Eesti Haigekassa
Estonian Health Insurance Fund

Annual Report 2007

Estonian Health Insurance Fund Annual Report 2007

Name	Estonian Health Insurance Fund
Registration number in the state register of central and local goverment agencies	74000091
Aaddress	Lembitu 10, Tallinn 10114
Telephone	+372 620 8430
Fax	+372 620 8449
E-mail	info@haigekassa.ee
Web page	www.haigekassa.ee
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Principal activity	Public health insurance
Management Board	Hannes Danilov (Chairman) Mari Mathiesen Maigi Pärnik-Pernik
Auditor	KPMG Baltics
Annexed documents:	Auditor's Report

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Statement by the Chairman of the Management Board

In 2007, the patient-friendliness of health care systems of European countries was assessed and the health care system of Estonia was ranked as the 12th among 29 countries. In terms of the ratio between the price of the service and the quality, Estonia was evaluated to be the best in Europe.

Such an acknowledgement shows that over the last 15 years we have built up a health care system which is oriented to the patient. If a few years ago there might have been doubts about as to all the steps taken were the right ones, then now we can be sure that we are on the right way.

At this point, I would like to bring out some changes of greater importance in the principles of the health care arrangement, which have been put into practice during this time and which serve as a basis for our sufficiently good results in developing the health care system.

The first great change was making all health care providers legal persons governed by private law. Health care providers are connected with the public authority only through the contracts of the Estonian Health Insurance Fund.

The public authority, Ministry of Social Affairs and the Estonian Health Insurance Fund assume responsibility for the training of medical staff, the sustainable financing and organisation of the health care system and creating opportunities for development. Both parties bear a collective responsibility for ensuring that the health services provided to people are of high-quality and comply with the good practice of treatment.

Another relevant change was the reorganisation of the financing of health care institutions. Family physicians will be paid on the principles of capitation fee which promotes the activity for preventing diseases carried out among the members of the practice list. Providing specialised medical care will be rewarded case-based, which motivates increasing the quantity of treated cases and thereby improving the accessibility of medical treatment.

Every payment system has its weaknesses as well. If family physicians are paid the capitation fee on the basis of the number of individuals, it motivates them to strive for longer practice lists, whereas case-based payment in specialised medical care causes multiple recalls of patients. Like in every big system, there is no good without bad, negative trends always need to be controlled and positive ones amplified.

With the described amendments, complying with the principle of subsidiarity is very important – decisions concerning the operation of the health care system are adopted on the level with the greatest competence for it – health care institutions decide on the treatment set-up, the state authority ensures the sustainable organisation of the system.

Certainly, all the facts provided above do not mean that everything is finished and nothing would change in the future. Health care is an open system, which constantly exchanges information with the surrounding environment and, hence, is itself in a constant change too.

In connection with the quick rise of salaries in Estonia, the increase of the revenues of the Estonian Health Insurance Fund continued also in 2007. The revenues increased almost by a quarter as compared to 2006. Obviously, the revenues of the Estonian Health Insurance Fund do not increase to such an extent every year, and worse years may come, thus, it is reasonable to put some resources in reserve.

Stable financing of the different areas of the system is likewise planned in the following years. If the level of financing changes abruptly, it causes dissatisfaction among the providers of health care as well as among the patients.

I want to thank all my colleagues and partners who during the past year contributed to the organisation of the health care system and treating our people.

Hannes Danilov, *Chairman of the Management Board of the Estonian Health Insurance Fund*

Management Report 2007

Short review of the Estonian Health Insurance Fund

The **mission** of the Estonian Health Insurance Fund is to ensure the availability of the health insurance benefits to people, as well as sustainability of the health insurance system.

The **vision** of the Estonian Health Insurance Fund is to build up a sense of security in the insured people for upon occurrence and elimination of possible health problems.

15 years since the revival

The first health insurance funds in Estonia were established in 1913. For example, the first ones were Sindi Ühishaigekassa, health insurance fund of Balti Puuvillamanufaktuur, etc. The main objective of the health insurance funds was to pay sickness, maternity and funeral benefits to the persons registered in the health insurance fund and provide the members of their families who had the right for the benefits with free or partially compensated medical care. At the beginning of the last century, it was mainly the employees of industrial enterprises that were insured. The sickness benefit formed 1/2 or 2/3 of the average wages. It was paid for up to 30 weeks per calendar year. Health insurance funds were liquidated at the end of 1940. After that health services were financed by the state.

Health insurance was re-established in 1992 with the adoption of the Health Insurance Act. Twenty-two health insurance funds were set up in counties and cities.

The health insurance system was centralized in 1994 when the Central Health Insurance Fund was established. The task of this Fund was to organize compulsory health insurance through the regional units. In 2001, the public Estonian Health Insurance Fund (EHIF) was established which organizes health insurance and pays to medical institutions for services provided to the insured persons.

Objectives and functions

The Estonian Health Insurance Fund Act sets the objectives, functions, competence, legal status, bases for activities and the bodies of the EHIF. The main function of the EHIF is to organize health insurance, ensuring the payment of health insurance benefits and the effective and purposeful use of the health insurance funds.

The EHIF enters each year into contracts with the health care institutions for the provision of health services, thus, funding general medical care as well as specialised medical care and dental care as well as nursing care. At the payment for the services, the EHIF takes into consideration the availability of the service[1], the efficiency and transparency of the provision of the service and quality of the service[2] and sustainability of the provider of the health services.

For the payment for the health services, the price of one or another service must be agreed upon. The EHIF does not provide any services itself. Thus, it does not form the average cost price. The Fund calculates the average price of the providers of the health services. The EHIF applies the principles of activity-based pricing which makes it possible for all the parties to see how the price of each service is formed. The pricing[3] is complicated because the providers of the services want to get as high price for the service as possible, but the EHIF is interested in paying the optimal price. The providers of the health services have the information of the costs related to the provision of the services. Therefore, the EHIF and the providers of the health services must work in close co-operation. Only then it is possible to calculate the most optimal price at the level of the system. The professional associations who are able to describe the health services from the medical point of view have also an important role.

1 Requirements for the availability of the health services – https://www.riigiteataja.ee/ert/act.jsp?id=12801865
2 Requirements for the quality of the health services - https://www.riigiteataja.ee/ert/act.jsp?id=828314
3 The calculation of the methodology of the price for the health services paid to the providers of the services - https://www.riigiteataja.ee/ert/act.jsp?id=12912348

The availability and quality of the health services is one of the most important goals of the activities of the EHIF. Harmonisation and improvement of the quality is one of the main objectives of the EHIF. For that purpose, the Fund assists in the preparation of treatment standards and clinical guidelines.

It is also important to continue the activities of health promotion and disease prevention. Health promotion contributes to the behaviour valuing the health of the persons (social campaigns, communication of health information, consulting services, etc), the further objective of which is the improvement of the state of health and quality of life. Preventive projects provide an opportunity to discover the health problems of risk groups at an early stage which makes it possible to interfere at the right time and retain one's health.

The EHIF manages and develops the processes deriving from the European Union legislation and international agreements, participates in the planning of health care and gives opinions on the drafts of legislative provisions and international agreements related to the Health Insurance Fund and health insurance and gives advice about issues related to health insurance.

Clients and partners

The clients of the EHIF are all persons with the public health insurance. The partners of the EHIF are providers of health services – hospitals, medical specialists, family physicians, dentists, pharmacies and sellers of medical aids, professional associations and associations of providers of health services, health promoters, Ministry of Social Affairs and other state authorities. The strategic partners are the hospitals within the Hospital Master Plan.

Organisation

The highest body of the EHIF is the Supervisory Board consisting of fifteen members, of whom five represent employers, five the insured persons and five state authorities. The Management Board is made up of three members. There are central units in the structure of the EHIF which deal with the development activities and four local departments: Harju, Pärnu, Tartu and Viru department which deal with clients, employers and partners.

As of December 31, 2007, the EHIF employed 232 people. Breakdown of the employees by education, length of service and age is given in the following table.

Table 1. Employees of the EHIF in 2007

Length of service		Age		Education	
Up to 1 year	19%	between 21 – 30	19%	secondary education	20%
Up to 3 years	18%	between 31 – 40	18%	secondary vocational education	20%
Up to 5 years	18%	between 41 – 50	18%	higher education	60%
Over 5 years	45%	between 51 – 67	45%	-	-
Total	**100%**	**Total**	**100%**	**Total**	**100%**

The EHIF has applied the internationally recognised management approaches – activity-based budgeting, the balanced scorecard, competence management and business process management. Strategic management based on the balanced scorecard is integrated with process management, activity-based budgeting and employees' motivation system.

The EHIF was awarded already for the fifth time with the title of the flagship of the financial reporting among public sector organisations for the most transparent and comprehensive annual report in the public sector.

Main values of the EHIF

Innovation – "We act today but we are thinking of tomorrow". We target our activities at continuous and sustainable development, relying on competent, committed and result-oriented employees.

Consideration – "Every person is important". We are open and friendly. Our decision-making is transparent and considerate of individual needs.

Collaboration – "It is easier together". We create a trusting atmosphere within our organisation and in relations with our partners and clients.

Objectives for 2008

In planning the health insurance expenses for the next financial year, the EHIF has set an objective to ensure the availability of the health insurance benefits to all insured people.

It is planned to:

- To guarantee the financing of the treated cases at least on the level of the year 2007, at the same time increasing the number of purchased treated cases in the specialities where the increase of the needs can be predicted (oncology, infectious diseases);
- To shorten the waiting lists: the maximum waiting list of the endoprothesis and operations of cataract must be shortened by half a year and operations of the prosthesis of the sphincter of the urinary bladder and installation of ear implant by one and a half year;
- To supplement the list of health services[4] with innovative evidence-based health services. The following services are included in the list of financed services since 2008 – eye cornea implantation, surgical ablation treatment of heart disorders and capsule endoscopy;
- To continue the improvement of the availability of medicinal products to the patients of different disease groups. Since 2008, the need for the medicine for treating the rare Fabry disease is covered; the number of the patients using biological medicines will double; the selection of the medicines of the oncological diseases must be remarkably increased;
- To continue the transfer of the medical services to the activity-based pricing in co-operation with the professional associations and health care service providers. Since 2008 the activity-based prices of the blood products and medical equipment were adopted. It is planned to work out the prices of the radiological studies in 2008;
- To develop the payment for performance in co-operation with the Estonian Family Physicians Association which enables to improve the surveillance of the state of health of the people, prevention of diseases and treatment of the chronic illnesses by the family physicians;
- To improve the motivation mechanisms of the family physicians working in the country-side (the family physician who services practice list in the area where there are less than 1,200 inhabitants is paid capitation fee for 1,200 people);
- To increase the number of the cases of nursing care, concentrating more on the development of the patient-friendly services delivered at home. In addition, support the quality and development of the nursing care, enabling to increase the average length of the treated case.

4 https://www.riigiteataja.ee/ert/act.jsp?id=12910893

Relevant statistics 2004 – 2007

Table 2. Summary of major indicators from 2004 to 2007

	2004	2005	2006	2007	2007/ 2006
Number of the insured	1,271,558	1,271,354	1,278,016	1,287,765	1%
Revenues (in EEK thousand)	6,350,129	7,346,892	8,909,947	11,182,824	26%
Expenditure on health insurance benefits (in EEK thousand)	6,136,989	6,983,752	7,946,048	10,148,769	28%
Operating expenses of EHIF (in EEK thousand)	80,112	89,385	87,044	95,132	9%
Insured who received specialised medical care (persons)	771,513	778,689	796,815	810,834	2%
Average length of stay (ALOS)	6,6	6,9	6,3	6,4	2%
Emergency care as a percentage of expenditure on specialised medical care					
- outpatient	15.0	15.2	17.3	17.6	2%
- day care*	-	-	6,9	7.1	3%
- inpatient	60.0	64.6	63.2	62.7	-1%
Average cost per case in specialised medical care (EEK)					
- outpatient	409	468	447	554	24%
- day care*	-	-	4,942	6,435	30%
- inpatient	8,701	10,079	10,981	13,629	24%
Number of reimbursed prescriptions	4,775,221	5,000,602	5,393,102	5,996,585	11%
Average reimbursed prescription cost for the EHIF (EEK)	180	173	179	187	4%
Days on incapacity covered by insurance	7,321,490	7,685,148	8,195,320	8,888,700	8%
Cost of incapacity benefit per day (EEK)	151	165	184	217	18%

* Day care is included in outpatient care up to the year 2006 as the rate of it was small

Strategic objectives of the Estonian Health Insurance Fund for 2007 and implementation of the objectives

The objective of the EHIF is to provide the insured persons with the maximum amount of necessary health services at the needed time and place.

The year 2007 was successful to the EHIF. The revenues increased by 26%. The EHIF together with the providers of the services offered 6.3% more services than in 2006.

But the most important factor is not the number of treated cases or the increase or decrease thereof but the satisfaction of the insured people with the health services. And we are glad to say that the satisfaction increased too – the satisfaction of the insured persons with the availability of health services increased by 7% reaching 60%. The satisfaction with the service quality increased by 3%, reaching 69%. It can be presumed that the increase of the satisfaction was promoted also by the improvement of the general economic situation of the state and increase of the income of the persons.

We are sure that the patient-doctor relationship will also improve year by year – the health awareness of the patients has increased and the patient-doctor relationship is more and more a partnership, not just a relationship between a service provider and a serviced person.

There are still problems with waiting lists of some specialties. The shortening of the waiting lists no longer depends so much on the money but more on the capacity of the doctors-nurses and medical institutions. It is not possible to increase the number of doctors so quickly. Quite big increase in salaries during the last three years decreases the motivation to work extra time and the doctors are ever more appreciative of their free time. The main possibility to increase the provision of medical services is to optimise the business processes.

The co-operation of the EHIF with the providers of medical services at the development of the treatment process has been active and effective. Five clinical guidelines were prepared in co-operation, the need for services of nephrology was assessed in co-operation with the professional associations, five clinical audits were conducted and the results thereof were discussed with the management of the hospitals.

In conclusion, the Management Board evaluates the implementation of the development plan and scorecard for 2007 as “good”. An overview of the objectives set for 2007, as well as the implementation, is given in Table 3.

Table 3. The scorecard of the Estonian Health Insurance Fund 2007

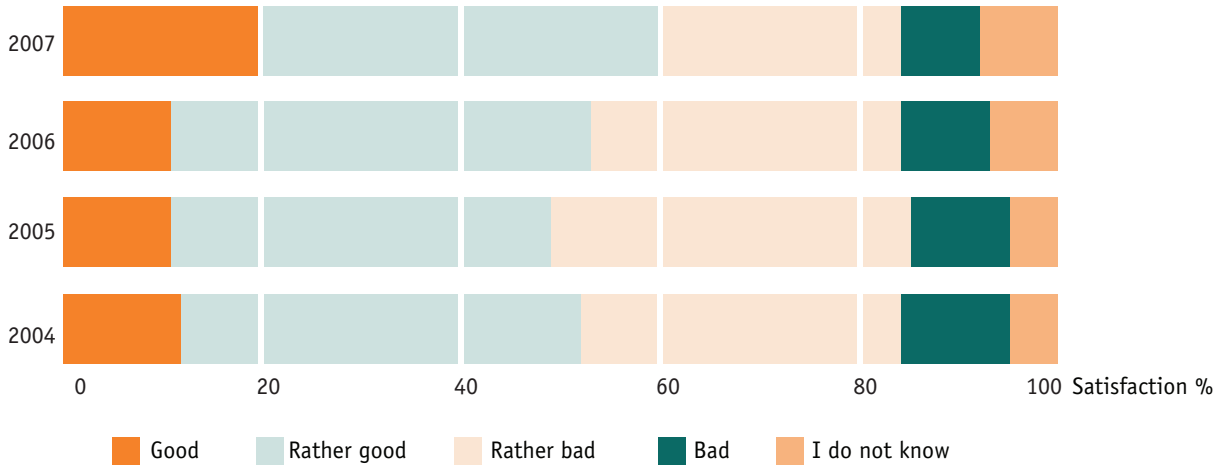
Objective	Performance measure	Weight	Unit	2006 actual	2007 objective	2007 actual	Performance level%
	Satisfaction of the insured persons with the health system	6%	%	56	61	60	5.9%
1. Ensure the accessibility of the health services, medicinal products and financial compensation		**40%**					**39.6%**
	Satisfaction with the accessibility of the health care	7.5%	%	53	57	60	100
1.1 Ensure uniform access							
	The insured having access to primary health care within established time limits	7.5%	%	99	98	98,5	100
	The insured having access to specialised health care within established time limits	7.5%	%	98,5	98	99.7	100
	Availability of the medicinal products	7.5%		-	10	15	100
1.2 Develop the partnership and guarantee the implementation of contractual obligations							
	Satisfaction of the partners with the co-operation with the EHIF	6%	%	77	85	81	95
	Involvement of the target groups of the prevention projects	4%	%	-	Definition of the basis		100
2. Develop the health system and quality of the health services		**12%**					**12.0%**
	Satisfaction with quality	4%	%	66	61	69	100
2.1. Develop the quality of health care services							
	Clinical guidelines prepared in co-operation with professional associations and EHIF	4%	pc	5	5	5	100
2.2. Develop the assessment and monitoring quality of health care services							
	Number of clinical audits	4%	pc	5	5	5	100
3. Ensure financial sustainability of the health insurance system through planning, purposefulness and efficiency		**18%**					**9.0%**
	Satisfaction with the range of services paid by health insurance	6%		49	47	51	100
3.1. Develop the assessment of needs of health insurance benefits and planning balancing the needs with budget opportunities							
	Agreements with the professional associations on the 4-year the needs of the insured persons for treatment by specialities	6%	%	3	2	1	50
3.2. Increase the efficiency of the use of resources							
	Average cost per case	6%	%	6,5	4	6	0
4. Ensure the awareness of the insured persons and partners of their rights and responsibilities		**6%**					**5.8%**
	Awareness of the insured persons of their rights	6%	%	71	72	69	96
5. Develop the operation of the organisation		**18%**					**17.5%**
5.1. Develop the competence and motivation of the employees							
	Satisfaction of the employees with corporate governance and organisation of work of EHIF	4%	%	3.5	3.5	3.4	96
5.2. Apply standard information systems with wide functionality							
	Availability	4%	%	-	100	92.6	92
5.3. Develop business processes							
	Rate of the electronic entries in the register of the insured persons	4%	%	-	70	79	100
	Satisfaction of the insured persons with the services level at EHIF	6%	%	93	85	96	100
	TOTAL	**100%**					**89.8%**

Objective 1
Ensure the accessibility of the health services, medicinal products and financial compensation

Satisfaction with the accessibility of the health services

The EHIF set an objective for 2007 that 57% of the persons would evaluate the accessibility of the medical care as "good". According to a satisfaction survey, 60% of the respondents regarded the accessibility of medical care as "good" or "rather good".

Figure 1. Accessibility of medical care



1.1. Ensuring equal access

One of the important tasks of the EHIF is to ensure that the insured person would have an access to the appointment of the family physician and medical specialist at an agreed time. Another task in 2007 was to harmonise the length of the waiting lists (shorten the waiting lists of endoprothesis and cataract and other operations, the waiting list of which is more than 3 years long) and increase the variety of medicinal products needed for the treatment of illnesses.

Timely appointment of the insured persons with a family physician

The objective of the EHIF for 2007 was to achieve a timely appointment with the primary care physician of 98% of the insured people. Timely appointment means that a patient in an acute condition must get an appointment with the family physician on the same day and a patient with a chronic disease within three workdays.

The accessibility of the primary health care (family physician) was measured during the whole year in 2007 - EHIF questioned the family physicians by phone and checked the registration for the appointments on-site. In total, 801 family practices were checked during a year. The accessibility of the primary health care was good in the whole state regarding both acute and chronic diseases.

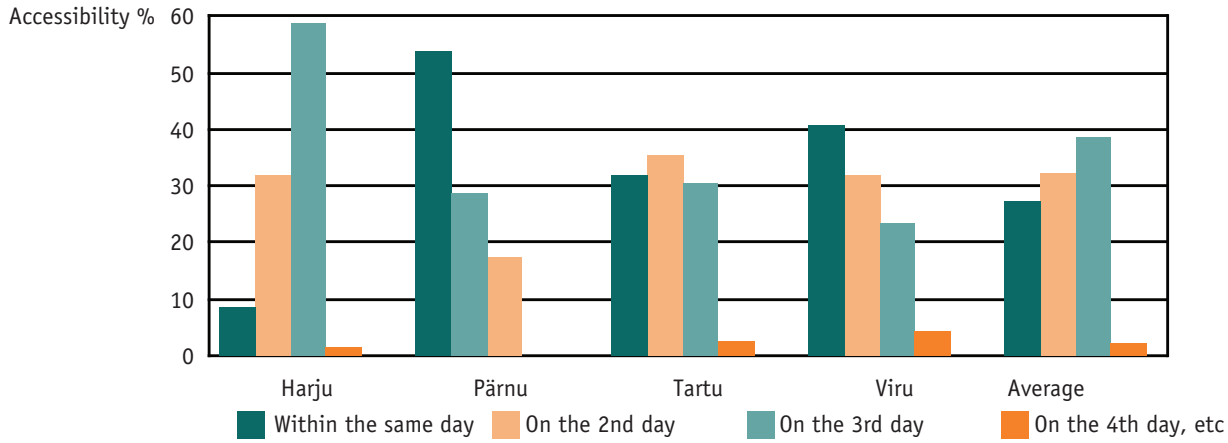
In the case of **acute conditions**, 99.1% of the patients got an appointment with the family physician within the same day. The accessibility was better for the practice lists with more than 2,000 persons (100%) and lower for smaller practice lists with less than 1,200 person (96.4%).

There are no differences in the accessibility of the health care in the case of acute conditions as compared with the indicators of the previous year.

In the case of **chronic diseases**, 98% of the patients got an appointment with the family physician within agreed three days, 27.3% within the same day, 32.2% on the next day and 38.5% on the third day.

The accessibility was better for the practice lists with the standard size, i.e. 1,200 – 2,000 persons (98.6%) and lower for the bigger practice lists (96.2%).

Figure 2. A review of the accessibility of the primary health care in the case of chronic diseases split by regions



In the autumn of 2007, the EHIF ordered a survey, the main objective of which was to measure the satisfaction of the patients with the quality of the work of the family physicians. Another objective was to get neutral and factual information about the accessibility of the family physician and the potential impact factors thereof. The survey was conducted by OÜ Dive Service Quality Development.

- The survey shows that the family physicians make to little use of the potential of family nurses use in their everyday work. 2/3 of the persons got the advice for the prevention of a disease from the family physician and 30% from the family nurse.
- 22% of the questioned persons said that the family physician or the nurse has contacted them himself/herself and invited them to the medical check due to a chronic disease or to participate in the preventive studies. This is most probably due to the system of the payment for performance.

The insured people having an access to specialised medical care within established time limits

The Supervisory Board of the EHIF sets the maximum length of the waiting lists[5]. These are used by the EHIF as the basis for setting the objectives related to the accessibility of the services. An appointment is timely when the maximum length of a waiting list laid down by the Supervisory Board is not exceeded due to the financial reasons[6] and limited capacity of the health care institution[7].

The objective of the EHIF for 2007 was to achieve that 98% of the insured people have a timely appointment with a specialist doctor. On the basis of the data on waiting lists submitted by health care institutions, 99.7% of patients had access to the planned reception of the specialist doctor (ca 15,800 people over the maximum length of the waiting list during the year) and 100% to the planned outpatient specialised medical care in 2007.

5 Maximum lengths of the waiting lists in 2007 http://www.haigekassa.ee/files/est_haigekassa_otsused_otsused/2007_13pdf
6 Financial reasons – the scope of the contract concluded with the health care institution
7 Capacity of the health care institution – the number of specialist doctors and the occupation of the facilities and apparatuses

The EHIF uses the data provided by the contractual partners in analysing the accessibility of the services. The regional department of the EHIF will study the accessibility of the problematic specialities in the whole region in case the waiting lists are longer than permitted and will specify the reasons. If necessary, the information regarding the waiting lists is controlled on-site and if the expansion of the scope of the concluded contracts will improve the accessibility of the services, the scope of the contracts is amended. Waiting lists at 78 medical institutions were controlled during the reporting period whereas the applications of 31 medical institutions for an additional contract were satisfied in order to shorten the waiting lists.

There are no waiting lists in **inpatient medical care** which are over the permitted time due to the monitoring of the contracts between the EHIF and hospitals.

The accessibility in the **outpatient medical care** has improved as compared to 2006. The waiting lists, prompted by financial reasons and limited capacity of the health care institution, have shortened.

Mostly due to the small number of doctors, problems concerning accessibility were bigger in the medical care for ophthalmology, gynaecology, urology and endocrinology.

Table 4. Access to specialised medical care (% of the total number of the insured who had timely access to specialised medical care during the regular reception hours)

	Outpatient		Inpatient	
Region	**2006**	**2007**	**2006**	**2007**
Harju	99.4%	99.5%	100%	100%
Pärnu	99.8%	99.8%	100%	100%
Tartu	99.8%	99.9%	100%	100%
Viru	99.8%	99.8%	100%	100%
Total	**99.6%**	**99.7%**	**100%**	**100%**

Waiting list for endoprothesis and operations of cataract. The Supervisory Board of the EHIF has approved separately the waiting list for endoprothesis and operations of cataract. The objective in 2007 was to shorten the maximum waiting list of the endoprothesis and operations of cataract by half a year (accordingly to 3 and 2 years). This aim was achieved.

Availability of the medicinal products

The objective in 2007 was to improve the availability of medicinal products to the patients of different disease groups. The availability was improved in regard of 15 different active substances.

