 31 December 2002**
The objective has been attained in part; two audits have been performed.

The performers of myocardial infarction treatment audit submitted in December 2002 a summary which indicates that the auditing process is conducted in line with the designated purpose and stage I of the audit has been duly completed and the final results will be delivered by May 2003. The contract for medical audit of the internal medicine departments of 22 hospitals was concluded with professor emeritus Vello Salupere who submitted on 23 December audit results which reveal on the basis of 459 disease files substantial deficiencies in the performance of internal medicine departments of hospitals. Proceeding from the audit results, negotiations are due with the Ministry of Social Affairs and the management boards of hospitals to seek opportunities for improving the work arrangements and treatment quality.

2.7. **Contracts have been concluded for compiling 10 treatment instructions, deadline 30 June 2002.** The objective was attained in part

Preliminary negotiations for compiling the treatment instructions selected by the Health Insurance Fund and based on the processing conditions for treatment instructions were held with 12 professional medical societies.

Contracts for developing treatment instructions were concluded for 6 treatment instructions (cholelithasis, peptic ulcer and reflux oesophagitis, uroinfections, chronic obstructive pulmonary disease and rheumatology). Negotiations were held also for the development of treatment instructions for paedodontics, sexually transmitted diseases and oncology.

As a result for negotiations for the development of treatment instructions for sexually transmitted infections, the Health Insurance Fund received a joint letter from the Estonian Union against Sexually Transmitted Infections, Society for Estonian Dermatovenerologists, Estonian Society for Infectious Diseases, Estonian Gynaecologists' Society, Estonian Society for Urologists and the Estonian Society for Rheumatology which declines from compiling the treatment instructions upon the conditions proposed by the Health Insurance Fund.

The negotiations indicate that the co-operation of the professional medical societies in preparing the treatment instructions is insufficient, there is a lack of shared vision on the structure of the instructions and preparation process. The Health Insurance Fund has to change its perspectives on the preparation of treatment instructions in the year 2003. The professional societies play a crucial role in this. The Health Insurance Fund will be a facilitator of collaboration.

2.8. **EHIF has approved 8 treatment instructions, deadline 31 December 2002.** The objective has not been attained.

Irrespective of the term for completing the treatment instructions fixed in the contracts and the reminders sent by the Health Insurance Fund to the professional societies, none of the six treatment instructions planned were completed by the end of 2002 and the Health Insurance Fund could not proceed with the approval of the instructions.

2.9. **Activity report and treatment quality and effectiveness reporting have been introduced in health care institutions and family practices, deadline 30 June 2002**

The objective has been attained in part during the second half of 2002.

Hospital activity report: by the beginning of November 2002, six hospitals submitted an activity report that is sufficient for evaluating the pilot project results. The data submitted was analysed and the Health Insurance Fund decided to review the existing report format. Negotiations will be opened with the representatives approved by the Estonian Hospitals' Association on the final format of the activity report in the first quarter of 2003.

Preparation of the **family practice activity report** format in co-operation with the representatives of the Management Board of the Estonian Society of Family Physicians has been postponed until the year 2003.

2.10. **Basis for conclusion of contracts, principles for contracting partner selection and conditions for the availability of health services have been approved, deadline 1 December 2002**

The objective has been attained by deadline.

Pursuant to the Health Insurance Act entered into force on 1 October 2002, the Supervisory Board of the Health Insurance Fund shall approve the conditions for the conclusion of contract for financing medical treatment and assessment of the term of the contract. The Supervisory Board of the Health Insurance Fund approved the conditions for concluding the contract for financing medical treatment and the term of the contract on 22 November 2002.

2.11. **Inspection of the completion of health records and treatment instructions based on random selection**

The objective has been attained.

In 2002, the Health Insurance Fund introduced the inspection of medical documentation based on random selection; the purpose of the inspection is not to file a great number of claims but to improve the accuracy of the "average" Estonian medical case. The Health Insurance Fund performs random inspections retroactively.

In the year 2002, altogether 5,966 documents certifying the provision of health services (medical records/disease files) were inspected. The general inspection of medical documentation involved the inspection of the accuracy of the issuance of prescriptions and certificates of incapacity for work. At the same time also the use of treatment instructions for the treatment of glaucoma and *helicobacter pylori* were inspected based on the medical documentation. Among the treatment cases inspected, 74 % had consulted treatment instructions.

Goal 3

Balance between HIB resources and benefits and purposefulness

3.1. **Contracts concluded for outpatient specialised medical care on the basis of a competition in Harju, Tartu and Ida-Viru regions in the specialities and to the extent specified, deadline 31 March 2002**

The objective has been attained by deadline

For providing outpatient specialised medical care, a selection was made in Ida-Viru department for 5 specialities in the amount of 7,500 thousand EEK, in Tartu department for 11 specialities in the amount of 21,500 thousand EEK and in Harju department for 5 specialities in the amount of 2,900 thousand EEK. The selection of contractual partners was conducted in three departments of the Health Insurance Fund in the amount of 31,900 thousand EEK, which constitutes 4.9 % of the volume of outpatient specialised medical care.

3.2. **A draft regulation of the Minister of the Social Affairs has been submitted for the introduction of reference prices, deadline 1 May 2002**

The attainment of the objective does not fall within the competency of the Health Insurance Fund pursuant to the Health Insurance Act.

Pursuant to the Health Insurance Act, the Health Insurance Fund has transferred the draft projects for regulations governing the compensation for medicinal products to the Ministry of Social Affairs.

3.3. **The reference prices of medicinal products for cardiovascular diseases have been approved in the list of medicinal products subject to a discount. Deadline 30 June 2002**

The attainment of the objective no longer falls within the competency of the Health Insurance Fund pursuant to the Health Insurance Act.

The Health Insurance Fund transferred the reference price proposals to the Ministry of Social Affairs pursuant to the competency set in the Health Insurance Act.

3.4 **The reference prices of anti-depressants have been approved in the list of medicinal products subject to a discount, deadline 31 December 2002**

The attainment of the objective no longer falls within the competency of the Health Insurance Fund pursuant to the Health Insurance Act.
The development and setting of reference prices falls within the competency of the Ministry of Social Affairs.

3.5. **Health insurance benefit requirements analysis and planning matrix has been developed and comparative analysis for the requirements has been performed, deadline 1 August 2002.** The objective was attained by 15 August 2002

The Central Department developed a matrix for the Health Insurance Fund operating costs and health insurance benefit requirements that was approved with a decision of the Management Board No. 147 of 14 August 2002. The requirements matrix was adopted as the basis for analysing and planning the health insurance benefits for the year 2003.

3.6. **The reviewed and improved service list has been submitted to the Supervisory Board for approval, deadline 30 September 2002**
The objective has been attained by deadline

The Supervisory Board of the Health Insurance Fund reviewed the amendment proposals to the list of health services pursuant to the new Health Insurance Act.

3.7. **The implementation principles for DRG prices have been developed and approved, deadline 1 September 2002**

The attainment of the objective was postponed until 30 September 2003.
The Management Board approved with decision No. 142 of 9 August 2002 the DRG Implementation Plan for 2003 based on which the DRG implementation principles for the year 2004 shall be drafted by 30 September 2003.

3.8. **The basis and regulation of the DRG prices have been introduced to the contracts concluded with health care institutions, deadline 1 December 2002**

The attainment of the objective has been postponed until 1 January 2004.

The attainment of the objective was postponed until 30 September 2003. The Management Board approved with decision No. 142 of 9 August 2002 the DRG Implementation Plan for 2003 based on which the DRG implementation principles for the year 2004 shall be drafted by 30 September 2003.

Thus the said objective has to be attained in the contracts for financing treatment for the year 2004.

3.9. **A proposal has been submitted to the Supervisory Board for more effective treatment of medicinal products subject to a discount in pharmacies and an implementing plan has been developed, deadline 1 September 2002**

The objective has been attained according to the time schedule for preparing draft acts on medicinal products subject to a discount of the Medicines Department of the Ministry of Social Affairs.

Pursuant to the Health Insurance Act enacted as of 1 October 2002, all the pharmacies shall submit prescriptions to the Health Insurance Fund in electronic format. The Health Insurance Fund and retailer of medicinal products may enter into a contract which specifies mutual obligations and requirements for electronic submission of prescriptions. During the third quarter, the terms and conditions of a standard contract were developed by the Health Insurance Fund and the retailer of medicines and in the fourth quarter the regional departments started to conclude contracts based on the standard contract.

In addition, the Health Insurance Fund submitted the Ministry of Social Affairs proposals on the margins for wholesale and retail of medicinal products.

3.10. **The draft budget for 2003 has been submitted to the Supervisory Board, deadline 15 October 2002.** The objective has been attained

The first reading of the draft budget by the Management Board was held on 2 October and the second reading on 16 October 2002. The draft budget was submitted to the Supervisory Board on 25 October for the first reading.

Goal 4
EHIF customer service quality

4.1 Customer and partner-centric customer service arrangements have been introduced, deadline 31 May 2002

As of the first half of the year, the Health Insurance Fund has a proper database of employers, family physicians and health care institutions front office personnel which enables an operative communication of information by e-mail to the said target groups. In the second half of the year, electronic data communication was launched with the Ministry of Education, Labour Market Board and Pension Board as the result of which senior citizens, persons receiving caregiver's and child allowance, students and the unemployed need not visit the Health Insurance Fund. Amendment of data for establishing, terminating and suspending insurance cover is conducted on the basis of data communicated by agencies. The satisfaction survey conducted by EMOR indicates that 79 % of the insured rate the health insurance customer service as "good". Among the employers, 98 % of those polled were satisfied with the customer service.

4.2. Readiness for introducing electronic exchange of information with employers, deadline 30 June 2002

The Health Insurance Fund has launched in accordance with plans electronic exchange of information with employers for the amendment of data for establishing, terminating and suspending insurance cover.

As of 30 December 2002, the Health Insurance Fund has concluded electronic data communication contract with 2,546 employers through whom 30 % of the persons insured by employers are insured. The employer satisfaction survey revealed that 66 % of the employers polled prefer to communicate data via electronic channels.

Having employers communicate data via electronic channels enables the Health Insurance Fund to process the dental care applications with the disengaged labour force. The planned amount of these applications is 650,000 per year.

4.3. Readiness for introducing electronic exchange of information with health care institutions and pharmacies, deadline 30 June 2002

The Health Insurance Fund has launched in accordance with plans electronic exchange of information between the health care institutions, pharmacies and the Health Insurance Fund. As of 30 December 2002, the Health Insurance Fund has concluded electronic data communication contract with 730 health care institutions and 195 pharmacies, which constitute respectively 75.5 % and 54.2 % of the partners who have concluded a contract with the Health Insurance Fund. The health care institutions have submitted electronically 7,041 summary bills and the pharmacies 4,330 summary bills.

Goal 5
EHIF management and effectiveness of work processes

5.1. New SAP business solutions have been introduced, deadline 1 May 2002

The transfer took place in the framework of the project, i.e. for personnel and financial accounting, on 1 April 2002

The budgetary funds of the budget were not overspent. In addition, in the year 2002 common financial and health care service contract planning and accounting for voluntary health insurance contracts was introduced on the basis of SAP.

5.2. Work processes in all the activity fields of EHIF are covered with procedural rules, deadline 1 May 2002

The objective was attained by deadline. All the main and support work processes of the Health Insurance Fund have been defined as procedures and updated in due time according to the internal developments and the requirements arising from legislation. The regulation of work processes under quality management principles has substantially harmonised the activities and quality and instilled satisfaction in customers and partners.

5.3. Activity-based cost-accounting has been introduced in EHIF, deadline 1 August 2002

Activity-based cost-accounting model was developed by deadline and technically realised. The activity-based cost-accounting methodology and model underpinned the planning of the Health Insurance Fund operating expenses budget for the year 2003.

5.4. Personnel competence level has been assessed, deadline 1 August 2002

In the first quarter of the year, a new training system and basis for the competence assessment were developed. The competence level of the employees was established by assessing their knowledge and skills by 15 April. Based on the results, training needs were specified, goals for enhancing competence set and training plan compiled. The training plan and budget are related to the attainment of the strategic goals of the Health Insurance Fund. The main and most extensive training for the year 2002 was related to enhancing the professional knowledge of the customer service assistants and medical advisers and the introduction of the new Health Insurance Act.

To enhance the assessment objectivity, assessment methodology was developed, more objective competence profiles set and management competence development project carried out in the fourth quarter. The next step is to combine competence with the wages system.

