Eesti Haigekassa
Estonian Health Insurance Fund

Annual Report 2006

Estonian Health Insurance Fund Annual Report 2006

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Principal activity	Public health insurance
Management Board	Hannes Danilov (Chairman) Arvi Vask Maigi Pärnik-Pernik
Auditor	KPMG Baltics

Annexed documents: Auditor's Report

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Relevant statistics 2003-2006

Table 1. Summary of major indicators of the Estonian Health Insurance Fund from 2003 to 2006

	2003	2004	2005	2006	2006/ 2005 %
Number of insured	1,272,051	1,271,558	1,271,354	1,278,016	100.5%
Revenue	5,690,137	6,350,129	7,346,892	8,909,947	121.3%
Expenditure on health insurance benefits	5,292,194	6,136,989	6,983,752	7,946,048	113.8%
Operating expenses	86,625	80,112	89,385	87,044	97.4%
Insured who received special medical care (persons)*	914,611	771,513	778,689	796,815	102.3%
Average duration of treatment (days)	6.8	6.6	6.9	6.3	91.3%
Emergency care as a percentage of expenditure on specialised medical care:					
- outpatient	13.9	15.0	15.2	15.6	102.6%
- inpatient	56.6	60.0	64.6	63.2	97.8%
Average cost per case in specialized medical care (EEK)					
- outpatient	346	409	468	525	112.2%
- inpatient	7,566	8,701	10,079	10,981	108.9%
Number of reimbursed prescriptions	4,012,989	4,775,221	5,000,602	5,393,102	107.8%
Average reimbursed prescription cost for the EHIF	171.2	180.0	173	179	103.5%
Days of incapacity covered by insurance	6,717,278	7,321,490	7,685,148	8,195,320	106.6%
Cost of incapacity benefit per day	138	151	165	184	111.5%

* Due to a change in the calculation method, data for 2004 and 2005 has been adjusted. The number of the insured who received specialized medical care changed on the account of people who received both outpatient and inpatient specialized medical care. The data for 2003 was not adjusted due for technical reasons.

Corporate overview

Estonian Health Insurance Fund (EHIF) is a legal person governed by public law, founded in 2001, whose objective, duties and bases of activities are laid down in the Estonian Health Insurance Act.

Principal activity

The main function of the Health Insurance Fund is to organise national health insurance, providing health service benefits, benefit for temporary incapacity for work, benefits for medicinal products compensated for to the insured, and other health insurance benefits to insured persons.
The objective of the Health Insurance Fund is to contribute to the preparation of treatment standards and clinical guidelines as well as to motivate health care institutions to improve the quality of health services. Additionally, the EHIF participates in health planning, expresses its opinion on the draft legislation and draft international agreements regarding the Health Insurance Fund and health insurance, organises the execution of international agreements related to health insurance and the EHIF, keeps the health insurance database and provides counselling in issues related to health insurance. Likewise, the EHIF engages in health promotion and disease prevention by conducting social campaigns.
The budget of the EHIF is formed of the 13% of social tax paid on personnel expenses. The tax is collected by the Tax and Customs Board and it is transferred to the account of the EHIF pursuant to law. Of the total expenditure on health, 67% is covered by the Health Insurance Fund, 21% by people themselves (mainly by paying for medicinal products), the rest comes from the state budget and local governments' budgets.

Organisation and management

Management of the Estonian Health Insurance Fund is carried out by a Supervisory Board comprised of fifteen members of whom five persons represent employers, five insured persons and five the state powers. A three-member Audit Committee has been established at the Supervisory Board to manage the functioning of the Internal Audit Department. Routines the EHIF are governed by a Management Board comprised of three members. Currently, the structure of the Health Insurance Fund comprises four regional departments. At the end of the financial year, the EHIF employed 226 employees.

Table 2. Breakdown of the EHIF employees by education and length of service, 2006.