Additional health services including medicinal products

The following additional health services including medicinal products were made available to the insured persons in the lists of the health services:

- Biological treatment with TNF-alfa inhibitor the main indicators of which are rheumatoid arthritis, ankylosing spondylitis, psoriatic arthropathy, juvenile idiopathic arthritis and Crohn's disease;
- Enzyme replacement treatment in the case of type 1 of Gaucher disease;
- Treatment with the risperidone injection which improves the availability of the treatment of the schizophrenic patients

The possibilities for using the oncological medicines in cytostatic treatment processes were also expanded.

Supplement of the outpatient list of the medicines. In 2007, the list was supplemented regarding 9 new active substances. The treatment possibilities of the patients were expanded due to the bigger amount of compensated medicinal products.

Higher compensation rate (100%) was immediately applied to bosentan and sildenafil. It is possible to treat the patients suffering from pulmonary arterial hypertension related to NYHA III-IV class idiopatic or systematic fibrose disease with the above-mentioned active substances. The treatment is based on the decision of a specialist council and takes place according to the clinical guidelines prepared by specialists.

The higher compensation rate is applied to ibandron acid, alendron acid (treatment of the osteoporosis with pathological fracture of bone) and insulin determine (treatment of diabetes mellitus).

1.2. Development of partnership and performance of obligations by partners

All parties are interested in the performance of the contract. Therefore, the co-operation between the partners is of essential importance. Different forms have been applied during the years in the co-operation between the EHIF and partners which help the contractual parties to understand each other better and solve problems quicker and in a more constructive way.

The EHIF will analyse the results of the satisfaction survey of the partners in order to further develop the partner relationship and find new ways of co-operation.

Satisfaction of the partners with the co-operation with the EHIF

The objective for the year 2007 was to achieve 85% satisfaction of the partners with the EHIF. The implementation of this objective is measured with the satisfaction survey among the partners.

According to satisfaction survey, 81% of the partners regarded the co-operation with the EHIF as "very good" (29%) or "rather good" (52%). In three years, the dissatisfaction has decreased in the following areas: checking of the insurance in the database of the Health Insurance Fund, quickness in answering the questions and solving problems and checking of the invoices for treatment and prescriptions in the Health Insurance Fund.

Motivated by the results of the survey conducted in 2006, several meetings were organised with the representatives of the hospitals[8] participating in the hospital network development plan in 2007.

The management of the EHIF met with the management boards of regional and central hospitals, and regional departments with the supervisory boards of the hospitals. The objective of the meetings was to exchange information on the subjects which are not directly related to the contract but are important in respect of the quality of health services, development of hospitalisation and smoothness of the co-operation. The areas having an impact on the everyday work were discussed at the meetings of the management boards. At the meetings of the supervisory boards, the managers of the regional departments of the EHIF gave a review of the results of the clinical audits. Also, it was discussed how to improve the accessibility of services and which are the areas that need to be developed. The parties considered the meetings a good initiative and were of the opinion that such discussions should be continued.

Involvement of the target groups of the preventive projects

In 2007, the EHIF has paid more attention to the objectives and results of the prevention of diseases as an essential area in protecting and promoting human health. Prevention of diseases is an active involvement of healthy people in medical screenings. Therefore, a good co-operation between the partners (EHIF, project leader, health care providers participating in the screening, media, etc), systematic informing of the target group and smooth operation of the activities are very important.

8 Government of the Republic Regulation No 105 of 02 April 2003 The development plan of the hospital network sets the list of the regional, central, general and local hospitals with the objective to ensure the accessibility of the health care and optimise the hospital network. The EHIF concludes 5-year financing contracts with the hospitals within the hospital network.

All persons in the risk group belong to the target group of the preventive projects. But the cases planned in the budget of the preventive projects are based on the actual amount of services needed by the participants. For example, all newborn children belong to the target group of the hearing tests. But there are no screening instruments in smaller obstetrical departments, thus, the number of participants planned in the budget is smaller. For many years, the number of actual participants in the preventive projects has been about 90% of the planned participants. Together with the partners, the EHIF has set an objective to improve the planning of the preventive projects and, thus, increase the involvement in the abovementioned projects.

The basic indicators, showing the participation rate of the target groups, were determined in 2007 to improve the efficiency of the projects where the participation rate was low.

The average involvement rate of the target groups in the preventive projects in 2007 was 90%.

Table 5. Involvement rate of the target groups in the preventive projects

Preventive activity	Target group of the preventive project in 2007	Involved target group in 2007	Participation rate in 2007
Early detection of breast cancer Women aged 50 to 59, breast cancer screening of the women invited in 2007	50,981	22,206	44
Early detection of cervical cancer Women aged 35 to 55, PAP-test of the women invited in 2007	38,359	12,051	31
The youth reproductive health project Young people aged 15 to 24, 60% of the young people who are sexually active	124,392	21,905	23
Prevention of cardiovascular diseases Persons aged 30 to 60, each 10th person aged 30 to 60 having a higher risk factor	54,690	5,055	9
Early detection of osteoporosis, rheumatic patients	2,500	1,357	54
Newborn phenylketonuria and hypothyroidism screening, all newborns	15,741	15,692	100
Prevention of hereditary diseases, the pregnant women over 37 years of age + cases detected in the prescreening, in total 13% of the pregnant women	2,028	2,150	106
The newborn hearing tests, all newborns	2,028	2,150	106

The explanations to the participation of the target groups are included in the part of the annual report discussing preventive measures (pp.32-33).

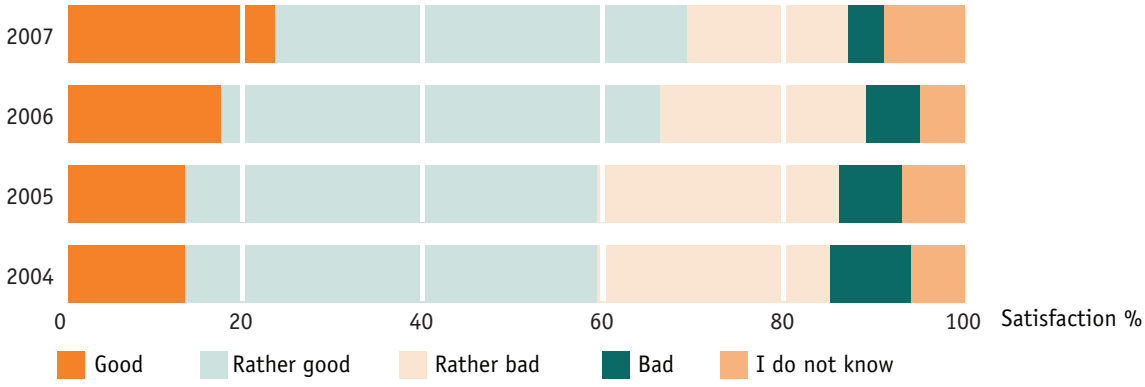
Objective 2
Develop the health system and quality of the health services

Satisfaction with the quality of health services

The task of the EHIF is to motivate the providers of the health services to follow, evaluate and improve the quality of the health services. The EHIF finances the preparation of clinical and action guidelines, the clinical audits, conducted by the professional associations, and controls the cases treated at health care institutions with the aim to harmonise and improve the quality of health services.

The questionnaires are worked out to define the satisfaction of the population with the quality and accessibility of the health services. The objective in 2007 was to achieve the target that 61% of the respondents would regard the quality of the health care "good". According to satisfaction survey, 69% of the respondents were satisfied with the quality of health care (in 2006, the corresponding indicator was 66%).

Figure 3. Assessment to the quality of the health care



2.1. Development of the quality of health services

The activities started in the course of years where the EHIF has been in the role of the coordinator help to develop the quality of health services.

- The work group comprising two representatives of the regional and four representatives of the central hospital and representatives of the EHIF has studied the PATH indicators of the WHO[9] hospitals. Data has been collected in several hospitals and presented to WHO for comparing with other hospitals
- A work group comprising representatives of all general hospitals has been established to improve the quality of the work in general hospitals. In 2007 the hospitals involved in the hospital network development plan carried out a satisfaction survey, based on common methods, among persons receiving inpatient medical care. Besides, the general hospitals carried out an internal audit to find out how the counselling of the patients has been documented
- In the 2nd half of 2007, the EHIF agreed with the representatives of the nursing hospitals that a quality improvement work group will be established. It is planned to start the principal work in 2008
- Methodology has been prepared for improving the quality of the health promotion projects. This is used for assessing the sustainability of the project organisations dealing with health promotion. In Rapla and Pärnu counties, the preliminary assessment project has been implemented. The results of this project are used for improving the quality of the preventive project of the injuries in the counties in 2008.

The co-operation with the professional associations in preparing clinical guidelines and audits has already evolved into a tradition.

9 WHO – World Health Organisation

Clinical guidelines completed in co-operation between the EHIF and professional associations

The objective of the compilation of the clinical guidelines is to harmonise and improve the diagnostics, treatment and approach to a certain illness/condition or the organisation of the health care and promote the application of the best cost-effective treatment practice.

The EHIF finances the compilation of the clinical guidelines to motivate the professional associations and analyses how economical the compiled guidelines are in regard of health care. The EHIF follows, through inspection of clinical audits and treatment documentation, the application of the clinical guidelines approved by the Fund.

In 2007 the objective was to analyse 5 clinical guidelines drawn up by the professional associations:

- Clinical guidelines for dementia in Estonia compiled by the Association of the Neurologists and Neurosurgeons (L. Puusepa nimeline Neuroloogide ja Neurokirurgide Assotsiatsioon);
- Requirements for the provision of nursing care compiled by the Estonian Association of Gerontology and Geriatrics;
- Guidelines for emergency medical care compiled by the Union of Estonian Medical Emergency;
- Clinical guidelines for acute cardiac insufficiency. Clinical guidelines for chronic cardiac insufficiency compiled by the Estonian Association of the Cardiologists;
- Clinical guidelines for gastro-intestinal malignant tumours in Estonia compiled by the Estonian Association of the Oncologists.

The EHIF signed the memoranda of the recognition of the clinical guidelines with the professional associations regarding the first four of the abovementioned guidelines.

2.2. Assessment and monitoring of the quality of health care systems

In order to assess the quality of the services paid for by the EHIF and determine whether the provision of services has been justified, clinical audits are carried out and the quality of recording the treated cases[10] in health care institutions checked. The providers of the health services are informed of the results of the audits and checks, and the methods for improving the quality are jointly planned.

Number of clinical audits

The objective of the audits is to check the quality and justification of the services fully or partially paid for by the EHIF. The providers of the services are motivated to provide services of a better quality on the basis of the feedback. Clinical audits are carried out by professionals renowned for their experience in the field on the basis of current laws, clinical guidelines, codes of conduct and good practice. Auditors are selected in co-operation with professional associations.

In 2007 five clinical audits were carried out:

- Justification of the length and organisation of treatment in the therapeutic departments in hospitals carried out by professor emeritus Vello Salupere;
- Justification and quality of the treatment of acute pancreatitis carried out by Dr Marko Murruste;
- Justification and quality of the outpatient treatment of glaucoma carried out by Dr Kuldar Kaljurand and Dr Tiia Jugaste
- Justification and quality of inpatient nursing care carried out by the team of the Estonian Association of Gerontology and Geriatrics;
- Justification of the treatment of oncological patients in general and central hospitals and the continuity of the treatment carried out by Dr Vahur Valvere, Dr Andrus Arak, Dr Peeter Padrik and Dr Jaan Tepp

10 Treated case – treatment invoice reflecting the medical examinations and services provided to one insured person in the course of one treated case

Inspected cases

In 2007, the objective was to check the cases related to the prescription of the discount medicines. In total, 1,400 cases were checked by randomized selection of four cases:

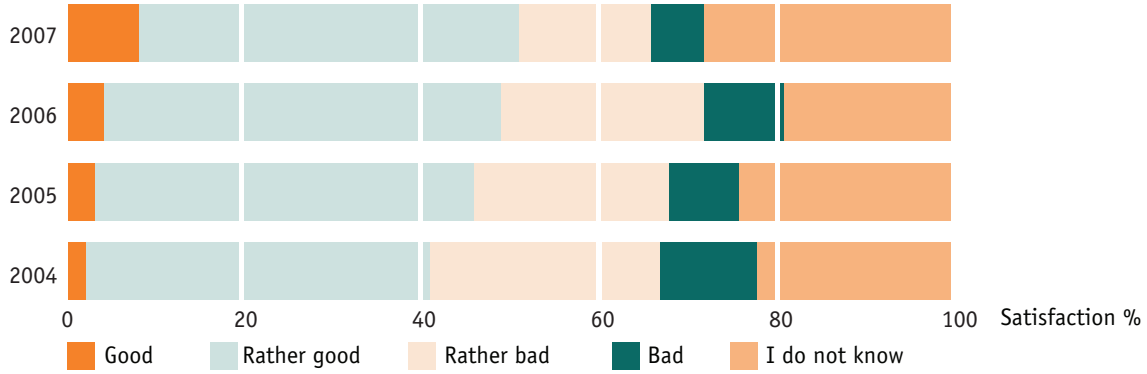
- Prescription of antibiotics for the treatment of pneumonia and inflammation of the middle ear to the children under the age of 16. The aim was to control, according to the clinical guidelines, how the family physicians use antibiotics in the above-mentioned cases. It was discovered that many family physicians do not fill in the discount prescriptions properly; coding of the diagnoses was not precise; health charts were not filled in according to the requirements. Two claims were filed as there were no entries in the treatment documentation and antibacterial treatment was not indicated. Remarks were made to the doctors in 182 cases;
- Prescription of medicine - with 50% discount for the treatment of fungal infections of the skin and nails. The aim was to control how the legal acts are followed at the prescription of the treatment. It was discovered that doctors often make mistakes in respect of the frequency of prescripting pills and application of the multiple-use prescriptions. In total, 82 claims were filed. Relevant remarks were made to the doctors in 158 cases;
- Prescription of drugs on the basis of active substances. The aim of the re-inspection was to find out whether there are changes in the prescription of the same medicines as compared to 2006. It was discovered that there are no changes for the better as compared to the previous year;
- Prescription of medicine for the treatment of bronchial asthma. The aim was to control how the legal acts are observed at the prescription of medicine with a higher discount rate and whether the limits set to the initial prescription are followed. It was discovered that the legal acts were, in principal, followed at the prescription of medicine with a higher discount rate. Taking into consideration the scope of the randomized selection, it is not possible to be satisfied with the fact that in 30% (89 cases) of the medical cases, the doctors had violated the existing legislation and limits set to the prescription of medicine. Therefore, 89 claims were filed, and remarks were made in 169 cases.

Objective 3
Ensure financial sustainability of the health insurance system through planning, purposefulness and efficiency

Limited revenue base is a threat to the financial sustainability of the health insurance due to the aging population. Therefore, it is very important to pay attention to the efficient and purposeful use of the health insurance resources which make it possible for the insured to get more services with a higher quality.

In planning, the expectations and assessments of the population regarding the health insurance are taken into consideration. On the basis of the satisfaction survey, a total of 51% of the respondents considered the quality of medical services to be "good".

Figure 4. Satisfaction with the benefic package



3.1. Improve the assessment and planning of needs of health insurance benefits by balancing needs with budget opportunities

The EHIF plans its work by taking into consideration the needs of the insured. The EHIF assesses the needs of the insured persons for treatment by specialities in co-operation with professional associations.

Agreement with the professional associations on the estimated needs of the speciality in 4 years

The objective of 2007 was to agree upon the need for treatment with two professional associations which would cover the needs for the health services and medicines in the 4 upcoming years. It was planned to have agreements with the Estonian Association of the Cardiologists and the Estonian Society of Nephrology.

The corresponding agreement was concluded with the Estonian Society of Nephrology, with which the assessment was given to the treatment needs in nephrology in the years 2008 – 2011.

The EHIF made the application analysis of the health services and medicines during the last 3-4 years to prepare the agreement in the cardiology. The results of the analysis were discussed together with the Estonian Association of the Cardiologists. The assessment was given in respect of the treatment needs. But the agreement was not concluded.

3.2. Improve the efficiency of use of resources of health insurance

The EHIF is implementing the case-based financing to improve the efficiency of the use of the resources of health insurance. The EHIF has introduced the activity-based pricing method.

Structural rise of average cost of a treated case (volume inflation)

The increase of the average structural cost of a treated case expresses a cost of the health services in constant price in the base period, i.e. in the case of the structural rise, it is concentrated on the rise of the average structural cost of an inpatient treated case (ASCITC[11]) not considering the impact of the changes in the reference prices[12] to the ASCITC.

We can talk about the structural rise in case the following factors are evident in respect of a treated case as compared to the reference period:

- The amount of the delivered health services has increased
- The services with a lower price have been replaced with the services with a higher price
- New health services have been applied

The objective for 2007 was to keep the increase of the average structural cost of an inpatient treated case in the limits of 4%.

The increase of the average structural cost of a treated case is a rise in the cost of ASCITC. For the assessment of the changes, the costs of the treated cases in constant reference prices in two periods (2006 and 2007) are compared, thus, eliminating the impact of the changes in the reference prices of the health services. This way it is possible to assess the extent of increase in ASCITC as a result of providing patients with a relatively larger number and more expensive services in a treated case. The changes may be reflected also in the structural reduction of ASCITC – this is in case cheaper or less services are provided as compared to the previous period.

A moderate structural increase in ASCITC is a natural process as medical technology develops and new treatment methods are applied. Fast increase in ASCITC can prevent the access to health services. Therefore, the EHIF has set an objective to impede the increase in ASCITC in inpatient specialised medical care by using DRG[13]-based financing, and agreeing upon the average increase in the cost per case upon financial appendixes of health care services contract.

The increase of average structural cots of an inpatient treated case in 2007 was 5.9% as compared to 2006. The set objective (4%) was not achieved. Still, the increase in the whole specialised medical care is still in the limits of 4%. In a longer perspective, it is practical to set an objective to prevent a structural increase not only in the inpatient care but also as an average of all treatment types. This makes it easier to follow the structural changes in the specialised medical care.

Table 6. Increase of ASCITC (EEK)

	2006 str ASCITC	2007 str ASCITC	2006 actual/ 2007 actual %	Change excl. DRG* as compared to 2006 %
Outpatient	529	554	4.7%	4.7%
Day care	5,488	6,435	17.2%	17.7%
Inpatient	12,881	13,646	5.9%	6.6%
TOTAL	**1687**	**1750**	**3.7%****	**4.0%****

* Shows the structural change of the ASCITC on the condition that the services are paid for with 100% fee-for-service price

** Total average str_ASCITC is smaller than the value of the separate treatment types. Upon finding the average, a big number of comparatively cheap outpatient and day care cases and a smaller amount of more expensive inpatient cases are summarised

11 ASCITC – average structural cost of an inpatient treated case, i.e. average sum of a treatment invoice which is received as a quotient of the sum and the number of the treated cases

12 Reference price – price in case the EHIF takes over the obligation to pay for the health services (price that the EHIF pays to the provider of the service). The reference price comprises the expenses related to the provision of the health care

13 DRG – Diagnoses related groups – case based payment system where the patients with the similar diagnosis are classified in the same group

The result of 2007 is impacted by the partially different structure of the health services in respect of the two big service groups (laboratory services and radiology) in the periods compared and, therefore, the data are not fully comparable.

Different changes in ASCITC in different specialities (Table 7) can be noticed due to the structure of the services and variation of the services/treated cases between different treatment types. In most of the specialities, except oncology, pulmonology and psychiatry, the ASCITC has structurally increased during the year.

In pulmonology, the structural reduction in prices in 2007 is caused by the decrease of the amount of the inpatient services (bed-days, laboratory studies) to one treated case. At the same time, a large amount of more expensive services were provided outpatient in pulmonology which caused a structural increase of the outpatient ASCITC by 10%.

More expensive services have been provided also in the speciality of oncology (structural increase of ASCITC was 16%). At the same time, the number of bed-days per treated case has decreased in inpatient medical treatment.

The reason for the structural reduction of prices in psychiatry is the decrease of the studies and procedures per treated case.

A bigger structural increase of ASCITC can be noticed in neurology, paediatrics, therapeutics and rehabilitation. This is caused by the increase in the number of the studies and procedures per treated case in 2007.

Table 7. Structural increase of ASCITC split by specialities (in EEK)

	2006 str ASCITC[14]	2007 str ASCITC	Change compared to 2006 %
Surgery	16,760	17,328	3.4%
Otorhinolaryngology	5,169	5,234	1.3%
Neurology	11,651	14,006	20.2%
Ophthalmology	8,527	8,806	3.3%
Orthopaedics	23,691	24,648	4.0%
Oncology	21,066	20,690	-1.8%
Obstetrics and gynaecology	7,608	8,083	6.2%
Pulmonology	23,883	23,796	-0.4%
Dermatovenerology	7,347	7,351	0.1%
Paediatrics	5,954	6,584	10.6%
Psychiatry	16,223	15,826	-2.4%
Infectious diseases	5,873	5,902	0.5%
Internal diseases	15,513	16,676	7.5%
Primary postoperative treatment	9,363	9,664	3.2%
Rehabilitation	8,568	9,471	10.5%
TOTAL	**12, 881**	**13,646**	**5.9%**

Development of DRG cost weights

The objective for 2007 was to develop the DRG cost weights and the principles of updating thereof. The purpose of developing of DRG cost weights was to make DRG pricing more transparent and stable in time. The initial methodology of the cost weights based only on the test base of DRG[15] was not the most suitable one as the information in the database is often outdated and it is not easy to update it. At present, the data from the operational system of EHIF is combined with the data from the test base and indicators of the structural increase of ASCITC. In 2007, the DRG cost weights were worked out. The methodology of the calculation of the DRG reference prices based on the cost weights is the basis for the calculation of the fee paid to the providers of the health services and DRG prices.

14 str_ASCITC expresses ASCITC in the case of which the impact of the increase in reference prices is eliminated. This is due to the calculation of the ASCITC in 2006 and 2007 based on the reference prices of 2007

15 DRG test base is an organised database separate from the operational system of EHIF for treated cases grouped in DRGs of 1 year

Improvement of the coding quality of the treated cases

The objective for 2007 was to compile, in co-operation with the professional association and the Ministry of Social Affairs, a single coding guideline of the treated cases.

In Estonia the international classification systems (RHK-10 and NSCP[16]) are used which enable to participate in the international statistics and data analysis. There are situations in classifying where it is possible to encode a particular case differently. Therefore, a coding manual or policies must be internally agreed upon in Estonia.

The objective of the coding guideline is to promote the DRG system by improving the coding quality of the treated cases. The efficiency of the DRG system depends on the quality of data, i.e. whether the treated case is described properly with the help of the classification systems and whether it corresponds to the actual situation. In 2007 the EHIF had a co-operation with the Estonian Association of the Cardiologists in working out the coding guidelines. Also, the coding of the treated cases of acute coronary syndromes was discussed.

In co-operation, the base document of the guidelines was prepared where the general principles and rules of encoding are described, and samples from cardiology have been added. The present text of the guidelines is reviewed and commented in the Estonian Association of the Cardiologists and the amendment and supplement proposals of the association are introduced in the guidelines. The coding guidelines were not completed in 2007. The document will be completed after the assessment of the Estonian Association of the Cardiologists.

Transition from the price calculation of health services to the activity-based methodology

To improve the transparency of health insurance funds, the EHIF has introduced an activity-based pricing method[17] for the calculation of the prices of health services. The objective is to start using the activity-based pricing method in all service types. The objective in 2007 was:

- To describe the blood products in the list of the health services in co-operation with the Estonian Society for Transfusion Medicine in order to adopt the cost-oriented financing of the blood products in 2008;
- To review with the specialities prices and the list of the medical equipment included in the list of health services

The descriptions of the blood products and medical equipment were specified and new prices worked out during the year.

Expert assessments to entering new medicines into the list, taking into consideration the evidence-basedness, medical efficiency and cost-efficiency of the medicines

The assessments take into consideration the medical evidence-basedness and cost-efficiency as well as how the price impacts the budget of the benefits for medicinal products of the health insurance.

In 2007, twenty-five expert assessments were given to medicinal products used for treating different diseases. Twenty expert assessments have been under discussion in the medical commission from which seventeen received a conditionally positive and three a negative response. Conditionally positive responses was given to these medicinal products, the retail sales price of which cause additional expenses in the budget of the benefits for medicinal products of the health insurance but are at the same time medically based on evidence. The retailers were given a possibility to adjust the prices. By the end of the year, fourteen medicinal products which had a positive assessment were introduced in the list.

16 NOMESCO – classification of the surgical procedures

17 Activity based pricing is based on the activity based cost accounting methodology, in the case of which the expenses needed for providing the services are related to the activities needed for providing the services. This approach makes the reference prices transparent and all parties know what the reference prices consist of.

Objective 4
Ensure awareness of the insured persons of their rights and responsibilities

The awareness of the insured persons of their rights

The EHIF assesses the awareness of the insured persons once a year with a questionnaire where 1,500 inhabitants of Estonia are questioned.

The survey "Assessment of the inhabitants of Estonia on health and health care" was conducted in co-operation with the Ministry of Social Affairs in October-November 2007. The objective was to find out which resources and how often people use for getting information, are they satisfied with the services of the general and specialised medical care, what disturbs the patients most, etc. The answers showed that the awareness of the people about their rights and responsibilities has increased as compared to the earlier periods.

The EHIF has created several possibilities for informing the people.

- One important channel of informing is the webpage of the EHIF www.haigekassa.ee where there is a lot of useful information for the employers, partners, insured and everyone interested in the subject. The amount of the people who find an answer to their question on the webpage is yearly increasing.
- People are using more and more the services of the client information line 16363 of the EHIF. During the year, 171,000 calls were answered (139,000 calls in 2006)
- People can call to the advisory line of the family physician 1220 twenty-four hours a day. The medical advice is provided both in Estonian and Russian languages, also both the insured and uninsured persons could use the 1220 service. According to the survey conducted in 2007, the spontaneous knowledge of the phone service[18] was 72%. The use of this service has increased. 17% of the population used the service in 2007 (10% in 2006). The population has been informed about the possibility of using the family physician advisory line in the media and booklets of the EHIF. The information about this possibility is less known among the Russian speaking population but also among young people (aged 15 to 24). The average number of calls a day in 2007 was 423.

