



# Estonia

Health system summary  
2022

## AUTHORS

Triin Habicht, Kristiina Kahur, Kaija Kasekamp, Kristina Köhler,  
Marge Reinap, Andres Võrk, Riina Sikkut, Laura Aaben,  
Ewout Van Ginneken, Erin Webb  
Anna Maresso (Series Editor)

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This Health system summary is based on the *Estonia: Health System Review* published in 2018 in the Health Systems in Transition (HiT) series, and is significantly updated, including data, policy developments and relevant reforms as highlighted by the Health Systems and Policies Monitor (HSPM) ([www.hspm.org](http://www.hspm.org)). For this edition, key data have been updated to those available in July 2022 unless otherwise stated. Health system summaries use a concise format to communicate central features of country health systems and analyse available evidence on the organization, financing and delivery of health care. They also provide insights into key reforms and the varied challenges testing the performance of the health system.

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# How is the health system organized?

Estonia has a centralised single health insurance fund with autonomous providers

## ORGANIZATION

The Ministry of Social Affairs (MoSA) oversees the health system for the 1.3 million people living in Estonia (see also Box 1). MoSA's agencies include the State Agency of Medicines (SAM), the Health Board, the National Institute for Health Development (NIHD), and the Center of Health and Welfare Information Systems (CeHWIS). These agencies used to have county-level representation but now have become more

centralized and cover several counties. The Estonian Health Insurance Fund (EHIF) operates as an independent public organisation for the statutory health insurance (SHI) system. EHIF pools most of the public funding for health and organises the purchasing of health care. The health system as a whole has become increasingly centralised since the early 1990s, and EHIF purchases health services for the whole population.

### BOX 1 | ESTONIA'S NATIONAL HEALTH PLAN

The main strategic document for the health system in Estonia is the national health plan. The main objectives for the National Health Plan (NHP) 2020–2030 include:

- The average life expectancy of Estonian people will increase to 78.0 years for men and 84.0 years for women by 2030, and healthy life expectancy (HALE) will increase to 62.0 for men and 63.0 for women.
- HALE will grow faster than life expectancy.
- Health inequalities (between gender, regions and levels of education) will be reduced by 2030.

The NHP aims to integrate all activities from various stakeholders aimed at improving the health of the population. The NHP contains measurable targets with specific indicators and a detailed list of activities that are directly linked to the state budget. All NHP activities and expenditures are reviewed annually and additional reviews also occur. The NHP is not, however, an overarching policy planning instrument that specifies longer term priorities and related future reforms.

## PLANNING

MoSA has responsibility for overall health system planning at the national level. At least once a year, EHIF updates the benefits package and prices for over 2800 health services and diagnosis-related groups (DRGs), about 2200 pharmaceuticals and 2100 medical products. The Estonian government approves the benefits,

and EHIF contracts with providers. The ongoing reorganization of the central level within Estonia's health system has strengthened EHIF's purchasing function and administrative capacity, reassigned administrative responsibilities related to primary health care (PHC) and centralised several management functions.

## PROVIDERS

Since the Health Services Organization Act came into effect in 2002, health care providers are largely autonomous in the outpatient sector. The Act categorizes

health care into four types: PHC provided by family doctors, emergency medical care, specialized medical care, and nursing care. Most hospital facilities are

publicly owned by central or local governments and provide most outpatient specialist care. Most ambulatory care facilities are privately owned. Family doctors and

dentists are mostly private entrepreneurs or salaried employees of private companies or municipalities, who are contracted by EHIF.



## How much is spent on health services?

Estonia spends a relatively low amount on health but a higher share out of pocket compared to other EU countries

### FUNDING MECHANISMS

Around two thirds of funding for the Estonian health care system comes from statutory health insurance contributions via an earmarked social payroll tax of 13%. Direct state budget transfers to EHIF have been increasing substantially and make up a growing share of Estonia's public sources of funding. While budget transfers were in place previously, the increasing share of this source of funding has the aim of improving the financial sustainability of the health system. This

includes, among other things, a transfer on behalf of non-working pensioners from the state budget to EHIF as well as extraordinary transfers conducted during the COVID-19 pandemic due to insufficient EHIF reserves. EHIF allocates the health budget by organizing purchasing with contracted providers. Private sources of funding represent about a quarter of all health spending, mostly due to co-payments for pharmaceuticals and dental care.

### HEALTH EXPENDITURE

Estonia has tripled its health expenditure per capita from less than €500 per person in the early 2000s to €1733 (or US\$ PPP 2617) per person in 2019, but as a percentage of GDP, health spending does not show a consistent trend (Fig. 1). During the financial crisis, health spending as a share of GDP rose to over 6.5% in 2009, before dropping to 5.8% in 2011, with gradual yearly increases to 6.7% in 2019. Health spending in Estonia is relatively low compared to the average across EU countries, both in terms of per-person spending

(Fig. 2) and as a share of GDP (6.7% vs. 9.9% in 2019). Nearly three quarters of health spending is public, while 23.9% comes from out-of-pocket (OOP) payments and 1.6% from Voluntary Health Insurance (VHI) (Fig. 3). The 2020–2030 NHP foresees a decrease in OOP payments and includes a target that public funding for health should make up 5.2% of GDP by 2030. Nevertheless, this remains well below the EU average and does not provide much space to reduce private OOP spending.

### OUT-OF-POCKET PAYMENTS

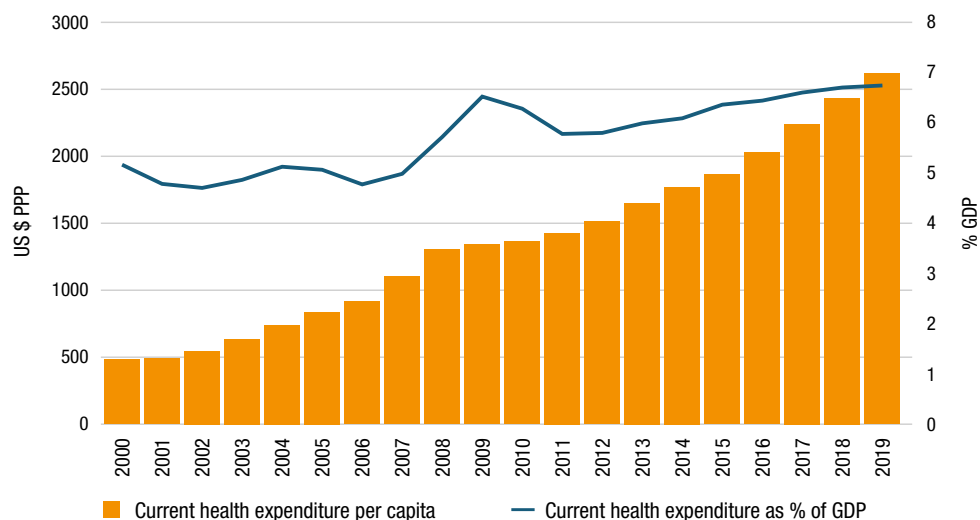
The share of OOP payments in Estonia exceeds the EU average of 15.4% of current health expenditure (Fig. 3). Most OOP spending goes towards outpatient pharmaceuticals (32%) and dental care (28%). The share of OOP spending on dental care

is particularly notable as it is more than double the EU average (13%). Recent reforms of adult dental and pharmaceutical coverage aim to reduce the high level of OOP spending in these areas (more details below).