Goal	Success criteria	Unit	Explanation	Objective for 2002	Results of 2002	Actual implementation	Weight	Weighted result
1. Satisfaction and awareness of the insured of their rights and obligations							**15 %**	**7 %**
	Satisfaction of the insured	%	Satisfaction of the insured as established by a survey	80 %	77.6 %	97 %		
	Awareness of the insured of their rights	%	Percentage of those polled who are aware of their rights for receiving health insurance benefits in the following fields at least at level "good": general medical care, specialised medical care, benefits for incapacity for work, medicinal products subject to a discount, extent of insurance cover	Define the basis	Basis not defined	0		
2. Availability and quality of health services							**30 %**	**17 %**
	Number of treatment instructions drafts initiated	Piece	New treatment instructions drafted by professional medical societies	10	6	0		
	Approved treatment instructions	Piece	Treatment instructions approved by the Health Insurance Fund	8	0	0		
	Frequency of treatment instruction use	%	Percentage of the use of treatment instructions use by disease files inspected during the medical audit	Define the basis	74 % according to two treatment instructions	100 %		
	Family practices		Inspected cases in health care	5700	5966			

	and health care institutions inspected		institutions			100 %		
	Number of medical audits	piece	Number of medical audits performed	3	2	0		
	Insured who were received by a family physician in due time	%	Insured who were received by a family physician in due time	95	99	100 %		
	Insured who were received by a specialist doctor in due time	%	Insured who were received by a specialist doctor in due time	95	98.5	100 %		
3. Balance and purposeful use of HIB resources and benefits							**30 %**	**23 %**
	HIB budget/budget implementation	**Rating**	Implementation of the budget according to HIB types and in general with the aim of ensuring a balanced budget and purposeful use of funds	"good"	"good"	100 %		
	Report of the State Audit Office or auditor		Report of the State Audit Office or auditor on the purposefulness of the Health Insurance Fund activities and use of funds	No admonitions	No admonitions	100 %		
	DRG prices developed	piece		498	0	0		
	Health insurance benefits purchased by way of a competition	%	Percentage of specialised medical care, nursing care and dental care budget in the extent of which contractual partners have been selected by way of a competition	20	Not applicable	-		
	Percentage of	%		100	100	100 %		

	medicinal products and health services covered by analysis of requirements							
4. EHIF customer service quality							**15 %**	**15 %**
	Satisfaction of the insured with EHIF customer service quality	%	Percentage of those polled whose of rating the EHIF customer service quality is at least "good"	Define the basis	79 %	100 %		
	Satisfaction of the employers with EHIF customer service quality	%	Percentage of those polled whose rating of the EHIF customer service quality is at least "good"	Define the basis	90 %	100 %		
5. EHIF management and effectiveness of work processes							**10 %**	**9 %**
	Processes covered with quality system	%	Main and support processes covered with the quality system	100	100 %	100 %		
	Competence of personnel	%	Relation of the personnel skills and qualifications to the requirements set for the positions	Define the basis	Basis defined	100 %		
	Personnel satisfaction %	%	Aggregated satisfaction index established by survey of personnel	65	56 %	86.2 %		
	Change in cost of main processes	%	Change in costs of the main processes per period according to the activity-	Define the basis	Basis defined	100 %		

			based cost model					
	Transactions via electronic channels	%	Volume of the health insurance benefit invoices (health services, prescriptions for medicines subject to a discount)	Environment established	Environment established	100 %		
	Quality of the activity plan implementation	%	Percentage of the activity plan tasks implemented at least with rating "good"	90	72 %	80 %		
Implementation of balanced scorecard							**100 %**	**71 %**

Approved with Supervisory Board of the Estonian Health Insurance Fund decision No. 42 of 13 December 2002

<u>Assessment of the Management Board performance</u>

	Assessment of the Management Board performance:	**Very good**	**Good**	**Satisfactory**	**Unsatisfactory**
	1. Satisfaction and awareness of the insured of their rights and obligations	95 to 100	80 to 95	60 to 80	<60
	2. Availability and quality of health services	95 to 100	90 to 95	80 to 90	<80
	3. Balance and purposeful use of HIB resources and benefits	95 to 100	90 to 95	80 to 90	<80
	4. EHIF customer service quality	95 to 100	90 to 95	80 to 90	<80
	5. EHIF management and effectiveness of work processes	95 to 100	90 to 95	80 to 90	<80

Notes to the implementation of the budget and analysis of the use of health insurance benefits in 2002

Introduction

Notes to the implementation of the budget reflect the implementation of the Estonian Health Insurance Fund 2002 budget and the analysis of the use of health insurance benefits.

The insured

As of 31 December 2002, the number of persons insured in the Health Insurance Fund was 1,284,076 and compared to the December of 2001 the number has increased by 5,990 persons.

Table 3. Number of the insured

Persons	31.12.2001	31.12.2002	Change (in %) 2002/2001
Insured persons	574,284	578,673	0.76 %
Persons insured by the state	40,140	48,469	20.75 %
Persons equal to insured persons	663,204	656,926	-0.95 %
Persons insured under international agreements	458	8	-98.25 %
Total	1,278,086	1,284,076	0.47 %

Consolidated report of the implementation of the budget (thousand EEK)

EHIF REVENUE	2001 actual*	2002 budget	2002 actual*	2002 actual/ 2002 budget %
Social tax	4,542,090	4,934,399	5,059,996	102.5 %
Claims collected from other persons	8,154	3,000	14,938	497.9 %
Financial revenue	6,843	10,000	20,652	206.5 %
Other revenue	6,952	2,000	3,738	186.9 %
TOTAL BUDGET REVENUE	**4,564,039**	**4,949,399**	**5,099,324**	**103.0 %**
EHIF EXPENDITURE				
Health service benefits	**2,823,685**	**3,072,741**	**3,025,728**	**98.5 %**
Disease prevention	44,628	45,733	42,400	92.7 %
General medical care	335,824	407,534	400,225	98.2 %
Total specialised medical care	2,170,073	2,336,523	2,310,635	98.9 %
Specialised medical care		2,246,877	2,231,562	99.3 %
Rehabilitation		31,623	34,888	110.3 %
Centrally purchased services		58,023	44,185	76.2 %
Long-term nursing care	48,001	51,945	49,006	94.3 %
Dental care	225,158	231,006	223,462	96.7 %
Health promotion expenditure	**12,958**	**13,500**	**13,218**	**97.9 %**
Medicinal products benefit expenditure	**666,123**	**772,000**	**772,369**	**100.0 %**
Medicinal products compensated for to the insured	627,897	730,000	731,359	100.2 %
Centrally purchased medicinal products	38,226	42,000	41,009	97.6 %
Benefit of temporary incapacity for work expenditure	**754,228**	**804,000**	**819,257**	**101.9 %**
Other health insurance benefit expenditure	**6,621**	**19,500**	**17,368**	**89.1 %**
Health service benefits arising from international agreements	1,235	1,500	1,364	90.9 %
Benefit for medical devices	5,386	18,000	16,004	88.9 %
Total health insurance benefit expenditure	**4,263,615**	**4,681,741**	**4,647,940**	**99.3 %**
Personnel and administration expenses	**34,487**	**44,997**	**42,796**	**95.1 %**
Remuneration	24,389	33,705	32,058	95.1 %
incl. remuneration of the Members of the Management Board	1,483	2,000	1,829	91.5 %
incl. remuneration of the Members of the Supervisory Board		5	3	60.0 %
Unemployment insurance tax		169	158	93.5 %
Social tax	8,614	11,123	10,580	95.1 %

* the actual implementation for 2001 ja 2002 does not include target financing revenue and expenditure

Management costs	**15,427**	**15,000**	**14,047**	**93.6 %**
IT costs	**12,471**	**14,500**	**14,561**	**100.4 %**
Health insurance benefit payment related costs	**1,529**	**900**	**1,284**	**142.7 %**
Development costs	**554**	**4,280**	**2,465**	**57.6 %**
Training		2,000	1,668	83.4 %
Consultation		2,280	797	35.0 %
Financial expenditure	**537**	**1,000**	**514**	**51.4 %**
Other operating costs	**11,916**	**6,981**	**7,287**	**104.4 %**
Pre-printed forms and publications	7,443	2,800	476	17.0 %
Health insurance system monitoring	454	1,821	527	28.9 %
Public relations/informing	0	1,320	1,185	89.8 %
Other expenditure	4,019	1,040	5,099	490.3 %
Health Insurance Fund reformation costs	**2,141**			
Health Insurance Fund operating costs	**79,061**	**87,658**	**82,954**	**94.6 %**
Reserve	**221,364**	**180,000**	**368,430**	**204.7 %**
Appropriation to legal reserve	189,810	100,000	225,597	225.6 %
Appropriation to risk reserve	31,554	80,000	142,833	178.5 %
TOTAL BUDGETARY EXPENDITURE	**4,564,039**	**4,949,399**	**5,099,324**	**103.0 %**

Revenue

Table 2. Revenue

Revenue (thousand EEK)	2001 actual	2002 budget	2002 actual	2002 actual/2002 budget %
Total revenue	**4,564,039**	**4,949,399**	**5,099,324**	**103 %**
Social tax	4,542,090	4,934,399	5,059,996	103 %
Claims collected from other persons	8,154	3,000	14,938	498 %
Financial revenue	6,843	10,000	20,652	207 %
Other revenue	6,952	2,000	3,738	187 %

Social tax
The Health Insurance Fund 2002 budget provided for 4,934,399 thousand EEK of health insurance income from social tax. Total of 5,059,996 thousand EEK was received. The amount received in excess constituted 3 % of the 2002 budget.

Revenue claimed from other persons
Revenue claimed from other persons constituted 14,938 thousand EEK in the year 2002. The excess revenue comes from improvement of the monitoring system, especially in monitoring the benefits for incapacity for work paid to the insured (claims made to social tax debtors, etc.).

Financial revenue
The interest income in 2002 was 20,652 thousand EEK. Higher than expected interest income can be attributed to greater legal reserve and risk reserve investments into bonds and fixed term deposits out of social tax amounts received in excess.

Other revenue
The amount of other revenue planned for 2002 was 2,000 thousand EEK. Actual accrual was 3,738 thousand EEK. The other revenue is mostly generated from economic activities in the volume of 3,310 thousand EEK and profit from the sales of fixed assets (real estate in the town of Valga) in the volume of 370 thousand EEK. Other revenue from economic activities was generated partially from the sales of pre-printed forms and administration income from transactions of the non-working military service pensioners of the Russian Federation in the volume of approximately 100 thousand EEK.

Expenditure

The expenditure of the Estonian Health Insurance Fund is divided into:

- Expenditure on health insurance benefits
- Health insurance administration or Health Insurance Fund operating costs

The expenditure on health insurance benefits constitutes 91.15 % of the total volume of the 2002 implemented budget, system administration costs 1.63 % and the reserve funds 7.23%.

Table 3. Percentage distribution of the Health Insurance Fund by years

	2001 actual	2002 budget	2002 actual	Change
Health insurance benefits	93.21 %	94.59 %	91.15 %	-3.4 %
EHIF operating costs	1.73 %	1.77 %	1.63 %	-0.1 %
Reserve funds	5.06 %	3.64 %	7.23 %	3.6 %

I Health insurance benefit expenses

1. Health services benefits

Table 4. Comparison of 2002 health services benefits with the 2002 budget and the actual implementation of the 2001 budget

Item of expenditure (thousand EEK)	2001 actual	2002 budget	2002 actual	2002 actual/2002 budget %
Disease prevention	44,628	45,733	42,400	92.7 %
General medical care services	335,824	407,534	400,225	98.2 %
Specialised medical care, incl.	2,170,074	2,336,523	2,310,635	98.9 %
rehabilitation		31,623	34,888	110.3 %
centrally purchased health services	79,533	58,023	44,185	76.2 %
Long-time nursing care	48,001	51,945	49,006	94.3 %
Dental care	225,158	231,006	223,462	96.7 %
Total	**2,823,685**	**3,072,741**	**3,025,728**	**98.5 %**

Disease prevention

The 45,733 thousand EEK were planned for disease prevention and 42,400 thousand EEK were spent which constitutes 93% of the implementation of the budget.

Table 5. Disease prevention projects and other prevention activities budget implementation in 2002

Prevention activity (thousand EEK)	2001 actual	2002 budget	2002 actual	2002 actual/ 2002 budget %
School health	17,950	18,000	18,236	101 %
Early detection of breast cancer	0	5,682	5,466	96 %
Early detection of malignant tumours of the female reproductive system and mammary glands	2,800	2,000	1,955	98 %
Hepatitis-B vaccination	4,110	9,777	9,143	94 %
Reproductive health counselling and STD prevention in young people	466	3,317	3,293	99 %
Cardiac risk factor screening	920	1,792	1,511	84 %
Early detection of osteoporosis	185	850	381	45 %
Phenylketonuria and hypothyroidism screening	550	771	771	100 %
Personnel regular and preliminary health check	2,603	3,565	1,644	46 %
Young athlete health check	2,000	0	0	0
Total	**44,628**	**45,733**	**42,400**	**93 %**

The school health projects involved 221,034 pupils 11 month a year.

In the framework of the project for early detection of breast cancer 14,785 medical tests were performed (99 % of the planned amount). The lower budgetary spending of the project can be attributed to the actual need for differential diagnosis being lower (5.3 % instead of the 10 % planned). As of the second half of the year, mobile mammography programme with collapsible devices was launched.

For the early detection of malignant tumours of the female reproductive system and mammary glands, 7,980 medical tests were performed (~100 %), incl. 3,743 female reproductive system and 4,237 mammary gland tests.

In the **national immunoprofylaxis programme for the prevention of infectious diseases** by way of hepatitis-B vaccination, 91 % of the target group was covered mostly through school health programmes. Additionally, the students of the Faculty of Medicine of the University of Tartu were vaccinated.

In the framework of the **project for reproductive health counselling and STD prevention in young people** 20,892 consultations (95 %) were provided, incl. 5,892 tests for STD (28.2 %), 6,354 sexual counselling sessions (30.4 %) and 8,646 contraception counselling sessions (41.4 %). The reproductive health counselling occasions exceeded the planned number and the number of tests for STD was lower than planned. The average share of first consultations was 30 % in the year 2002. Young men accounted for 3.9 % of the visitors. Within the project, Internet counselling was provided on 872 occasions and telephone counselling on 6,991 occasions.

The cardiac risk factor screening engaged 81 family practices (out of the 100 planned). The project covered 8,090 persons (69 %), the more extensive use of the funds against the target groups arose from recurrent visits, and the need for medical tests and performance of screenings in county heart examination cabinets.

During the **project for early detection of osteoporosis,** 659 patients (33 %) were examined. The low coverage is related to the very narrowly defined target groups and availability of bone densitometry in Tallinn, Tartu and Pärnu only.

The phenylketonuria and hypothyroidism screening entailed 12,776 tests (97 %); using up of the funds is related to the need of recurrent tests (646). As of the second half of 2002, preliminary and preventive health checks were no longer financed out of the prevention funds. In the first half of 2002, 63 preliminary and 16,182 regular/periodic health checks were made.

General medical care services

Table 6. General medical care budget implementation in 2002.