18 Spontaneous knowledge means that a person knows what a certain service means without having any hints

Objective 5
Improve the operation of the organisation

To fulfil the objectives set in the scorecard, on the one hand, competent employees are needed and, on the other hand, smooth and consistent management of the processes must be guaranteed.

5.1. Develop competence and motivation of employees

The development of the employees is assessed regularly once a year (competence assessment) and the results of the work twice a year (filling in of performance charts). Performance charts give systematic feedback to the employees about their work and are a good basis for planning further development. The objective of the development of the employees in the EHIF is to enhance professionalism through constant improvement of knowledge, skills and attitudes.

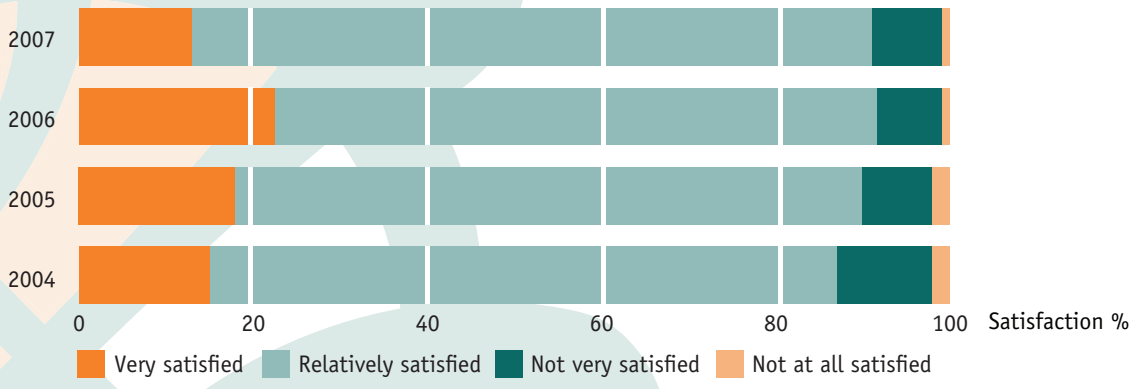
In 2007, the main priority was to improve the management and operation of the client and partner relationships through different training courses. Regular information days where legal issues were discussed were organised regularly by the legal department of the EHIF. Internal consulting days took place in different professional groups.

Employees took an active part in the work of several international work groups. Specialists were involved in the work of the sub-commissions of the CEC social insurance systems coordination administrative commission, e.g. in the technical commission of the data processing where the main subject under discussion was the preparation of the transition to the international electronic data transmission. Specialists took part also in the work of the audit board dealing with the issues related to international payments.

Satisfaction of employees with corporate governance and organisation of the work of the EHIF

At the end of each year, an internal survey is conducted to find out the employees' opinion of the corporate governance and organisation of the work of the EHIF. In 2007, 77% of the employees of the EHIF took part in the survey. The objective for 2007 was to achieve a staff satisfaction with the corporate governance and organisation of the work of level 3.5. The objective was 96% fulfilled with the result of 3.4.

Figure 5. Satisfaction of employees with corporate governance and organisation of the work of the EHIF



5.2. Use standard and functional information systems

The EHIF has set an objective to implement and use standard and functional information systems which can be handled (i.e. could fulfil the set tasks at wanted or planned time) and be compatible to SAP business software.

- In 2007 it was started to transfer the information related to the processes of the monetary benefits into the software. The same software (SAP CRM-customer management software) is the basis of the register of insured persons. The abovementioned works should be implemented in 2008
- In 2007 the digital prescription agreement was concluded and necessary hard- and software purchased

The objective was to make the communication with the partners and insured persons as comfortable and electronic as possible. Different services are used in the data exchange between the partners and the EHIF and in informing interested parties. The services include, for example, data transfer of the family physicians, automatic introduction of the data of the newborn into the register of the insured, etc.

5.3. Improve work processes

In 2007 the activity-based need-matrix of the EHIF was updated specifying the division of work and responsibility between the departments and relations and statistic indicators of the activities and resources. System of the procedures was upgraded specifying the descriptions of the basic and supporting processes.

The objective of improving work processes in 2007 was to make the communication with the partners and insured persons as quick, comfortable and smooth as possible.

- Administration of the health insurance was 97% electronic by the end of 2007 and the data exchange took place between the registered databases through the data exchange layer X-way environment. The administration of the data of those persons about whom there was no necessary information in the state database was performed manually. These persons are, for example, pregnant women having no job, dependent spouses, students studying abroad, etc.
- The EHIF and Finnish KELA (Kansaneläkelaitos) started the electronic repayment system of the expenses of the health services in 2007 for which the TESTA-server administered by the CEC is used
- The EHIF joined in 2007 with the work group preparing the electronic European health insurance card. At the same time, the card standardisation work group (CEN) with whom the EHIF joined started the work. During the year, the main advantages of the European electronic card were worked out and the standards which the card should meet were fixed. Both the CEN work group and the work group preparing the electronic European health insurance card are continuing their work in 2008. It is planned to describe the more precise technical conditions of the card and make the first draft of the electronic European health insurance card
- The satisfaction with the customer service is assessed on the basis of Mystery shopping method which means that test clients are used at the assessment of the service situations. In the survey of 2007 the service places, professionalism of the service staff, communication skills and appearance were assessed.

Health Insurance Fund's explanatory notes to the budget implementation statements in 2007

The budget of the EHIF comprises the accrued expenses of the financial year and sources for covering expenditure – revenues of the financial year and retained profits.

Table 8. Budget (in EEK thousand)

REVENUE	2006 actual	2007 budget	2007 actual	Budget implementation %	Change compared to 2006 %
Social tax	8,808,806	10,879,599	11,000,420	101.1%	24.9%
Premiums paid by persons covered as insured under a contract	30,299	30,000	34,071	113.6%	12.4%
Amounts due from other persons	12,601	11,000	9,356	85.1%	-25.8%
Financial income	52,489	49,300	97,104	197.0%	85.0%
Other revenues	5,752	4,719	41,873	887.3%	628.0%
TOTAL BUDGET REVENUE	**8,909,947**	**10,974,618**	**11,182,824**	**101.9%**	**25.5%**
BENEFIT EXPENDITURE					
Health care services benefits	**5,329,563**	**6,829,289**	**6,812,753**	**99.8%**	**27.8%**
Disease prevention	77,562	101,000	90,148	89.3%	16.2%
General medical care	666,609	900,111	886,076	98.4%	32.9%
Specialised medical care	4,260,081	5,392,164	5,407,270	100.3%	26.9%
Nursing care	132,386	188,787	189,267	100.3%	43.0%
Dental care	192,925	247,227	239,992	97.1%	24.4%
Health promotion expenses	12,676	14,000	12,688	90.6%	0.1%
Medicinal products compensated for the insured	966,796	1,064,535	1,120,559	105.3%	15.9%
Expenditure on benefits for temporary incapacity for work	1,506,355	1,834,429	1,926,851	105.0%	27.9%
Other monetary benefits	77,171	187,800	197,380	105.1%	155.8%
Other benefit expenses	53,487	87,000	78,538	90.3%	46.8%
THT benefits form the foreign contracts	20,833	17,000	34,200	201.2%	64.2%
Benefit for medical devices	32,654	70,000	44,338	63.3%	35.8%
Total benefit expenses	**7,946048**	**10,017,053**	**10,148,769**	**101.3%**	**27.7%**
OPERATING EXPENSES					
Personnel and administrative expenses	51,259	64,057	60,030	93.7%	17.1%
Salaries and wages	38,459	48,055	45,038	93.7%	17.1%
incl. remuneration of the members of the Management Board	1,908	2,108	2,109	100.0%	10.5%
Unemployment insurance premium	109	146	129	88.4%	18.3%
Social security tax	12,691	15,856	14,863	93.7%	17.1%
Management costs	16,867	19,025	17,261	90.7%	2.3%
Information technology costs	9,885	11,618	8,023	69.1%	-18.8%
Development costs	3,257	4,356	3,738	85.8%	14.8%
Training	1,455	1,852	1,527	82.5%	4.9%
Consultation	1,802	2,504	2,211	88.3%	22.7%
Financial expenses	1,185	1,298	1,450	111.7%	22.4%
Other operating expenses	4,591	4,719	4,630	98.1%	0.8%
Pre-printed forms and publications	1,051	812	948	116.7%	-9.8%
Supervision of the health insurance system	1,060	960	1,033	107.6%	-2.5%
Public relations/public information	860	1,148	1,101	95.9%	28.0%
Other expenses	1,620	1,799	1,548	86.0%	-4.4%
Total operating expenses	**87,044**	**105073**	**95132**	**0.5%**	**.3%**
TOTAL BUDGET EXPENDITURE	**8,033,092**	**10 122,126**	**10,24301**	**101.2%**	**27.5%**
Reserve	**876,855**	**852,492**	**938,923**	**110.1%**	**7.1%**
Transfer in legal reserve	58,000		122,000		
Transfer in risk reserve	14,000		41,000		
Earnings of fiscal year	804,855	852,492	775,923	110.1%	7.1%
TOTAL	**8,909,947**	**10 974,618**	**11,182,824**	**101.9%**	**25.5%**

Table 9. Main indicators for the years 2002 – 2007

	2002	2003	2004	2005	2006	2007
Social tax as a percentage of total revenue	99.2	98.9	98.9	99.1	98.9	98.4
General medical care as a percentage of total expenditure	7.9	8.0	7.7	8.1	8.3	8.7
Specialised medical care as a percentage of total expenditure	45.3	49.9	51.0	51.6	53.0	52.8
Incapacity benefits as a percentage of total expenditure	16.1	16.2	17.4	17.4	18.8	18.8
Prescription of medicinal products as a percentage of total expenditure	15.2	12.0	13.6	12.0	12.0	11.1
Operating expenses as a percentage of total expenditure	1.6	1.5	1.3	1.2	1.1	0.9
Reserves / appropriations as a percentage of total expenditure	3.7	9.9	10.1	7.8	7.2	7.2
Health insurance benefits as a percentage of GDP*	3.8	3.9	4.1	4.0	3.8	4.2

* The indicators are amended acc. to the specified data of GDP provided by the Statistical Office in 2006 and 2007

Table 10. Number of the insured

	31.12.2006	31.12.2007	31.12.2007/ 31.12.2006%
Insured persons in employment	651,141	672,706	3%
Government insured persons	30,663	31,942	4%
Persons covered as insured	592,687	579,698	-2%
Persons covered by international health agreements	3,525	3,419	-3%
TOTAL INSURED	**1,278,016**	**1,287,765**	**1%**

The EHIF takes two important values into consideration in health insurance:

- Solidarity – the solidarity between the persons in employment and the persons not yet or not any more in employment, different generations, people with different monetary input and health risk
- Equal and uniform treatment - the EHIF guarantees equal rights and possibilities to all the insured people in getting health insurance benefits and guarantees uniform treatment according to the legal situation in the country

Figure 6. Proportion of the insured and social tax paid

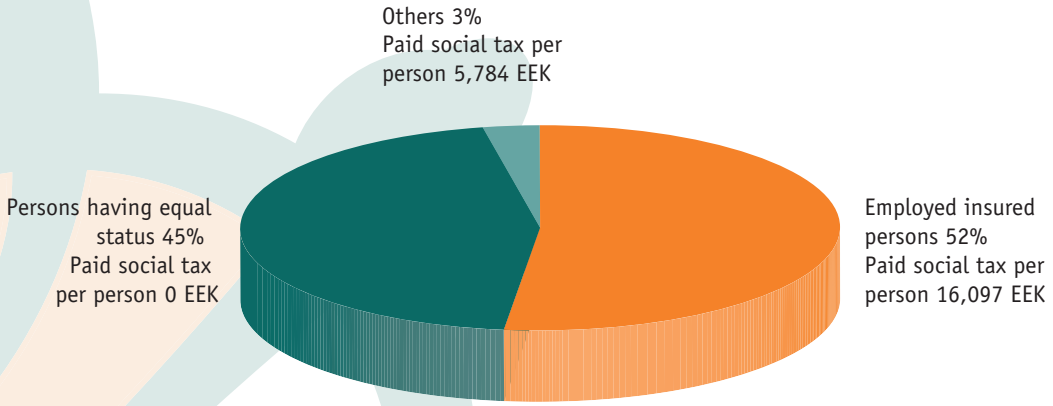


Table 11. Average expenditure in 2007 on health services to a resident of the Republic of Estonia registered in the Health Insurance Fund

Age groups (years of age)	Number of the insured as of 31 December 2007	Expenditure of general medical care in EEK	Expenditure of specialised medical care in EEK	Expenditure of prescription of medicinal products in EEK	Total expenditure in EEK
0-9	135,356	722	3,264	242	4,228
10-19	164,030	615	2,750	251	3,616
20-29	177,893	629	3,014	450	4,093
30-39	172,549	645	3,117	535	4,297
40-49	169,646	676	3,455	746	4,877
50-59	167,915	714	5,084	1,189	6,987
60-69	138,576	721	7,624	1,840	10,185
70-79	111,687	793	9,880	2,223	12,896
80-89	45,072	840	9,328	1,857	12,024
90-99	5,039	684	8,289	1,091	10,064
100-109	108	679	4,448	-	5,127,

Revenues

Table 12. Revenues (in EEK thousand)

	2006 actual	2007 budget	2007 actual	Budget implementation %	Change compared to 2006 %
Social tax	8,808 806	10,879,599	11,000,420	101%	25%
Premiums paid by persons covered as insured under a contract	30,299	30,000	34,071	114%	12%
Amounts due from other persons	12,601	11,000	9,356	85%	-26%
Financial income	52,489	49,300	97,104	197%	85%
Other revenues	5,752	4,719	41,873	887%	628%
TOTAL	**8 909,947**	**10 974,618**	**11 182,824**	**102%**	**26%**

Social tax

Revenue from the social tax was 11 billion kroons which is ca 25% more than in 2007 (budget implementation 101%).

Premiums paid by persons covered as insured under a contract

Revenue from voluntary insurance contracts and non-working retirees of the armed forces of the Russian Federation currently living in the Republic of Estonia was 34 million kroons (budget implementation 114%).

Amounts due from other persons

The biggest amount of the claims is from medical institutions, family physicians, pharmacies and insurance companies. The claims are for the sums paid out without basis (benefits to the non-insured persons, treatment and benefits related to the car accidents, etc) and sums discovered in the course of random inspection. Besides, the EHIF makes claims on third persons liable for causing bodily harm for the insured persons and non-insured who have received treatment in a foreign country without basis. Revenues received in the reporting period amounted to 9 million kroons (budget implementation 85%).

Financial income

Financial revenues were planned on the basis of the estimated average balance of the legal reserve, risk reserve and earnings of fiscal year and the rate of return, foreseen by the Ministry of Finance. The actual financial income was 97 million kroons (budget implementation 197%).

Table 13. Main indicators for liquidity portfolio and investments in legal reserve

	Investments in risk reserve and revenue	Investments in legal reserve
Fund volume at cost (in EEK thousand)	2,529,010	454,585
Fund volume at market value (in EEK thousand)	2,548,904	458,055
Realised gains from beginning of year (in EEK thousand)	74,572	6,255
Gain on revaluation	19,894	3,470
Profitability (on a yearly basis)	3.9%	3.4%
Average duration of investment (on a yearly basis)	0.21	1.18

Other revenues (incl. government grants)

The EHIF received a revenue of 12 million kroons from the processing and inspection of bills for emergency medical care of persons without medical coverage, from the sale of prescription forms to health care institutions, remuneration for medical services rendered to the persons insured by other EU member states and other economic transactions of the EHIF.

Other revenues include also the government grants from the state budget. Starting from 2007, the EHIF compensates in the scope of the means planned in the state budget of the EHIF the prescription of medicinal products and some procedures related to the external in vitro fertilisation. During the year, these appropriations formed ca 30 million kroons.

Expenditure

The expenditure of the EHIF is divided into the expenditure on health insurance benefits and the operating expenses.

Table 14. Breakdown of expenditure

	2006	2007	Change %
Benefit expenditure	98.92%	99.07%	0.2%
Operating expenses	1.08%	0.93%	-0.2%

Expenditure on health insurance benefits

Decisions having the major impact on the expenditure on the health insurance benefits in 2007.

- Increase of the reference prices of the health services, incl. the rise of the salary component 25%
- The average cost of the treated case was increased to enable the development of the medical technology and treatment practices
- Application of the payment for performance system of the family physicians to improve the efficiency of the doctors in observation of the chronic patients and promoting preventive activities
- Compensation of the biological medicinal products was started
- The selection of the modern oncological medicinal products in cytostatic treatment processes was expanded
- 176.6 million kroons was used from the retained profits to shorten the waiting lists of specialised medical care

1. Health benefits

For the first time, the rise of the estimated expenditure on health services exceeded the limit of 1 billion kroons. As compared to 2006 the rise of the total expenditure on health services was ca 1.5 billion kroons, i.e. 28%.

Table 15. Health benefits (in EEK thousand)

	2006 actual	2007 budget	2007 actual	Budget implementation%	Change compared to 2006 %
Disease prevention	77,562	101,000	90,148	89%	16%
Health services of general medical care	666,609	900,111	886,076	98%	33%
Specialised medical care	4,260,081	5,392,164	5,407,270	100%	27%
Nursing care	132,386	188,787	189,267	100%	43%
Dental care benefits	192,925	247,227	239,992	97%	24%
TOTAL	**5,329,563**	**6,829,289**	**6,812,753**	**100%**	**28%**

In 2007 the EHIF continued also the internationally noticed trend that the rate of the outpatient treatment expenses increases and the rate of the inpatient treatment expenses decreases.

Developing medical technology brings along the changes in the treatment practice and there are more and more possibilities for good quality outpatient treatment. It is more comfortable for the patient as it is not necessary to stay at the hospital for having the studies or recovering from the procedures. On another hand this enables to use the means of the health insurance more efficiently as the outpatient and day care are cheaper and the free means can be used for the treatment of other patients.

The EHIF considers it positive that the rate of expenses of the outpatient treatment increased by 1.3% as compared to the year 2006.

Table 16. Expenditure on outpatient and inpatient health services (in EEK thousand)

	2005 actual	2006 actual	2007 actual
Disease prevention	74,436	77,562	90,148
General medical care	592,155	666,609	886,076
Outpatient specialised care	1,159,411	1,364,234	1,823,376
Centrally contracted outpatient health services	27,224	40,862	37,878
Outpatient nursing care	15,435	19,092	28,684
Dental care benefits	183,520	192,925	239,992
Total benefits for outpatient health services	**2,052,181**	**2,361,284**	**3 106,154**
Centrally contracted inpatient health services	33,489	19,246	58,630
Inpatient specialised medical care	2,435,521	2,738,601	3,389,760
Inpatient nursing care	98,485	113,294	160,583
Expenditure of emergency response	97,138	97,138	97,626
Total benefits for inpatient health services	**2,664,633**	**2,968,279**	**3,706,559**
Total benefits for outpatient and inpatient health services	**4,716,814**	**5,329,563**	**6,812,753**
Proportion of benefits for outpatient health services	**43.5%**	**44.3%**	**45.6%**
Proportion of benefits for inpatient health services	**56.5%**	**55.7%**	**54.4%**
Changes in the rate of the benefits for outpatient health services as compared to the previous year	-	0.8%	1.3%
Changes in the rate of the benefits for inpatient health services as compared to the previous year	-	-0.8%	-1.3%

176.6 million kroons was planned in the budget of the specialised medical care from the retained profits for improving the accessibility of the specialised medical services. During the year, 208 million kroons was spent for achieving the abovementioned objective. General accessibility of the specialised medical care improved most (additionally, ca 120,000 treated cases were financed).

Table 17 gives a review of the resources used for improving the accessibility of the specialised medical care.

Table 17. Additional resources used for improving the accessibility of the specialised medical care. 2007 budget

	2007 budget		2007 actual		Budget implementation %	
Objectives	**Additional treated cases/ persons/ services**	**Expense in EEK thousand**	**Additional treated cases/ persons/ services**	**Expense in EEK thousand**	**Additional treated cases/ persons/ services**	**Expense in EEK thousand**
General accessibility (treated case)	20,896	101,105	21,470	105,967	103%	105%
Operations of endoprothesis (shortening of the waiting list by 6 months) (treated case)	90	4,800	101	5,495	112%	114%
Operations of cataract (shortening of the waiting list by 6 months) (treated case)	1,250	18,584	1,134	10,122	91%	54%
Enzyme replacement treatment in case of type 1 of Gaucher disease (persons)	4	5,374	3	6,302	75%	117%
Biological treatment with TNF-alfa inhibitor (persons)	75	16,000	103	13,540	137%	85%
Cytostatic treatment processes (treatment processes): treatment of the tumours of the digestive tract and gynaecological sphere	3,192	26,000	4,853	65,064	152%	250%
New health services: (number of services): deep brain stimulation, irradiation of blood products, laboratory services	4,999	4,745	5,231	1,496	105%	32%
TOTAL		**176,608**		**207,986**		**118%**

Disease prevention

The objective of the disease prevention is to detect pre-disease conditions as early as possible and to apply preventive measures. Prevention activities could decrease in the future the expenditure of the EHIF on the treatment of specific diseases. An amount of 90,148,000 kroons was spent on the prevention of diseases in 2007 which forms 89% of the total budget for disease prevention.

Table 18. Disease prevention[19] (in EEK thousand)

	2006 actual	2007 budget	2007 actual	Budget implementation %	Change compared to 2006 %
School health care	40,553	49,904	46,343	93%	14%
Reproductive health councelling centres for young people	7,753	12,622	10,022	79%	29%
Early detection of breast cancer	9,874	12,616	11,750	93%	19%
Early detection of cervical cancer	2,336	4,884	2,553	52%	9%
Early detection of the risk factors of heart diseases	2,432	3,130	2,310	74%	-5%
Early detection of osteoporosis	829	1,092	1,050	96%	27%
Phenylketonuria and hypothyroidism screening	1,233	2,755	2,807	102%	128%
Prevention of hereditary diseases by prenatal diagnostics	10,077	9,560	10,198	107%	1%
The newborn hearing tests	2,034	3,776	3,089	82%	52%
Immunization against hepatitis B	35	350	26	7%	-26%
Evaluation of prevention activities	406	311	0	0%	-100%
Total	**77,562**	**101,000**	**90,148**	**89%**	**16%**

School health care. According to the Ministry of Education, the number of the pupils decreased in 2007/2008 more than planned, i.e. by 8,500 pupils. This was also one of the reasons why the school health budget was not completely used. During the year, the number of those schools increased where no school health services were provided as there was no contractual partner.

Early detection of breast cancer. The planned budget was used according to the plan. More women living in the country area participated in the screening due to the availability of the service by the mammography bus.

Early detection of cervical cancer. The planned budget was not completely used as the number of the women who participated in the screening was smaller than invited and only every third woman from those who received the invitation came to the survey. Women have been informed of the screening personally and through media to increase the participation rate in the abovementioned study. Preventive tests of the cancer of the cervix are performed also in the course of the routine gynaecological medical check-up. The woman who has received the invitation can have the procedure also at her personal gynaecologist.

Early detection of the risk factors of heart diseases. The project was addressed mainly to the persons with a higher cardiovascular risk. The comprehensive medical tests for patients belonging to the risk group are performed at the centres of the counties (14 centres participate). The number of the participants was not very big as the family physicians did not need to send the patients with a higher risk to the heart centre of the county.

Early detection of osteoporosis. The project was addressed to the patients with rheumatic disease.

Phenylketonuria and hypothyroidism screening. The studies were carried out according to the number of births.

Prevention of hereditary diseases by prenatal diagnostics. The need for the prevention tests was bigger than estimated in the planning process. This is related to the increased awareness of the pregnant women, earlier serum screening carried out and partially to the age of the pregnant women (51% of the studies were performed due to the age risk of the women).

The newborn hearing tests. The tests were carried out in 2007 also in the hospitals in Narva, Põlva and Valga. The planned budget was not completely used as the need for the further studies was smaller.

Immunization against hepatitis B. Mainly the medical students in the University of Tartu were vaccinated. The budget was planned also for the vaccination of the students of the medical schools.

19 The target groups of the prevention projects are formed by all persons in the risk group but the budgets of the projects are projected taking into consideration the actual number of participants

The external assessment of the impact and efficiency of **the projects for reproductive health counselling of young people and prevention of hereditary diseases by prenatal diagnostics** were started in 2007. Neutral analysis gives a detailed review of the project implementation. The EHIF and the organisers of the project can improve the implementation of the project on the basis of the analysis and make the achievement of the set objectives more efficient.