**FIG. 1 TRENDS IN HEALTH EXPENDITURE, 2000–2019**

**Note:** CHE: current health expenditure; GDP : gross domestic product.

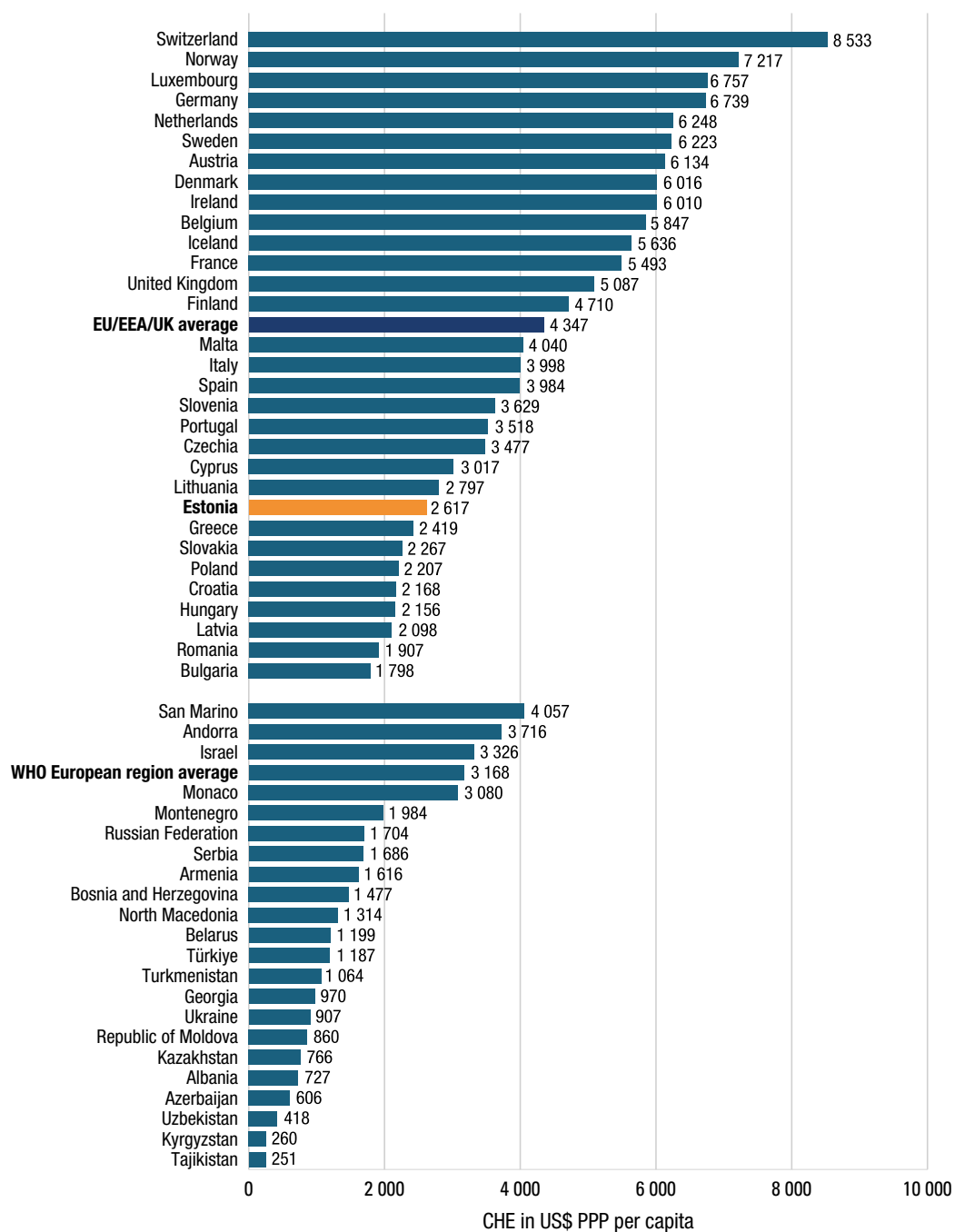
**Source:** WHO Global Expenditure Database, 2022.



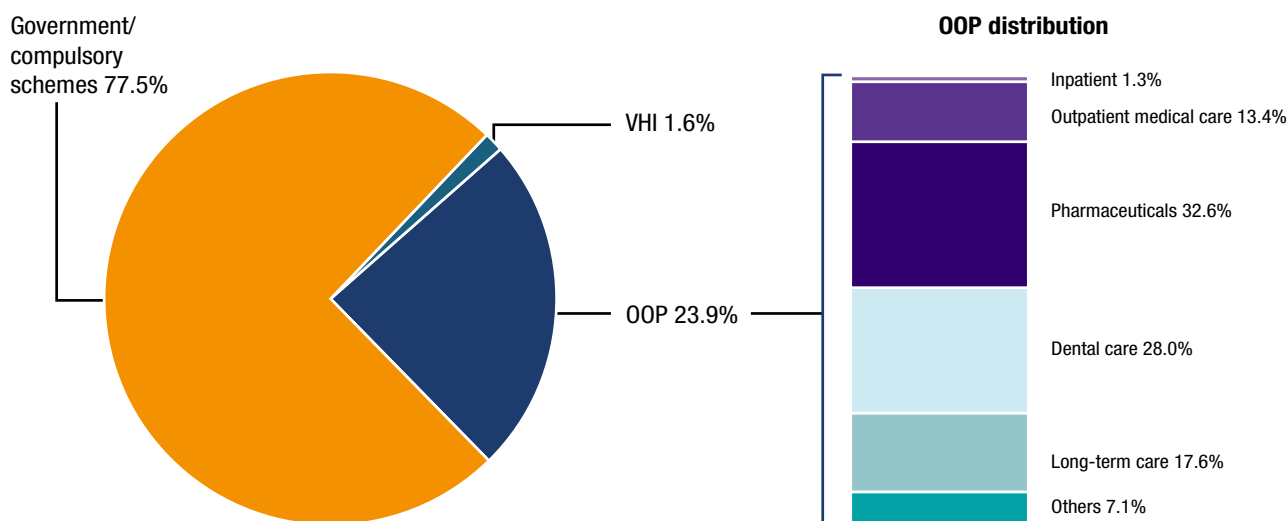
**FIG. 2 CURRENT HEALTH EXPENDITURE (US\$ PPP) PER CAPITA IN WHO EUROPEAN REGION COUNTRIES, 2019**

**Notes:** CHE: current health expenditure; EEA: European Economic Area; EU: European Union; PPP: purchasing power parity; UK: United Kingdom. Data for Albania are from 2018.

**Source:** WHO Global Expenditure Database, 2022.



**FIG. 3 COMPOSITION OF OUT-OF-POCKET PAYMENTS, 2019**



**Note:** OOP: out-of-pocket; VHI: voluntary health insurance.

**Sources:** OECD Health Statistics; Eurostat Database, 2021 (data refer to 2019).

## COVERAGE

Only about 95% of the population have SHI coverage, with those in temporary or unstable employment among the uninsured (Box 2). Men, people of working age, the non-Estonian speaking population, and people with lower

levels of education are more likely to be uninsured. EHIF covers a broad basket of benefits and the uninsured still have access to emergency care, TB and HIV treatment, COVID-19 care and vaccinations, and cancer screenings.