General medical care services budget (thousand EEK)	2001 actual	2002 budget	2002 actual	2002 actual/2002 budget %
Base fee	35,462	51,133	48,274	94 %
Additional fee for distance	1,642	2,003	1,974	99 %
Additional fee for certificate	5,805	6,867	7,131	104 %
Capitation fee (up to 2 years)	4,046	7,024	6,862	98 %
Capitation fee (2 -70 years)	160,409	242,825	249,693	103 %
Capitation fee (above 70 years)	25,013	37,244	37,541	101 %
General medical care capitation fee	59,628	0	0	0
Medical tests fund	43,819	52,825	48,750	92 %
Reserve	0	7,613	0	0

Total	335,824	407,534	400,225	98 %

The implementation of the 2002 general medical care budget was 400,225 thousand EEK (98%). Compared to 2001, total of 64,401 EEK (19 %) was spent more on general medical care.

Expenses grew most in Tallinn where new family physicians started to practice. All in all the number of family physicians working under a contract for financing medical treatment rose to 813, with 78 % of them holding a family physician diploma at the end of 2002. The capitation fee funds were used in the extent of 100 % whereas the base fee and medical tests funds were underspent, 94 % and 92 % respectively against the corrected budget. The medical tests fund expenses constituted 16.6% of the capitation fee resources which is by 8 % less than planned.
The increase of the number of family physicians was not accompanied by a growth of consultations number compared to 2001 (the number fell by 8 % year-on-year), the reason behind this can be the influenza outbreak in 2001 and the obligation of family physician to assign the severity of disability in 2001. There is a 24.4 % drop in the number of consultations in a family practice per month, when comparing 2002 to 2001. The family physicians provided medical care to 875,444 insured persons (862,581 insured in 2001), who visited the family physician on the average of 4.5 times a year. The medical care availability survey conducted for the first time indicated that there were no major problems with the availability of family medical care in due time as in the four quarters an average of 97 % of patients were received in due time.

Table 7. General medical care consultations

	2000	2001	2002
Total consultations	2,572,076	4,338,268	3,987,121
Consultations per practice a year	5,336	6,494	4,904
Consultations per practice a month	430	546	413

Outpatient and inpatient specialised medical care

In 2002, the Health Insurance Fund paid for **outpatient and inpatient specialised medical care** services 2,231,562 thousand EEK.

Table 8. Outpatient and inpatient specialised medical care (excl. rehabilitation) in 2002, comparison with 2001

		2001 actual		2002 actual		Comparison 2002/2001	
SPECIALITY	Health service type	Medical treatment expenses (thousand EEK)	Treatment cases	Medical treatment expenses (thousand EEK)	Treatment cases	Medical treatment expenses	Treatment cases
Dermatovenerology		31,308	174,329	30,427	171,076	-3 %	-2 %

	Outpatient	22,161	171,631	23,576	169,154	6 %	-1 %
	Inpatient	9,147	2,698	6,851	1,922	-25 %	-29 %
Primary post acute care		16,779	3,946	12,116	2,576	-28 %	-35 %
	Inpatient	16,779	3,946	12,116	2,576	-28 %	-35 %
Surgery		473,286	319,471	505,218	315,645	7%	-1 %
	Outpatient	63,338	268,292	71,762	263,861	13 %	-2 %
	Inpatient	409,947	51,179	433,456	51,784	6 %	1 %
Other main specialities		60,380	140,904	35,561	133,203	-41 %	-5 %
	Outpatient	40,146	139,904	26,682	132,599	-34 %	-5 %
	Inpatient	20,234	1,000	8,879	604	-56 %	-40 %
Infectious diseases		26,686	17,465	24,628	18,321	-8 %	5 %
	Outpatient	5,581	7,606	5,644	8,973	1 %	18 %
	Inpatient	21,105	9,859	18,984	9,348	-10 %	-5 %
Neurology		74,322	132,433	84,882	130,356	14 %	-2 %
	Outpatient	22,534	121,002	27,290	119,401	21 %	-1 %
	Inpatient	51,788	11,431	57,592	10,955	11 %	-4 %
Ophthalmology		69,744	256,731	83,120	259,715	19 %	1 %
	Outpatient	41,725	251,431	64,329	256,326	54 %	2 %
	Inpatient	28,019	5,300	18,791	3,389	-33 %	-36 %
Oncology		126,785	77,986	145,563	80,086	15 %	3 %
	Outpatient	41,326	69,649	47,857	71,243	16 %	2 %
	Inpatient	85,460	8,337	97,705	8,843	14 %	6 %
Otorhino-laryngology		65,535	180,876	74,231	183,351	13 %	1 %
	Outpatient	36,178	171,324	42,868	173,533	18 %	1 %
	Inpatient	29,356	9,552	31,364	9,818	7 %	3 %
Paediatrics		106,685	96,609	109,906	106,696	3 %	10 %
	Outpatient	15,262	66,398	23,209	79,334	52 %	19 %
	Inpatient	91,423	30,211	86,697	27,362	-5 %	-9 %
Psychiatry		109,926	160,565	107,165	163,240	-3 %	2 %
	Outpatient	20,552	147,330	21,716	151,059	6 %	3 %
	Inpatient	89,374	13,235	85,449	12,181	-4 %	-8 %
Pulmonology		59,081	66,375	62,512	63,304	6 %	-5 %
	Outpatient	21,536	61,512	22,508	59,057	5 %	-4 %
	Inpatient	37,545	4,863	40,004	4,247	7 %	-13 %
Obstetrics and gynaecology		232,060	478,897	258,590	480,692	11 %	0 %
	Outpatient	94,848	437,840	113,934	438,886	20 %	0 %
	Inpatient	137,212	41,057	144,656	41,806	5 %	2 %
Therapy		431,948	328,832	483,943	326,739	12 %	-1 %
	Outpatient	86,658	269,216	114,656	272,914	32 %	1 %
	Inpatient	345,290	59,616	369,287	53,825	7 %	-10 %
Traumatology and orthopaedics		181,970	209,816	213,699	201,417	17 %	-4 %
	Outpatient	45,324	196,965	48,907	188,391	8 %	-4 %
	Inpatient	136,645	12,851	164,791	13,026	21 %	1 %

Total		**2,066,494**	**2,645,235**	**2,231,562**	**2,636,417**	**8 %**	**0 %**
	Outpatient	557,169	2,380,100	654,939	2,384,731	18 %	0 %
	Inpatient	1,509,325	265,135	1,576,623	251,686	4 %	-5 %

Total number of treatment cases has gone up in the specialities of infectious diseases, ophthalmology, oncology, paediatrics, psychiatry, obstetrics and gynaecology, and otorhinolaryngology. Total number of treatment cases has fallen in the specialities of dermatovenerology, surgery, neurology, pulmonology, therapy, traumatology and orthopaedics and post-acute care. In the specialities of dermatovenerology, pulmonology and neurology, the main decrease of treatment cases is applicable to inpatient cases. In the specialities of surgery and traumatology and orthopaedics, the inpatient treatment case number has gone up. One of the reasons behind the drop in outpatient treatment cases is the processing of accident and emergency and reception room medical bills as a part of other specialities.

Although the 2002 number of treatment cases has dropped by 8,818 incidents (0.3 %) compared to 2001, it can be said that the availability of health services has not decreased for the insured. According to the Health Insurance Fund, one of the reasons behind the drop of total number of treatment cases is the merging of hospitals in 2001 whereby the need for completing several medical bills during one treatment case disappeared. In the year 2001, not all of the tests and treatment procedures performed during one treatment case were recorded on the same medical bill and this resulted in an artificially high number of medical bills (= treatment cases) in 2001.

In order to **ensure the availability** of health services important and expensive for the insured (endoprosthesis, deliveries, cardiosurgery and cataract operations and pregnancy monitoring), the Health Insurance Fund specified in the contracts for financing medical treatment the number of treatment cases and the allocation of funds for providing the relevant services.

In 2002, the Health Insurance Fund paid for the services specified in contracts as follows:

Special cases	2001		2002		Change %	
	Amount (thousand EEK)	Treatment cases (piece)	Amount (thousand EEK)	Treatment cases (pieces)	Amount (thousand EEK)	Treatment cases (piece)
Endoprosthesis	54,900	1,704	79,233	2,151	44 %	26 %
Deliveries	63,220	12,162	69,455	12,711	10 %	5 %
Cardiosurgery	55,842	696	63,869	741	14 %	6 %
Cataract operations	30,400	4,577	41,029	5,785	35 %	26 %
Pregnancy monitoring	12,639	22,552	16,944	31,833	34 %	41 %

In 2002, the price of health services rose twice (1 June 2002 and 1 September 2002) entailing a rise in the price of the outpatient consultation, DRG services, laboratory tests, surgery, bed days, etc. The outpatient consultation and bed day reference prices added 15 % during the year and thus the cost of outpatient and inpatient treatment cases increased compared to 2001.
The Health Insurance Fund focused in 2002 on increasing the volume of outpatient services and day surgery. The specialised medical care budget was increased by 53,020

thousand EEK which was mostly allocated for covering the outpatient consultation and bed day reference price rise and curbing the waiting lists through amendments into contracts for financing treatment.

The next table provides and overview of the costs and use of outpatient and inpatient specialised medical care.

Table 9. Comparison of 2002 outpatient and inpatient specialised medical care (excl. rehabilitation) costs and use to 2001

	2001 actual		2002 actual		Change %	
	Outpatient	Inpatient	Outpatient	Inpatient	Outpatient	Inpatient
Inpatient bed days (days)		2,036, 809		1,785, 818		-12.3 %
Outpatient consultations (piece)	3,266,714		3,223,441		-1.3 %	
Operations (piece)	33,475	89,569	37,871	90,200	13.1 %	0.7 %
Insured who used specialised medical care services (person)	750,533	181,488	744,367	175,103	-0.8 %	-3.5 %
Average treatment case cost (EEK)	234	5,693	275	6,264	17.5 %	10.0 %
Average treatment case length (days)		7.8		7.2		-7.7 %

Outpatient specialised medical care services were used by 744,367 insured persons (58.2 % of all the insured), the 2001 figures were 750,533 insured persons (58.7 %).

Inpatient services were used by 175,103 insured persons (13.7 % of all the insured), the 2001 figures were 181,488 insured persons (14.2 %).

The average increase of o**utpatient treatment case** cost was due to the rise of health service price and greater number of day surgery operations and rise of the average cost of day surgery operations.

The average increase of **inpatient treatment case** cost was due to the transfer of simpler regular treatment cases to outpatient care and intensification and the rise in price of medical tests and laboratory diagnostics. Compared to 2001, the number of inpatient medical tests and treatment procedures rose by 4 %, the cost by 13 % and the number of laboratory tests by 5 % and cost by 15 %. More procedures and more expensive procedures were performed. The current system of financing according to the number of services provided encourages health care providers to provide more services.

The services provided under **outpatient emergency care** were paid for in the amount of 94,494 thousand EEK (14 % of the total volume of outpatient specialised medical care) in 2002 and 68,413 thousand EEK (12 %) in 2001.

The services provided under **inpatient emergency care** were paid for in the amount of 889,333 thousand EEK (56.4 % of total volume of inpatient specialised medical care) in 2002 and 747,473 EEK (49.5 %) in 2001.

The total number of inpatient treatment cases and days indicates a downward trend. The treatment days drop can be attributed to the shortening of a treatment case by 0.7 days compared to 2001.

Table 10. Comparison of the indicators of 2002 specialised medical care use to 2001 in the EHIF regional departments (per 1000 insured persons)

	2001	**2002**	**2001**	**2002**	**2001**	**2002**
Regional department	**Consultations**		**Total operations**		**Operations in hospitals**	
Harju	3,024	2,882	97	96	71	69
Ida-Viru	2,781	2,945	86	97	74	79
Kagu	1,890	1,818	100	109	65	64
Lääne	2,113	2,188	103	106	71	73
Pärnu	2,123	2,124	91	98	72	72
Rakvere	2,086	2,056	93	101	76	77
Tartu	2,407	2,223	103	105	64	65
EHIF average	**2,589**	**2,519**	**96**	**100**	**70**	**70**

Comparing the 2001 and 2002 **outpatient consultations,** the consultation figures have fallen by 3 % per 1,000 insured persons nation-wide. At the same time, consultation figures have gone up in Ida-Viru and Lääne-Viru regions by 6 % and 4 % respectively. In other regions the figures have fallen, incl. 8 % in Tartu and 5 % in Harju.

The number of outpatient and inpatient operations in 2002 was 128,071, with 29.6 % of them outpatient (day surgery) and 70.4 % inpatient. In the year 2001, total of 123,146 operations were performed (27.2 % outpatient and 72.8 % inpatient)

The 4 % rise of **total number of operations** and the 13.1 % rise of outpatient operations compared to 2001 is related to the allocation of resources by the Health Insurance Fund for curbing the waiting lists of cataract, endoprosthesis and otorhinolaryngology operations and more effective management of hospitals and better treatment opportunities for outpatient surgery.

Rehabilitation

Table 11. Rehabilitation budget implementation in 2002

Rehabilitation (thousand EEK)	**2001 actual**	**2002 budget**	**2002 actual**	**2002 actual / 2002 budget %**
Outpatient rehabilitation	16,391	12,428	13,355	107 %
Inpatient rehabilitation	15,947	19,195	21,533	112 %

Total	32,338	31,623	34,888	110 %

During the amendment of the 2002 budget, the rehabilitation budget was increased by 5,700 thousand EEK to cover the rehabilitation requirements with the decision of the Supervisory Board of the Health Insurance Fund.

In 2002, total of 34,888 EEK were paid for rehabilitation services (8 % increase compared to 2001), which was divided between 32,800 outpatient and inpatient treatment cases.

Centrally purchased health services

In 2002, the Health Insurance Fund paid 44,185 thousand EEK (76.2 % of the planned amount for centrally purchased health services). The discrepancy with the planned amount arises from 12,000 thousand EEK been used less for expensive treatment cases risk mitigation, small number of applications for transfer to treatment to in a foreign state and lower emergency air transport costs.

Out of the amount planned for risk mitigation, 58.4 % (in the extent of 7,005 EEK) was used to cover the expensive treatment cases in Harju, Tartu and Lääne regions recorded under specialised medical care costs.