Table 19. Results of the disease prevention projects

	Target group participated in 2006	Target group planned in 2007	Target group participated in 2007	% of the participated target group 2007	Results
School health care	184,335	189,048	175,537	93%	There were no school health contracts in 13 schools by the end of the year (ca 2,600 pupils). Health councils have been established in 34% of the schools.
Reproductive health of young people (number of cases or visits)	27,763	30,000	28,395	95%	The rate of the primary visitswas 21% (incl. 11% young men), 4% of the visitors were men and 21% non-Estonians. SDT screening was carried out in 36% and sexual consulting in 64% of the visits. A SDT was discovered in 541 cases (8% of the screened persons), incl. 3 cases of HIV. Pregnancy was detected in 152 cases and 206 women were referred for abortion in the age group of up to 19 years.
Early detection of breast cancer	23,170	28,000	26,467	95%	Ca 2.3% of the screened women were invited to additional study, 119 women were invited to the further mammology studies. 95 cases of cancer were detected of which early stage cancer accounted for 79%
Early detection of cervical cancer	9,410	23,000	11,659	51%	Pre-cancer condition or cancer was detected in ca 700 women (6% of the studied persons)
Early detection of the risk factors of heart diseases	16,226	8,000	5,055	63%	28% of the participants in the project were men with a higher heart risk. Non-medical or medical influencing of risk factors was initiated for 22% of the people who participated in the project, reduction of the CVD risk in the course of the project was 5%, drop of the systolic pressure of people with a high blood pressure was 6.7 mm/hg, drop of the cholesterol level of the patients with lipaemia was 0.8 mmol/l, 7% of the participants quit smoking
Early detection of osteoporosis	1,368	1,500	1,357	90%	Osteporosis was detected in 34% and osteopenia in 38% of the screened persons with rheumatic disease. 85% of the repeatedly screened persons consumed calcium and vitamin D products
Phenylketonuria and hypothyroidism screening	14,081	15,000	15,692	105%	99% of the newborn children were screened. Phenylketonuria was timely detected in two patients and hypothyroidism in four children.
Prevention of hereditary diseases by prenatal diagnostics	1,951	1,800	2,150	119%	51% of screenings was carried out due to age risk. Chromosome abnormality was detected in 61 cases (incl. 27 cases of Down syndrome)
The newborn hearing tests	10,028	13,000	11,536	89%	11 deviations from the standard were observed in the course of the screening. Two children whose deviation from the standard was observed in 2006 have received inner ear implants.
Immunization against hepatitis B	364	1,800	231	13%	Mainly carried out among medical students of University of Tartu

General medical care

The most important achievement in 2007 was that starting from 1 July 2007 family physicians receive a performance bonus. In a longer perspective, the implementation of the performance bonus system makes the activities of the family physicians in preventing and treating chronic illnesses more efficient. Thus, the impact of the performance bonus system is oriented to the patients.

Expenditure of general medical care amounted to 886,076,000 kroons which is 98% of the general medical care budget. In the total expenditure, the capitation fees formed the major part – 69%, research fund formed 16%, base fee 13% and 2% was spent on financing of other expenses in the general medical care.

Table 20. Expenditure of general medical care (in EEK thousand)

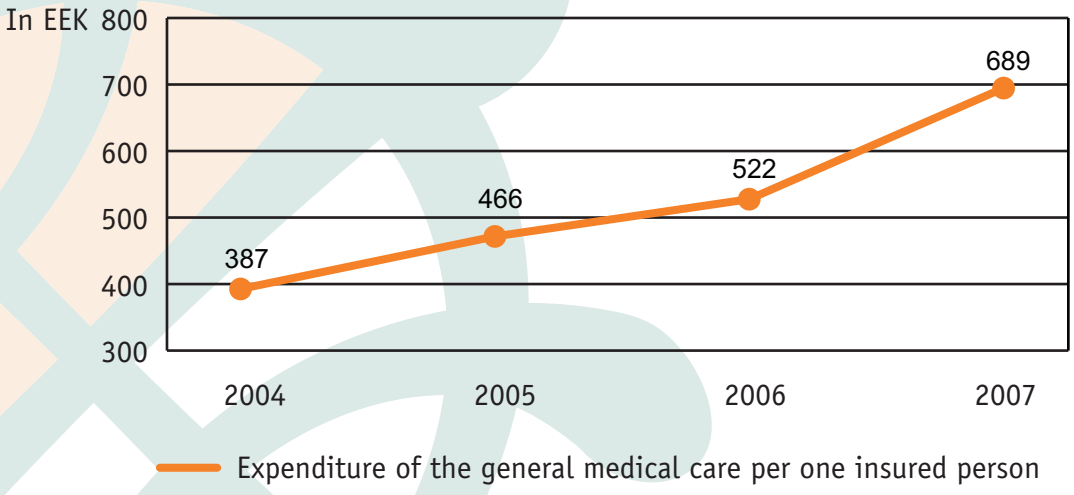
	2006 actual	2007 budget	2007 actual	Budget implementation %	Change compared to 2006 %
Base fee	63,238	116,600	115,046	99%	82%
Distance allowance	2,662	5,366	5,325	99%	100%
Qualification allowance*	9,475	4,854	4,760	98%	-50%
Capitation fee (under age 2)	21,175	30,319	28,551	94%	35%
Capitation fee (aged 2 – 70)	396,832	490,820	495,110	101%	25%
Capitation fee (over age 70)	67,258	84,191	86,419	103%	28%
Research fund	99,867	151,333	140,391	93%	41%
Performance for family physicians**	0	5,808	3,435	59%	-
Advisory line	6,102	9,320	7,039	76%	15%
General medical care reserve	0	1,500	0	0%	-
Total	**666,609**	**900,111**	**886,076**	**98%**	**33%**

* Qualification fee for the certificate of the family physician was paid until the end of I half-year 2007

** Performance bonus is paid from II half-year 2007

Compared to 2006, the expenditure has increased by 33% or ca 220 million kroons which is mainly due to the rise in the reference prices of the health services. As compared to the year 2006, the rise was in the reference prices of the capitation and base fee, distance allowance doubled and the research fund increased. All these rises are reflected in the expenditure of the general medical care per one insured person.

Figure 7. Expenditure of the general medical care per one insured person



Performance bonus system. In the first half-year of 2007, the EHIF paid a qualification allowance

to the family physicians for the last time. Starting from July 1, 2007, performance bonus is paid.

The objective of this system is to promote the prevention of diseases and monitoring patients with chronic illnesses.

Starting from the second half of 2007, the EHIF started to pay the performance bonus based on the results of 2006 (either based on the coefficient 1.0; 0.8; 0.5 or 0.25 from the reference price of the corresponding service depending on the implementation of the criteria and depending on the number of scores of the family physician) to 500 family physicians. Nine family physicians were paid with the coefficient 1.0 and twenty-one family physicians with the coefficient 0.8. They deserve the biggest recognition for the good results.

Joining the system of the performance bonus is voluntary. Thus, bonus with the coefficient 0.25 was paid during the first year also in these cases when the family physician had submitted her/his list of the patients with chronic diseases but had not yet achieved the required involvement. This was the recognition to the more active family physicians for joining the new progressive system.

Research fund. 27% of the capitation fee was planned for studies in 2007 (23% in the year 2006). One of the reasons for increasing the research fund was the application of the payment for performance system which is connected with the follow-up of the patients with chronic diseases and prevention activities, among other things, performing more tests and studies. The research fund budget was not implemented (implementation 93%) as the number of the family physicians participating in the payment for performance system was smaller than planned.

Capitation fee. The EHIF projected that the number of births is bigger and, thus, only 94% of the planned financial means have been spent on the children under the age of 2. The number of the persons aged 2 – 70 and over 90 has increased (1 – 3%)

Advisory line of the family physician. 154,467 calls (on average 423 calls a day) were answered in 2007. Most of the persons who called needed advice in health issues, only 1% asked about the health care administration.

The advisory line of the family physician 1220 works in cooperation with the Estonian Alarm Centre. If there is an urgent need and depending on the problem, the 1220 call will be transferred to the Alarm Centre. According to the information of the Alarm Centre, the workload of the doctors working at the Alarm Centre has decreased in solving not dangerous health problems due to the advisory phone services. Thus, the line 112 is more easily accessible to those who need immediate help.

According to the survey conducted in 2007 the spontaneous knowledge of the phone was 72%. 17% of the population has been used the service in 2007.

According to the statistics more people call 1220 after the working hours, in the weekend and on public holidays. So, the service has increased the accessibility of the primary medical consultation.

General medical care reserve. Here the resources for following normal pregnancy were projected. The reserve includes also finances used for autopsy. In the annual report the expenses are reflected in the expenses of the research fund.

Table 21. Practice lists of the family physician and the number of insured persons in the list

	2006 actual*	2007 actual	Change compared to 2006 %
Number of practice lists			
Practices**	797	800	0%
Distance allowance (practices)	197	196	-1%
Qualification allowances (practices)	797	794	0%
Average number in the list (persons)	1,601	1,607	0%
Number of insured persons in the list			
Insured up to the age 2	25,574	26,629	4%
Insured aged 2 – 70	1,095,011	1,100,233	0%
Insured over 70	155,259	158,790	2%
Insured patients in total	**1 275,844**	**1 285,652**	**1%**

* the numbers of the year 2006 have been corrected as starting from 2007 the number of practice lists is described in the report instead of the base fee

** the practice list of a family physician comprises the persons who have submitted a written registration application and persons not registered but appointed on the basis of the permanent residence

There were 72 practice lists in Estonia which were smaller and 183 which were bigger than the norm list size (1 200 – 2 000 persons[20] per list), incl. 46 lists where there was more than 2 300 persons. Eight family physicians worked in the location where the number of permanent residents was less than 1 000 people. The EHIF paid to these physicians capitation fee for 1 000 persons. The EHIF paid with the coefficient 1.5 to those physicians who have several places of work due to the regional peculiarities.

Table 22. Appointments by family physicians

	2006 actual*		2007 actual		Change compared to 2006 %	
	Receptions	Persons	Receptions	Persons	Receptions	Persons
Primary appointment	1,698,045	773,727	1,908,182	786,552	12%	2%
Subsequent appointment	2,242,853	667,775	2,599,830	693,875	16%	4%
Prophylactic appointment	366,743	215,097	395,760	213,363	8%	-1%
Home visit	138,392	87,513	132,162	75,415	-5%	-14%
Independent appointment at the family nurse	196,720	98,627	318,691	152,593	62%	55%
Planned appointment of the non-insured	12,376	7,317	13,762	7,469	11%	2%
Subsequent appointment at the family nurse	18,153	8,972	21,476	9,793	18%	9%
Telephone contact	160,742	98,121	202,942	114,653	26%	17%

* the numbers of the year 2006 have been corrected and adjusted to the calculation method used in 2007

The number of appointments made by a family physician has increased as compared to the previous year. The rise is especially big regarding the appointments at the family nurse (62%). It is due to the fact that the independent work of family nurses has increased in the frames of the performance bonus system applied.

20 persons – both insured and not insured persons

Specialised medical care

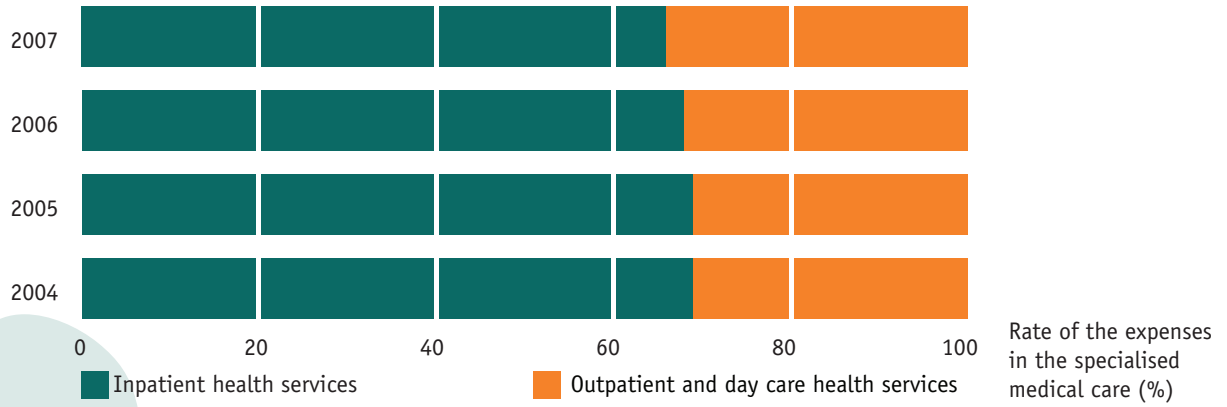
The expenditure of the specialised medical care in 2007 amounted to 5 billion 407 million 270 thousand kroons from which 96 million 508 thousand kroons was for centrally contracted health services.

Centrally contracted health services include the specialised medical care provided to the small amount of insured persons but the price of which is comparatively high. The expenses of these services are reflected separately in order not to impact the general indicators of the specialised medical care.

Outpatient, inpatient and day care health services (excl. centrally contracted health services)

The efficiency of the health services improved in the specialised medical care in 2007. The rate of the expenses of the outpatient and day care services has increased constantly. This refers to the more efficient use of money and the fact that it was preferred to use diagnostics and treatment methods in the conditions of the outpatient and day care services.

Figure 8. Rate of the expenses of the outpatient and day care services



Supplementary budget adopted in 2007 allocated additionally ca 63.9 million kroons to the improvement of the accessibility of the outpatient and day care health services. Ca 2.98 million treated cases were financed from the budget from which 92% were outpatient and day care and 8% inpatient cases. The number of treated cases in the specialised medical care have been exceeded as compared to the budget by ca 2% (64,900 cases). The bigger amount of cases in outpatient and day care services than planned has guaranteed the access to the specialised medical care to more patients.

A more detailed expenditure of resources and distribution of the treated cases by specialities are given in the following tables.

Table 23. Expenses of the specialised medical care (in EEK thousand)

	2006 actual	2007 budget	2007 actual	Budget implementation %	Change compared to 2006 %
Surgery	867,389	1,081,101	1,055,556	98%	22%
Outpatient	134,028	166,829	174,425	105%	30%
Day care	30,634	39,079	39,301	101%	28%
Inpatient	702,727	875,193	841,830	96%	20%
Otorhinolaryngology	129,308	164,208	162,367	99%	26%
Outpatient	49,450	63,157	64,422	102%	30%
Day care	19,191	25,935	32,670	126%	70%
Inpatient	60,667	75,116	65,275	87%	8%
Neurology	126,142	153,232	171,594	112%	36%
Outpatient	56,051	67,589	75,165	111%	34%
Inpatient	70,091	85,643	96,429	113%	38%
Ophthalmology	165,585	205,332	212,714	104%	28%
Outpatient	74,272	99,271	105,816	107%	42%
Day care	79,542	84,005	93,042	111%	17%
Inpatient	11,771	22,056	13,856	63%	18%
Orthopaedics	362,623	443,851	442,935	100%	22%
Outpatient	74,897	93,363	94,439	101%	26%
Day care	19,828	29,736	29,890	101%	51%
Inpatient	267,898	320,752	318,606	99%	19%
Oncology	262,542	367,667	390,639	106%	49%
Outpatient	112,673	161,364	177,641	110%	58%
Day care	0	0	2,729		-
Inpatient	149,869	206,303	210,269	102%	40%
Obstetrics and gynaecology	452,620	575,984	569,486	99%	26%
Outpatient	192,270	238,604	246,490	103%	28%
Day care	25,111	32,570	33,281	102%	33%
Inpatient	235,239	304,810	289,715	95%	23%
Pulmonology	115,004	151,071	155,986	103%	36%
Outpatient	49,974	60,519	65,393	108%	31%
Inpatient	65,030	90,552	90,593	100%	39%
Dermatovenerology	48,641	60,877	62,388	102%	28%
Outpatient	38,533	48,189	50,407	105%	31%
Day care	564	700	720	103%	28%
Inpatient	9,544	11,988	11,261	94%	18%
Paediatrics	184,651	235,715	241,613	103%	31%
Outpatient	40,050	50,296	50,714	101%	27%
Day care	4,527	5,514	6,485	118%	43%
Inpatient	140,074	179,905	184,414	103%	32%
Psychiatrics	195,905	254,494	248,273	98%	27%
Outpatient	47,556	62,634	61,818	99%	30%
Day care	788	1,231	847	69%	7%
Inpatient	147,561	190,629	185,608	97%	26%
Infectious diseases	60,777	79,082	76,540	97%	26%
Outpatient	14,189	18,446	18,906	102%	33%
Day care	46,588	60,636	57,634	95%	24%
Inpatient	1,034,625	1,274,826	1,281,387	101%	24%
Internal diseases	217,573	218,846	236,714	108%	9%
Outpatient	41,248	98,094	102,483	104%	148%
Inpatient	775,804	957,886	942,190	98%	21%
Follow-up care	10,835	14,123	16,929	120%	56%
Inpatient	10,835	14,123	16,929	120%	56%
Rehabilitation	78,516	112,715	113,412	101%	44%
Outpatient	33,614	48,135	48,261	100%	44%
Inpatient	44,902	64,580	65,151	101%	45%
Unspecified specialities	7,672	10,969	11,317	103%	48%
Outpatient	7,672	10,969	11,317	103%	48%
Total	**4,102,835**	**5,185,247**	**5,213,136**	**101%**	**27%**
Total outpatient	1,142,802	1,408,211	1,481,928	105%	30%
Total day care	221,433	316,864	341,448	108%	54%
Total inpatient	2,738,600	3,460,172	3,389,760	98%	24%
Emergency response expense	**97,138**	**98,115**	**97,626**	**100%**	**1%**
Total expenses	**4,199,973**	**5,283,362**	**5,310,762**	**101%**	**26%**

Table 24. Treated cases in specialised medical care

	2006 actual	2007 budget	2007 actual	Budget implementation %	Change compared to 2006 %
Surgery	354,479	356,213	368,518	103%	4%
Outpatient	297,457	297,926	310,980	104%	5%
Day care	8,121	8,645	8,953	104%	10%
Inpatient	48,901	49,642	48,585	98%	-1%
Otorhinolaryngology	200,208	202,553	206,292	102%	3%
Outpatient	182,005	183,145	187,440	102%	3%
Day care	4,544	5,157	6,378	124%	40%
Inpatient	13,659	14,251	12,474	88%	-9%
Neurology	130,155	131,315	129,989	99%	0%
Outpatient	123,122	124,138	123,001	99%	0%
Inpatient	7,033	7,177	6,988	97%	-1%
Ophthalmology	324,815	340,380	350,052	103%	8%
Outpatient	313,893	328,397	337,630	103%	8%
Day care	9,406	9,471	10,808	114%	15%
Inpatient	1,516	2,512	1,614	64%	6%
Orthopaedics	249,199	258,790	259,000	100%	4%
Outpatient	232,830	241,387	241,724	100%	4%
Day care	3,406	4,233	4,324	102%	27%
Inpatient	12,963	13,170	12,952	98%	0%
Oncology	75,923	81,687	83,598	102%	10%
Outpatient	67,171	72,250	73,186	101%	9%
Day care	-	-	202	-	-
Inpatient	8,752	9,437	10,210	108%	17%
Obstetrics and gynaecology	489,662	504,639	513,144	102%	5%
Outpatient	436,848	450,324	461,217	102%	6%
Day care	15,041	15,192	16,083	106%	7%
Inpatient	37,773	39,123	35,844	92%	-5%
Pulmonology	57,744	59,000	61,334	104%	6%
Outpatient	54,415	55,375	57,521	104%	6%
Inpatient	3,329	3,625	3,813	105%	15%
Dermatovenerology	159,893	159,324	164,535	103%	3%
Outpatient	158,034	157,430	162,676	103%	3%
Day care	292	295	327	111%	12%
Inpatient	1,567	1,599	1,532	96%	-2%
Paediatrics	139,234	140,863	140,111	99%	1%
Outpatient	109,594	111,302	110,174	99%	1%
Day care	1,690	1,631	1,924	118%	14%
Inpatient	27,950	27,930	28,013	100%	0%
Psychiatrics	196,378	198,873	203,927	103%	4%
Outpatient	184,929	187,271	192,030	103%	4%
Day care	175	225	172	76%	-2%
Inpatient	11,274	11,377	11,725	103%	4%
Infectious diseases	25,090	25,204	26,999	107%	8%
Outpatient	15,027	15,225	17,242	113%	15%
Day care	10,063	9,979	9,757	98%	-3%
Inpatient	376,243	380,516	395,390	104%	5%
Internal diseases	317,358	319,126	334,924	105%	6%
Outpatient	2,127	3,182	3,891	122%	83%
Inpatient	56,758	58,208	56,575	97%	0%
Follow-up care	1,535	1,520	1,750	115%	14%
Inpatient	1,535	1,520	1,750	115%	14%
Rehabilitation	52,350	55,102	55,892	101%	7%
Outpatient	46,025	48,576	49,013	101%	6%
Inpatient	6,325	6,526	6,879	105%	9%
Unspecified specialities	17,093	17,935	18,340	102%	7%
Outpatient	17,093	17,935	18,340	102%	7%
Total	**2,800,001**	**2,913,914**	**2,978,871**	**102%**	**5%**
Total outpatient	2,555,801	2,609,807	2,677,098	103%	5%
Total day care	44,802	48,031	53,062	110%	18%
Total inpatient	249,398	256,076	248,711	97%	0%
Emergency response expense	**128**	**188**	**129**	**69%**	**1%**
Total treated case	**2,850,129**	**2,914,102**	**2,979,000**	**102%**	**5%**

Table 25. ACPC of the specialities of specialised medical care

	2006 actual	2007 budget	2007 actual	Budget implementation %	Change compared to 2006 %
Surgery	2,447	3,035	2,864	94%	17%
Outpatient	451	560	561	100%	24%
Day care	3,772	4,520	4,390	97%	16%
Inpatient	14,371	17,630	17,327	98%	21%
Otorhinolaryngology	646	811	787	97%	22%
Outpatient	272	345	344	100%	27%
Day care	4,223	5,029	5,122	102%	21%
Inpatient	4,442	5,271	5,233	99%	18%
Neurology	969	1,167	1,320	113%	36%
Outpatient	455	544	611	112%	34%
Inpatient	9,966	11,933	13,799	116%	38%
Ophthalmology	510	603	608	101%	19%
Outpatient	237	302	313	104%	32%
Day care	8,457	8,870	8,609	97%	2%
Inpatient	7,769	8,780	8,585	98%	10%
Orthopaedics	1,455	1,715	1,710	100%	18%
Outpatient	322	387	391	101%	21%
Day care	5,821	7,025	6,913	98%	19%
Inpatient	20,666	24,355	24,599	101%	19%
Oncology	3,458	4,501	4,673	104%	35%
Outpatient	1,677	2,233	2,427	109%	45%
Day care	-	-	13,511	-	-
Inpatient	17,124	21,861	20,594	94%	20%
Obstetrics and gynaecology	924	1,141	1,110	97%	20%
Outpatient	440	530	534	101%	21%
Day care	1,669	2,144	2,069	97%	24%
Inpatient	6,228	7,791	8,083	104%	30%
Pulmonology	1,992	2,561	2,543	99%	28%
Outpatient	918	1,093	1,137	104%	24%
Inpatient	19,534	24,980	23,759	95%	22%
Dermatovenerology	304	382	379	99%	25%
Outpatient	244	306	310	101%	27%
Day care	1,933	2,371	2,201	93%	14%
Inpatient	6,091	7,497	7,351	98%	21%
Paediatrics	1,326	1,673	1,724	103%	30%
Outpatient	365	452	460	102%	26%
Day care	2,678	3,381	3,370	100%	26%
Inpatient	5,012	6,441	6,583	102%	31%
Psychiatrics	998	1,280	1,217	95%	22%
Outpatient	257	334	322	96%	25%
Day care	4,504	5,471	4,920	90%	9%
Inpatient	13,089	16,756	15,830	94%	21%
Infectious diseases	2,422	3,138	2,835	90%	17%
Outpatient	944	1,212	1,097	91%	16%
Day care	4,630	6,076	5,907	97%	28%
Inpatient	2,750	3,350	3,241	97%	18%
Internal diseases	686	686	707	103%	3%
Outpatient	19,393	30,828	26,338	85%	36%
Inpatient	13,669	16,456	16,654	101%	22%
Follow-up care	7,059	9,292	9,674	104%	37%
Inpatient	7,059	9,292	9,674	104%	37%
Rehabilitation	1,500	2,046	2,029	99%	35%
Outpatient	730	991	985	99%	35%
Inpatient	7,099	9,896	9,471	96%	33%
Unspecified specialities	449	612	617	101%	37%
Outpatient	449	612	617	101%	37%
Total ACPC					
Total outpatient	**447**	**540**	**554**	**103%**	**24%**
Total day care	**4,942**	**6,597**	**6,435**	**98%**	**30%**
Total inpatient	**10,981**	**13,512**	**13,629**	**101%**	**24%**

The most essential changes by specialities:

- The number of outpatient appointments has increased. This has improved the satisfaction of the demand for the planned treatment in surgical specialities. The number of general treatment cases in surgery and otorhinolaryngology has increased due to the increased application of outpatient treatment
- New services included in the list of health services and updated reference prices of the cytostatic medical treatment have increased the general expenses in oncology by 49% and increased the number of treated cases in the speciality by 10%
- A new principle of financing the medical rehabilitation (applied in 2006) has impacted through the application of physiotherapeutic services the structural increase of the price of the treated case by 12% and increased the number of treated cases in the speciality by 7%
- The number of outpatient appointments has increased in infectious diseases by 15%. This is due to the increased need for the outpatient follow-up of the patients getting antiretrovirus[21] treatment
- Almost all hospitals have updated the radiological equipment in the last two years. This has impacted mainly radiology where the increase in the price of the treated case was 36% in the year 2007
- The invasive methods are used more and more in cardiology. This has impacted the average cost of the treated case in therapeutics (increase in the speciality 18%)
- The expenses in obstetrics and gynaecology include 16.8 million kroons used for artificial insemination which are covered according to the agreement between the EHIF and the Ministry of Social affairs from the government grants from the state budget

There have been 64.9 thousand more than planned treated cases of insured persons in 2007. This shows that the providers of health services have reorganised their work in 2007 in order to offer more outpatient services. At the same time, also the percentage of the planned treatment has increased applying more the day care services. The results of the analyses of the waiting lists also prove the indicators of the expenses in the specialised medical care and application of the treated cases – there are no longer very long waiting lists in inpatient specialised medical care.