### BOX 2 | WHAT ARE THE KEY GAPS IN COVERAGE?

In 2019, 5% of the Estonian population did not have health insurance. Individuals with part-time work, unstable jobs or informal employment are more likely to be uninsured because most eligibility criteria relate to employment and it is difficult for citizens to navigate the system and maintain coverage if they have unstable employment. Estonia generally has high levels of OOP payments and catastrophic spending, and coverage gaps in adult dental care, pharmaceutical products and long-term care contribute to this. Ongoing efforts and several recent reforms aim to improve financial protection.

## PAYING PROVIDERS

EHIF is the main purchaser of health care services for the population, including both the insured and uninsured. EHIF has contractual relationships with providers for health system purchasing and payment mechanisms, as well as financial incentives,

have continuously developed over time. For example, EHIF has adopted a payment mechanism to increase the role of PHC and nurses and provides top-up payments for family doctors working in rural areas (Fig. 4).

FIG. 4 | PROVIDER PAYMENT MECHANISMS IN ESTONIA

GPs	Ambulatory specialists	Hospitals	Dental care for adults	Long-term nursing care
Capitation, fee-for-service, pay-for-performance, different allowances e.g. additional allowances for remote areas, additional nurse	Fee-for-service	Fee-for-service, per diem, diagnosis-related group, global budget, bundle payment for stroke care	Fee-for-service	Per diem, fee-for-service



## What resources are available for the health system?

Not enough health professionals are being trained to meet future needs, especially in primary care

### HEALTH PROFESSIONALS

Estonia has fewer doctors and nurses per 100 000 population than EU countries on average (348 compared to 397 and 638 compared to 835 in 2019) (Fig. 5). Moreover, the volume of graduating doctors and nurses is insufficient, and many health professionals, especially in PHC, are retiring. The wide gap between workforce requirements and trained staff will become a challenge for addressing future needs. The ratio of nurses to physicians (1.93) is considerably below

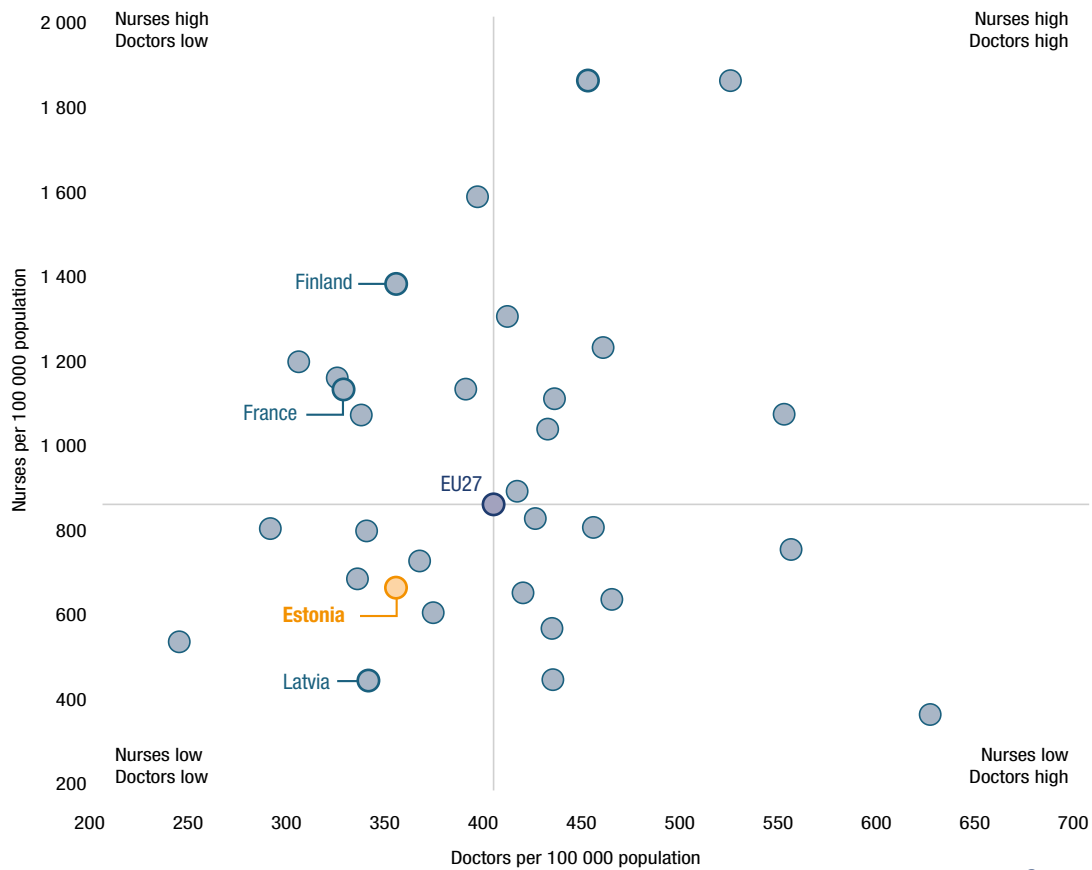
the EU28 average (2.47). The low numbers of nurses and other allied health professionals, including nutritionists and physiotherapists, also reduces the future potential for task-shifting in Estonia and other workforce developments. Nonetheless, significant task-shifting to family nurses and specialist nurses has already occurred and nurses are now able to prescribe certain medicines and authorize sick leave for patients.

### HEALTH INFRASTRUCTURE

The number of hospitals and the number of beds in Estonia have fallen dramatically since 2000 (Fig. 6). Most small hospitals have been closed, merged or turned into nursing homes operated by municipalities to provide social services. The number of MRI scanners in Estonia for its population is equal to the OECD average, while the share of CT scanners

exceeds that of most other OECD countries (Fig. 7). EU structural funds have been used for infrastructure investments, such as building new or renovating existing acute and nursing care facilities. The latest investments established PHC centres with the aim of moving away from solo PHC practices and expanding services at PHC level.