Length of service		**Education**	
Up to 1 year	19%	Secondary vocational	20%
Up to 3 years	18%	Secondary	20%
Up to 5 years	18%	Higher	60%
Over 5 years	45%		
Total	**100%**	**Total**	**100%**

Since 2001, a number of internationally recognised management approaches have been introduced in the EHIF: activity-based budgeting, the balanced scorecard, competence management and business process management.

Management based on strategic balanced scorecard is integrated with process management, activity-based budgeting and employees' motivation system. Feedback from employees and external recognition are proof of the successful execution of the projects: in 2006, the EHIF was awarded the first prize among public sector organisations in the competition Estonian Quality Management Award, and European Foundation for Quality Management acknowledged the EHIF as an organisation excellently managed on the European level (Recognised for Excellence, or R4E).

Clients, stakeholders, partners

The clients of the EHIF are a total of one million and 278 thousand insured persons. During a year, the EHIF has a direct contract with ca 20% of the employers and clients, either via telephone or direct customer contact in customer service offices.

The EHIF's partners 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 EHIF's strategic partners are hospitals covered by the Hospital Master Plan.

Partners and employers are included in improvement activities and exchange of data has become faster and simpler for both parties through cooperation projects.

Main values

Innovation – we target our activities at sustainable development, relying on competent, committed and result-oriented employees.
Respect – we are reliable, open and responsive. Our decision-making is transparent and considerate of individual needs.
Collaboration - we create a trustworthy atmosphere within our organisation and in relations with our partners and clients.

Mission

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

Vision

The vision of the EHIF is to build a sense of security in the insured for facing and solving health problems.

Statement by the Chairman of the Management Board

The year 2006 was characterized by a steady expansion of the state, which also influenced the Estonian Health Insurance Fund. Proceeds exceeded the estimated budget by EEK 898 million and the EHIF's retained earnings exceeded EEK 2 billion. In order to use the earnings for the establishment of legal basis, it was necessary to amend the Estonian Health Insurance Act. The amendment provided that with a decision adopted by the EHIF's Supervisory Board, the retained earnings may be put into use in the amount of up to 30% a year. Using the total amount of earnings within one year would be hazardous for the sustainability of financing the health insurance system. Increase in financing health care institutions shortened waiting lists: availability of endoprosthetic surgeries of big joints and cataract surgeries improved significantly. The annual survey revealed that people's satisfaction with access to health services increased from 49% to 53% and satisfaction with the quality of services increased by 7%, from 59 to 66.

While the increase in financing improved satisfaction with services, which is the main objective of the EHIF's activity, it also created a situation where, for the first time, health care institutions could not carry out contracts for financing medical treatment. We are about to reach the point where hospitals, with today's capacities, will not be able to provide more services than they do now. It is always possible to create better working conditions and improve the organization of work, but the number of cases cannot be expected to increase noticeably in the next few years.

Shortage of doctors and nurses is still a large obstacle. As of the end of 2006, 237 doctors and 126 nurses had left Estonia. Said numbers are not big but every absent pair of hands has a negative effect on a system suffering from a chronic shortage of funds. There are no simple and fast solutions for the problem of shortage of workforce. We have to use all opportunities to create such working conditions for health care professionals that would ensure their stay at work in Estonia. It is especially relevant to find motivation mechanisms to make the residents stay in Estonia. Concern about the shortness of the number of health care professionals is not only characteristic of Estonia; the World Health Organisation has declared a crisis in the whole of Europe due to the shortness of medical staff.

Last year, we continued with the information technology development of the Health Insurance Fund. The database of insured persons was transferred to SAP platform, cooperation with the Ministry of Social Affairs was continued to carry out the project of e-prescription. The project will be finished and digital prescription introduced in 2008.

The Health Insurance Fund also participated in the competition for European Award for Quality Management, where we were awarded the first prize among public sector organizations: the EHIF received the acknowledgment of being an excellently managed organisation. This is an acknowledgement to everyone employed by the EHIF and shows that we have received significant results in improving the organisation's activity. For the fourth year in a row, the EHIF received the title of Public Sector Accounting Flagship.