The Health Insurance Fund assumed the payment obligation of the insured persons for medical care in a foreign state in the extent of 1,527 thousand EEK (51 % of the budget). In 2002, total of 18 persons (13 of them children) were transferred to treatment in a foreign state. In 2001, total of 2,497 EEK were paid for the regular treatment of insured persons abroad. 17 insured persons (15 of them children) were transferred to treatment in a foreign state. The Hiiumaa hospital around-the-clock emergency medical care support payments were made out of the reserve.

Table 12. Centrally purchased health service budget implementation in 2002

Centrally purchased health service (thousand EEK)	2001 actual	2002 budget	2002 actual	2002 actual/2002 budget %
Bone marrow transplantation		2,700	3,057	113 %
Regular treatment in a foreign state		3,000	1,527	51 %
Peritoneal dialysis		17,000	18,584	109 %
Emergency transport of the insured (aeroplane, helicopter)		2,500	1,548	62 %
Collection of fractionated plasma		11,340	11,340	100 %
Risk mitigation*		12,000		

Young athlete health check		2,000	2,001	100 %
Expensive medical equipment depreciation costs		5,466	5,679	104 %
Reserve		2,017	449	0.22 %
TOTAL	79,533**	58,023	44,185	76.2 %

* Planned under centrally purchased health services, actual implementation under specialised medical care, amount 7,005 thousand EEK.
** As to structural changes, the 2001 and 2002 data are incompatible by items of expenditure.

Long-term nursing care

Table 13. Outpatient and inpatient long-term nursing care budget implementation in 2002

Outpatient and inpatient long-term nursing care (thousand EEK)	2001 actual	2002 budget	2002 actual	2002 actual /2002 budget %
Inpatient long-term nursing care		50,821	48 ,064	95 %
Cancer patient palliative home care		1,124	942	84 %
Total long-term nursing care	48,001	51,945	49,006	94 %

** As to structural changes, the 2001 and 2002 data are incompatible by items of expenditure.

Total long-term nursing care costs in 2002 were 49,006 thousand EEK which constitute 94 % of the annual budget. The cancer patient palliative home care required 942 thousand EEK (84 % implemented). Compared to 2001, the long-term nursing care costs increased by 2 %.
Long-term nursing care was provided to 10,177 persons, 650 of them received home care. The patients spent 242 thousand days in long-term nursing care with the average treatment case length being 21 days. Out of the 9,526 inpatient patients, 75 % were hospitalised into specialised long-term nursing care departments (70 % of long-term nursing care bed days can be attributed to long-term nursing care in specialised long-term nursing care departments). The other patients were treated in acute care departments which explains the rather short duration of average treatment case.

Dental care

Table 14. Dental care budget implementation in 2002

Dental care (thousand EEK)	2001 actual	2002budget	2002 actual	2002 actual/2002 budget %
Dental care	162,897	135,626	146,574	108 %

Orthodontics	13,785	23,400	18,313	78 %
Dentures	48,303	58,000	48,657	84 %
Dental condition prevention*	7,628	13,980	9,918	71 %
Total dental care	**232,613**	**231,006**	**223,462**	**97 %**

* the 2001 dental care costs have been corrected in table 14 to ensure compatibility as 2001 dental condition prevention was financed out of the 2001 prevention budget.

In 2002, the Health Insurance Fund paid 223,462 thousand EEK for dental care which constitutes 96.7 % of the 2002 budget. 368,030 insured persons (28.8 % of the total number of the insured) used dental care services.

Pursuant to the Health Insurance Act entered into force on 1 October 2002, the Health Insurance Fund assumes the payment obligation for dental care services only of persons under 19 years of age. Thus the Health Insurance Fund did not pay for adult dental care in the fourth quarter.
For the sake of providing an overview, the dental conditions and dental care costs have been analysed below in a single table. The priority of the Health Insurance Fund according to the decision of the Supervisory Board and the contracts concluded is the financing of child dental care and dentures for persons above 65 years of age.

Table 15. Dental care, dental condition prevention and dentures cost in 2002

Health service type		**Age groups**			
		0-18	**19-59**	**60 and above**	**Total**
Dentures	Amount (EEK)	231,980	4,587,868	43,836,946	48,656,794
	Persons treated	142	3,375	28,718	32,235
	Cost per person (EEK)	1,634	1,359	1,526	1,509
Orthodontics	Amount (EEK)	18,290,629	18,402	3,874	18,312,905
	Persons treated	53,032	48	9	53,089
	Cost per person (EEK)	345	383	430	345
Prevention	Amount (EEK)	9,908,798	9,294	44	9,918,136
	Persons treated	106,841	215	2	107,058
	Cost per person (EEK)	93	43	22	93
Dental care	Amount (EEK)	89,313,919	39,679,393	17,581,223	146,574,534
	Persons treated	234,413	199,874	86,304	520,591
	Cost per person (EEK)	381	199	204	282
Total	**Amount (EEK)**	**117,745,326**	**44,294,956**	**61,422,087**	**223,462,369**
	Persons treated	**394,428**	**203,512**	**115,033**	**712,973**
	Cost per person (EEK)	**299**	**218**	**534**	**313**

2. Health promotion expenses

13,500 thousand EEK were planned for health promotion and 13,218 thousand EEK were spent (98 %).

Table 16. Health promotion budget implementation in 2002

Health promotion field (thousand EEK)	2001 actual	2002 budget	2002 actual	2002 actual/2002 budget %
Cardio-vascular disease prevention	918	1,896	1,893	99.8 %
Prevention of home and leisure time injuries and intoxication	815	2,376	2,178	89.6 %
Malignant tumour prevention	313	1,296	1,283	99 %
Mental problems prevention	835	2,207	2,193	99.4 %
Infectious diseases, incl. STD prevention	713	1,187	1,161	97.8 %
Projects focusing on various priority areas	9,364	4,538	4,510	99.4 %
Total	**12,958**	**13,500**	**13,218**	**98 %**

All the 99 financed projects were carried out. The activities in the field of trauma prevention were less intensive than planned.

More than 123,000 people participated at the training courses and events planned for the public in the framework of the 2002 health promotion projects; individual counselling has been provided to more than 40,000 children and adults. Seminars involved the training of more than 1,500 health care professionals and 2,100 teachers and additional training has been provided to 3,000 other inclusive group members (social workers, leaders, working groups, etc.). 10 posters, 11 information bulletins, 7 stickers, 34 flyers, 7 brochures and 6 books have been issued; the total circulation of the publications was more than 325,000 copies. The public has been informed by 115 health-related radio programmes and 20 TV programmes/clips.

3. Expenditure on medicinal products benefits

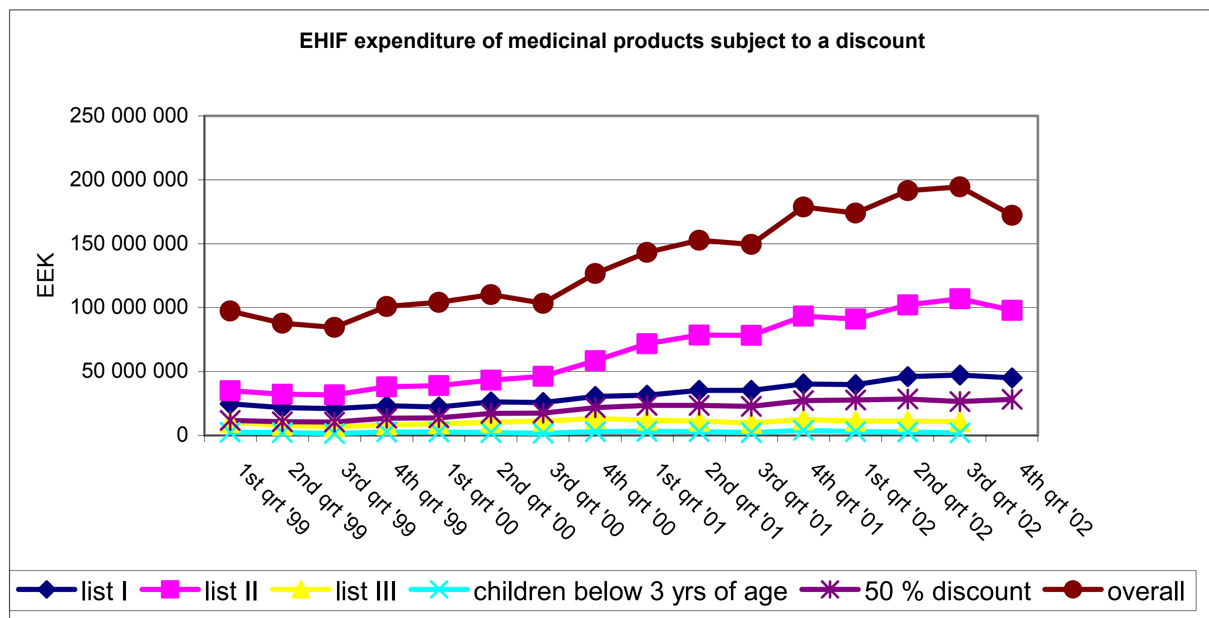
Total amount of the medicinal products compensated for to the insured in 2002 was 731, 359 thousand EEK, that is 100.2 % of the budget. The expenses rose compared to 2001 by 17.2 % (107,500 thousand EEK).

The medicinal products compensated for to the insured by quarters were as follows:

Quarter I	173,887 thousand EEK or 97.7 % of the quarterly budget
Quarter II	193,269 thousand EEK or 107.4 % of the quarterly budget
Quarter III	194,412 thousand EEK or 111 % of the quarterly budget
Quarter IV	169,791 thousand EEK or 86.2 % of the quarterly budget

Compared to the previous years, the sales of medicinal products deviated from the regular seasonal pattern. As a result of the proceeding and entry into force of the new Health Insurance Act, several so-called purchase panics emerged in the second and third quarter. This was especially apparent in September (right before the entry in to force of the new act) when medicinal products were compensated for in twice as large amount as planned. Due to the September purchase panic, the compensation for medicinal products fell in the fourth quarter. The reference prices enacted as of 1 January 2003 gave rise to another slight purchase panic in the second half of December.

Figure 1. EHIF expenditure on medicinal products subject to a discount by quarters in the years 1999-2002



In 2002, the Health Insurance Fund paid 731,359 thousand EEK to compensate for the medicinal products subject to a discount which is by 17.2 % more than in 2001. Compared to 2001, the compensation amounts decreased for children under 3 years of age and for medicinal products on list III of medicinal products subject to a discount. The

drop in compensation amount was related to the entry in to force of the new Health Insurance Act as of 1 October which repealed the 100 % compensation of all the medicinal products for children under three years of age and list III of medicinal products subject to a discount.

In 2002, both the average number of prescriptions and the cost of prescriptions rose. In 2000, the Health Insurance Fund compensated for 3.4 million prescriptions, in 2001, for 3.9 prescriptions and in 2002, already for 4.05 million prescriptions. The prescription number increase has resulted in the increase of the number of persons whom medicinal products are prescribed and the number of prescriptions issued per person.
Compared to the previous years, the prescription number increase has slowed down. The slowing down can be attributed to the less intensive of prescription of medicinal products to children under 3 years of age and medicinal products on list III of medicinal products subject to a discount.

In 2002, the average cost per prescription for the Health Insurance Fund was 180.6 EEK which is by 13.8 % more than in 2001. Compared to 2001, the highest increase has been that of the prescription of medicinal products compensated for 100 % on list I of medicinal products subject to a discount by 18.5 % (86.6 EEK). The prescription cost growth has been due to the new and more expensive medicinal products being prescribed more often and the rise in medicinal product prices. The average prescription cost growth has slowed down compared to previous periods.

Figure 2. The average cost of prescriptions paid for by the Health Insurance Fund by the quarters in the years 1999-2002

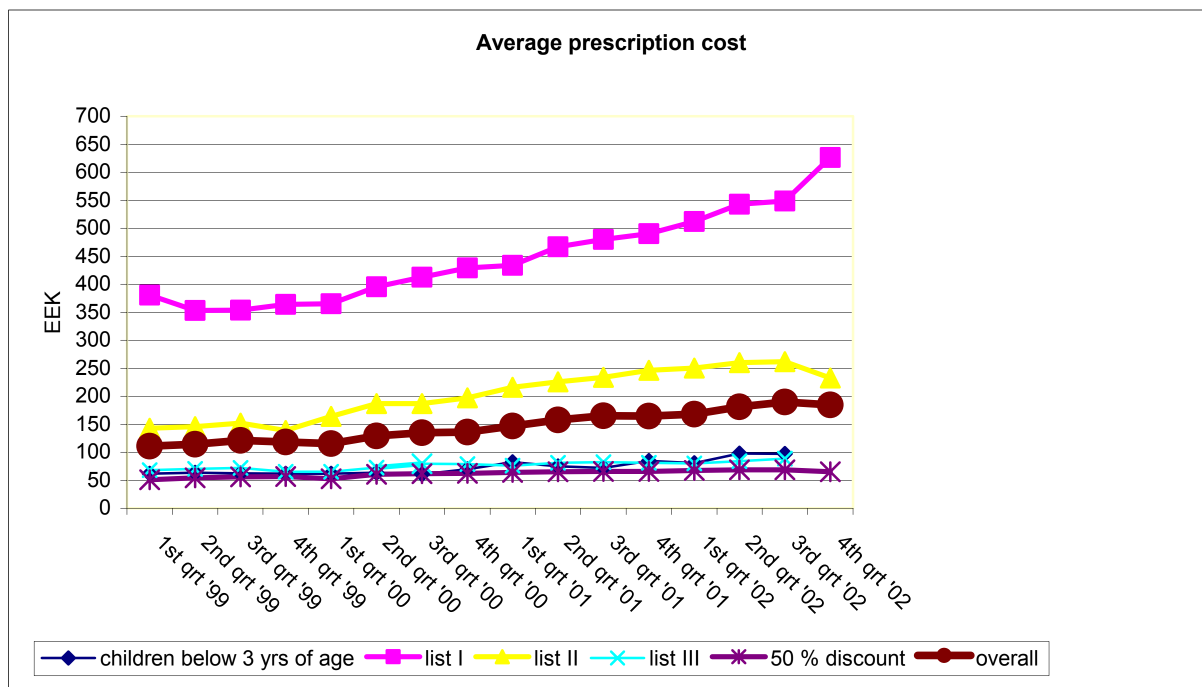


Figure 3. The number of prescriptions paid for by the Health Insurance Fund by the quarters in the years 1999-2002