21 Treatment of AIDS patients

Special cases

In the process of budget planning, the EHIF pays special attention to special cases (operations of endoprosthesis and cataract, cardiac surgeries, deliveries).

The following table gives a review of the financing of special cases in 2004 – 2007.

Table 26. Number of special cases

	Special cases 2004 – 2007				Changes%		
	2004	2005	2006	2007	2005/ 2004	2006/ 2005	2007/ 2006
Endoprosthesis	2,509	2,600	2,643	2,743	4%	2%	4%
Cataract operations	8,161	7,820	9,102	10,236	-4%	16%	12%
Cardiac surgeries	843	982	1,062	1,081	16%	8%	2%
Deliveries	13,517	13,813	14,573	15,439	2%	6%	6%
Total	**25,030**	**25,215**	**27,380**	**29,499**	**1%**	**9%**	**8%**

Table 27. Expenses of special cases (in EEK thousand)

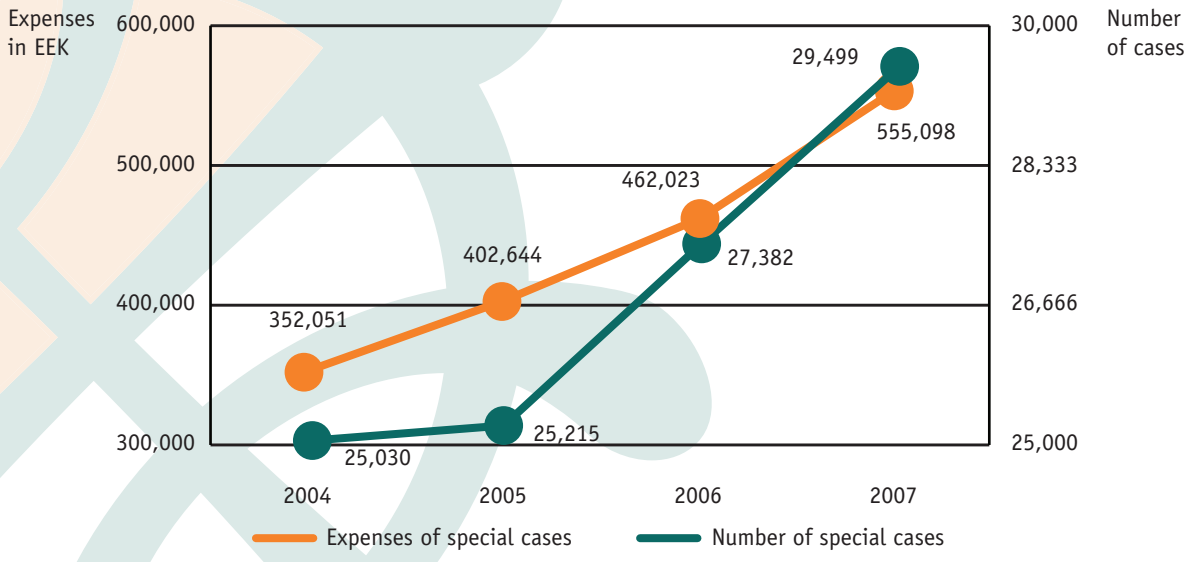
	Actual expenses 2004 – 2007				Changes%		
	2004	2005	2006	2007	2005/ 2004	2006/ 2005	2007/ 2006
Endoprosthesis	110,750	121,211	128,824	149,243	9%	6%	16%
Cataract operations	63,771	68,308	78,967	91,362	7%	16%	16%
Cardiac surgeries	88,624	113,078	127,433	145,210	28%	13%	14%
Deliveries	88,906	100,047	126,782	169,283	13%	27%	34%
Total	**352,051**	**402,644**	**462,006**	**555,098**	**14%**	**15%**	**20%**

Endoprothetic surgery and cataract operations. In 2007, the EHIF set an objective to shorten the waiting lists of endoprosthesis and operations of cataract (the maximum waiting lists were so far 3 and 2 years). The number of endoprothetic surgery has increased by 4% (rise in expenses 16%) and the number of cataract operations by 12% (rise in expenses 16%) in 2007 as compared to 2006.

Cardiac surgeries. In 2007, the number of operations increased by 2% as compared to 2006. The increase of the abovementioned operations has stopped because the hospitals do not have enough capacity.

Deliveries. The number of deliveries has increased by 6% as compared to 2006.

Figure 9. Special cases 2004 – 2007



Centrally contracted health services

In 2007, the expenses of the centrally contracted health services was 96 million 508 thousand kroons which forms 89% of the estimated budget. As compared to 2006 the rise of expenses has been 61% which is partially due to the increased need. The main reason is the rise in reference prices and inclusion of new services in the list (centrally contracted medicinal products).

Table 28. Centrally contracted health services (in EEK thousand)

	2006 actual	2007 budget	2007 actual	Budget implementation%	Change compared to 2006 %
Bone marrow transplants	9,499	13,648	12,954	95%	36%
Planned treatment in a foreign state	6,455	18,500	8,740	47%	35%
Peritoneal dialysis	23,077	26,384	29,684	113%	29%
Emergency transportation of the insured (airplane, helicopter)	1,703	2,500	1,830	73%	7%
Medical check-up of young athletes	4,592	7,051	6,364	90%	39%
Haematological treatment sessions	10,802	14,000	12,482	89%	16%
Antidotes and serums	200	200	200	100%	0%
Artificial urinary sphincters	587	587	620	106%	6%
Cochlear implants	2,505	2,332	2,916	125%	16%
Pathoanatomical autopsy	688	1,700	1,023	60%	49%
Centrally contracted medicinal products	0	21,900	19,695	90%	-
Total	**60,108**	**108,802**	**96,508**	**89%**	**61%**

Incomplete implementation of the budget reserved for the **services of bone marrow transplants, emergency transportation of the insured, medical check-up of young athletes and haematological treatment sessions** is mostly due to a lower cost per case than intended (accordingly 94%, 84%, 82% and 81% from the planned).

The application of the abovementioned services (except medical check-up of young athletes) where the ratio of the easier and more complicated cases is not the same in the run of the years is comparatively small. This causes the fluctuation of the cost of a treated case.

The incomplete implementation of the budget for the medical check-up of young athletes is due to the fact that some contractual partners used more single studies and repeated studies which are cheaper than complex studies.

The number of cases of the **planned treatment in a foreign state** has increased as compared to 2006. In 2007 the EHIF assumed the responsibility for paying for the treatment of 78 persons in a foreign state. In 2006, 59 people were treated abroad. In 2007 the EHIF paid for the treatment of 75 persons (incl. 37 children). The average cost of a treated case has increased.

The application of the services of **pathoanatomical autopsy and centrally contracted medicinal products** is smaller than planned. The agreement of the division of the means between the hospitals for biological treatment with TNF-alfa inhibitor, treatment of Gaucher disease and treatment with the risperidone injection in the list of services was achieved with the professional associations in February – March. Therefore, the application of treatment with TNF-alfa inhibitor and the risperidone injection was smaller than planned.

Peritoneal dialysis. The estimated budget was exceeded due to the increased need for the procedure. The number of patients and the number of days per patient has increased as compared to the previous periods. It was not foreseen in planning. Artificial urinary sphincters budget was exceeded by 6% due to the rise in the price of the operations in 2007.

Table 29. Treated cases of the centrally contracted health services (CL – caseload, ACPC – average cost per case)

	2006 actual		2007 actual		Change compared to 2006 %	
	CL	ACPC In EEK	CL	ACPC In EEK	CL	ACPC
Bone marrow transplants	63	150,778	85	152,400	35%	1%
Planned treatment in a foreign state	59	109,407	75	116,532	27%	7%
Peritoneal dialysis	856	26,959	1,096	27,084	28%	0%
Emergency transportation of the insured (airplane, helicopter)	84	20,274	84	21,786	0%	7%
Medical check-up of young athletes	8,922	516	9,428	675	6%	31%
Haematological treatment sessions	274	39,423	282	44,262	3%	12%
Antidotes and serums	2	100,000	2	100,000	0%	0%
Artificial urinary sphincters	7	83,815	7	88,571	0%	6%
Cochlear implants	9	278,307	10	291,600	11%	5%
Pathoanatomical autopsy	423	1,628	622	1,645	47%	1%
Centrally contracted medicinal products	0	0	718	27,430	-	-

Comparison of main indicators

The review of the main indicators of the inpatient and outpatient specialised medical care is presented in the following table.

Table 30. Main indicators of the inpatient and outpatient specialised medical care

	2006 actual	2007 actual	Change compared to 2006 %
ACPC – average cost per case			
Outpatient	447	554	24%
Day care	4,942	6,435	30%
Inpatient	10,981	13,629	24%
Number of inpatient bed-days	1,579,573	1,590,749	1%
Average inpatient treatment in days	6.3	6.4	1%
Number of outpatient appointments	3,536,036	3,695,585	5%
Outpatient	3,481,857	3,624,744	4%
Day care	54,179	70,841	31%
Number of outpatient appointments per treated case	1.24	1.24	0%
Outpatient	1.36	1.35	-1%
Day care	1.20	1.33	11%
Number of persons who used the services of specialised medical care*			
Outpatient	771,070	786,178	2%
Day care	40,036	45,612	14%
Inpatient	169,703	168,912	0%
Number of treated cases per person			
Outpatient	3.31	3.41	3%
Day care	1.12	1.16	4%
Inpatient	1.47	1.47	0%
Rate of the emergency care in treatment expenses			
Outpatient	17.3%	17.6%	0.3%
Day care	6.9%	7.1%	0.1%
Inpatient	63.2%	62.7%	-0.5%
Rate of emergency care in treated cases			
Outpatient	16.6%	17.1%	0.5%
Day care	14.4%	16.5%	2.1%
Inpatient	58.6%	56.6%	-2.1%
Number of operations	154,361	167,027	8%
including the number of deliveries	14,576	15,439	6%
Outpatient	16,987	20,359	20%
Day care	40,150	48,394	21%
Inpatient	97,224	98,274	1%

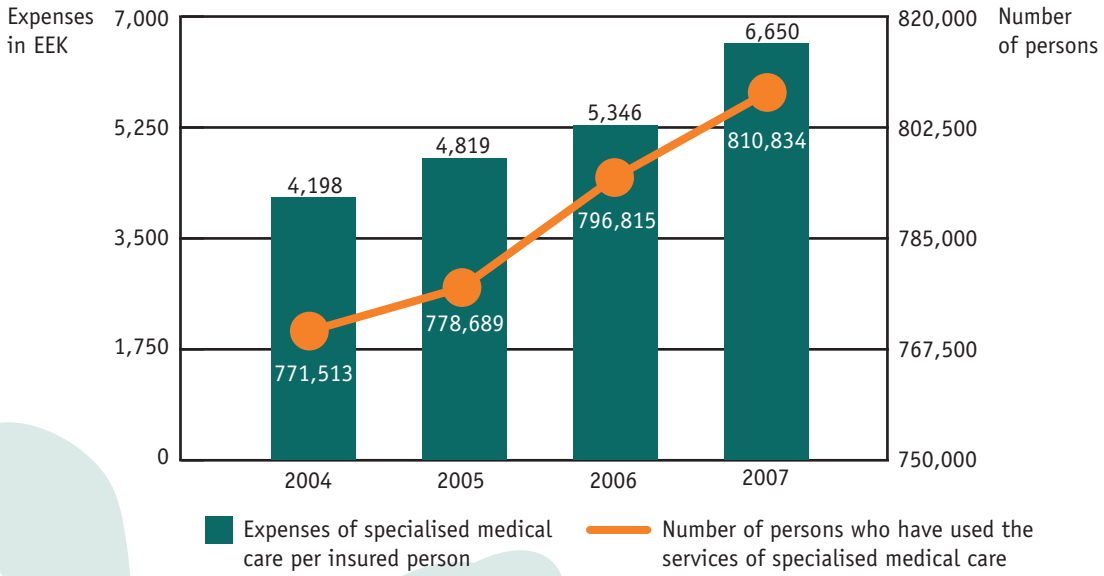
* Number of persons who used the services of specialised medical care split by types of treatment and the number of persons shown in Figure 9 are not comparable. The sums are different as one person can use the services of outpatient, inpatient and day care treatment

ACPC – average cost per case has increased in 2007 in all three categories – outpatient, day care and inpatient treatment. This is mainly due to the new reference prices of the services applied in 2007. The smaller increase in the ACPC as compared to the rise split by the types of treatment shows that the rate of outpatient and day care which are more efficient has increased.

Number of inpatient bed-days. In 2006 the time in the inpatient treatment shortened (in 2005 it was 6.9 and in 2006 6.3 days) and the EHIF prognosticated that there are practically no additional resources for essential shortening of the treatment. So the number of inpatient bed-days has increased a bit in 2007 up to 6.4 days as the cases with a shorter duration have been transferred to the day care.

Number of persons who used the services of specialised medical care. In 2007, 2% more people used the services of specialised medical care as compared to 2006. In case of outpatient and day care services, also additional treated cases have been financed. Regarding inpatient treatment, both the number of treated cases and the number of patients is on the level of the year 2006.

Figure 10. Expenses of the specialised medical care per insured person and the number of persons who have used the services of the specialised medical care



Rate of emergency care in treated cases. The EHIF has constantly followed the rate of the emergency care in respect of the treated cases as well as expenses because the rise in the rate of the emergency care refers to a problem that an insured person has no access to the specialised medical care when needed. Besides, the emergency care is more expensive as compared to the planned treatment. In 2007, the rate of the cases and expenses of the emergency care decreased in the inpatient treatment which is the most expensive form of treatment.

In day care the rate of the emergency care has increased due to the tendency to have more operations in day care if possible.

Operations. The number of operations has increased in more efficient outpatient treatment (20%) and day care surgery (21%). The number of operations increases yearly. The total increase in 2007 is 8% (ca 12,700 operations) as compared to 2006.

Most of the operations are performed still in inpatient treatment but the rate is decreasing. In the recent years, the number of operations performed in outpatient treatment and day care has increased (in 2007 it was 41%; in 2004 it was 31%).

Cost of medicinal products in the budget of specialised medical care

In 2007, the EHIF paid 248 million 423 thousand kroons for the medicinal products used in specialised medical care (i.e. medicinal products not included in the reference price of the bed-day). Expenses of the medicinal products in specialised medical care increased by ca 68% as compared to 2006.

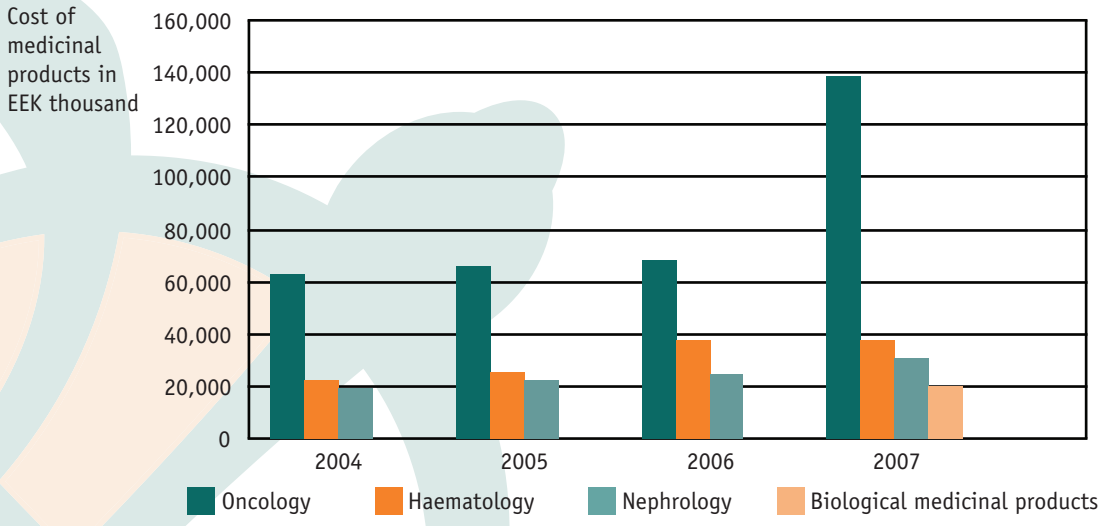
There were 27 different treatment processes where medicinal products are used in the list of the EHIF. According to the development plan, the EHIF considers it important to harmonise the accessibility of the medicinal products to the patients of different disease groups in the upcoming years. Thus, in 2007 the biological treatment with TNF-alfa inhibitor, treatment of Gaucher disease, treatment with the risperidone injection (financed as centrally contracted medicinal products) and chemotherapy of the chronic lymphocytic leukaemia were included in the list of health services, chemotherapy of tumours in several locations was updated including new medicinal products or changing the application of the existing courses of treatment (tumours of the digestive tract and gynaecological tumours). All the abovementioned factors have brought about an increase in the expenditure of the medicinal products used upon provision of services of special medical care.

Table 31. Cost of medicinal products in specialised medical care (in EEK thousand)

	2005	2006	2007
Cost of medicinal products in specialised medical care	130,978	148,158	248,423
Change as compared to the previous year %	12.3%	13.1%	67.7%

The specialities where the need for the medicinal products is the biggest are presented in Figure 11. The expenses and the rise in expenses have been the biggest in oncology where the expenses in 2007 were about twice as big as compared to 2006. The rate of the covered expenses on medicinal products in oncology is ca 35% of the total expenses in the speciality that was 391 million kroons in 2007.

Figure 11. The specialities with the highest cost of medicinal products 2004 - 2007



Nursing care

The objective of the EHIF is to improve the accessibility of the nursing care by developing, above all, outpatient treated cases in the nursing care to enable nursing care at home to those insured patients who need it.

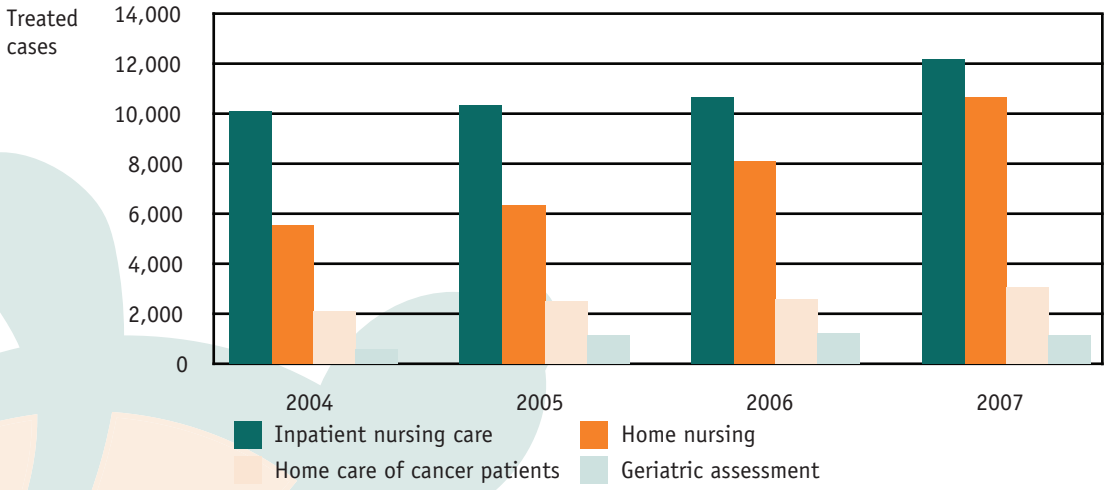
In 2007 the EHIF paid 189 million 267 thousand kroons for nursing care.

Table 32. Expenses of nursing care (in EEK thousand)

	2006 actual	2007 budget	2007 actual	Budget implementation%	Change compared to 2006 %
Inpatient nursing care	113,294	163,627	160,583	98%	42%
Outpatient nursing care, including	19,092	25,160	28,684	114%	50%
home nursing	16,470	20,438	23,792	116%	44%
home care of cancer patients	1,769	3,869	4,043	104%	129%
geriatric assessment	853	853	849	100%	0%
Total	**132,386**	**188,787**	**189,267**	**100%**	**143%**

New reference prices of the services were applied in 2007. Increase in the prices is also one of the reasons for the rise of the expenses in nursing care (incl. the average cost of a treated case). Rise in the reference prices influenced the rise of the expenses both in inpatient and outpatient treatment.

Figure 12. Treated cases in nursing care 2004 - 2007



Apart from the rise in prices, the expenses have increased also because last year a larger amount of treated cases was financed, including inpatient cases by 14% and outpatient cases by 25% more.

Table 33. Caseload (CL) and average cost per case (ACPC)

	2006 actual		2007 actual		Change compared to 2006 %	
	CLS	ACPC in EEK	CL	ACPC in EEK	CL	ACPC
Inpatient nursing care	10,658	10,630	12,185	13,179	14%	24%
Outpatient nursing care, including	11,809	1,617	14,806	1,937	25%	20%
home nursing	8,052	2,045	10,635	2,237	32%	9%
home care of cancer patients	2,581	686	3,023	1,337	17%	95%
geriatric assessment	1,176	725	1,148	740	-2%	2%
Total	**22,467**	**5,892**	**26,991**	**7,012**	**20%**	**19%**

Dental care

Dental care includes the cost of dental services provided to the insured persons under age 19 and to adults in the case of emergency dental care.

In 2007, the EHIF paid 239 million 992 thousand kroons for dental care provided for the insured persons which forms 97% of the planned budget.

Table 34. Dental care (in EEK thousand)

	2006 actual	2007 budget	2007 actual	Budget imple-mentation%	Change compared to 2006 %
Dental treatment of children	151,149	190,496	185,522	97%	23%
Orthodontia	27,414	10,768	9,180	85%	25%
Dental diseases prevention	7,340	38,120	35,435	93%	29%
Emergency dental care to adults	7,022	7,843	9,855	126%	40%
Total	**192,925**	**247,227**	**239,992**	**97%**	**24%**

The expenses of the EHIF on dental care have increased by 24% as compared to 2006. The reason is mainly the rise in reference prices.

Table 35. Caseload of dental care

	2006 actual	2007 budget	2007 actual	Budget imple-mentation%	Change compared to 2006 %
Dental treatment of children	288,476	288,085	290,220	101%	1%
Orthodontia	36,327	57,507	48,423	84%	1%
Prevention of dental diseases	47,940	41,584	38,143	92%	5%
Emergency dental care to adults	17,901	15,543	18,248	117%	2%
Total	**390,644**	**402,719**	**395,034**	**98%**	**1%**

It is positive that the number of treated cases has increased in all types of services. The biggest rise of 5% is in the preventive dental treatment of children.

2. Health promotion expenses

The EHIF is financing health promotion activities on the basis of the projects according to the priorities approved by the Supervisory Board and approval of the Ministry of Social Affairs. Health promotion activities of the EHIF are part of the activities of the public health strategies.

In 2007 the EHIF expenses on health promotion were 12 million 688 thousand kroons which is 91% of the planned budget.

In 2007 the activities of 14 projects which started in 2006 continued and 37 new projects were launched.

Table 36. Health promotion expenses (in EEK thousand)

Priority area	2006 actual	2007 budget	2007 actual	Budget implemen-tation%	Change compared to 2006 %
Health promotion activities targeted at children	4,146	3,500	2,914	83%	-30%
Prevention of cardio-vascular diseases	810	1,300	1,254	96%	55%
Early detection of cancer	328	700	433	62%	32%
Prevention of home and leisure injuries and intoxication	2,075	3,300	3,442	104%	66%
Prevention of damages to the health caused by alcohol	2,285	2,000	1,521	76%	-33%
Projects targeted at various priority areas	3,032	3,200	3,124	98%	3%
Total	**12,676**	**14,000**	**12,688**	**91%**	**0%**

The promotion activities aimed at the implementation of priority goals were targeted mainly at two groups: schoolchildren and adults, incl. pregnant women, parents and patients with chronic diseases.

The target groups were approached through media or associated groups. Associated group is a group of people on whose work the promotion activities in the area depend substantially (organisation). Involved associated groups were the health teams at schools and kindergartens, employees of local municipalities and family physicians and nurses. In 2007 lots of activities were planned in local level for the prevention of injuries as the prevention of injuries is one of the most cost-effective areas in health promotions.

The budget was not completely used due to the fact that the activities of several projects started later than planned.

Table 37. Quantitative indicators of the project activities

Health promotion activities	2006	2007
People participating in sports, training courses and activities intended for the general public	25,100	39,300
People in personal counselling	4,470	8,240
Participants in training courses for health care professionals	600	1,830
Participants in training courses for teaching staff	3,300	2,310
Participants in training courses for other associated groups (social workers, managers, work groups)	2,440	3,000
Different publications	24	24
Full circulation of publications	346,500	354,700
TV and radio programmes /clips	19	11

In 2007 the following promotion activities were organised:

- Campaigns “A beautiful woman is sober” and “Exercise is a man’s best friend”. Visibility of the campaigns was more than 75%.
- Special editions dedicated to health issues were published in newspapers Postimees, Eesti Päevaleht, Maaleht and Meditsiiniuudised
- 275,000 copies of leaflets “Take care of your health, take care of your heart”, “High blood pressure. How to protect your heart”, “Tumours of digestive tract. How to prevent cancer and recognise signs of cancer”, “How to prevent the injuries of schoolchildren”, “Alcohol in my body” were circulated to the family physicians, hospitals and other relevant institutions. The film “Alcohol. Enemy no 1” was replicated.
- Guidelines to the patients about epilepsy and Parkinson’s disease were prepared and delivered to the patients and their relatives. Guidelines have been given also to different associated groups (health teams of schools, etc)
- More than 39,000 people have participated in local activities. Besides different events, more than 66,000 copies of leaflets have been circulated in the counties in co-operation with local newspapers.

Advice in sexual issues was given to 5,749 young people on the webpage www.amor.ee and advice related to pregnancy, delivery and child care was given to 3,137 persons on the homepage www.perekool.ee.