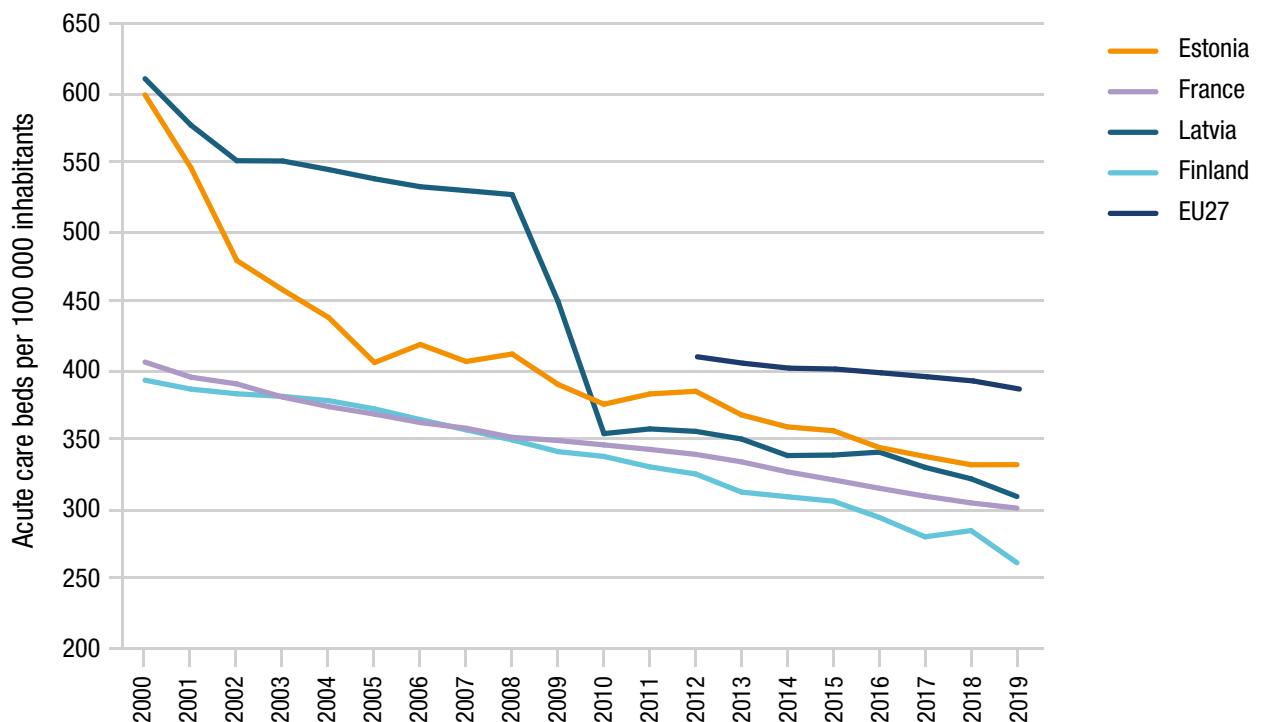
**FIG 5 PRACTISING NURSES AND PHYSICIANS PER 100 000 POPULATION, 2019**



Source: Eurostat, 2022.

**Notes:** Data on doctors for Slovakia refer to professionally active physicians; data for Greece and Portugal refer to doctors who are licensed to practice, which leads to an overestimation. Data on nurses for France, Portugal and Slovakia data refer to professionally active nurses.

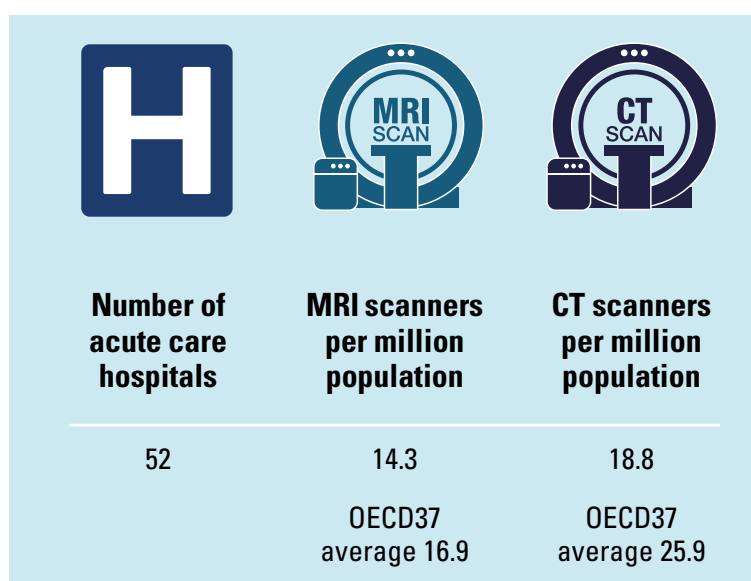
**FIG. 6 BEDS IN ACUTE HOSPITALS PER 100 000 POPULATION IN ESTONIA AND SELECTED COUNTRIES, 2000–2019**



Source: Eurostat, 2022.



**FIG. 7 HOSPITALS, MAGNETIC RESONANCE IMAGING (MRI) AND COMPUTED TOMOGRAPHY (CT) SCANNERS IN ESTONIA, 2015**

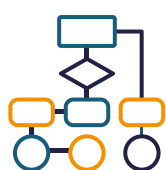


Source: OECD, 2021.

## DISTRIBUTION OF HEALTH RESOURCES

The two largest hospitals in Tartu and Tallinn account for almost 50% of the total budget for specialized medical care in Estonia. Three regional hospitals and four central hospitals provide over 30% of outpatient visits to medical specialists and approximately two thirds of bed days. The other general hospitals provide treatment for common diseases and have 17 to 200 beds. The geographic location

of hospitals ensures that treatment is available to everyone within an hour's drive. The networking between regional and general hospitals has been promoted, including through state financial incentives, to enhance access to specialist care and improve care coordination. Financial incentives are also in place to promote PHC activities in rural areas.



## How are health services delivered?

Estonia's health system has moved towards outpatient care and making primary care the centre of service delivery

## PRIMARY AND AMBULATORY CARE

The outpatient sector has a large role in Estonia, and emphasis has shifted towards disease prevention, health promotion and addressing the determinants of health. Several reforms since the 1990s have aimed at making primary care the centre of service delivery (see Box 3). A PHC network of independent family doctors acts as the first point of contact and gate-keeper for most health care services. Patients must pay full costs for specialist consultations without a referral from their family doctor except for certain specialists (e.g., ophthalmologists, gynaecologists,

psychiatrists, dentists). Family doctors work solo or in groups and are expected to have a practice list of 1200–2000 patients. Every patient list with a doctor must have at least one nurse or face a significant reduction in funding. Reforms over the past two decades have aimed to strengthen PHC by establishing health centres (through incentivizing mergers between solo practices) that provide a wider scope of PHC services. However, many family doctors still prefer to work independently, which creates a barrier to implementing this transformation.

## BOX 3 | WHAT ARE THE KEY STRENGTHS AND WEAKNESSES OF PRIMARY CARE?

Since the 1990s, Estonia has transitioned its health system towards primary care delivered by family doctors instead of at specialist clinics. Financial incentives have supported this transition and have been designed to provide continuity of care, to compensate health professionals for the financial risks of caring for older populations and working in remote areas, and to encourage multidisciplinary care by increasing the involvement of home nurses, midwives and physiotherapists in PHC. However, the uncertainty of long-term funding in PHC remains a key challenge and the supply of family physicians is becoming problematic, since the number of permanently vacant positions has quadrupled in the past 5 years; almost half of family doctors are 60 years of age or older (National Audit Office, 2020). Nonetheless, access to PHC remains high. Based on survey data, 68% of Estonian residents were able to consult with their family doctor or nurse within 3 days, and 80% were satisfied with the availability of the family doctor. Satisfaction with the most recent visit was also high (85%), and 83% of the population believed that their family doctor could help them with most health issues (EMOR, 2021).

## HOSPITAL CARE

Hospitals in Estonia fall into the following categories: regional, central, general, local, special, rehabilitation care and nursing care. Based on the hospital category, several factors, including the catchment area, services provided as well as the standards for rooms, equipment and staffing, are defined by special requirements established by MoSA. The 20 hospitals in the Hospital Network Development Plan have favourable contract

negotiations with EHIF and have received substantial investments from EU structural funds. Rates of day surgery vary by procedure and by hospital and there are opportunities for improvement, but 99% of cataract operations are performed in a day care setting, which is among the highest rates in the EU. Efforts to improve the integration of care between sectors are continuing (Box 4).

## PHARMACEUTICAL CARE

Pharmaceuticals are approved at the EU or national level to be sold in Estonia, but Estonia has only very limited pharmaceutical manufacturing capabilities which created a risk during the COVID-19 crisis when delivery of the

medicines to the country was challenging. Pharmaceuticals in Estonia are distributed from wholesalers to privately owned pharmacies operated by pharmacists. Pharmacies distribute all pharmaceuticals to the population.