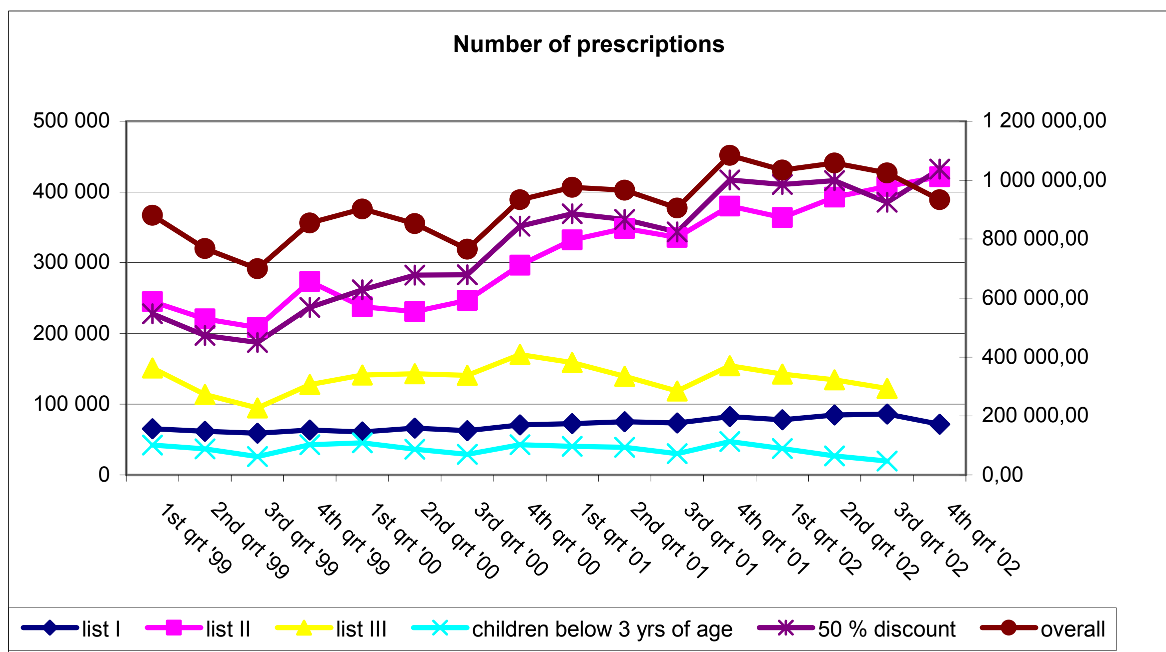
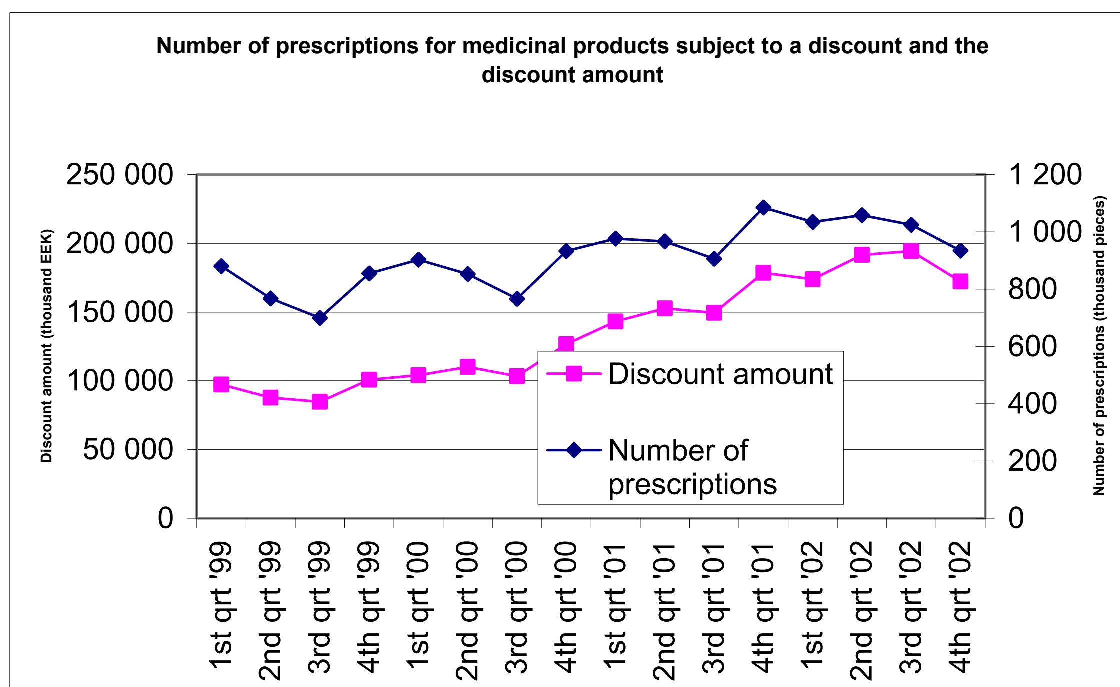


Figure 4. The number of prescriptions of medicinal products subject to a discount paid for by the Health Insurance Fund and the discount amounts by the quarters of the years 1999-2002



The medicinal product compensation has been an "open" obligation for the Health Insurance Fund. According to legislation, the only tool in the hands of the Health Insurance Fund for managing the funds allocated for compensation is to affect the physicians prescribing drugs by providing feedback. As physicians prescribing medicinal products do not perceive the real expenditure on the products, the Health Insurance Fund introduced a system in 2001 to provide regular feedback to family physicians. The aim of the system is to give the family physician regular prescription issuance feedback on the volume and cost of the prescriptions issued by a family physician to influence the physicians to better perceive the "cost of the habit" of prescribing medicinal products and give the physicians an opportunity to compare themselves with colleagues all over Estonia. In conclusion, the feedback system can be considered effective as the average increase of cost of prescriptions by family physicians has slowed down against the average general issuance of prescriptions in Estonia.

Centrally purchased medicinal products

Table 17. Centrally purchased medicinal products

Speciality (thousand EEK)	**2001 actual**	**2002 budget**	**2002 actual**	**2002 actual/2002 budget %**
Paediatrics		3,600	3,404	94.6 %
Haematology		8,000	8,213	102.7 %
Oncology		9,524	9,044	95 %
Nephrology		5,100	5,100	100 %
Gastroenterology		800	800	100 %
Rheumatology		800	736	92 %
Neurology		4,200	4,192	99.8 %

Gynaecology		1,036	1,035	99.9 %
Urology		500	499	99.8 %
Endocrinology		1,500	1,501	100.1 %
Single cases		6,640	6,281	94.6 %
Antidotes and serums		300	205	68.3 %
TOTAL	**38 226***	**42 000**	**41 009**	**97.6 %**

* As to structural changes, the 2001 and 2002 data is incompatible by items of expenditure

The centrally purchased medicinal products budget implementation for 2002 was 41,009 thousand EEK which is 97.6 % of the budget. Less than planned amount of funds was spent by the specialities of paediatrics, oncology, gynaecology and single cases and antidotes as medicinal products were compensated for according to the actual consumption in the said specialities and by items of expenditure. For instance, for purchasing antidotes and serums 100,000 EEK was allocated to the reserve 95,000 of which was not spent. Also the 6640 thousand EEK allocated for single cases were booked in full extent because of the obligations assumed by the Health Insurance Fund. Actually, the Health Insurance Fund paid 360,000 EEK less for the single cases as some of the extraordinary applicants for the medicinal products did not realise the opportunity to take out the medicinal products at a higher discount.

4. Expenditure on benefits for temporary incapacity for work

In the 2002 budget, 804,000 thousand EEK was planned for the benefits for temporary incapacity for work. The actual expenditure exceeded the planned expenditure by 2 %.

Table 18. Expenditure on benefits for temporary incapacity for work in 2002

Expenditure on benefits for temporary incapacity for work (thousand EEK)	**2001 actual**	**2002 budget**	**2002 actual**	**2002 actual/ 2002 budget %**
Sickness benefit	499,097	539,700	529,829	98 %
Care allowance	86,802	88,300	82,229	93 %
Maternity benefit	148,353	155,000	182,022	117 %
Benefits for accident at work	19,976	21,000	25,177	120 %
Total	**754,228**	**804,000**	**819,257**	**102 %**

Compared to 2001, the expenditure on the benefits for temporary incapacity for work has risen in 2002 by 9 %. The greatest growth resulted from the increased costs on sickness benefits and maternity benefits. One of the reasons behind increase of benefits for temporary incapacity for work has been the increase of the cost of 1 average benefit day related to the growth of gross wages.

The number of days of incapacity for work has in 2002 fallen by 0.3 % compared to 2001. The changes in the days of incapacity for work by types of incapacity benefits has been brought about by the Health Insurance Act entered in to force 1 October 2002.

Table 19. Comparison of 2002 incapacity for work days and the cost of 1-day benefit (in EEK) to the 2001 data

Benefits for incapacity for work	**Incapacity for work days compensated in 2001**	**Incapacity for work days compensated in 2002**	**Cost of 1 day benefit in 2001**	**Cost of 1 day benefit in 2002**
Sickness benefits	4,550,804	4,503,983	110	118
Care allowance	633,256	557,545	137	148
Maternity benefit	1,059,199	1,177,729	140	155
Benefits for accident at work	151,097	171,850	132	147
Total benefits for incapacity for work	**6,394,356**	**6,411,107**		

Sickness benefits

Sickness benefit costs have increased in 2002 compared to 2001:

- Increase of expenditure 6 %
- Increase of average 1-day benefit 7 %

- Decrease of days of incapacity for work 1 %.

Care allowances

Care allowance is the only type of benefit for temporary incapacity for work the costs of which have fallen in 2002 compared to 2001

- Decrease of expenditure 5 %
- Increase of average 1-day benefit 8 %
- Decrease of days of incapacity for work 12 %.

Changes in the aforementioned figures have been brought about by the following:

1. The demographic situation of the Estonian society in 1992-1998 when the number of births dropped in Estonia*:

   The children born during these years belonged to the age group of 4-11 in 2002 and therefore the number of children needing care was lower.

2. The number of persons receiving care allowance has dropped due to the Health Insurance Act that entered into force 1 October 2002 which replaced the care of child below 14 years of age with care of a child below 12 years of age.
3. The growth of average gross wages has increased the cost of 1 average benefit day.

Maternity benefits

In the case of maternity benefits, all the figures have risen:

- Increase of expenditure 23 %
- Increase of average 1-day benefit 10 %
- Increase of days of incapacity for work 11 %.

Reasons:

1. The increase of cost and number of days compensated for incapacity for work can be attributed to the extension of period for which maternity benefit is paid from 126 days to 140 days and as an exception 154 days pursuant to the Health Insurance Act entered into force 1 October 2002.
2. Partially, the increase of expenditure is related to the increase of birth complications and multiple births which entails the right to an additional period of 14 calendar days. The number of secondary maternity benefit records constitutes 30 % of the maternity benefit records.
3. Increase of the number of the insured which is related to the increase of the number of working women among the women who have given birth. Comparing the benefit for temporary incapacity for work data with the health services medical bills, it can be seen that the number of persons receiving maternity benefits was 70 % in 2001 and 73 % in 2002 of the persons who received delivery service.

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* Estonian Medical Birth Registry 1992 - 2000

Table 20. Comparison of data of persons who received maternity benefit

	2001	2002	2002/2001 %
Delivered persons	12,157	12,597	104 %
Persons who received maternity benefit	8,527	9,211	108 %
Difference of the persons who delivered and persons who received maternity benefit (%)	**70 %**	**73 %**	**104 %**

Benefits for accident at work
In the case of benefits for accident at work, all the figures have risen

- Increase of expenditure 26 %
- Increase of 1-day average benefit 11 %
- Increase of days of incapacity for work 14 %.

During the past years, the number of accidents at work** resulting in a severe health injury has risen which is reflected in the increase of expenditure on sickness benefits for accidents at work.

As of 31 December 2002, the number of persons entitled to benefits for temporary incapacity for work was 557,277 constituting 44 % of the general number of the insured.

In 2002, the benefits for temporary incapacity for work were paid to 215,860 persons. The number of the insured receiving benefits fell in 2002 by 1 % compared to 2001.

The major changes (increase of the expenditure on one benefit type or decrease of that on another) are related to the change in living standard or demographic indicators as well as to the changes brought about by the new Health Insurance Act entered into force 1 October 2002. The general increase of expenditure on benefits for temporary incapacity for work in 2002 by 9 % compared to 2001 was caused by the increase of 1 benefit day cost by an average of 8 to 10 %.

5. Other expenditure on health insurance benefits

Expenditure on health insurance benefits arising from international agreements

The Republic of Estonia has concluded agreements in the sphere of social security (incl. health insurance) with Lithuania, Latvia and Finland. Estonia has entered into a social security agreement with the Ukraine but as of 4 June 2002, the emergency care part of the agreement has been suspended. Estonia has concluded with Sweden an agreement for the provision of medical care only. Under the agreements, the insured from the said states receive upon stay in Estonia emergency medical care financed out of the funds of the Estonian Health Insurance Fund.
In 2002, the Estonian health care institutions were paid for emergency medical care provided to the insured of the states covered by the international agreements in the amount of 1,364 thousand EEK, incl. 937 thousand EEK for emergency care provided to the Finnish citizens, 182 thousand EEK to Swedish citizens, 134 thousand EEK to Latvian citizens, 83 thousand EEK to Lithuanian citizens and 28 thousand EEK to Ukrainian citizens.