I want to thank all the EHIF's employees and partners, interest groups and supporters, everyone who contributed to our activity in 2006.

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

Management report 2006

The objectives of the Estonian Health Insurance Fund for 2006 were set on the basis of the development plan for 2006-2008.

Management report gives an overview of the EHIF's objectives for 2006 and the implementation of said objectives (scorecard), as well as use of the budget.

Strategic objectives of the Health Insurance Fund for 2006 and implementation of said objectives

For the attainment of strategic objectives, the EHIF has been using the balanced scorecard method since 2002, which enables to set up and interrelate strategic corporate objectives in a systemic and comprehensive way and to monitor their implementation in a clear and measurable manner. In 2006, the Management Board of the Estonian Health Insurance Fund has been guided by two documents approved by the Supervisory Board of the Fund for corporate management and strategy implementation: the 2006-2008 development plan and the 2006 scorecard. The EHIF scorecard covered all strategic objectives defined and measured in the development plan. In conclusion, the EHIF scorecard was implemented within 93%.

Below is an evaluation of the implementation of the objectives set in development plan and the scorecard in 2006 by the Estonian Health Insurance Fund.

Satisfaction of insured persons with health insurance system – achievement rate was 93%.

1. Providing access to health services in the presence of limited resources – achievement rate was 99%.
2. Improving efficiency of the quality of health services – achievement rate was 100%.
3. The purposeful planning and use of the resources, ensuring balance, efficiency and transparency – achievement rate was 78%.
4. Ensuring awareness of insured persons of their rights and responsibilities – achievement rate was 100%.
5. Improving efficiency of operation of the Health Insurance Fund – achievement rate was 100%.

In conclusion, the Management Board evaluates the implementation of the development plan and the scorecard for 2006 as "good". We have succeeded in accomplishing all major tasks of the public health insurance system and EHIF.

Overview of objectives set for 2006, as well as their implementation, is given in Table 3.

Table 3. The scorecard of the Estonian Health Insurance Fund, 2006

Objective	Performance measure	Weighting	Unit of measure	2005 outturn	2006 target	2006 outturn	Performance level %
	Satisfaction of insured persons with health system	6%	%	51	60	56	93%
1. Access to health insurance benefits under limited resources		**30%**					**99%**
	Satisfaction with access	7.5%	%	49	56	53	95%
1.1.	Ensuring uniform access						
	Insured having access to primary health care within established time limits	7.5%	%	99	98	99	100%
	Insured having access to specialised care within established time limits	7.5%	%	100	98	99.8	100%
1.2.	Performance of obligations by partners						
	Quality of contract execution	7.5%	rating	Good	Good	Good	100%
2. Quality of health services		**16%**					**100%**
	Satisfaction with quality	4%	%	59	60	66	100%
2.1.	Development of quality of health care services						
	Approved clinical guidelines	4%	piece	5	5	5	100%
2.2.	Assessment and monitoring of quality of health care services						
	Clinical audits	4%	piece	5	5	5	100%
	Inspected cases	4%	piece	10,384	10,000	13,827	100%
3. Purposefulness, balance, efficiency and transparency in planning and use of resources		**30%**					**78%**
	Satisfaction with range of services paid by health insurance	6%	%	46	46	49	100%
3.1.	Assessment of needs of health insurance benefits and balance with budget opportunities						
	Agreements with professional associations on the needs of health service specialities	6%	piece	2	2	3	100%
3.2.	Efficiency of use of resources						
	Preventing structural rise in price of average cost of a treated case	6%	%	Level determined	2.4	6.5	0
3.3.	Efficiency and quality of service and partnership relations						
	Satisfaction of partners and clients with cooperation in the EHIF	6%	%	83*	85	77	91%
	Satisfaction of the insured with service in the EHIF	6%		82	85	93	100%
4. Awareness of insured persons of their rights and responsibilities		**6%**					**100%**
	Awareness of insured persons of their rights	6%	%	71	70	71	100%
5. Operation of organization		**12%**					**100%**
	Participation in quality competition of public sector organizations	4%	rating	Very good	Very good	100	100%
5.1.	Competence and motivation of employees						
	Satisfaction of employees with corporate governance and organization of work of EHIF	4%	rating	3.4	3.5	3.5	100%
5.3.	Business processes						
	Change in the cost of core processes	4%	%	100	100	89	100%
	TOTAL	**100%**					**93%**