## MENTAL HEALTH CARE

Mental health care in Estonia is seen as part of specialized medical care and includes the diagnosis, treatment, rehabilitation and prevention of mental disorders. Mental health care is provided mainly by psychiatrists, psychiatric nurses, nurses and psychologists and does not require a referral from a family doctor; however, there are huge shortages of psychiatrists. Mental health care is provided both in outpatient and inpatient settings; the latter is mostly used in the event of short-term crises or for solving complex differential diagnostic and treatment problems. In recent years daily follow-up for mental health problems, such as mild depression, has

also been shifted towards PHC. Having a mental health nurse in a PHC centre is financially incentivized. An integrated child mental health service delivery concept was developed using grant funding from the Norway and European Economic Area scheme that created four regional child mental health centres (in regional and central hospitals) with four regional satellites by the end of 2016. More recently in 2021, the Estonian government adopted a mental health green paper with the main goal of focusing on prevention and early detection of mental health issues, along with timely and quality access to services.

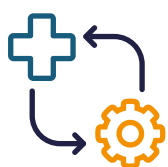
## BOX 4 | ARE EFFORTS TO IMPROVE INTEGRATION OF CARE WORKING?

Strengthening PHC has been a longstanding policy priority in Estonia, especially as a means to improve access to care, chronic disease management, and care continuity, but efforts to improve integration of care can still be advanced. A World Bank Group study published in 2015 initiated wide-scale discussions about care integration between different service providers in light of the ageing population and increasing numbers of people with (multiple) chronic conditions. The need to develop new service delivery and financing models is now broadly acknowledged and some smaller-scale initiatives are piloting options for system-wide changes. However, because the health care and social welfare systems are organized and financed separately, there are still structural barriers to overcome. Opportunities to strengthen the integration of care are present with the new hospital development plan focused on integrated hospital network and the upcoming hospital and PHC network development plan.

## DENTAL CARE

Dental care in Estonia can be delivered in private health care settings and publicly owned hospitals by companies or private entrepreneurs with a licence to provide such care. EHIF stopped cash benefits for adult dental care in 2009 as part of the austerity package, except for individuals with higher needs. In-kind dental care

benefits for the adult population were re-introduced in 2017 and give partial coverage for necessary dental care services. This has increased access to dental care services, but dental care still creates a heavy financial burden for households because the benefit only covers expenses up to a defined cap.



## What reforms are being pursued?

Box 5 highlights some of the main health reforms over the last 10 years. In 2017, the Estonian government took the historic step of expanding the revenue base of the health system away from only employment-based contributions. The reform was widely considered to be as important as the initial decision to establish the health insurance system in the 1990s and took place after a decade of discussions. The reform was expected to improve the financial sustainability of the health system and make it more resilient to future economic shocks. However, during the COVID-19 pandemic, EHIF reserves were insufficient and central government transfers have increased. A recent study commissioned by a think tank at the Estonian parliament concluded that, by 2035, the shortfall in EHIF revenues will be equivalent to 24% of total annual health expenditure, or 1.8% of GDP.

Estonia has introduced reforms to further strengthen the role of primary care by setting up PHC centres

with a broader scope of services, which is hoped to improve access, care coordination and management of chronic diseases. To further support this process, since 2015 family nurses can prescribe a limited number of medicines, mainly for chronic conditions, and additional medicines have been added over time. Estonia introduced a revised payment model for PHC centres in mid-2017 that incentivizes family doctors to switch to the new model of care. EU funds have also supported infrastructure investments in PHC, and the new PHC development plan is under development.

Estonia had reduced its level of public spending on adult dental coverage to cut costs after the financial crisis, but in 2017 the government introduced a new dental care benefits package, which was extended in 2019. This covers the most basic dental services for all adults, along with a 50% co-payment and a €40 annual cap in reimbursement for most of the

EHIF's gradually broadening revenue base is moving Estonia away from a solely contributions-funded health system

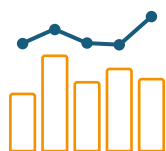
population; for certain population groups with higher needs there is a 15% co-payment and a €85 annual cap in reimbursement. In 2022, Estonia expanded the eligibility criteria for the increased dental care benefit to those who receive a subsistence allowance or are registered as unemployed. This is the first benefit that links to household income, although indirectly,

because the subsistence allowance is a means-tested benefit.

Future reforms will have to address (among other things) the population health coverage gap to ensure all individuals have insurance and the growing health workforce shortages. Further, long-term sustainability of health system financing is not yet guaranteed.

## BOX 5 | KEY HEALTH SYSTEM REFORMS OVER THE LAST 10 YEARS

- **Broadening the health insurance revenue base (ongoing):** introducing a state budget transfer of 13% on behalf of non-working pensioners and gradually increasing the share of the state budget as part of the total health budget.
- **Consolidation of smaller programmes under EHIF (2019):** EHIF has assumed responsibility for purchasing emergency care for the uninsured, ambulance care, HIV and drug dependency treatment, as well as other drugs and services that were previously financed from the state budget.
- **PHC reforms (ongoing):** reforms to incentivize practices in PHC, increase infrastructure investments, encourage multidisciplinary practices, and move PHC system organization functions from the Health Board to EHIF.
- **Dental care reform (2017 and 2022):** re-introducing dental care benefits for adults and increasing benefits for the unemployed and people receiving basic subsistence income.
- **Remote consultations (2021):** EHIF has started to finance remote consultations for specialist care.



## How is the health system performing?

### HEALTH SYSTEM PERFORMANCE MONITORING AND INFORMATION SYSTEMS

An annual report on the progress of the NHP implementation is prepared and presented to stakeholders for discussion. The achievement of the objectives of the NHP, the fulfilment of the tasks and the efficiency of the measures will also be comprehensively assessed in 2025 in the framework of an interim evaluation. Estonia is quite advanced with regard to its e-health solutions and services such as electronic health records, digital images, e-prescriptions, and

e-consultations. Over 96% of the population hold an identification card that enables digital authentication for government services and the health portal. Nevertheless, there is room for improvement to enable better use of the data for service integration, clinical decision-making and outcome measurement.

Estonia has seen substantially improved health outcomes but many inequalities persist

### ACCESSIBILITY

Access to health care in Estonia could be enhanced by reducing the number of uninsured and decreasing waiting times. Around 5% of the population is uninsured and more than 10% experience temporary gaps in their

health coverage during the year. In 2020, more people in Estonia reported unmet needs for medical care than in any other EU country, with 15.5% experiencing unmet needs for medical care due to cost, distance or waiting time

compared to an EU average of 1.7% (Fig. 8). Nearly 15% of the population self-reported unmet needs for medical care due to waiting lists, compared to an EU average of

only 0.7%. In 2019, 86% of patients waited more than 3 months for cataract surgery, 89% for hip replacement surgery and 93% for knee replacement surgery.