Medical device benefits

Table 21. Medical device benefit budget implementation in 2002

Medical device benefits (thousand EEK)	2001 actual*	2002 budget	2002 actual	2002 actual/2002 budget %
First early prostheses and orthoses		6,000	5,976	99.6 %
Diabetes test strips		4,300	5,134	119.4 %
Stoma maintenance devices		3,800	4,409	116 %
Other medical devices		3,900	485	0.12 %
Total	**5,386***	**18,000**	**16,004**	**88.9 %**

* As to structural changes, the 2001 and 2002 data is incompatible by items of expenditure

In 2002, the Health Insurance Fund compensated for the medical devices in the amount of 16,004 thousand EEK (89 % of the amount planned for the year). The Health Insurance Fund compensated out of the funds for other medical devices for the pressure garments of burn patients, medical contact lenses and breathing device rental.
First early prostheses and orthoses were compensated for in the extent of 5,976 thousand EEK to 670 insured persons. In 2001, prostheses and orthoses were compensated for in the extent of 5,400 thousand EEK to 450 persons. Up to 1 October 2002, medical devices were purchased under public procurement procedure, but as of 21 October 2002, medical devices are compensated for to the extent of 90 % according to the list of medical devices of the Health Insurance Fund.

II Health Insurance Fund operating costs

The Health Insurance Fund health insurance benefit administration operating costs were 82,954 thousand EEK in 2002.

6. Personnel and administration costs

Table 22. Personnel and administration costs budget implementation in 2002

Personnel and administration costs (thousand EEK)	2001 actual	2002 budget	2002 actual	2002 actual/2002 budget %
Total personnel and administration costs	**34,486**	**44,997**	**42,796**	**95.1 %**
Total remuneration	25,872	33,705	32,058	95.1 %
Basic remuneration	24,389	26,935	26,066	96.8 %
Performance-related remuneration	0	4,765	4,159	87.3 %
Management Board basic and performance-related remuneration	1,483	2,000	1,830	91.5 %
Supervisory Board remuneration	0	5	3	60.0 %
Unemployment insurance tax	0	169	158	93.5 %
Social tax	8,614	11,123	10,580	95.1 %

Personnel costs include personnel, Management Board and Supervisory Board Member remuneration: basic remuneration and performance-related remuneration, social tax and unemployment insurance tax.

Personnel and administration costs in 2002 amounted to 42,796 thousand EEK.

Remuneration constitutes 95.1 % of the annual budget. The underspending can be attributed to lower performance-related remuneration and the tax calculated thereupon.

Performance-related remuneration was planned for according to the maximum limit values, but the performance management procedure developed at the beginning of 2002 specified performance-related remuneration criteria which tie the performance-related remuneration directly to the actual performance.

7. Management costs

Management costs are divided into office expenditure, equipment purchase costs, rooms maintenance costs, travel expenses, vehicle maintenance costs and other expenditure.

Table 23. Management costs budget implementation in 2002

Management costs (thousand EEK)	2001 actual*	2002 budget	2002 actual	2002 actual/2002 budget %
Management costs	**14,397**	**15,000**	**14,047**	**94 %**
Office expenditure	5,057	5,140	3,604	70 %
Rooms maintenance costs	4,451	5,770	5,980	104 %
Equipment	2,614	860	1,413	164 %
Vehicle maintenance costs	1,743	2,050	1,872	91 %
Travel	191	780	280	36 %
Other expenditure	341	400	898	225%

* The 2001 management costs have been reduced by the training costs (1,030 thousand EEK) to ensure comparability in table 23; training expenses are recorded under development costs as of 2002.

Management costs – the 14,047 thousand EEK constitute 94 % of the annual budget. The implementation of the budget differs by expenditure items. Funds were overspent as to equipment, rooms and other expenditure.

Office expenses – 3,604 thousand EEK. These include stationery, postage and communication expenses and newspaper and publication costs. The greatest expense articles are other office expenses, incl. paper and printer toner cartridges the cost of which amounted to 1,800 thousand EEK in 2002. The communication expenses, constituted mostly of telephone costs amount to 1,500 thousand EEK. The 2002 post office expenses were planned based on the level of previous periods but the actual expenses were lower as to the structural reform (cutting down of departments and personnel).

Rooms maintenance costs – 5,980 thousand EEK. The costs increased because of the rise of the price of electricity and heating, relocation of the Harju department after the expiry of rental agreement with location at Hariduse 8 and increase of rental costs at the premises at Lembitu 10.

Equipment – 1,413 thousand EEK. These include fittings of the rooms (furniture), office machines and the maintenance and renovation of office equipment. In 2002, equipment was not purchased in large quantities. The main expense articles were the purchase of furniture for single workplaces and costs for replacing the existing furniture (front office chairs), office machines and home appliances and the uniform for front office personnel. The main reason for overspending is that the residual value of the fittings and equipment fixed asset depreciation adjusted after the 2001 audit has not been incorporated into the planning of the budget.

Vehicle maintenance costs – 1,872 thousand EEK. In addition to the Health Insurance Fund vehicle maintenance costs, the lease payments have been included. The Health Insurance Fund has 22 vehicles. Every regional department has one commonly used vehicle usually at the disposal of medical advisers; also the Management Board Members, regional department heads, customer service head and administrative head have a vehicle.
Travel expenses - 280 thousand EEK. Compensation of work-related travel expenses. The greatest expense article planned for 2002 were the missions of the Health Insurance Fund central department personnel to the regional departments and the IT-specialists participation at conferences. Although the travel expenses have risen compared to 2001, the travel funds are underspent as the participation of the personnel at conferences and missions to the regional departments were not realised to the full extent.

Other expenditure - 898 thousand EEK. Personnel recruitment expenses, treatment and health care expenses, outsourced services (incl. translation services), representation costs and fringe benefit costs. The main reason for overspending were underestimated personnel recruitment expenses and expenditure on treatment and health care.

8. Information technology costs

Table 24. Information technology budget implementation in 2002

Information technology costs (thousand EEK)	2001 actual*	2002 budget	2002 actual	2002 actual/2002 budget %
Infrastructure		8,390	8,390	100 %
Management information system		4,940	4,940	100 %
Other		1,170	1,231	105 %
Total	**12,471**	**14,500**	**14,561**	**100 %**

* As to structural changes, the 2001 and 2002 data is incompatible by items of expenditure

The information technology costs were 14,561 thousand EEK, the budget was fully implemented. The infrastructure development and maintenance required 8,390 thousand EEK, management information system development and maintenance 4,940 thousand EEK and other expenses 1,231 thousand EEK.

The main information technology related development work in 2002:

- Gradual integration of SAP governance and business solutions with the health insurance registry.

- Data protection procedures development and implementation as a result of which the Data Protection Inspectorate registered the processing of sensitive personal data in the Estonian Health Insurance Fund database.

- Fast development of e-services as the result of which

1) the insured and employers can monitor and amend their data via the electronic secure channels of banks;
2) health care institutions and pharmacies can transmit to the Health Insurance Fund medical bills and prescriptions of medicinal products subject to a discount via electronic secure channels.

- Substantial reorganisation of the infrastructure was launched to bring it in line with the renewed structural logic of the Health Insurance Fund.

- Health insurance registry development in accordance with the new Health Insurance Act.

9. Expenditure on the payment of health insurance benefits

The expenditure on the payment of the health insurance benefits constitute 1,284 thousand EEK. The overspending was caused by the fees paid to the Estonian Post Office for the disbursement of benefits to the insured (according to postal orders in the post offices). Upon the drafting of the budget the entry into force of the new act was taken account. The draft act provided the payment benefits for incapacity for work only into the bank accounts of the insured. Therefore the relevant expenditure item in the 2002 budget was 47 % lower than in 2001.

10. Development costs

Table 25. Development costs budget implementation in 2002

Development costs (thousand EEK)	**2001 actual***	**2002 budget**	**2002 actual**	**2002 actual/2002 budget %**
Training	1,030	2,000	1,668	83 %
Consultations	553	2,280	797	35 %
Business consultations	*553*	*1,900*	*341*	18 %
Legal consultations	*0*	*380*	*456*	120 %
Total	**1,583**	**4,280**	**2,465**	**58 %**

* The 2001 development costs have been added by the training expenses (1030 EEK) in table 25 to ensure comparability. In 2001, training expenses were recorded under management costs.

Development costs – 2,465 thousand EEK constitute 58 % of the annual budget. The underspending is caused by less than planned use of training and business consultation services.

Training expenses – constitute 83 % of the annual budget. The funds are underspent as during the first quarter a new training system and the basis of personnel competence assessment were developed to define training needs.

Proceeding from the personnel assessment results, the Management Board approved training programme for April-December 2002 and thus less training courses were financed in the first quarter.

Business consultation expenses are related to the outsourcing of consultation services (mostly committees, expert assessments, advisory body and working groups). The 2002 development budget entailed also several projects which were not implemented in full extent.

The health services DRG prices project deadline was postponed by a year, that is until 1 January 2003, the medicinal products reference prices development project was suspended as the new Health Insurance Act transferred the relevant function to the Ministry of Social Affairs.

Consultation funds for treatment instruction development and approval were underspent since despite the conclusion of contracts for treatment instruction development, professional medical societies did not submit the Health Insurance Fund a single treatment instruction in 2002.

The planning had also taken account of the transfer of the committee for medicinal products subject to a discount from the Ministry of Social Affairs to the Estonian Health Insurance Fund and the outsourcing of consultations for the transferred committee.

Table 26. Business consultation budget lines and implementation in 2002

Business consultation thousand EEK	**2002 budget**	**2002 actual**
Price list	100	55
Health services DRG prices	576	
Treatment instructions	500	
Medicinal products reference prices	114	20
List of medicinal products subject to a discount	340	33
Other	270	233
Total	**1,900**	**341**

The funds for **legal consultations** are related both to legislative drafting and preparing of contracts and the list of medicinal products subject to a discount, etc (draft acts, expert assessments). The legal consultation expenses exceed the annual budget by 76 thousand EEK constituting 120 % of the annual budget. The overspending arises from the amendment proposals made during the proceeding of the new Health Insurance Act and the drafting costs of the medicinal products implementation acts.

11. Financial expenditure

Table 27. Financial expenditure budget implementation in 2002

Financial expenditure (thousand EEK)	**2001 actual**	**2002 budget**	**2002 actual**	**2002 actual/2002 budget %**

Bank service charge	537	800	435	54 %
National Treasury maintenance costs	0	200	50	25 %
Other financial expenditure	0	0	29	0 %
Total	**537**	**1,000**	**514**	**51 %**

Financial expenditure (bank service charge and legal reserve administration costs and other financial expenditure) is 514 thousand EEK and constitutes 51.4 % of the annual budget.

Other financial expenditure entails losses from exchange rates in the amount of 29 thousand EEK which is expenditure related to currency exchange.

Bank service charges in 2002 constituted 435 thousand EEK. Banking services funds were underspent as the benefit for incapacity for work was partially disbursed to the insured by post offices of Estonian Post Office.

For the administration of **legal reserve,** a more favourable contract was concluded with the National Treasury after the adoption of 2002 budget and thus less was paid for the administration.

12. Other operating costs

Table 28. Other operating costs budget implementation in 2002

Other operating costs (thousand EEK)	2001 actual	2002 budget	2002 actual	2002 actual/2002 budget %
Pre-printed forms and publications	7,443	2,800	476	17 %
Supervision	454	1,821	527	29 %
Public relations/informing	0	1,320	1,185	90 %
Other expenditure	4,019	1,040	5,099	490 %
Total	**11,916**	**6,981**	**7,287**	**104 %**

Other operating costs in the amount of 7,287 thousand EEK constitute 104 % of the annual budget. Out of the other operating expenditure, 2,800 thousand EEK was planned for health insurance pre-printed forms and publications. During 2002, no new pre-printed forms were ordered due to the delayed adoption of the new Health Insurance Act. Initially it was planned to introduce new pre-printed forms in relation to the payment of benefits for incapacity for work. The expenditure has been transferred into the year 2003. The 2002 **audit expenses** included financial audit, outsourcing of internal audit and health insurance medical audits. The Health Insurance Fund did not succeed in securing contracts with prospect performers of medical audits. The reason behind this was the complexity of preparatory work (definition of the task and negotiations with area specialists) in a situation where there is no previous experience in the field in Estonia.

The other expenditure was composed of fringe benefit costs, in-house notification and planning expenses and pension payments. It was planned to have liability insurance for the Estonian Health Insurance Fund Management Board and Supervisory Board but this was not effected and therefore the budgetary funds underspent. In addition the other expenditure includes the claims in the amount of 4,373 thousand EEK that are declared as unlikely to be recovered. Proceeding from the conservative principle, the Health Insurance Fund declares claims older than a year as unlikely to be recovered.

Public relations/informing expenses include also the publication of a yearbook. The yearbook was published in an electronic format and therefore the budgetary funds were underspent.

13. Legal reserve
225,597 thousand EEK

The legal reserve formation is governed by § 38 of the Estonian Health Insurance Fund Act as follows:

- The legal reserve of the Health Insurance Fund means the reserve formed of the budget funds of the Health Insurance Fund for the reduction of the risk which macro-economic changes may cause to the health insurance system.

- The legal reserve shall amount to 8 per cent of the budget. Each year, at least one-fiftieth of the total budget of the Health Insurance Fund and revenue from the social tax revenue prescribed for the payment of health insurance benefits which is higher than prescribed in the state budget shall be transferred to the legal reserve, until the amount of the legal reserve provided by this Act is reached or restored.

- The legal reserve may only be used as an exception by an order of the Government of the Republic on the proposal of the Minister of Social Affairs. Prior to submitting a proposal to the Government of the Republic, the Minister of Social Affairs shall hear the opinion of the Supervisory Board of the Health Insurance Fund.