Counselling for patients with pregnancy crisis was introduced as a new service. 254 people have used the service once and 377 people recurringly. 55 companies have joined the network of health promoting workplaces.

In 2007 pilot-project was initiated in the frames of which the assessment of the sustainability of the health promoting project organisations in 2 counties (Pärnu and Rapla) was started. The objective is to develop the quality of the health promotion work and integrate the assessment model into the injury prevention projects in all counties.

The efficiency of the health promotion activities is assessed also with the rate of the adults who consider their lifestyle healthy (37% in 2004 and 41% in 2007).

3. Medicinal products reimbursed to the insured persons

Spending on reimbursed prescription medicinal products is an open commitment for the Estonian Health Insurance Fund which means that the EHIF is obliged to reimburse the expenses of a person on medicinal products according to the need of a person in the amount established by law.

Possible measures of cost-containment, i.e. lists of illnesses and covered medicinal products, reference prices, price agreements, procedure for the prescription and dispense of medicines, mark-up on wholesale and retail are prescribed by the Ministry of Social Affairs and the Government of the Republic.

In 2007 the overall spending on prescription medicinal products reimbursed for the insured amounted to 1 billion 120 million 550 thousand kroons which exceeds the planned budget by 5.3%.

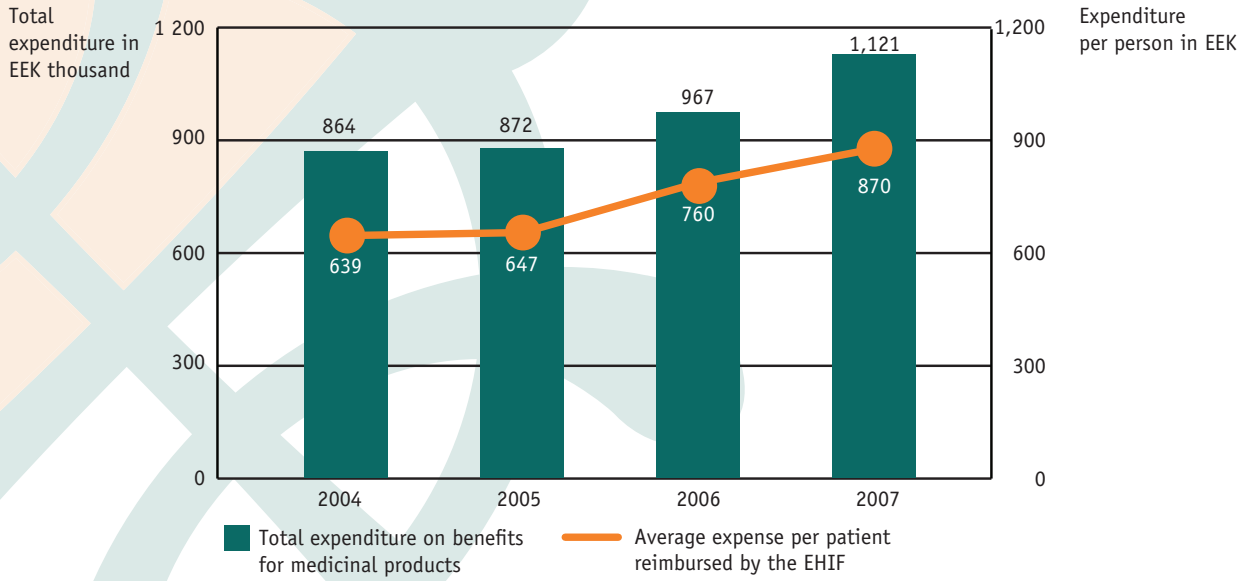
Table 38. Medicinal products reimbursed for the insured (in EEK thousand)

	2006 actual	2007 budget	2007 actual	Budget implementation %	Medicinal products reimbursed for the insured 2006	2007
Medicinal products reimbursed 100%	406,654	449,100	480,988	107%	42%	43%
Medicinal products reimbursed 90%	289,957	314,152	327,324	104%	30%	29%
Medicinal products reimbursed 75%	71,239	77,183	76,584	99%	7%	7%
Medicinal products reimbursed 50%	194,876	219,900	235,377	107%	20%	21%
Medicinal products reimbursed under special conditions	4,070	4,200	286	7%	1%	0%
TOTAL	**966,796**	**1,064,535**	**1,120,559**	**105%**	**100%**	**100%**

Compared to the previous years, increase in the consumption of reimbursed prescription medicinal products continued in 2007. In the previous years, the rise in the consumption and expenses of the reimbursed medicines has been usually in March but in 2007 the expenditure on benefits for medicinal products was high already in January. This can be explained with the fact that the patients are no longer afraid of the changes in the list of medicines which takes place 4 times a year and there is no stockpiling of medicinal products before the end of a quarter.

Following the changes which have taken place in the course of years it can be stated that irrespective of the fact that outpatient expenses of medicinal products (in the last years 16 – 18%) do not exceed 20% of the expenses prescribed for health service benefits in the annual health insurance budget according to the Health Insurance Act, the rise in the expenses of the benefits for medicinal products has still been 1.5 times in the last 5 years and the expense per person has also essentially increased, being 870 kroons per insured person in 2007.

Figure 13. Total expenditure on benefits for medicinal products and expense per patient



The number of reimbursed prescriptions increased by 11.2% as compared to the previous year. The rate of increase in the category of prescriptions reimbursed at 50% was quicker, being 13.8%. This is due to the changes in the consumption habits and increase in the income of employed inhabitants caused by a continuous economic growth.

Connections can be found also between the awareness of the patients, better treatment compliance and number of purchased prescriptions.

Table 39. Number and average cost of reimbursed prescriptions (CP)

	2006 actual		2007 actual		Change compared to 2006 %	
	Number of CP	Average cost of CP for the EHIF in EEK	Number of CP	Average cost of CP for the EHIF in EEK	Number of CP	Average cost of CP for the EHIF in EEK
Reimbursed 100%	563,593	722	620,426	775	10%	7%
Reimbursed 90%	1,750,253	166	1,901,540	172	9%	4%
Reimbursed 75%	433,489	164	462,618	166	7%	1%
Reimbursed 50%	2,645,767	74	3,012,001	78	14%	6%
TOTAL	**5,393,102**	**179**	**5,996,585**	**187**	**11%**	**4%**

The average cost of the prescription has increased regarding all reimbursed prescriptions but more of the prescriptions reimbursed at 100%. This is due to the fact that the number of diabetes patients getting an expensive insulin treatment has increased in the reporting period. The number of chronic C-hepatitis patients getting interferon treatment has also remarkably increased. The average cost of a reimbursed prescription in the latter case is 16,606 kroons. The average cost of a reimbursed prescription for the EHIF is 775 kroons.

The causes of the rise in the cost of the prescriptions reimbursed 50% is not clear. This can be most probably explained by the increase in the income and hence a possibility to purchase more expensive medicinal products with a reimbursement rate of 50%. This might be caused also by the rise in the prices of the medicinal products as there are no reference prices set to the medicinal products with a reimbursement rate of 50%. Also there are very little amount of price agreements concluded in this category of medicinal products.

Figure 14. Changes in the reimbursement of the prescriptions and number of prescriptions

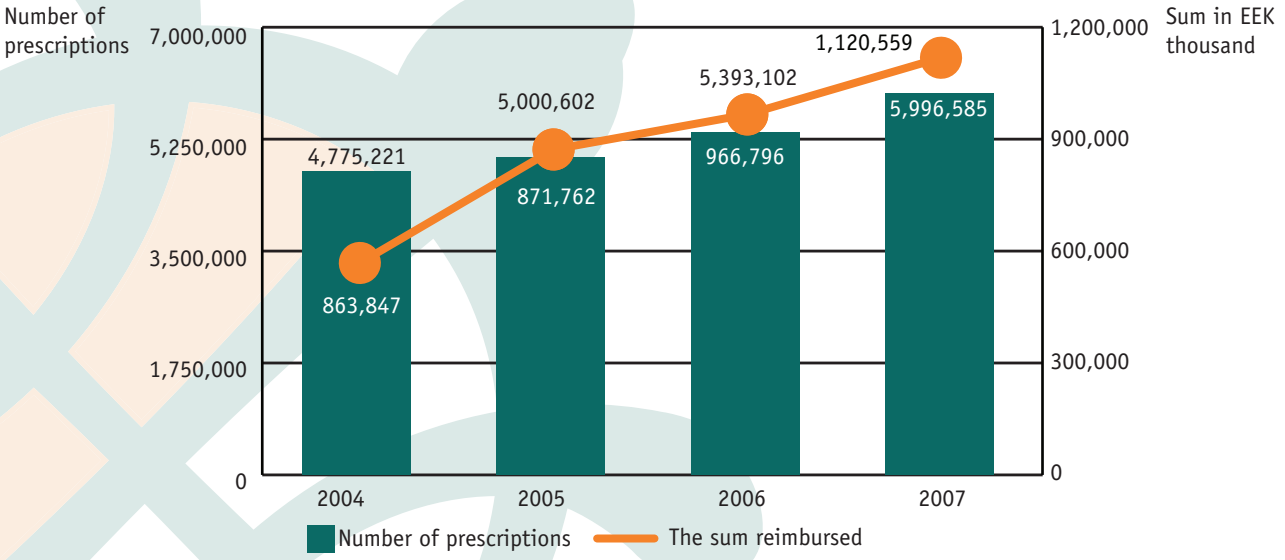
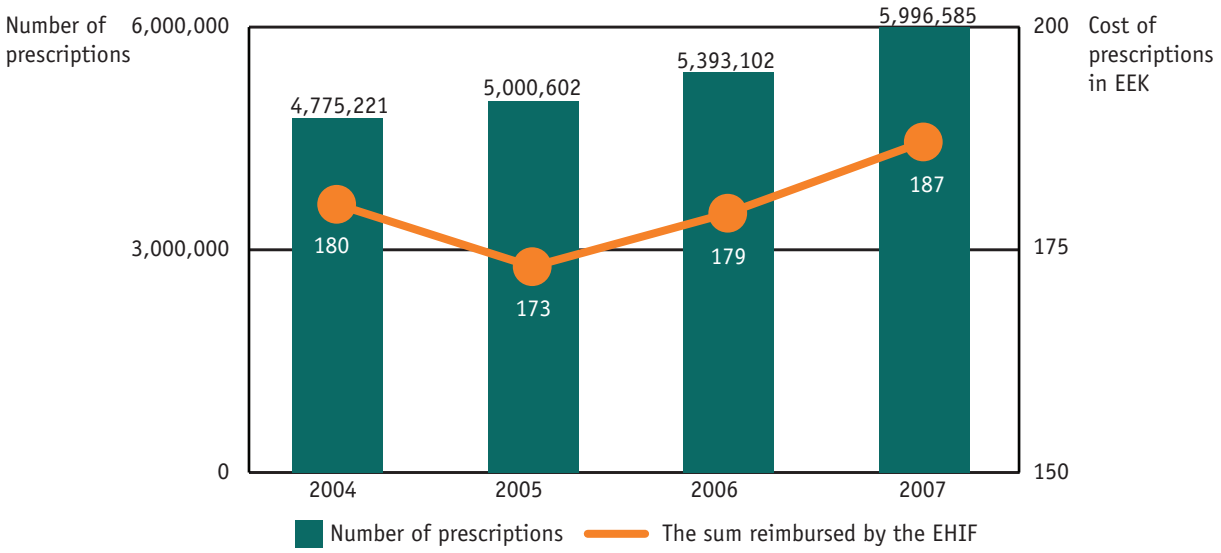


Figure 15. Changes in the number and average cost of prescriptions



Changes in the number of reimbursed prescriptions and expenses on the benefits of the medicinal products are quite similar. Still, the expenses on the benefits of the medicinal products in 2007 have increased proportionally more than the number of prescriptions. This is due to the increase of the average cost of the prescription since the year 2005 which in 2007 was 187 kroons. No matter that the average cost of the prescription has increased for the EHIF (except prescriptions reimbursed 100%), the percentage of the cost-sharing of the insured persons has also increased.

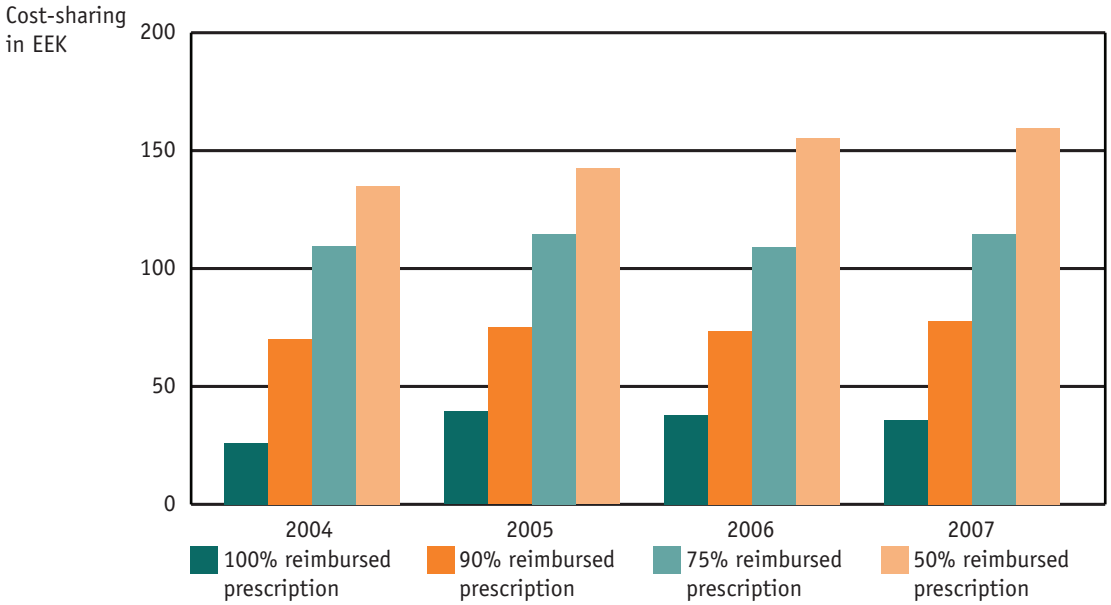
Changes in the cost-sharing are the smallest in respect of the 90% and 75% reimbursed prescriptions. These are also medicinal products where the variety is the biggest. The most remarkable is the rise in the cost-sharing regarding 50% reimbursed prescriptions rising yearly on average 8 kroons per prescription and reaching 160 kroons in 2007.

The situation of the insured persons would improve if the 200 kroons limit per prescription regarding 50% reimbursed prescriptions would be changed or repealed. But before making any changes the medical evidence-basement of the 50% reimbursed prescriptions should be evaluated, the list adjusted and reference prices or price agreements to the abovementioned medicinal products set.

Table 40. Cost-sharing of the insured %

	2006	2007	Variation
Reimbursed 100%	4.7	4.3	-0.4
Reimbursed 90%	30.5	31.2	0.7
Reimbursed 75%	39.7	41.0	1.3
Reimbursed 50%	66.8	67.1	0.3
Average cost-sharing of the insured	**37.8**	**8.6**	**0.8**
including 75%, 90% and 100% reimbursed prescriptions	20.2	20.2	

Figure 16. Changes in the cost-sharing per prescription in EEK



The diagnoses with the highest expenses reimbursed have been the same in the course of the years. The biggest expenditure upon reimbursement of prescription has been several years the diagnosis of hypertension. The number of patients and selection of the medicinal products is continuously growing. However, the average cost of the prescription of this diagnosis is decreasing due to the wider selection of medicinal products and more effective competition between different manufacturers with the resulting pressure on pricing.

Other diagnoses with high expenses of reimbursement are diabetes mellitus, bronchial asthma, cancer, mental disorders, glaucoma and primary hypercholesterolaemia. In 2007 the patients with chronic viral hepatitis were included in the list of diagnoses. This is due to the need for diagnosing the disease and increase in the number of patients.

Table 41. Diagnoses with the highest expenditure on benefits of medicinal products

	2006 actual		2007 budget		2007 actual	
	Reimbursed by the EHIF (in EEK thousand)	% of total amount of expenses on benefits	Reimbursed by the EHIF (in EEK thousand)	% of total amount of expenses on benefits	Reimbursed by the EHIF (in EEK thousand)	% of total amount of expenses on benefits
Hypertension	173,689	18%	202,576	19%	185,074	17%
Diabetes mellitus	132,462	14%	157,204	15%	145,030	13%
Incl. Insulin	110,217	11%	132,844	13%	118,517	11%
Oral medicines	22,245	2%	24,360	2%	26,513	2%
Cancer	79,366	8%	79,383	8%	91,895	8%
Bronchial asthma	59,149	6%	67,099	6%	67,075	6%
Glaucoma	48,704	5%	51,138	5%	55,854	5%
Mental disorders	37,878	4%	41,666	4%	44,868	4%
Chronic C-hepatitis	16,060	2%,			31,767	3%
Primary hypercholes-terolaemia	24,467	3%	26,180	3%	29,933	3%
Total	**571,775**	**59%**	**625,246**	**59%**	**651,496**	**58%**

When analysing the expenditure on benefits for medicinal products in 2007, it can be pointed out that the usage of medicinal products increased in all types of coverage and the average cost for the EHIF of a reimbursed prescription and figures of cost-sharing increased as well.

4. Expenditure on benefits for temporary incapacity for work

In 2007 the expenditure on benefits for temporary incapacity for work was 1 billion 926 million 851 thousand kroons. As compared to 2006, the increase was 28%.

Table 42. Expenditure on benefits for temporary incapacity for work (in EEK thousand)

	2006 actual	2007 budget	2007 actual	Budget implementation%	Change compared to 2006 %
Sickness benefits	957,692	1,120,196	1,222,322	109%	28%
Nursing benefits	162,514	216,616	212,274	98%	31%
Maternity benefits	358,758	463,541	459,507	99%	28%
Work injury benefits	27,391	34,076	32,748	96%	20%
Total	**1,506,355**	**1,834,429**	**1,926,851**	**105%**	**28%**

Expenditure on benefits for temporary incapacity for work increases due to changes in the social, economic and demographic conditions.

- The number of employed insured persons[22] increased due to the decrease of the unemployment which brings along the increase in the number of certificates of incapacity for work and days of incapacity for work
- The average cost of one day of the benefits for temporary incapacity for work increases in connection with the increase of the income of people

A small decrease in the percentage of the expenses on the sickness benefits and increase in the percentage of the maternity benefits and nursery benefits can be noticed due to the increasing birth rate.

Table 43. Usage of the benefits for temporary incapacity for work

	2004	2005	2006	2007	Change 2005/ 2004	Change 2006/ 2005	Change 2007/ 2006
Sickness benefit							
Number of certificates	412,363	433,944	469,274	508,428	5%	8%	8%
Number of days	5,222,195	5,454,390	5,751,163	6,209,512	4%	5%	8%
Benefit amount (in EEK thousand)	723,458	817,636	957,692	1,222,322	13%	17%	28%
Average income per day (in EEK)	139	150	167	197	8%	11%	18%
Average length of the sick leave	12.7	12.6	12.3	12.2	-1%	-2%	-1%
Maternity benefit							
Number of certificates	11,537	11,441	11,903	12,982	-1%	4%	9%
Number of days	1,356,258	1,414,096	1,515,333	1,676,152	4%	7%	11%
Benefit amount (in EEK thousand)	253,219	297,413	358,758	459,507	17%	21%	28%
Average income per day (in EEK)	187	210	237	274	12%	13%	16%
Average length of the sick leave	117.6	123.6	127.3	129.1	5%	3%	1%
Nursery benefit							
Number of certificates	73,325	81,850	96,379	104,649	12%	18%	9%
Number of days	624,096	691,348	797,316	871,070	11%	15%	9%
Benefit amount (in EEK thousand)	104,890	127,114	162,514	212,274	21%	28%	31%
Average income per day (in EEK)	168	184	204	244	10%	11%	20%
Average length of the sick leave	8.5	8.4	8.3	8.3	-1%	-1%	0%
Work injury benefit							
Number of certificates	5,863	5,996	6,406	6,472	2%	7%	1%
Number of days	118,941	125,314	131,508	131,966	5%	5%	0%
Benefit amount (in EEK thousand)	20,413	22,900	27,391	32,748	12%	20%	20%
Average income per day (in EEK)	172	183	208	248	6%	14%	19%
Average length of the sick leave	20.3	20.9	20.5	20.4	3%	-2%	-1%
Total benefits							
Number of certificates	503,088	533,231	583,962	632,531	6%	10%	8%
Number of days	7,321,490	7,685,148	8,195,320	8,888,700	5%	7%	8%
Benefit amount (in EEK thousand)	1,101,980	1,265,063	1,506,355	1,926,851	15%	19%	28%
Average income per day (in EEK)	151	165	184	217	10%	12%	18%,
Average length of the sick leave	14.6	14.4	14.0	14.1	-1%	-3%	0%

22 Table 44. Number of insured persons, number of days and certificates per insured person, 2004 - 2007

The increase in the expenditure of the sickness benefits in the period 2004 – 2007 is on average 19%, maternity benefits 24%, work injury benefits 17% and nursing benefits 27%.

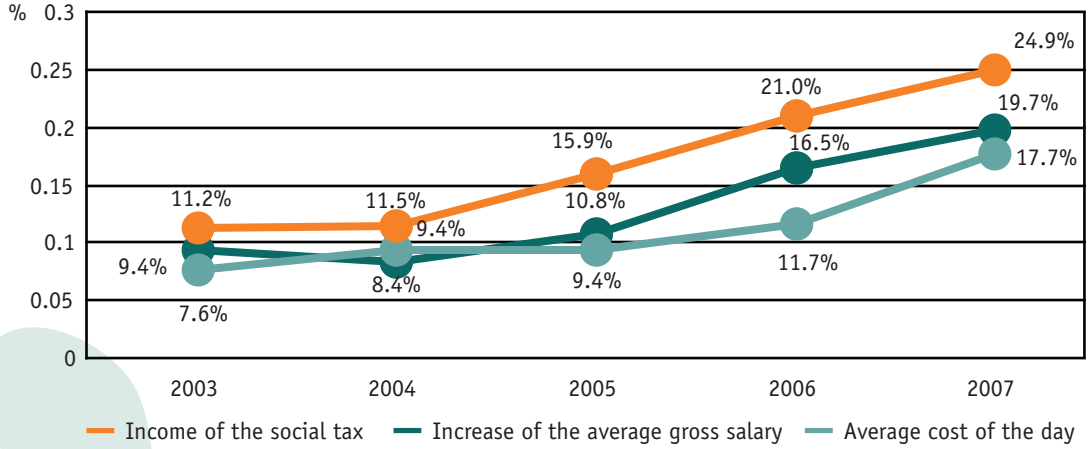
The continued growth in expenditure of benefits for temporary incapacity for work in the years 2004 – 2007 was caused by:

- Growth in the average earnings per day;
- Growth in the number of days of incapacity for work.

Growth in the average income per day

The factor which has a direct impact on the expenditure of benefits for temporary incapacity for work is the average cost of the reimbursed day which is related to the income taxed with the social tax. This brings along also the increase of the average cost of the day. A rise in gross wages[23] as compared to the average cost of the day of the benefits for temporary incapacity for work increases less which is caused by the fact that in case of the cost of the day the total income taxed with the social tax is taken into consideration and not only gross wages (Figure 17). In the chart the increase in the gross wages of the previous period is reflected on the line of the gross wages as basis for the payment of the benefit for temporary incapacity for work is the income taxed with the social tax of the previous year.

Figure 17. Increase in the cost of the day of the benefit for temporary incapacity for work compared with the increase in the income of the social tax and gross salary[24]



Increase in days of incapacity for work

The number of reimbursed days of incapacity for work per insured persons has increased[25] in 2007. The increase has been caused by:

- The increased number of employed insured persons
- Increased number of the certificates of incapacity for work and average length in days

The number of employed insured persons

The increase in days of incapacity for work is caused by the decrease of unemployment which has caused the rise in the number of employed insured persons and changes in the behaviour of the people. The number of employed insured persons has increased in 2004 – 2007 by 80 thousand people and forms 53% of the total number of the insured in 2007. Increase of the employment is positive as the group of people capable of paying increases but this brings along also the increase of the number of people getting benefit for temporary incapacity for work.

23 Statistical yearbook of Estonia

24 he average gross salary involves only the salary of the full-time employees. The salary of the employees with the contract for services is not considered

25 Table 44. Number of insured persons, number of days and certificates per insured person, 2004 - 2007

Table 44. Number of insured persons, number of days and certificates per insured person

Average number of persons in period	2004	2005	2006	2007	Change 2005/ 2004	Change 2006/ 2005	Change 2007/ 2006
Number of the insured	1,271,919	1,270,601	1,279,680	1,283,356	-0.1%	1%	0.3%
Number of insured in employment	593,769	611,524	649,910	674,676	3%	6%	4%
Insured in employment as a percentage of all insured	47%	48%	51%	53%	-	-	-
Reimbursed days of incapacity for work	7,321,490	7,685,148	8,195,320	8,888,700	5%	7%	8%
Reimbursed days of incapacity for work per insured in employment	12.3	12.6	12.6	13.2	2%	0.3%	4%
Reimbursed certificates of incapacity for work	503,088	533,231	583,962	632,531	6%	10%	8%
Reimbursed certificates of incapacity for work per insured in employment	0.85	0.87	0.90	0.94	3%	3%	4%

Number of certificates of incapacity for work and average length in days

The number of appointments[26] at the family physician has increased and the certificates of incapacity for work are used more often. The number of certificates of incapacity for work has increased in average by 8% in the period 2004 – 2007.