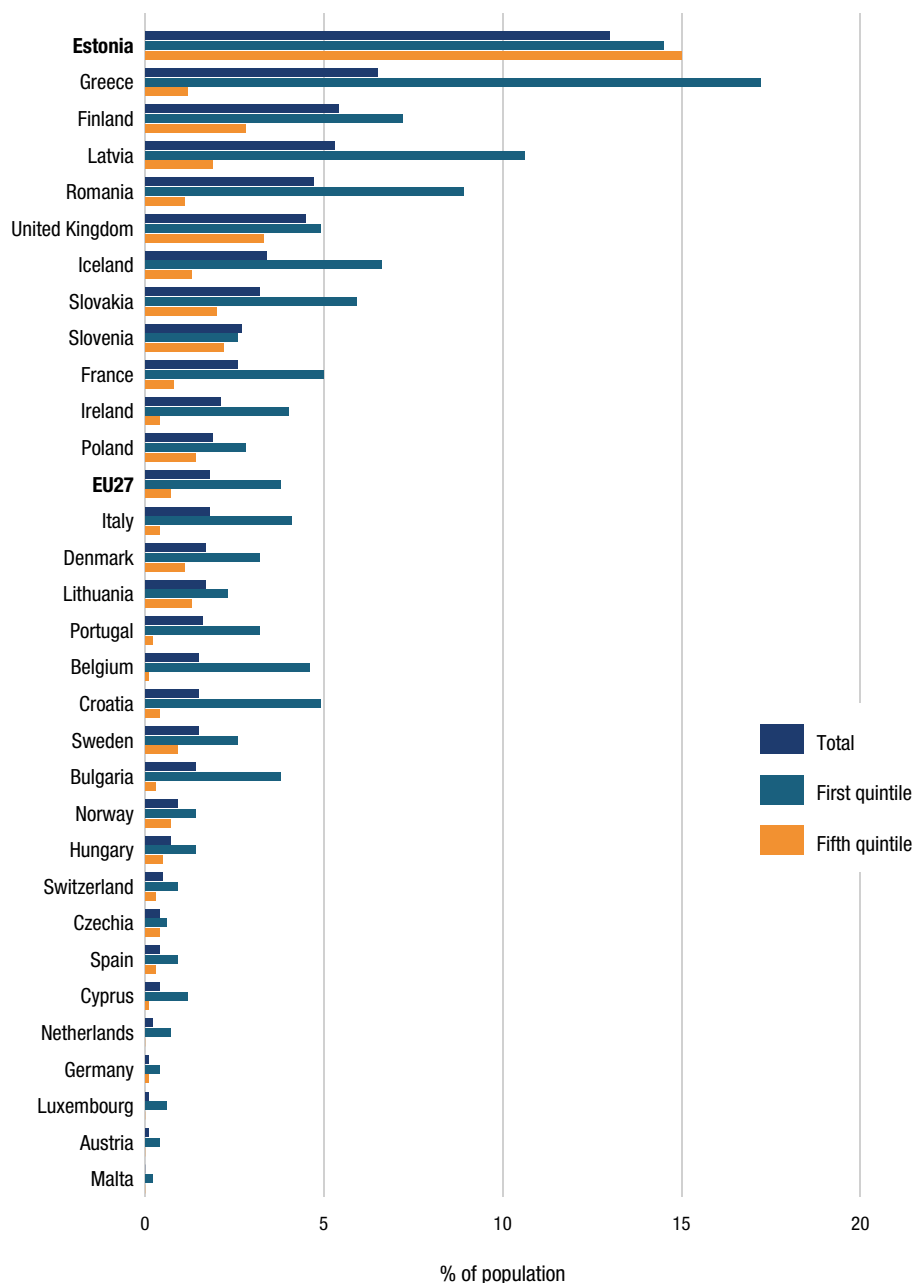
## HEALTH CARE QUALITY

Estonia’s hospitalisation rates for conditions that could have been effectively managed in outpatient settings are lower than in most other EU countries, following a sizeable decrease in the number of avoidable hospital admissions registered over the past few years. Between 2014 and 2018, avoidable admissions for diabetes and congestive heart failure declined by 25% and 18%, respectively, and now Estonia has lower avoidable hospital admission rates than many other EU countries (Fig. 9). Despite indications of improved quality in some areas

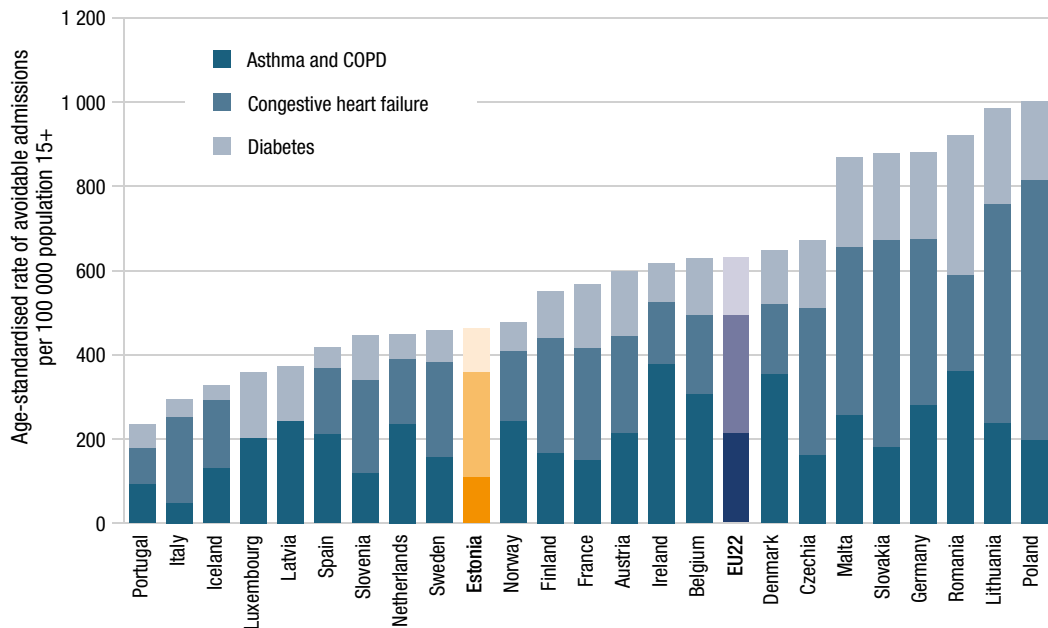
and several quality-related national initiatives, Estonia still lacks a cohesive quality monitoring and development system for health care. Further, the 30-day in-hospital mortality rates for AMI are among the worst in Europe while the rate for ischaemic stroke ranks as the tenth highest among the 26 countries with available data (Fig. 10). These outcomes suggest substantial room to further improve service quality and care coordination. Regular surveys show relatively high levels of patient satisfaction with the care they receive (Box 6).

**FIG. 8 UNMET NEEDS FOR A MEDICAL EXAMINATION (DUE TO COST, WAITING TIME OR TRAVEL DISTANCE), BY INCOME QUINTILE, EU/EEA COUNTRIES, 2020**

**Note:** EEA: European Economic Area; EU: European Union. Data refer to 2020 except for Italy (2019), Iceland (2018) and United Kingdom (2018).  
**Source:** Eurostat (2021), based on EU-SILC.