The amount transferred to the legal reserve shall be specified with the decision of the Supervisory Board after the approval of the audited annual report.

The amount of the Health Insurance Fund legal reserve is currently 189,810 thousand EEK which was transferred to the legal reserve after the approval of the annual report with the Supervisory Board decision No. 15 of 7 June 2002.

The 2002 net surplus distribution proposal by the Management Board provides the transfer of the 100,000 thousand EEK planned in the 2002 budget and the health insurance share of the excessively collected social tax in the amount of 125,597 thousand EEK to the legal reserve. The total amount transferred to the legal reserve in 2002 is 225,597 thousand EEK.

14. Risk reserve
142,833 thousand EEK

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

- The risk reserve of the Health Insurance Fund is the reserve formed from the budgetary funds of the Health Insurance Fund in order to minimise the risks arising for the health insurance system from the obligations assumed.

- The size of the risk reserve shall be 2 per cent of the health insurance budget of the Health Insurance Fund.

- The funds of the risk reserve may be used upon a decision of the Supervisory Board of the Health Insurance Fund.

The Health Insurance Fund has the obligation to establish a risk reserve as of 1 October 2002 with regard to the entry into force of the new Health Insurance Act. The said act amended the Estonian Health Insurance Act by adding § 39[1] to it.

The amount transferred to the risk reserve shall be specified with the decision of the Supervisory Board after the approval of the audited annual report.

Currently, no appropriations to the risk reserve have been made with the decision of the Supervisory Board.

In the 2002 budget drafting, 80,000 thousand EEK was planned for cash reserve. The reserve was intended for risk mitigation and may be deemed as a planned appropriation to the risk reserve. The said amount shall be transferred to the risk reserve with the decision of the Supervisory Board after the approval of the 2002 annual report.

The 2002 net surplus distribution proposal by the Management Board provides the transfer of the 80,000 thousand EEK planned in the 2002 budget and the underspent budgetary funds in the amount of 62,833 thousand EEK to the risk reserve. The total amount of the risk reserve in 2002 is 142,833 thousand EEK.

Annual accounts 2002

Statement by the Management Board

The Management Board declares its responsibility for the accuracy of the Estonian Health Insurance Fund's annual accounts for 2002 as set out on pages 52 to 67 and confirms, to the best of its kowledge, that:

- the accounting principles used in preparing the annual accounts are in compliance with the generally accepted accounting principles;
- the annual accounts present a true and fair view of the financial situation and the revenue and expenditure of the Estonian Health Insurance Fund;
- all relevant circumstances, which have occured before the completion of the report, i.e. 31.03.2003, have been duly recognised and reflected in the annual accounts;
- the Estonian Health Insurance Fund is a going concern.

		Date	Signature
Chairman of the Management Board	**Hannes Danilov**		
Member of the Management Board	**Arvi Vask**		
Member of the Management Board	**Andres Rannamäe**		
Member of the Management Board	**Rein Parelo**		

Balance sheet

	Adjusted 31.12.2001	31.12.2002	Note
ASSETS			
Current assets			
Cash and bank accounts	268,883,547	309,026,470	2
Shares and other securities	91,707,662	327,975,972	3
Customer receivables			
Accounts receivable	8,134,173	14,546,593	
Allowance for doubtful receivables	-2,117,439	-4,839,180	
Total	6,016,734	9,707,413	
Other receivables			
Other short-term receivables	29,932,236	36,325,153	4
Accrued income			
Interest receivable	4,103,805	10,985,207	
Other accrued income	57,790,394	82,955,228	5
Prepaid expenses			
Other prepaid expenses	541,895	490,399	
Inventories			
Raw materials	0	0	
Goods for resale	1,439,596	445,955	
Prepayments to suppliers	1,030	0	
Total	1,440,626	445,955	6
Total current assets	**460,416,900**	**777,911,797**	
Fixed assets			
Long-term financial assets			
Other shares and securities	180,000	180,000	3
Miscellaneous long-term receivables	29,080,168	156,018,399	3; 9
Total	29,260,168	156,198,399	
Tangible fixed assets			
Land and buildings (at cost)	3,501,796	3,106,240	
Machinery and equipment (at cost)	483,966	7,971,250	
Other inventories (at cost)	30,250,366	18,277,871	
Accumulated depreciation	-23,182,888	-20,675,400	
Prepayment for tangible assets	0	0	
Total	11,053,240	8,679,961	8
Intangible fixed assets			
Purchased licences	2,279,357	3,201,853	8
Total fixed assets	**42,592,765**	**168,080,213**	
TOTAL ASSETS	**503,009,664**	**945,992,010**	

LIABILITIES AND EQUITY CAPITAL

PASSIVA	**Adjusted 31.12.2001**	**31.12.2002**	**Note**
Liabilities			
Current liabilities			
Short-term debt obligations			
Unsecured debt obligations	1,551,306	1,623,893	10
Supplier payables			
Accounts payable for medical care services	215,388,612	252,237,724	
Accounts payable for medicinal products subject to discount	48,536,976	65,919,973	
Supplier payables for health insurance benefit	15,255,893	31,569,659	
Other supplier payables	3,138,948	2,436,917	
Total supplier payables	282,320,429	352,164,273	
Taxes payable	18,425,619	21,539,752	7
Accrued expenses			
Employee-related liabilities	1,958,966	4,857,058	
Interest payable	0		
Other accrued expenses	0	170,988	
Total	1,958,966	5,028,046	
Short-term provisions	125,214	405,757	
Total current liabilities	**304,381,533**	**380,761,722**	
Long-term liabilities	**5,298,654**	**3,674,761**	10
Total current liabilities	**309,680,188**	**384,436,482**	
Equity capital			
Legal reserve	0	189,810,061	
Net surplus/deficit for previous periods	-28,034,370	3,315,300	
Net surplus/deficit for financial year	230,760,935	368,430,167	
Total equity capital	**202,726,564**	**561,555,528**	
TOTAL LIABILITIES AND EQUITY CAPITAL	**512,406,752**	**945,992,010**	

Statement of revenue and expenditure

	Adjusted Year 2001	Year 2002	Note
Revenue from the health insurance part of social tax and claims collected from other persons	4,550,244,404	5,074,934,231	11
Operating expenses grant financed by the Ministry of Social Affairs	257,599	244,242	
Expenditure on health insurance	-4,263,614,855	-4,647,939,687	11
Gross surplus/deficit	**286,887,148**	**427,238,786**	
General administration expenses	-76,392,910	-75,397,446	11
incl. grant financed operating expenses	-257,599	-244,242	
Other operating revenue	5,160,407	3,738,500	
Other operating expenses	-2,925,421	-2,914,018	
Operating surplus/deficit	**212,729,224**	**352,665,822**	
Financial revenue			
other interest and financial revenue	8,634,622	20,651,426	
Total financial revenue	**8,634,622**	**20,651,426**	
Financial expenses			
other financial expenses	0	-4,887,081	
Total financial expenses	**0**	**-4,887,081**	
Net deficit/surplus for financial year	**221,363,846**	**368,430,167**	

In connection with the presentation of expenditure on benefits for incapacity for work the health insurance expenditure has been adjusted upwards by 9,397,088 kroons, in order to ensure comparability. The reason was a change in the accounting principle in 2002: formerly, benefits for incapacity for work were expensed and shown as a liability after the official acceptance of the certificate of incapacity for work following their processing, but now the liability is recognised at the time of registering the said certificate in the information system of the Health Insurance Fund.

Cash flow statement

	2001	2002
Cash flow from operating activities		
Social tax received	4,578,437,928	5,028,908,106
Payments to suppliers	4,228,375,374	4,602,092,838
Personnel expenses paid	21,085,820	28,721,038
Taxes paid	12,691,641	10,646,364
Interest paid	0	
Other revenue received	40,191,997	27,253,464
Other expenses paid	980,147	347,826
Total cash flow from operating activities	**355,496,943**	**414,353,503**
Cash flow from investing activities		
Purchase of fixed assets	516,820	5,973,634
Proceeds from disposals of fixed assets	413,163	369,595
Proceeds from disposals of short-term financial assets		787,078,106
Purchase of short-term financial assets	91,707,662	1 023,346,416
Purchase of long-term financial assets	0	132,338,231
Total cash flow from investing activities	**-91,811,319**	**-374,210,580**
Total cash flow	**171,977,961**	**40,142,923**
Cash and cash equivalents at the beginning of period	96,905,586	268,883,547
Change in cash and cash equivalents	171,977,961	40,142,923
Cash and cash equivalents at the end of period	268,883,547	309,026,470
incl. short-term deposits	257,000,000	291,000,000

Statement of changes in equity

	2001	2002
Legal reserve		
Legal reserve at the beginning of the year	**0**	**0**
Formation	0	189,810,061
Legal reserve at the end of the year	**0**	**189,810,061**
Net surplus/deficit of previous periods		
At the beginning of the year	**-21,215,922**	**193,329,476**
Transfer of a building (Põllu 1a, Tartu) for no consideration	-6,818,448	0
Transfer of apartment ownership (in Põlva) to the Ministry of Social Affairs for no consideration	0	-204,115
Payment to form legal reserve	0	-189,810,061
Net surplus/deficit for financial year	221,363,847	368,430,167
At the end of the year	**193,329,476**	**371,745,467**
Equity at the beginning of the year	**-21,215,922**	**193,329,476**
Equity at the end of the year	**193,329,476**	**561,555,528**

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

General information

The Estonian Health Insurance Fund (EHIF) is a legal person in public law established pursuant to the Estonian Health Insurance Fund Act adopted on June 14, 2000. The EHIF started its activities under the said Act on January 1, 2001. The EHIF is the successor in title of the Central Health Insurance Fund and the regional health insurance funds, which operated until the entry into force of the Estonian Health Insurance Fund Act. The purpose of the EHIF is the provision of health insurance benefits in accordance with the Health Insurance Act and other legislation of the Republic of Estonia and with the health insurance expenditure specified in the budget of the EHIF.

The EHIF derives the funds necessary for the performance of its functions mainly from the health insurance expenditure specified in the state budget, and also from the amounts of social tax collected in excess of the budgeted amount and earmarked for health insurance. The EHIF uses the received social tax to finance the provision of healthcare services to persons covered by health insurance and persons having equivalent status as well as the provision of medicinal products subject to discount, and to pay benefits for incapacity for work.

General principles

The annual accounts of the EHIF have been drawn up in accordance with the Accounting Act of Estonia and the generally accepted accounting principles based on internationally recognised accounting and reporting policies.

The financial year began on January 1, 2002 and ended on December 31, 2002. The figures in the annual accounts have been given in Estonian kroons.

Economic transactions are recorded at actual value according to the historical cost principle at the time of effecting. Financial statements are prepared on the basis of the accrual method.

Layouts used for reporting purposes and adjustment of the accounts for the preceding financial year

The balance sheet layout specified in the Accounting Act is used for the purpose of drawing up the annual accounts. For the purpose of the revenue and expenditure account, layout no. 2 of the profit and loss account set out in the Accounting Act is used with some entries being renamed to accommodate the specific features of the activities of the EHIF.

As changes have been made in the principles of accounting for the expenditure on benefits for incapacity for work paid to the insured, the annual accounts for 2001 have been adjusted to ensure comparability.

Foreign exchange accounts

Transactions in foreign currency are recorded in Estonian kroons on the basis of the exchange rate published by the Bank of Estonia applicable on the transaction day. Assets and liabilities established in foreign currency are revalued on the basis of the exchange rate valid on the balance sheet date and the currency translation reserve is shown in the revenue and expenditure account.

Revenue and expenditure accounts

Revenue and expenditure have been recorded in accordance with the accrual method. Interest income is recorded as accrued and dividends are recorded when the entitlement to dividends is established.

Financial investment accounts

Short-term financial investments relate to securities, which have been acquired for the purpose of subsequent resale during the financial year following the balance sheet date or which have a redemption time limit of one year or less, calculated from the balance sheet date.

Accounts for securities acquired for short-term holding

Securities acquired for short-term holding are recorded either on the basis of their acquisition cost or the net realisable value, whichever is the lower. The FIFO method is used for the valuation of securities.

Long-term financial investment accounts

Portfolio investments in shares and other securities are appraised on the basis of either the historical cost of the investment or the net realisable value, whichever is the lower.

If the acquisition cost of long-term bonds differs from their nominal value, the difference between the acquisition cost and the nominal value is distributed between the periods covered by the term of maturity of the security and recorded in the revenue and expenditure account under financial income.

Receivable and loan accounts

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

Receivables and loans, which do not justify any recovery measures for practical or economical reasons, are deemed irrecoverable and written off.

Stock accounts

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

Tangible fixed asset accounts

Tangible fixed assets are assets having an expected useful life of more than one year and an acquisition cost of more than 10,000 kroons. Assets, which have a shorter expected useful life and a smaller acquisition cost, are expensed at the time of acquisition.

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

The following depreciation time limits are applied:

- buildings 20 to 25 years;
- machinery, equipment and other tangible fixed assets 3 to 10 years.

Intangible fixed asset accounts

Intangible fixed assets are identifiable non-monetary assets, which have no physical substance, have an expected useful life of more than one year, are used for own activities or administrative purposes and have an acquisition cost of more than 10,000 kroons.

Intangible fixed assets are recognised at their acquisition cost and depreciated on a straight-line basis in accordance with their expected useful life within 3 to 5 years.

Expenditure on tangible and intangible assets incurred after acquisition are, as a rule, expensed for the period. Additional expenditure are added to the cost of intangible fixed assets, if it is likely that this expenditure allows the asset to generate more economic benefits in the future than expected and if this expenditure can be reliably assessed and related to the asset.

Operating and financial lease accounts

Operating lease refers to lease, which the lessee can terminate without any complementary payments and where the ownership of the leased asset is not transferred to the lessee during or at the end of the lease period. Operating lease payments are entered under expenditure as accrued.