Sickness benefits

The causes for the incapacity for works are following: illness 90%, non-job-related injuries 8%, transfer to an easier job 1%, percentage of the certificates issued on other reasons (occupational disease, injuries in traffic accidents, etc) is marginal and forms ca 1%. The structure of certificates for sick leave by reasons for leave has remained relatively stable over the past years.

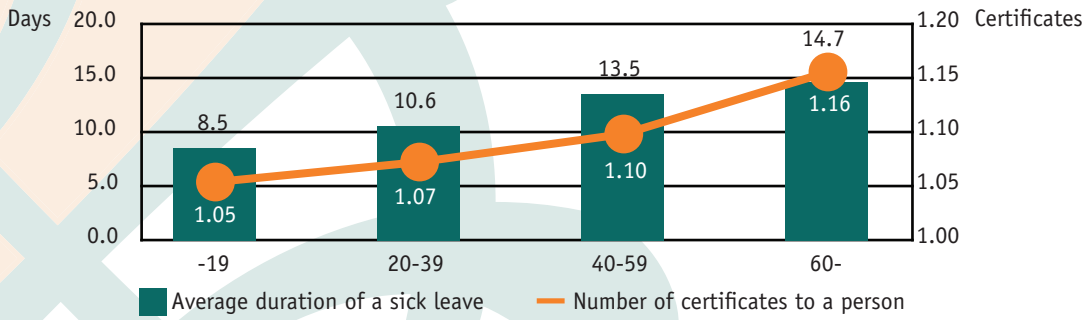
The number of sickness benefit days of incapacity for work increased by 8% in 2007. This has been caused by:

- Aging of the population
- More frequent incidence of the inflammation of upper respiratory tract

Aging of the population

Aging of the population brings along changes in the age structure of the employed insured persons. The number of certificates issued to people belonging to the age group 40 – 59 is the biggest (in average 51%). They are longer on the sick leave and take more often the certificate for sick leave[27].

Figure 18. Average duration of a sick leave and number of certificates per person depending on the age



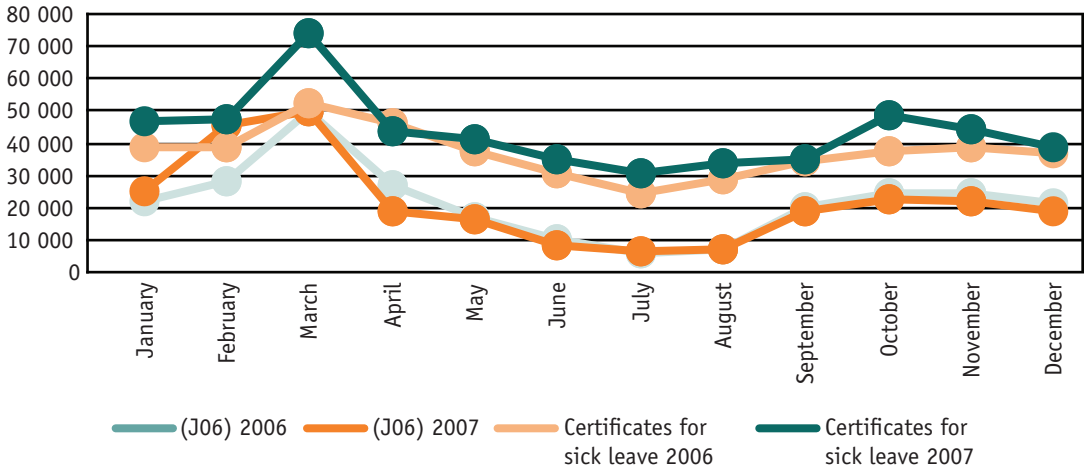
At the same time there were no changes in the division of the certificates for sick leaves by age during the last 4 years.

26 The number of appointments of the family physicians has increased as compared to 2006 (see Table 22)
27 Figure 18. Average duration of a sick leave and the number of certificates per person depending on the age

More frequent incidence of the inflammation of upper respiratory tract

The number of certificates for sick leave has increased but the average duration is decreasing[28]. This tendency shows that the issuing of short-term certificates for sick leave has increased. For example, in January – March 2007 , the incidence of the inflammation of upper respiratory tract[29] is by 38% higher than during the same period in 2006. It can be seen from the comparison of development of the inflammation of upper respiratory tract and the general data about issuing certificates for sick leave that the number of certificates increases similarly to the increase of development of the acute inflammation of the upper respiratory tract (Figure 19).

Figure 19. Falling ill with the acute inflammation of upper respiratory tract (J06), certificates for sick leave 2006 - 2007



Maternity benefits

Maternity benefit days of incapacity for work have increased by 11% and the average cost of day by 16% in 2007. The rise in the expenditure on the maternity benefits is caused, besides the general rise in salaries, also by demographic situation – the average age of the women giving birth and the number of women of fertile age has increased[30]. Analysis of the maternity benefits split by the age shows that the amount of the maternity benefit for 1 day is higher in the case of the women over 30 as compared to younger women.

The continuing increase in the number of days of maternity leave per person is caused by increase in the number of cases of taking maternity leave in time[31].

It can be estimated that the number of women giving birth will increase in 2008. The presumption of the increase in the number of days of maternity leave is the bigger number of the women of fertile age and the impact of the payment of the parental benefit.

28 Table 42. Expenditure on benefits for temporary incapacity for work, 2004 – 2007
29 Infectious diseases. Statistics. Incidence of infectious diseases in Estonia 2005 – 2007. http://www.tervisekaitse.ee
30 Population. Statistical yearbook of Estonia. 2006:37
31 According to the Holidays Act, a woman has the right to commence her pregnancy and maternity leave at least 70 calendar days before the estimated date of delivery as determined by a doctor

Nursing benefits

In the structure of certificates for nursing care the main reasons for leave include nursing of a child under 12 years of age (98%), providing care for a child under 3 years of age or disabled child under 16 years of age (81%) and nursing a sick family member (1%). Most, i.e. in average 65% of the leaves issued for nursing a child under 12 years of age form leaves for nursing children of the age between 2 and 5. The usage of the certificates for nursing leave shows that the increase in the number of certificates in this age group is 2% which is due to the fact that certificates for nursing leave are issued for providing care for a child under 3 years of age.

The number of the days of incapacity for work for nursing care is increased by the increasing birth-rate. Women who have given birth and are back at work from the maternity leave are potential users of the certificates for nursing leave. Therefore, the increase in the expenditure in nursing benefits can be projected.

The average cost of the day of nursing care has been 37 kroons higher than the cost of the day of the sickness benefit during the last 4 years. One of the reasons is that the number of the applicants for maternity benefit with a higher income has increased. On the other hand, parents have the opportunity to choose who of the parents will be on a parental leave. Very often it is the parent with a higher income. The analysis of the payment of nursing benefits shows that in the case of almost 19% of certificates for care leave, the caregiver is a male parent whose average earnings of a nursing day are twice as high as the average earnings of the nursing day of a female caregiver.

Work injury benefits

The number of benefit days related to work injuries has been on the same level in 2007 as compared to 2006.

According to Labour Inspectorate, the number of accidents at work decreased in general and in respect of accidents of serious nature. The average cost of sickness day related to work injury has increased by 19%. The increase in the average cost of the calendar day related to work injury is due to the increased wages in the production sector and the fact that the work injuries of serious nature take place more in processing industry.

5. Other monetary benefits

Other monetary benefits are dental benefit for adults, supplementary benefit for medicinal products and government grants from the state budget for the infertility treatment.

Dental benefit for adults

The EHIF reimbursed 178 million 361 thousand kroons in 2007. Compared to 2006 the expenditure increased by 144%. This is due to the increase of the rates of dental benefit from 01.01.2007 based on which the EHIF reimburses the cost of dental services for the insured according to the following rates:

- EEK 300 for a person aged 19 and over;
- EEK 450 for a pregnant woman;
- EEK 450 for a person with an increased need for dental treatment;
- EEK 450 for a mother with a child under 1 year of age;
- EEK 4,000 spread over a period of 3 years as reimbursement for dentures to an insured person aged at least 63 years and to an old-age pensioner who may be younger than 63.

The rate of the dental benefits for a person aged 19 and over and the rate for dentures of the pensioners increased 50% as compared to 2006. The rate of the dental benefits for a person with an increased need and the rate for a mother with a child under 1 year of age increased 15%.

Table 45. Expenditure on the dental benefits (in EEK thousand)

	2006 actual	2007 budget	2007 actual	Budget imple-mentation%	Change compared to 2006 %
Denture benefit	39,950	82,600	103,566	125%	159%
Dental treatment benefit	33,198	100,200	74,795	75%	125%
Total	**73,148**	**182,800**	**178,361**	**98%**	**144%**

Table 46. Number of dental benefit cases

Dental services	2006 actual CL	2007 budgeted CL	2007 actual CL	Budget imple-mentation %	Change compared to 2006 %
Denture benefit	27,471	33,769	43,899	130%	60%
Dental treatment benefit	206,346	323,226	267,338	83%	30%
Total	**233,817**	**356,995**	**311,237**	**87%**	**33%**

Supplementary benefit for medicinal products

The insured became entitled to supplementary benefit for medicinal products in 2003. The knowledge of the patients about this type of benefit has increased year by year. This shows also the increase of the number of patients as compared to 2004. The expenditure of the EHIF on this benefit has also increased and in the last 3 years the average sum paid out to an insured person has also increased.

Figure 20. Supplementary benefit for medicinal products

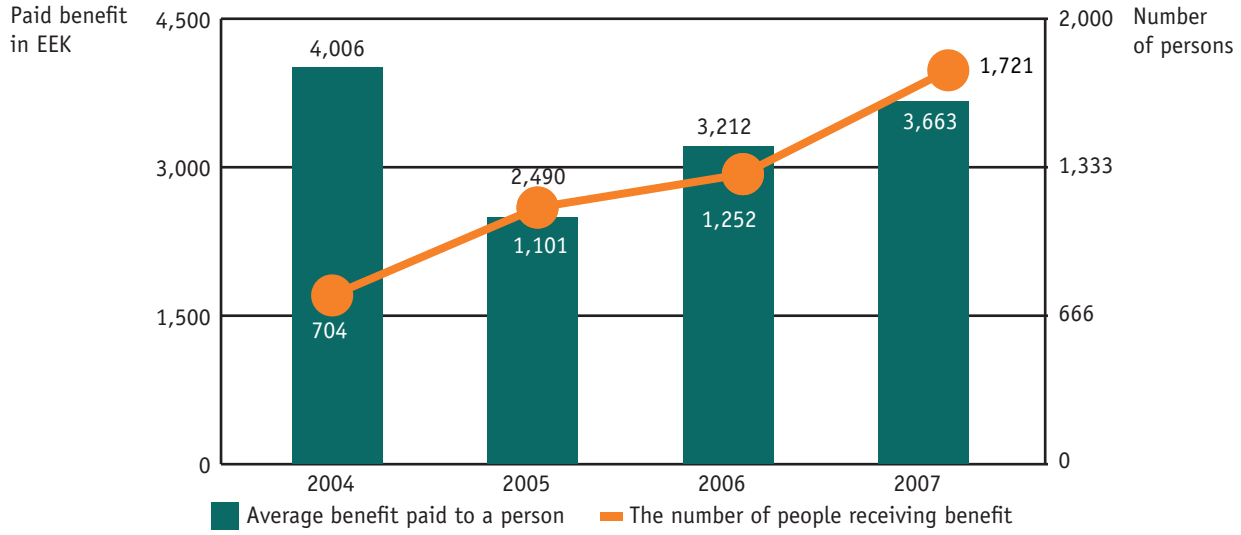


Table 47. Supplementary benefit for medicinal products

	2006 actual	2007 actual	Change compared to 2006 %
Sum paid in EEK thousand	4,023	6,304	57%
The number of people receiving benefit	1,252	1,721	37%

The sum paid has increased by 57% in 2007. This is partially due to the possibility to apply for a benefit for in vitro fertilisation which the state pays to the insured women (government grants). Applying for one benefit related to the medicinal products means also the application for another benefit. The bases for both benefits are the medicinal products entered in the list of medicines.

Government grants

The EHIF has paid from the state budget benefit for in vitro fertilisation to the insured persons in the amount of 12 million 715 thousand kroons during the financial year.

6. Other expenditure on health insurance benefits

The budget includes benefits and benefits for medical devices paid pursuant to regulations coordinating social insurance systems of EU Member States.

Benefits paid pursuant to regulations coordinating the social insurance systems of EU Member States

Benefits for health services are a strict obligation to the EHIF pursuant to regulations coordinating social insurance systems of EU Member States since the year 2004 when Estonia joined the European Union.

The persons insured at the EHIF have the right to:

- Get necessary health care while staying temporarily in another state
- Get comprehensive health care while living in another state

The expenses are covered by the EHIF.

The persons insured in other countries of the EU have the right to:

- Get necessary health care while staying temporarily in Estonia
- Get comprehensive health care while living in Estonia

The expenses are covered at first by the EHIF but the final reimbursement is made by the country where the person is insured.

The expenditure of health insurance benefits has increased in EU since 2004. In 2004 it was 1 million 856 thousand kroons because only a few states could submit invoices to Estonia for the health services provided after 1 May 2004. In 2007 the expenditure was 34 million 200 thousand kroons. As compared to the year 2006, the increase was 64%.

Table 48. Expenditure of EU (in EEK thousand)

	2004 actual	2005 actual	2006 actual	2007 actual	Change compared to 2006 %
Reimbursements	1,856	15,317	20,833	34,200	64%

Benefits for medical devices

In the case of medical devices the EHIF is bound by an open obligation, i.e. it must reimburse the expenses of all recipients of medical devices pursuant to the conditions fixed in the legal acts.

In 2007 the EHIF paid benefits for medical devices in the total amount of 44 million 338 thousand kroons which is 63% from the projected budget.

Table 49. Benefits for medical devices (in EEK thousand)

	2006 actual	2007 budget	2007 actual	Budget implementation %	Change compared to 2006 %
Primary prostheses and orthosis	11,094	11,038	11,814	107%	6%
Diabetes test strips	11,634	43,848	21,078	48%	81%
Stoma appliances	8,846	9,700	9,756	101%	10%
Spacer devices	8	0	0	0%	-100%
Insulin pumps	0	2,000	1,066	53%	-
Other devices	1,072	3,414	624	18%	-42%
Total	**32,654**	**70,000**	**44,338**	**63%**	**36%**

* Since 2007 the expenditure on spacer devices is included in the cost of other devices

The budget for accounting period was not implemented mainly because of the smaller need especially concerning the diabetes test strips. Less money than planned was also spent on insulin pumps and related devices and other devices. The money left from the budget planned for other devices was spent on covering the cost of those medical devices where the need was bigger.

Diabetes test strips. The EHIF planned the expansion of the reimbursement of diabetes test strips to all diabetes patients and therefore the 369% rise was planned. The decision was caused by the increase of the target group and increase of the limit amount to the insured patients with I type diabetes, children, pregnant women and mother of children under 1 year of age. The size of the target group was planned according to the discussion with the Estonian Society for Endocrinology and the Estonian Union of Diabetes. But the involvement and demand of the target group is smaller than planned. The actual application is smaller also because the amendment of the regulation came into effect only in the second quarter of 2007. Test strips were reimbursed in the reporting period to 12,958 insured persons (i.e. 57% of the projected target group) whereas mainly the part planned to the patients with easier form of diabetes who visit doctors more seldom was not used.

The budget of the **primary prostheses and orthosis** was exceeded in the reporting period due to the bigger need. The number of persons in need of post-operative or post-traumatic orthosis has increased by 25% as compared to 2006. The demand for prostheses is stable.

Expenditure was bigger than planned in respect of **stoma appliances** as the average expenditure on the insured person was bigger.

Operational expenditure of the EHIF

7. Personnel and administrative expenditure

Table 50. Personnel expenditure (in EEK thousand)

	2006 actual	2007 budget	2007 actual	Budget implementation %	Change compared to 2006 %
Total salaries	38,459	48,055	45,038	94%	17%
Basic salary	31,895	38,753	37,338	96%	17%
Performance pay	4,653	7,189	5,587	78%	20%
Management Board remuneration (basic and performance fee)	1,908	2,108	2,109	100%	11%
Supervisory Board remuneration	3	5	4	80%	33%
Unemployment insurance premium	109	146	129	88%	18%
Social tax	12,691	15,856	14,863	94%	17%
Total	**51,259**	**64,057**	**60,030**	**94%**	**17%**

Personnel expenditure in 2007 was impacted most by:

- Additional development activities – project of financial compensation and project of e-prescription ordered by the Ministry of Social Affairs
- Rise in salary pursuant to the salary agreement of the doctors and structure of the employees – more than 20% of the employees are doctors who shall be paid in minimum 90 kroons per hour pursuant to the salary agreement
- Reorganisation of the business processes in the course of which the number of employees with high qualification increased as compared to the number of employees doing routine work

The EHIF plans its activities and operational expenditure based on the development plan approved by the Supervisory Board and scorecard's objectives for the current year. The EHIF uses activity-based planning in the course of which the activities/functions for the attainment of the organisational goals are reviewed and the resources required for the performance of these functions proposed.

Tables 51 and 52 include a few samples of the volume of services and review of the resources needed in the work processes.

Table 51. Examples of the volume of services

In pieces	2006	2007	2007 pcs/ 2006 pcs
Medical bills processed	4,020,332	4,126,764	3%
Reimbursed prescriptions processed	5,393,102	5,996,585	11%
Certificates of incapacity for work processed	605,000	621,585	3%
Treatment records inspected	10,020	10,662	6%
Applications for reimbursement processed	238,565	373,500	57%

Table 52. Resources required for the implementation of processes/functions of the EHIF

Business process and required resource	2006	2007	Change 2007/2006
Health coverage administration	22	22	0
Communication with partners and the insured	29	27	-2
Management of the communication	4	4	0
Analysis of health insurance benefits	9	8	-1
Planning of health insurance benefits	5	5	0
Administration of health insurance contracts	9	8	-1
Processing of health insurance benefits	56	55	-1
Processing of covered medicinal products	9	8	-1
Processing of health services	9	9	0
Processing of benefits of incapacity for work	28	28	0
Processing of financial benefits	9	9	0
Processing of other health services	1	1	0
Health insurance benefit inspection	34	34	0
Health insurance benefit development	10	10	0
Personnel management and development	2	2	0
IT development activities	6	9	3
Ensuring of the IT supporting and servicing activities	7	7	0
Management of business procedures	5	6	1
Management of economic activities	14	13	-1
General management	18	18	0
Performance of internal audit	3	3	0
Total required resources	**233**	**231**	**-2**

8. Management expenditure

Table 53. Management expenditure (in EEK thousand)

	2006 actual	2007 budget	2007 actual	Budget implementation %	Change compared to 2006 %
Office expenditure	3,036	3,344	2,977	89%	-2%
Facilities maintenance	7,669	8,211	7,701	94%	0%
Supplies and equipment	1,573	1,583	1,410	89%	-10%
Vehicle operation and maintenance	1,822	2,024	1,861	92%	2%
Business travel	679	808	544	67%	-20%
Other management expenses	2,088	3,055	2,768	91%	33%
Total	**16,867**	**19,025**	**17,261**	**91%**	**2%**

Implementation of the projected budget was 91%. Due to some unfilled job positions, several planned business trips were cancelled. Due to the same reason, there was no need for purchasing supplies and equipment and have office expenses.

9. Information technology expenditure

Table 54. Information technology expenditure (in EEK thousand)

	2006 actual	2007 budget	2007 actual	Budget implementation %	Change compared to 2006 %
Personal hard- and software	1,721	2,168	1,805	83%	5%
Development of IT systems	3,700	3,313	1,280	39%	-65%
Maintenance of IT systems	3,949	5,898	3,976	67%	1%
Other IT expenses	515	239	962	403%	87%
Total	**9,885**	**11,618**	**8,023**	**69%**	**-19%**

Implementation of the planned budget was only 69% as most of the expenses are related to the projects where there are several parties.

Underspending of IT expenditure was mainly due to the fact that the planned project of financial benefits is behind the schedule and no payment is made to the partner yet.

Due to the delay of the projects of financial benefits and benefits of the incapacity for work no investments have been made into the hard- and software and therefore there are no maintenance expenses. Also, several maintenance contracts were not concluded as the present partners in IT have no corresponding competence and no better partners have been found.

10. Development expenditure

Table 55. Development expenditure (in EEK thousand)

	2006 actual	2007 budget	2007 actual	Budget implementation %	Change compared to 2006 %
Training	1,455	1,852	1,527	82%	5%
Consultations	1,802	2,504	2,211	88%	23%
Business consultation	1,356	1,724	1,870	108%	38%
Legal consultation	446	780	341	44%	-24%
Total	**3,257**	**4,356**	**3,738**	**86%**	**15%**

Training expenses. Implementation of the budget has been impacted by the postponement of some expensive IT (SAP-programme) and other professional training courses to the year 2008.

Planned expenses on **business consultation:**

- Payment for the right of use of the NordDRG logic to the Nordic Centre for Classifications in Health Care and assistance of the external expert and experts of the professional societies;
- Expenses on the expert opinion related to the inclusion of new health services and medicinal products into the list;
- Expenses on other business consultation: IT, expenses on the business consultation of the personnel department and development of the organisation

The projected budget is exceeded in respect of the business consultation as the payment for the right of use of the NordDRG logic was bigger than projected.

Expenditure on **legal consultation** covers preparation of draft legislation, expenses on solving the issues related to the health services and provision of medicinal products. The budget has not been fully implemented as the expenditure on legal consultations was planned to be bigger than required.

11. Financial expenditure

Table 56. Financial expenditure

	2006 actual	2007 budget	2007 actual	Budget implementation %	Change compared to 2006 %
Banking charges	1,032	1,100	1,267	115%	23%
Reserves administration expenses	66	126	93	74%	41%
Other financial expenditure	87	72	90	125%	3%
Total	**1,185**	**1,298**	**1,450**	**112%**	**22%**

Financial expenditure covers bank charges, administration expenses of reserves and other financial expenditure which includes the difference between the daily exchange rates of the transactions made in foreign currency of the Bank of Estonia and commercial banks.

Administration expenses of reserves were smaller than projected as the conclusion of the cash reserves administration agreement between the EHIF and State Treasury was delayed. Other financial expenditure and bank charges are bigger than planned due to the inaccurate planning of expenses.

12. Other operating expenses

Table 57. Other operating expenses

	2006 actual	2007 budget	2007 actual	Budget implementation %	Change compared to 2006 %
Forms and publications	1,051	812	948	117%	-10%
Supervision	1,060	960	1,033	108%	-3%
Public relations / public information	860	1,148	1,101	96%	28%
Other expenses	1,620	1,799	1,548	86%	-4%
Total	**4,591**	**4,719**	**4,630**	**98%**	**1%**

The expenditure on forms and publications is bigger than projected due to the increased use of medicinal products. Other expenses cover also the expenditure on doubtful receivables which was smaller than projected.

13. Legal reserve

Legal reserve is a reserve formed from the budget funds of the EHIF pursuant to the Estonian Health Insurance Fund Act to reduce risks on health insurance system arising from macroeconomic changes.

The legal reserve shall amount to 6% of the budget.

As of 31 December 2007, the legal reserve of the EHIF was 603 million 363 thousand kroons. Pursuant to the volume laid down by the law, the amount of the legal reserve will be 765 million kroons in 2008. Arising from this an appropriation of 162 million kroons has been planned to the legal reserve from the retained earnings of 2007.

14. Risk reserve

The risk reserve equals 2% of the health insurance budget of the EHIF pursuant to the Estonian Health Insurance Fund Act.

As of 31 December 2007, the risk reserve of the EHIF was 201 million 148 thousand kroons. Pursuant to the volume laid down by the law, the amount of the legal reserve will be 255 million kroons in 2008. Arising from this an appropriation of 54 million kroons has been planned to the risk reserve from the retained earnings of 2007.

15. Retained earnings

As of 31 December 2007, the accumulated retained earnings of the EHIF constituted 2 billion 799 million 518 thousand kroons. Since 2003 the retained earnings include an excessive inflow of social tax and underspent expenses.

As the amount of paid social tax exceeded the estimate by 25% in 2007, the retained earnings of the financial year were 938 million 923 thousand kroons.

The Management Board of the EHIF shall submit a proposal to the Supervisory Board to allocate 162 million kroons of the retained earnings of 2007 into the legal reserve and 54 million kroons into the risk reserve to fill the reserves to the amount required by the law by the year 2008.

Annual financial statements 2007

Declaration by the Management Board

The Management Board declares its responsibility for the accuracy of the Estonian Health Insurance Fund's annual financial statements set out on pages 68 to 82 and confirms, to the best of its knowledge, that:

- the accounting principles used in preparing the annual financial statements are in compliance with the generally accepted accounting principles;
- the annual financial statements present a true and fair view of the financial situation, the revenues and expenditure and the cash flow of the Estonian Insurance Fund;
- all relevant circumstances, which have occurred before the completion of the report on 31 March 2008, have been duly recognised and reflected in the annual financial statements ;
- The Estonian Health Insurance Fund is a going concern.

		Date	Signature
Chairman of the Management Board	**Hannes Danilov**	.....	.....
Member of the Management Board	**Mari Mathiesen**	.....	.....
Member of the Management Board	**Maigi Pärnik-Pernik**	.....	.....