**FIG. 9 AVOIDABLE HOSPITAL ADMISSIONS FOR ASTHMA AND CHRONIC OBSTRUCTIVE PULMONARY DISEASE, CONGESTIVE HEART FAILURE AND DIABETES, 2019**



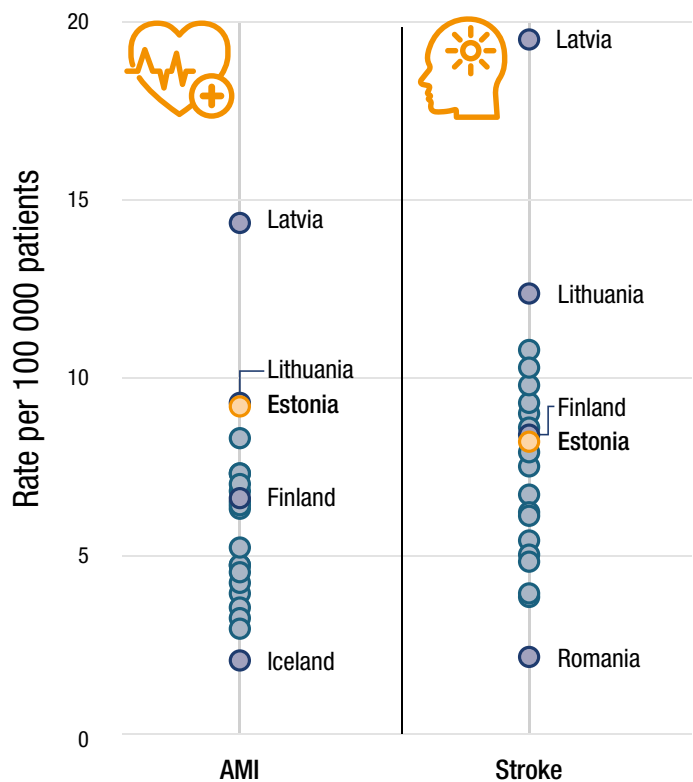
**Note:** Data for congestive heart failure are not available in Latvia and Luxembourg. Data for diabetes for Luxembourg are from 2015.

**Source:** OECD Health Statistics 2021 (data refer to 2019 or nearest year).

**FIG. 10 IN-HOSPITAL MORTALITY RATES (DEATHS WITHIN 30 DAYS OF ADMISSION) FOR ADMISSIONS FOLLOWING ACUTE MYOCARDIAL INFARCTION AND ISCHAEMIC STROKE, ESTONIA AND SELECTED COUNTRIES**

**Note:** Figures are based on patient data and have been age-sex standardised to the 2010 OECD population aged 45+ admitted to hospital for heart attack (AMI) and ischaemic stroke. Data refer to 2019.

**Source:** OECD Statistics, 2022.





## BOX 6 | WHAT DO PATIENTS THINK OF THE CARE THEY RECEIVE?

Since 1996, EHIF (in collaboration with the Ministry of Social Affairs since 2005) has conducted annual surveys on patient satisfaction with different aspects of the health system. The scope of the surveys has been broadened over time and now allows for observation of time trends. In general terms, the satisfaction of the population with health service access and quality has been relatively high over the years. A 2021 EHIF survey found that 70% of the Estonian population considered access to medical services good or quite good. The same survey found that 85% of patients were satisfied with the services of their family physician (EMOR, 2021).

## HEALTH SYSTEM OUTCOMES

Many health outcomes have shown strong improvements since the mid-2000s, and the increase in life expectancy in Estonia was the highest among EU countries until 2020. However, between 2020 and 2021, life expectancy fell 1.7 years for men and 1.4 years for women, dropping to the life expectancy in Estonia 8 years ago, which may be partly due to the impact of deaths from the COVID-19 pandemic. Overall, the pace of life expectancy improvements has slowed down and many extra years are lived with disabilities. In fact, large inequalities in health outcomes exist between different population groups, based on gender, education, income and region; and disability-adjusted life expectancy between regions varies by 14 years.

Mortality from treatable causes – from deaths that could have been avoided through timely and

appropriate treatment – are relatively high compared to other EU countries (Fig. 11). Preventable mortality (deaths from causes that could be avoided through public health policies) is also high, ranking the fifth-highest in the EU in 2019. The most frequent causes of preventable mortality include alcohol-related diseases, ischaemic heart disease and lung cancer. High mortality rates from these causes reflect the relatively high prevalence of risk factors such as obesity, alcohol consumption and smoking. Estonia has among the highest levels of obesity in the EU, and nearly one in five adults are obese. More than half of adults aged 16–64 years were either overweight or obese in 2020, with the share of overweight or obese men almost 10 percentage points higher than a decade ago (Box 7).

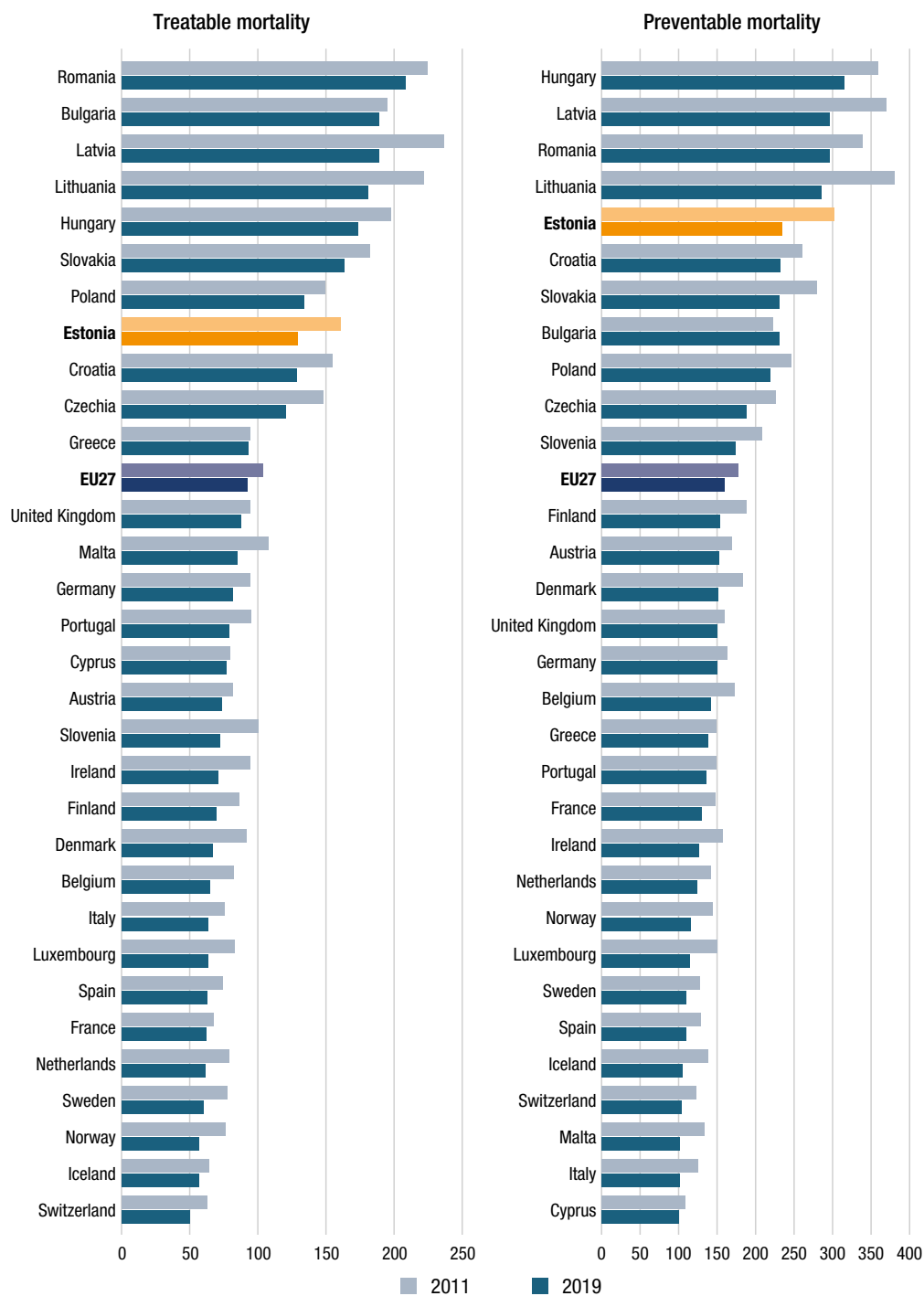
## BOX 7 | ARE PUBLIC HEALTH INTERVENTIONS MAKING A DIFFERENCE?