Financial lease refers to lease other than operating lease. The asset leased in the form of financial lease and the respective liability are recognised on the balance sheet. Where, according to the lease contract, the ownership of the leased asset is transferred to the lessee depreciation is calculated according to the standard procedure. If the leased asset is to be returned, the maximum depreciation period for the asset is the period of the leasing relationship.

Risk reserve

The risk reserve of the EHIF budget is a reserve governed by § 39^1 of the Estonian Health Insurance Fund Act as follows:

- The risk reserve of the health insurance fund is the reserve formed from the budgetary funds of the health insurance fund in order to minimise the risks arising for the health insurance system from the obligations assumed.

- The size of the risk reserve shall be 2 per cent of the health insurance budget of the health insurance fund.

- The funds of the risk reserve may be used upon a decision of the supervisory board of the health insurance fund.

The health insurance fund has the obligation to establish a risk reserve as of 1 October 2002 with regard to the entry into force of the new Health Insurance Act. The said Act amended the Estonian Health Insurance Act by adding § 39^1 to it.

The amount transferred to the risk reserve shall be specified with the decision of the supervisory board after the approval of the audited annual report.

Legal reserve

The legal reserve formation is governed by § 38 of the Estonian Health Insurance Fund Act as follows:

- The legal reserve of the health insurance fund means the reserve formed of the budget funds of the health insurance fund for the reduction of the risk which macro-economic changes may cause to the health insurance system.

- The legal reserve shall amount to 8 per cent of the budget. Each year, at least one-fiftieth of the total budget of the health insurance fund and revenue from the social tax revenue prescribed for the payment of health insurance benefits which is higher than prescribed in the state budget shall be transferred to the legal reserve, until the amount of the legal reserve provided by this Act is reached or restored.

- The legal reserve may only be used as an exception by an order of the Government of the Republic on the proposal of the Minister of Social Affairs. Prior to submitting a proposal to the Government of the Republic, the Minister of Social Affairs shall hear the opinion of the supervisory board of the health insurance fund.

The amount transferred to the legal reserve shall be specified with the decision of the supervisory board after the approval of the audited annual report.

Note 2. Cash and bank accounts

	31.12.2001	31.12.2002
Deposits at call	11,883,547	18,026,470
Fixed term deposits	257,000,000	291,000,000
Total cash and bank accounts	**268,883,547**	**309,026,470**

Fixed term deposits:		
due within 1 month	227,000,000	166,000,000
due within 1 to 3 months	30,000,000	125,000,000
Total	**257,000,000**	**291,000,000**

Note 3. Shares and other securities

Short-term investments

Bond	Date of acquisition	Acquisition value (at cost)	Maturity date	Rate of return
NordRheinWest LB	11.09.2002	37,454,787	20.01.2003	3,26 %
Bond of the Republic of Finland	13.09.2002	8,064,346	05.02.2003	3,26 %
Bond of the Kingdom of Spain	11.12.2002	8,077,520	04.03.2003	2,86 %
LB NordRheinWest	11.09.2002	31,937,717	17.03.2003	3,25 %
Depfa Pfandbriefbank	11.09.2002	32,249,382	03.04.2003	3,24 %
Eesti Ühispanga KP	21.08.2002	48,911,050	07.04.2003	3,50 %
LB Bade-Württemberg	13.09.2002	40,404,930	28.04.2003	3,26 %
Bond of the Government of Germany	12.12.2002	21,429,247	02.05.2003	2,84 %
Sampo Panga KP	20.11.2002	19,668,720	20.05.2003	3,35 %
Deutsche Hypothekenbank	12.09.2002	32,827,635	03.06.2003	3,25 %
AB Spintab	12.12.2002	31,302,199	11.07.2003	2,92 %
Deutsche Hypothekenbank	27.09.2002	15,648,440	27.08.2003	3,03 %
Total		**327,975,972**		

Inerest receivable from short-term financial investments is shown under accrued income on the balance sheet.

Long-term investments

The Estonian Health Insurance Fund has acquired shares with the following nominal values:

	Shares of AS Viimsi Haigla (at cost)		Shares of AS Pärnu Mudaravila (at cost)	
	2001	**2002**	**2001**	**2002**
Balance at the beginning of year	90,000	90,000	90,000	90,000
Balance at the end of year	90,000	90,000	90,000	90,000

The Estonian Health Insurance Fund owns less than 20% of the shares of mentioned companies.

The Estonian Health Insurance Fund has acquired long maturity bonds as follows:

Bond	**Date of acquisition**	**Acquisition value (at cost)**	**Maturity date**	**Rate of return %**
Sachsen LB	18.09.2002	39,094,030	18.03.2004	2,98 %
AB Spintab	04.10.2002	31,280,728	05.04.2004	3,34 %
Eesti Ühispank	26.03.2002	10,000,000	01.04.2005	5,15 %
Eesti Ühispank	21.11.2002	20,593,740	01.04.2005	3,80 %
Hansapank	12.11.2002	15,720,179	10.09.2005	3,22 %
Bayerische LB	29.11.2002	15,649,555	27.11.2006	3,40 %
Total		**132,338,231**		

Note 4. Other short-term receivables

Essence	**31.12.2001**	**31.12.2002**	**Note**
Claim to the Russian Federation	15,475,469	18,585,202	
Claim to Tallinn Social Welfare and Health Care Department (Tallinn Diagnostic Centre)	9,541,194	9,541,194	
Short-term part of loans granted	4,893,300	9,600,000	9
Claims for reimbursement of maintenance costs	11,435	84,966	
Contractual claims against insured persons	0	75,456	
Allowance for doubtful receivables	0	- 1,561,665	
Unused part of health promotion funds	10,838	0	
Total	**29,932,236**	**36,325,153**	

The social department at the Embassy of the Russian Federation shall pay the debt arising from expenditure on the treatment of unemployed military pensioners in accordance with the earlier agreement, after the new international agreement has been signed.

Note 5. Other accrued income

Interests as of 31.12.2002

1. Interest receivable from bank deposits in the amount of 6,714 kroons.

2. Interest receivable from loans granted in the amount of 169,901 kroons.

3. Interest receivable from bonds acquired by the Estonian Health Insurance Fund in the amount of 10,808,593 kroons.

Other accrued income

Other accrued income include health insurance income from social tax paid by tax-payers as of 31.12.2002, but not transferred by the National Treasury in the amount of 82,955,228 kroons.

Note 6. Inventories

As of 31.12.2002, the Estonian Health Insurance Fund has purchased pre-printed prescription forms costing 445,955 kroons.

Note 7. Taxes

Tax	Pre-payment	31.12.2001 Taxes payable	31.12.2002 Taxes payable
Income tax	1,109	16,526,830	18,775,485
Social tax	1,314	1,851,362	2,611,352
Income tax from fringe benefits	0	47,427	54,597
Land tax	492	0	0
Unemployment insurance premium			78,882
Mandatory funded pension premiums			19,435
Total	**2,915**	**18,425,619**	**21,539,751**

The individual income tax arrears include individual income tax in the amount of 17,701,475 kroons deducted from the benefits for incapacity for work pay by the Health Insurance Fund to the insured.

The social tax arrears include social tax in the amount of 525,965 kroons calculated from the holiday pay not disbursed to the employees.

Note 8. Fixed assets

Tangible fixed assets

	Land and buildings	Machinery and equipment	Other inventories	Total
Acquisition cost				
31.12.2001	3,501,796	483,966	30,250,366	34,236,128
Purchase of fixed assets		1,248,181	413,555	1,661,736
Proceeds of fixed assets	-175,000			-175,000
Transferred free of charge / written off	-220,556	-548,545	-5,598,402	-6,367,503
Reallocation between fixed		6,787,648	-6,787,648	-

asset groups				
31.12.2002	3,106,240	7,971,250	18,277,871	29,355,361
Accumulated depreciation				
31.12.2001	1,870,205	444,442	20,868,240	23,182,887
Calculated depreciation	160,514	509,274	2,924,707	3,594,495
Fixed assets sold / written off / transferred	-172,648	-376,852	-5,552,483	-6,101,983
Reallocation between fixed asset groups		5,719,038	-5,719,038	-
31.12.2002	1,858,071	6,295,902	12,521,426	20,675,399
Residual value				
31.12.2001	1,631,591	39,524	9,382,125	11,053,240
31.12.2002	1,248,169	1,675,348	5,756,445	8,679,961

In 2002 the ownership of apartments in Põlva worth 220,556 kroons at cost was transferred to the Ministry of Social Affairs.

Intangible fixed assets

Acquisition cost	**Purchased licences**
31.12.2001	5,261,646
Purchase of fixed assets	2,688,005
31.12.2002	7,949,651
Accumulated depreciation	
31.12.2001	2,982,290
Calculated depreciation	1,765,509
31.12.2002	4,747,799
Residual value	
31.12.2001	2,279,357
31.12.2002	3,201,852

Note 9. Loans granted by the Estonian Health Insurance Fund

As of 31.12.2001

Medical institution	**Loan balance as of 31.12.2001**	**incl. the short-term part of the loan**	**incl. the long-term part of the loan**	**Balance of unpaid interest as of 31.12.2001**
Mustamäe Hospital	16,633,500	0	16,633,500	4,068,529
Estonian Oncological Centre	13,046,668	600,000	12,446,668	0
Tallinn Central Hospital	4,200,000	4,200,000	0	29,334
Ahtme Hospital	93,300	93,300	0	0
Total	**33,973,468**	**4,893,300**	**29,080,168**	**4,097,863**

As of 31.12.2002

Medical institution	**Loan balance as of 31.12.2002**	**incl. the short-term part of**	**incl. the long-term part of the**	**Balance of unpaid interest**

		the loan		loan as of 31.12.2002
SA Põhja-Eesti Regionaalhaigla	29,080,168	5,400,000	23,680,168	0
incl. under former contracts				
Mustamäe Hospital	16,633,500	3,600,000	13,033,500	0
Estonian Oncological Centre	12,446,668	1,800,000	10,646,668	0
AS Ida-Tallinna Keskhaigla*	4,200,000	4,200,000	0	169,901
Total	**33,280,168**	**9,600,000**	**23,680,168**	**169,901**

* The loan balance of the reorganised Tallinn Central Hospital.

Note 10. Financial and operating lease

Financial lease

The following table contains information on the current financial lease contract (a server has been leased)

Type of fixed asset	**Other inventories**
Final date of the contract period	01.01.2006
Interest rate	5.35 %
Acquisition cost of assets	6,849,960
Accumulated depreciation	1,855,198
Depreciation calculated for the accounting year	1,712,491
Paid during the accounting year	1,551,306
Interest calculated for the accounting year	290,368
Balance of liability as of 31.12.2002	**5,298,654**
incl. repayments during the next accounting year (without interest)	1,623,893

Operating lease

The revenue and expenditure account includes operating lease payments in the total amount of 4,662,715 kroons, whereof 522,789 kroons were paid for the lease of means of transport and 860,004 kroons for the operating lease of computer equipment. Under lease contracts concerning premises, the Estonian Health Insurance Fund has paid a total of 3,279,921 kroons for 2002.

Note 11. Revenue

Revenue from principal activity (thousands of Estonian kroons)	2001	2002
Health insurance part of social tax	4,542,090	5,059,996
Claims collected from other persons	8,154	14,938
Total	**4,550,244**	**5,074,934**

Note 12. Health insurance expenditure

Health insurance expenditure (thousands of Estonian kroons)	Adjusted 2001	2002
Health service benefits	2,823,685	3,025,728
Disease prevention	44,628	42,400
General medical care	335,824	400,225
Specialised medical care	2,170,073	2,310,635
Long-term nursing care	48,001	49,006
Dental	225,158	223,462
Health promotion expenditure	12,958	13,218
Medicinal products benefit expenditure	666,123	772,369
Medicinal products compensated for to the insured	627,897	731,359
Centrally purchased medicinal products	38,226	41,009
Benefit of temporary incapacity for work expenditure	754,228	819,257
Other health insurance benefit expenditure	6,621	17,368
Health service benefits arising from international agreements	1,235	1,364
Benefit for medical devices	5,386	16,004
Total expenditure on health insurance benefits	**4,263,615**	**4,647,940**

Note 13. General administrative expenditure

General administrative expenditure (thousands of Estonian kroons)	2001	2002
Personnel and administrative expenditure	34,487	42,796
remuneration	24,389	32,058
incl. Management Board Members' remuneration	1,483	1,829
incl. Supervisory Board Members' remuneration		3
unemployment insurance tax		158
social tax	8,614	10,580
Management costs	26,814	14,291
IT costs	12,471	14,561
Health insurance benefit payment related cost	1,529	1,284
Development costs	554	2,465
Total general administrative expenditure	**75,855**	**75,397**

Signatures to the Annual Report

The Management Board of the Estonian Health Insurance Fund has prepared the annual report for the financial year 2002. The Supervisory Board of the Estonian Health Insurance Fund has examined and approved the said annual report, which comprises the management report, notes to the implementation of the budget, the annual accounts, the auditor's report and the net surplus distribution proposal.

	Date	**Signature**
Management Board:		
Chairman of the Management Board, Hannes Danilov		
Member of the Management Board, Arvi Vask		
Member of the Management Board, Andres Rannamäe		
Member of the Management Board, Rein Parelo		

Supervisory Board:

Chairman of the Supervisory Board, Marko Pomerants

Member of the Supervisory Board, Tõnis Palts

Member of the Supervisory Board, Mai Treial

Member of the Supervisory Board, Kalle Jürgenson

Member of the Supervisory Board, Ivi Normet

Member of the Supervisory Board, Endel Eero

Member of the Supervisory Board, Helve Luik

Member of the Supervisory Board, Harri Taliga

Member of the Supervisory Board, Ene Tomberg

Member of the Supervisory Board, Peeter Ross

Member of the Supervisory Board, Toomas Annus

Member of the Supervisory Board, Sandor Liive

Member of the Supervisory Board, Tiit Laja

Member of the Supervisory Board, Kaido Kotkas

Member of the Supervisory Board, Enn Veskimägi