Balance sheet

ASSETS

In EEK thousand	31.12.2006	31.12.2007	Note
Current assets			
Cash and bank accounts	538,014	674,312	2
Shares and other securities	1,580,886	2,045,688	3
Claims and advance payments			
Trade receivables	4,759	10,889	
Other short-term receivables	11,705	14,877	4,8
Interest receivables	738	2,132	
Social tax receivable	942,873	1,260,479	5
Prepaid expenses	1,873	3,486	
Total	**961,948**	**1,291,863**	
Inventories			
Goods for resale	247	130	6
Total currents assets	**3,081,095**	**4,011,993**	
Fixed assets			
Long-term financial investments			
Shares	90	90	3
Long-term securities and bonds	185,545	284,828	3
Other long-term receivables	9,689	6,142	7,8
Total	**195,324**	**291,060**	
Tangible fixed assets			
Land and buildings (residual value)	1,831	1,860	
Other inventories (residual value)	5,721	5,731	
Total	7,552	7,591	9
Intangible fixed assets			
Purchased licences	1,915	2,749	9
Total fixed assets	**204,791**	**301,400**	
TOTAL ASSETS	**3,285,886**	**4,313,393**	

LIABILITIES AND EQUITY CAPITAL

In EEK thousand	31.12.2006	31.12.2007	Note
Liabilities			
Current liabilities			
Debts and advance payments			
Supplier payables			
Accounts payable for medical care services	449,994	496,460	
Accounts payable for medicinal products subject to discount	81,338	86,965	
Supplier payables for health insurance benefits	47,612	79,106	
Other supplier payables	2,493	3,211	
Total supplier payables	581,437	665,742	
Taxes payable	29,430	34,099	11
Employee-related payables	6,788	8,098	
Other debts	652	886	
Received advance payments	2,472	538	
Total	620,779	709,363	
Total current liabilities	**620,779**	**709,363**	
Total liabilities	620,779	709,363	
Equity capital			
Reserves	641,512	804,512	
Net surplus / deficit for previous periods	1,146,740	1,860,595	
Net surplus / deficit for financial year	876,855	938,923	
Total equity capital	**2,665,107**	**3,604,030**	
TOTAL LIABILITIES AND EQUITY CAPITAL	**3,285,886**	**4,313,393**	

Statement of financial performance

In EEK thousand	2006	2007	Note
Revenue from the health insurance part of social tax and claims collected from other persons	8,821,407	11,009,776	12
Income from government grants	0	29,549	16
Expenses related to government grants	0	-29,549	16
Expenditure on health insurance	-7,946,048	-10,119,220	13
Gross surplus / deficit	**875,359**	**890,556**	
General administrative expenditure	-81,268	-89,052	14
Other operational revenue	36,051	46,395	
Other operational expenditure	-4,591	-4,630	
Operating surplus / deficit	**825,551**	**843,269**	
Financial revenue and expenditure			
Interest and financial revenue	52,489	97,104	
Financial expenditure	-1,185	-1,450	
Total financial revenue and expenditure	**51,304**	**95,654**	
Net deficit / surplus for financial year	**876,855**	**938,923**	

Cash flow statement

In EEK thousand	2006	2007
Cash flow from operations		
Social tax received	8,618,341	10,682,923
Payments to suppliers	-7,893,987	-10,095,738
Personnel expenses paid	-38,509	-43,416
Other revenue received	-13,531	-15,006
Other expenses paid	76,977	106,978
Total cash from operations	**749,291**	**635,741**
Cash flow from investment		
Purchase of fixed assets	-3,849	-4,559
Proceeds from disposal of financial assets	2,167,188	2,573,804
Purchase of financial assets	-2,794,492	-3,068,688
Total cash flow from investment	**-631,153**	**-499,443**
Net change in cash and bank accounts	**118,138**	**136,298**
Bank accounts at the beginning of the period	419,876	538,014
Change in cash and cash equivalents	118,138	136,298
Cash and cash equivalents at the end of the period	538,014	674,312
incl. short-term deposits	490,795	645,476

Statement of changes in equity

In EEK thousand **Reserves**	**2006**	**2007**
Reserves at the beginning of the year	569,512	641,512
Increase of reserves	72,000	163,000
Reserves at the end of the year	641,512	804,512
Net surplus / deficit for previous periods		
At the beginning of the year	1,218,740	2,023,595
Increase of reserve capital	-72,000	-163,000
Net surplus / deficit for financial year	876,855	938,923
At the end of the year	2,023,595	2,799,518
Equity at the beginning of the year	**1,788,252**	**2,665,107**
Equity at the end of the year	**2,665,107**	**3,604,030**

Notes to the Annual financial statements

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

General principles

The annual financial statements for 2007 of the EHIF have been prepared in conformity with good accounting practice of the Republic of Estonia based on internationally recognised accounting and reporting policies. The main requirements of good accounting practice are laid down in the Accounting Act of the Republic of Estonia, which is supplemented by instructions issued by the Accounting Committee.

The financial year began on 1 January 2007 and ended on 31 December 2007. The annual financial statements are prepared in thousands of Estonian kroons.

Layouts used for reporting purposes

For the purpose of the revenue and expenditure account, layout no 2 of the profit and loss account set out in the Accounting Act is used, whereas the structure of the entries thereof is adjusted pursuant to the specific feature of the activities of the EHIF.

Financial assets and liabilities

Financial assets are deemed to be money, short-term financial investments, customer receivables and other current and long-term receivables. Financial liabilities are deemed to be supplier payables, accruals and other short and long-term loan commitments.

Financial assets and liabilities are initially registered in their acquisition cost, which is just the value of the amount paid or received for the said financial asset or liability. Initial acquisition cost covers all transaction expenses directly related to the financial asset or liability.

Financial liabilities are recorded on the balance sheet in the adjusted acquisition cost.

Financial liabilities are removed from the balance sheet when the EHIF loses the right for cash flows from financial assets or it gives to the third party the cash flows arising from the assets and most of the risks and benefits related to financial assets. Financial liability is removed from the balance sheet when it has been performed, terminated or expired.

The purchase and sale of financial assets is recorded in a consistent manner on the value date, i.e. on the date when the EHIF becomes the owner of the purchased financial assets or loses the right of ownership for the sold financial assets.

Foreign exchange accounts

Transactions in a foreign currency are recorded in Estonian kroons on the basis of the exchange rate published by the Bank of Estonia applicable on the transaction day. Assets and liabilities established in a foreign currency are re-valuated on the basis of the exchange rate valid on the balance sheet date and the currency transaction reserve is shown in the statement of financial performance.

Cash and cash equivalents

Cash and cash equivalents are cash in the bank, deposits at call and short-term bank deposits (with the redemption term of less than 3 months) which do not have an essential risk of changes in the market value.

Cash flow statement is prepared using the direct method.

Financial investment accounts

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

Long-term financial investments are securities which are most probably not resold during the financial year and securities with a fixed redemption date which is later than year after the balance sheet date.

Receivables 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. Previous receivables put to expenses but have been accrued in the reporting period are reflected as a reduction of the uncollectible claims.

Receivables and loans which do not justify any recovery measures for a practical or economic reason, are deemed irrecoverable and put to expenses.

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, which 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 30,000 kroons. Assets, which have a shorter expected useful life and a smaller acquisition cost, are put to expenses at the time of acquisition.

Tangible 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 (in years) are applied:

- Buildings 10 – 20
- Inventories 2 – 4
- Equipment and computers 3 – 5
- Intangible fixed assets 2 - 4

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 and have an acquisition cost of more than 30,000 kroons.

Intangible fixed assets are recognised at their acquisition cost and depreciated on a straight-line basis.

Expenditure on tangible and intangible assets incurred after acquisition are, as a rule, put to expenses for the period. Additional expenditure are added to the cost of intangible 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.

Government grants

Government grants are the grants which are targeted, given or received on certain conditions and in the case of which the provider of the targeted financing will check the targeted use of the grant. Government grants are not shown as revenue or expenditure before there is sufficient evidence that the grant recipient meets the requirements set for government grants and the government grants are actually paid..

Revenue and expenditure accounts

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

Operating and financial lease accounts

A lease is deemed to be financial lease, if all the main risks and benefits related to the ownership of the assets are transferred to the lessee. In the opposite case the lease is deemed to be an operating lease.

The property leased by way of financial lease is recognised on the balance sheet as assets and liabilities, according to the just value of the leased property. The lease payments are divided into finance costs and downward adjustment of liabilities. Finance costs are recognised during the lease period.

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

Risk reserve

The risk reserve of the EHIF budget is a reserve governed by § 391 of the Estonian Health Insurance Fund Act as follows:

- The risk reserve of the EHIF is the reserve formed from the budgetary funds of the EHIF in order to minimise the risks arising for the health insurance system from the obligations assumed
- The risk reserve equals 2% of the health insurance budget of the EHIF
- The funds of the risk reserve may be used upon a decision of the Supervisory Board of the EHIF

The EHIF has the obligation to establish a risk reserve as of 1 October 2002 with regard to the entry into force of the new Health Insurance Act. The said Act amended the Estonian Health Insurance Act by adding § 391 to it.

The amount transferred to the risk reserve shall be specified with a 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 Act as follows:

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

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.

Events following the balance sheet date

The Annual financial statements include significant circumstances affecting the assessment of assets and liabilities, which were identified between the date of 31 December 2007, the date of the balance sheet, and the date when the report was prepared, but are related to the transactions carried out in the accounting period or previous periods.

Events following the balance sheet date that were not taken into account in the assessment of assets and liabilities but significantly affect the result of the next financial year, are published in the notes to Annual financial statements .

Note 2. Cash and bank accounts

In EEK thousand	31.12.2006	1.12.2007
Deposits at call	47,219	28,836
Fixed term deposits	490,795	645,476,
Total cash and bank accounts	**538,014**	**674,312**
Fixed term deposits		
due within 1 month	334,795	424,876,
due within 1 to 3 months	156,000	220,600
Total	**490,795**	**645,476**

Note 3. Shares and other securities

Short-term investments

In EEK thousand

Bond	Date of acquisition	Maturity date	Underlying currency	Acquisition cost	Just value	Rate of return
Bond of BCP Bank	9.07.2007	9.01.2008	EUR	122,469	125,052	4.32%
Bond of the Government of the Netherlands	13.07.2007	15.01.2008	EUR	54,270	56,054	4.20%
Bond of the Government of Belgium	24.07.2007	14.02.2008	EUR	32,084	32,716	4.24%
Bond of Depfa bank	14.11.2007	14.02.2008	EEK	98,539	99,215	5.80%
Bond of Kommunalkredit Bank	16.08.2007	18.02.2008	EUR	152,841	155,538	4.59%
Bond of Sampo Bank	28.12.2007	5.03.2008	EEK	39,345	39,516	8.82%
Bond of the Government of France	2.08.2007	13.03.2008	EUR	79,286	80,770	4.21%
Bond of the Government of Germany	17.07.2007	14.03.2008	EUR	32,566	33,596	4.27%
Bond of Kommunalkredit Bank	28.09.2007	31.03.2008	EUR	152,738	154,644	4.75%
Bond of the Government of the Netherlands	31.07.2007	31.03.2008	EUR	46,386	47,302	4.25%
Bond of the Government of Germany	31.08.2007	11.04.2008	EUR	31,077	31,887	4.04%
Bond of Sampo Bank	28.12.2007	14.04.2008	EEK	51,624	51,923	8.89%
Bond of the Government of Belgium	22.08.2007	17.04.2008	EUR	45,714	46,413	4.04%
Bond of Depfa bank	13.12.2007	15.05.2008	EEK	194,303	196,507	5.80%
Bond of Sampo Bank	28.12.2007	19.05.2008	EEK	33,783	33,991	9.07%
Bond of the Government of Italy	24.08.2007	15.06.2008	EUR	38,657	38,891	4.01%
Bond of SEB Eesti Ühispank	14.06.2007	16.06.2008	EEK	10,501	10,645	4.65%
Bond of the Government of the Netherlands	16.11.2007	30.06.2008	EUR	68,679	69,046	4.00%
Bond of the Government of Finland	20.08.2007	4.07.2008	EUR	95,970	97,921	4.19%
Bond of Dexia Bank	26.07.2007	12.07.2008	EUR	46,409	47,351	4.47%
Bond of Depfa bank	13.12.2007	15.09.2008	EEK	121,424	122,460	7.52%
Bond of SEB Eesti Ühispank	1.10.2007	1.10.2008	EEK	38,065	37,919	5.00%
Bond of Sampo Bank	15.08.2006	15.08.2008	EEK	20,000	19,834	3.32%
Bond of Hansapank	19.10.2004	19.10.2009	EUR	31,278	31,620	2.41%
Bond of General Electric KP	10.05.2004	4.05.2011	EUR	15,603	15,696	2.24%
Bond of Citigroup	3.11.2004	3.06.2011	EUR	24,974	24,647	2.34%
Bond of Danske Bank	29.06.2007	29.06.2012	EUR	31,265	31,063	4.29%
Bond of ING Grupp	26.06.2006	18.09.2013	EUR	46,874	45,678	3.57%
Bond of General Electric KP	28.01.2005	28.07.2014	EUR	31,209	30,886	2.37%
Bond of Barclays Bank	23.11.2005	23.11.2015	EUR	7,796	7,831	2.92%
Bond of General Electric KP	17.03.2006	22.02.2016	EUR	31,215	30,451	2.88%
Bond of ING Grupp	11.04.2006	11.04.2016	EUR	31,211	30,762	2.99%
Bond of General Electric KP	17.01.2007	17.05.2021	EUR	31,154	29,377	4.14%
Bond of SEB Eesti Ühispank	14.06.2007	16.06.2008	EEK	18,138	18,387	4.65%
Bond of the Government of France	29.08.2007	31.07.2008	EUR	33,904	34,394	4.10%
Bond of Sampo Bank	15.08.2006	15.08.2008	EEK	20,000	19,834	3.32%
Bond of Depfa bank	13.12.2007	15.09.2008	EEK	20,371	20,545	7.52%
Bond of the Government of Germany	11.12.2007	12.12.2008	EUR	45,289	45,326	3.88%
Total				**2 027,011**	**2 045,688**	

Short-term investments are bonds maturing in 2007 and bonds acquired for the purpose of contributing to the risk reserve which in the opinion of the EHIF, shall probably be redeemed in 2008.

The revenue and expenditure of the revaluation are reflected in the statement of revenue and expenditure.

Long-term investments

In EEK thousand

The EHIF has acquired shares with the following nominal value:

Shares of AS Viimsi Haigla (at cost)

	2006	2007
Balance at the beginning of the year	90	90
Balance at the end of the year	90	90

The EHIF owns 900 shares of AS Viimsi Haigla.

The EHIF has acquired long maturity bonds as follows:

Short-term investments	Date of acquisition	Maturity date	Underlying currency	Acquisition cost	Just value	Rate of return
Bond of the Government of Ireland	10.10.2007	18.04.2009	EUR	20,099	20,595	4.03%
Bond of the Government of France	25.10.2006	25.04.2009	EUR	15,765	16,059	3.67%
Bond of the Government of Germany	9.11.2007	12.06.2009	EUR	45,044	46,118	4.04%
Bond of the Government of Austria	10.10.2007	15.07.2009	EUR	23,459	23,889	4.02%
Bond of the Government of the Netherlands	15.10.2007	15.07.2009	EUR	15,557	15,847	4.09%
Bond of the Government of France	13.11.2007	12.09.2009	EUR	22,699	22,927	3.96%
Bond of Dexia Bank	8.10.2007	21.09.2009	EUR	11,248	11,367	4.33%
Bond of the Government of France	26.11.2007	25.10.2009	EUR	15,715	15,739	3.76%
Land Nordrhein-Westfalen	25.06.2007	30.06.2010	EUR	15,050	15,496	4.63%
Bond of the Government of the Netherlands	13.11.2007	15.07.2010	EUR	8,119	8,289	3.97%
Bond of the Government of Finland	30.10.2007	15.09.2010	EUR	34,024	34,316	4.01%
Bond of the Government of Belgium	30.10.2007	28.09.2010	EUR	22,907	23,139	4.05%
Bond of Citigroup	15.08.2006	9.02.2016	EUR	15,619	14,938	3.44%
European Investment Bank KP	6.06.2005	24.03.2020	EUR	16,967	16,109	3.14%
Total				**282,272**	**284,828**	

The coupon payments of long-term investments are reflected in the just value of the securities.

Note 4. Other short-term receivables

In EEK thousand	31.12.2006	31.12.2007
Claim to Tallinn Diagnostic Centre	6,577	6,577
Short-term part of loans granted (see Note 8)	4,933	3,397
Advance payment of wages	19	38
Claims for reimbursement of maintenance costs	32	4,723*
Contractual claims against insured persons	154	145
Allowance for doubtful receivables	-10	-3
Total	**11,705**	**14,877**

* Incl. 4,661 thousand kroons claim to the Ministry of Social Affairs for the financing of external in vitro fertilisation

The principal amount of claim to Tallinn Diagnostic Centre as of 31.12.2005 in the amount of 9 million 541 thousand kroons, was received pursuant to court judgement in 2006.

The claim to Tallinn Diagnostic Centre as of 31.12.2006 has been filed pursuant to court judgement:

- Fines in the amount of 5 million 789 thousand kroons
- State fee in the amount of 484 thousand kroons
- Costs for legal assistance in the amount of 304 thousand kroons

Fines of the year 2007 are not reflected in the Annual financial statements as the arguments about paying the fines are still going on. Supreme Court sent the issue of the fines back to the court of first instance on 10.10.2007.

Note 5. Social tax receivables

Social tax receivable in the amount of 1 billion 260 million 479 thousand kroons (31.12.2006 942 million 873 thousand kroons) comprises a short-term claim to the Tax and Customs Board for the health insurance part of social tax.

Note 6. Inventories

As of 31.12.2007, the EHIF has in stock unused prescription forms worth 130 thousand kroons (as of 31.12.2007, 247 thousand kroons). Inventories belonging to the EHIF are deposited into storage with liability with other persons with balance sheet value of 56 thousand kroons (as of 31.12.2006, 126 thousand kroons).

Note 7. Miscellaneous long-term receivables

In EEK thousand	31.12.2006	31.12.2007
Long-term part of loans granted to health care institutions by the EHIF (see Note 8)	3,397	0
Long-term tax claim against the Tax and Customs Board	518	410
Long-term part of the amount paid to the Social Insurance Board for renovating the premises of the Pärnu Department and Rapla Office	5,774	5,732
Total	**9,689**	**6,142**

Note 8. Loans granted by the EHIF

In EEK thousand

As of 31.12.2006

Health care institution	Loan balance as of 31.12.2006	Incl. the short-term part of the loan	incl. the long-term part of the loan
The North Estonia Medical Centre	8,330	4,933	3,397
incl. under previous contracts			
Mustamäe Hospital	3,083	3,083	0
Estonian Oncological Centre	5,247	1,850	3,397
Total	**8,330**	**4,933**	**3,397**

As of 31.12.2007

Health care institution	Loan balance as of 31.12.2007	Incl. the short-term part of the loan	incl. the long-term part of the loan
The North Estonia Medical Centre	3,397	3,397	0
incl. under previous contracts			
Estonian Oncological Centre	3,397	3,397	0
Total	**3,397**	**3,397**	**0**

The average interest rate of granted loans is 4%, the loans have been granted in Estonian kroons, maturity dates of repayment are June and August 2008.

Note 9. Fixed assets

In EEK thousand

Tangible fixed assets Acquisition cost	Land and buildings	Other inventories	Total
31.12.2006	4,170	22,177	26,347
Purchase of fixed assets	246		3,038
Written off		-825	-825
31.12.2007	4,416	24,144	28,560
Accumulated depreciation			
31.12.2006	2,339	16,456	18,795
Calculated depreciation	217	2,779	2,996
Written off		-822	-822
31.12.2007	2,556	18,413	20,969
Residual value			
31.12.2006	1,831	5,721	7,552
31.12.2007	1,860	5,731	7,591

Intangible fixed assets Acquisition cost	Purchased licences
31.12.2006	4,783
Purchase of fixed assets	1,521
31.12.2007	6,304
Accumulated depreciation	
31.12.2006	2,868
Calculated depreciation	687
31.12.2007	3,555
Residual value	
31.12.2006	1,915
31.12.2007	2,749

Note 10. Leased assets

Financial lease

As of 31.12.2007 there are no valid financial lease contracts.

Operating lease

The profit and loss account includes operating lease payments in the amount of 5 million 704 thousand kroons from which 622 thousand kroons was paid for the lease of means of transport, 5 million 82 thousand kroons pursuant to commercial lease contracts of premises. In 2008 the amount of operating lease payments is 5 million 689 thousand kroons.

Note 11. Taxes payable

In EEK thousand	31.12.2006	31.12.2007
Individual income tax	25,615	29,386
Social tax	3,624	4,459
Income tax from fringe benefits	58	84
Unemployment insurance premium	63	77
Mandatory funded pension premium	70	91
VAT	0	2
Total	**29,430**	**34,099**

The individual tax arrears include individual income tax in the amount of 28 million 4 thousand kroons (as of 31.12.2006, 24 million 459 thousand kroons) deducted from the benefits for incapacity for work paid by the EHIF to the insured persons.

The social tax arrears include social tax in the amount of 778 thousand kroons (as of 31.12.2006, 634 thousand kroons) calculated from the holiday pay not disbursed to the employees.

Note 12. Revenue from the principal activity

In EEK thousand	2006	2007
Health insurance part of social tax	8,808,806	11,000,420
Amounts due from other persons	12,601	9,356
Total	**8,821,407**	**11,009,776**

Note 13. Expenditure on health insurance

In EEK thousand	2006	2007
Health service benefits, incl.	5,329,563	6,795,919
Disease prevention	77,562	90,148
General medical care	666,609	886,076
Specialised medical care*	4,260,081	5,390,436
Nursing care	132,386	189,267
Dental care	192,295	239,992
Health promotion activities	12,676	12,688
Expenditure on benefits of medicinal products, incl.	966,796	1,120,559
Centrally equipped medicinal products	4,070	286
Expenditure on benefits for temporary incapacity for work	1,506,355	1,926,851
Other monetary benefits*	77,171	184,665
Other expenditure on health insurance benefits	53,487	78,538
Health service benefits arising from international agreements	20,833	34,200
Benefit for medical devices	32,654	44,338
Total	**7,946,048**	**10,119,220**

* The expenditure of 2007 differs from the expenditure on the budget implementation sheet as government grants from the state budget (see Note 16) is included in the budget on the line of expenditure

Note 14. General administrative expenditure

In EEK thousand	2006	2007
Personnel and administrative expenditure	51,259	60,030
Remuneration	38,459	45,038
Incl. remuneration of the members of the Management Board	1,908	2,109
Incl. remuneration of the members of the Supervisory Board	3	4
Unemployment insurance premium	109	129
Social tax	12,691	14,863
Management costs	16,867	17,261
Information technology costs	9,885	8,023
Development costs	3,257	3,738
Total	**81,268**	**89,052**

Note 15. Transactions with related parties

Related parties are the members of the management Board and Supervisory Board as well as business connected with them. No transactions have been made with the members of the management Board and Supervisory Board or with companies connected with them.

Remuneration paid to the members of the Management Board and Supervisory Board in 2007 is indicated in Note 14.

Note 16. Government grants

Government grants is made by the Ministry of Social Affairs pursuant to subsection 5 of § 351 of Artificial Insemination and Embryo Protection Act reimbursing the expenditure on the medicinal products in external in vitro fertilisation and paying to the insured person for the infertility treatment based on the agreements with the providers of the services.

Expenses related to government grants (in EKK thousand):

- reimbursing the expenditure on the medicinal products in vitro fertilisation 12,715
- reimbursement of the infertility treatment pursuant to health services 16,834

The total revenues and expenditure of the government grants is 29 million 549 thousand kroons.

Signatures to the annual report

Management Board of the Estonian Health Insurance Fund

The Management Board of the EHIF has prepared the annual report for the financial year 2007.
The annual report comprises the management report, notes to the implementation of the budget and the annual financial statements, and to which the auditor's report and the net surplus distribution proposal are annexed, has been examined and approved by the Supervisory Board of the EHIF.

		Date	Signature
Chairman of the Management Board	**Hannes Danilov**	.....	.....
Member of the Management Board	**Mari Mathiesen**	.....	.....
Member of the Management Board	**Maigi Pärnik-Pernik**	.....	.....

Supervisory Board of the Estonian Health Insurance Fund

	Date	Signature
Maret Maripuu	.....	.....
Ivari Padar	.....	.....
Heljo Pikhof	.....	.....
Jaak Aab	.....	.....
Ivi Normet	.....	.....
Lagle Suurorg	.....	.....
Valdek Mikkal	.....	.....
Senta Michelson	.....	.....
Harri Tali	.....	.....
Peeter Ross	.....	.....
Tõnis Allik	.....	.....
Tarmo Kriis	.....	.....
Oliver Kruuda	.....	.....
Tiit Kuuli	.....	.....
Tarmo Noop	.....	.....

KPMG Baltics AS
Narva mnt 5
Tallinn 10117
Estonia

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

INDEPENDENT AUDITOR'S REPORT

To the Council of Eesti Haigekassa

(translation from the Estonian original)

We have audited the accompanying financial statements of Eesti Haigekassa, which comprise the balance sheet as at 31 December 2007, and the statement of financial performence, statement of changes in equity and cash flow statement for the year then ended, and a summary of significant accounting policies and other explanatory notes, as set out on pages 68 to 82.

Management's Responsibility for the Financial Statements

Management is responsible for the preparation and fair presentation of these financial statements in accordance with the accounting principles generally accepted in Estonia. This responsibility includes: designing, implementing and maintaining internal control relevant to the preparation and fair presentation of financial statements that are free from material misstatement, whether due to fraud or error; selecting and applying appropriate accounting policies; and making accounting estimates that are reasonable in the circumstances.

Auditor's Responsibility

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

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

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

Opinion

In our opinion, the financial statements present fairly, in all material respects, the financial position of Eesti Haigekassa as of 31 December 2007, and its financial performance and its cash flows for the year then ended in accordance with the accounting principles generally accepted in Estonia.

Tallinn, 31 March 2008

KPMG Baltics AS

(signature)

Andres Root
Authorized Public Accountant

(signature)

Eeli Lääne
Authorized Public Accountant