The NIHD carries out most disease prevention activities, which are planned in the NHP and financed by the state budget and EU funds. EHIF meanwhile finances PHC, including medical testing and screening, counselling and immunisation, as well as some national prevention projects such as reproductive health counselling for youth and school health services, which have been provided by nurses since 2010. Worryingly, family physicians do not consider preventive services as within their remit, and do not see the value of some types of preventive services (World Bank, 2015).

Overweight and obesity rates in Estonia are particularly concerning due to a lack of policy action. The government began working on a green paper on nutrition and physical activity in 2014, but it has not yet been approved by the government. This has delayed policy actions that might tackle the rising overweight and obesity rates, although some measures are under development.

**FIG. 11 MORTALITY FROM PREVENTABLE AND TREATABLE CAUSES 2011 AND 2019**

Source: Eurostat, 2022.



## HEALTH SYSTEM EFFICIENCY

Indicators of technical efficiency (e.g. average length of stay (ALOS), bed occupancy rates, diffusion of generic medicines) are close to European averages but still show scope for further development (see Box 8). EHIF contracts that incentivise greater use of outpatient care and day care surgery seem to be effective and ALOS has in fact dropped below the EU average.

Compared to its Baltic neighbours, Latvia and Lithuania, which have similar levels of health expenditure

per capita, Estonia performs better in terms of its rate of treatable mortality (Fig. 12). However, low levels of health financing may limit further improvements, particularly due to the existing health outcome inequalities among different population groups and issues surrounding accessibility to care. Furthermore, reliance on employment-related contributions as well as EU funds for infrastructure investments challenges long-term financial sustainability and reduces resilience to future health system shocks.



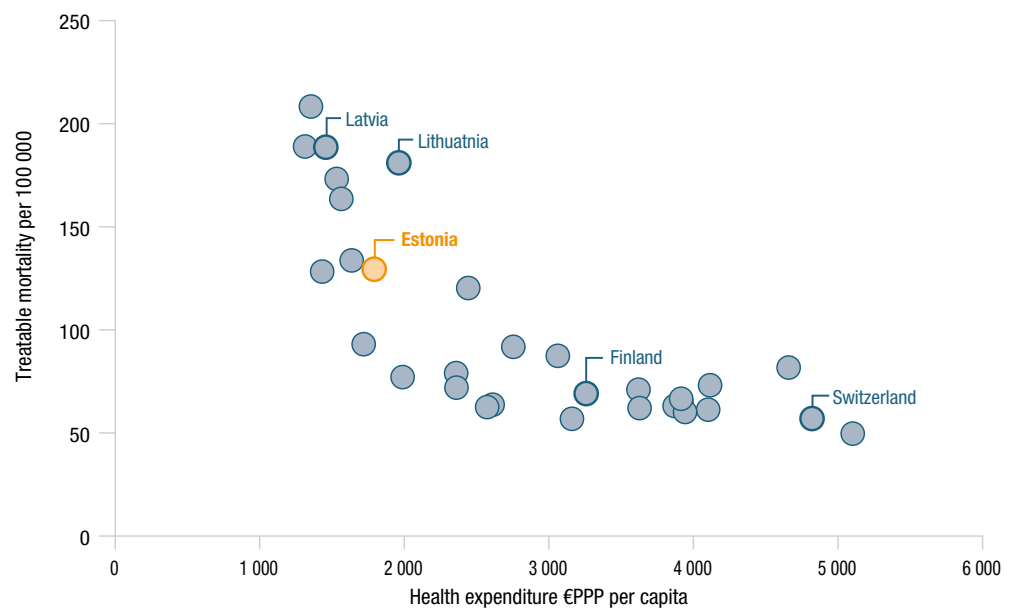
## BOX 8 | IS THERE WASTE IN PHARMACEUTICAL SPENDING?

Pharmaceuticals in Estonia did not always provide good value. Since 2002, however, Estonia has introduced legislative changes to stimulate reimbursement and prescribing of generic medicines. As a result, medical goods account for 21.4% of total health expenditure (slightly above the EU average). This shows that Estonia does not suffer from the same burden of pharmaceutical spending that its Baltic neighbours do; these countries spent around 30%. Nevertheless, Estonia has the opportunity to further increase the use of generic medicines, which made up only 36% of total pharmaceutical volume in 2017, below the EU as a whole of 50% and Latvia at 74%.

**FIG. 12 TREATABLE MORTALITY PER 100 000 POPULATION VERSUS HEALTH EXPENDITURE PER CAPITA, ESTONIA AND SELECTED COUNTRIES, 2019**

**Note:** PPP: purchasing power parity. Data are for 2019 except for France (2017), Malta (2018) and United Kingdom (2018).

**Source:** Eurostat, 2022.



## Summing up

Although life expectancy in Estonia has risen more quickly than in any other country in the EU since 2000, in recent years it has plateaued together with disability-adjusted life expectancy, and health inequalities across regions and socioeconomic groups have widened. In 2017, the Estonian government took the historic step of expanding the revenue base of the health system, but long-term sustainability of health system financing is still a challenge. Estonia's National Health Plan sets health goals for the country. To achieve the objectives of the National Health Plan 2020–2030 and continue to make health gains, targeted interventions are needed to reduce behavioural risk factors that result

in differences in health outcomes. Estonia may also require an increase in its health system financing and more sustainable funding mechanisms. Currently, health spending in Estonia is among the lowest in the EU, and OOP payments make up nearly a quarter of all health expenditure. Other challenges include filling gaps in population coverage by extending health insurance to the whole population of Estonia, as currently around 5% of the population is uninsured due to complex eligibility criteria.

Although several health indicators in Estonia show positive trends, sustaining these improvements may require more investments in health

# POPULATION HEALTH CONTEXT

## KEY MORTALITY AND HEALTH INDICATORS

### LIFE EXPECTANCY (YEARS)

Life expectancy at birth, total	77.2
Life expectancy at birth, male	72.76
Life expectancy at birth, female	81.4

### MORTALITY (PER 100 000)

All causes	1127.0
Circulatory diseases*	570.3
Malignant neoplasms*	279.5
External causes of death*	60.5
Infant mortality rate (per 1 000 live births)	1.4
Maternal mortality rate (per 100 000 live births)	9

**Notes:** \*Age-adjusted rates with the European standard population 2010. Life expectancy data are for 2020. Mortality data are for 2019. Infant mortality data are for 2019. Maternal mortality data are estimates from 2017.

**Source:** Eurostat, 2022; World Bank, 2022 for maternal mortality; Statistics Estonia, 2022.

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