* 2003 indicator has been adjusted for comparability

Objective 1.
Ensure access to health insurance benefits under limited resources

Satisfaction with access to medical care

People regard the functioning of the health care system as good when health services are timely and accessible for them. According to satisfaction surveys, more than half of the recipients, i.e. 53%, regarded the accessibility of medical care as 'Good' or 'Rather good'. This indicator is lower than the set objective (56%), but compared to 2005, satisfaction indicators have risen by 4%.

1.1 Ensuring uniform access

The Health Insurance Fund's objective is to ensure uniform access in order to harmonise the length of waiting lists and accessibility to health services for people in rural and urban regions, as well as to harmonise the availability of medicinal products for patients of different disease groups, so as to reduce inequality. In 2006, the main focus was on the improvement of access.

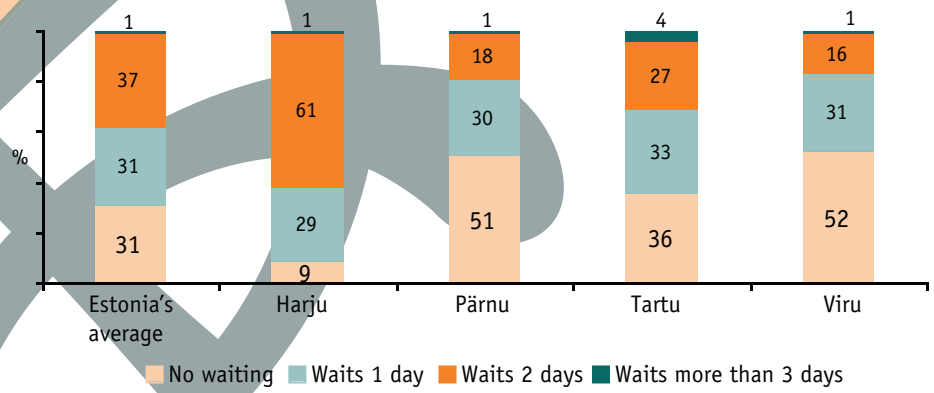
Insured having access to primary health care within established time limits

The objective of the Health Insurance Fund for 2006 was a timely appointment with the primary care physician of 98% of the insured. Accessibility surveys conducted by the EHIF during the year revealed that 99% of the insured had a timely appointment with a family physician. However, there were problems concerning access to some family physicians in the regions. According to the agreement concluded between a family physician and the Health Insurance Fund, a patient 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. In the case of acute condition, only 99% of the patients got an appointed with the family physician on the same day. In the case of chronic diseases, an average of 99% of patients got an appointment with the family physician within the established limit of three workdays (an average of 31% of patients had an appointment on the same day, ca 31% on the next day, and 37% on the second workday after registration). Patients in patient lists comprising less than 1,200 people, patient lists of permitted size limit (1600±400) and large patient lists (over 2,000 people) have to wait more than three workdays to get an appointment with their family physician. Chart 1 gives an overview of access to family physicians by regions.

One of the reasons for the problem is shortness of qualified family physicians and family nurses, which impedes the establishment of new family practices and a more effective organisation of work.

To improve access to family medicine, a day-and-night Family Physicians' Advisory Line 1220 has been available all through the year for all those in need of assistance. In 2006, an average of 380 calls was made within 24 hours.

Chart 1. Access to general medical care in the case of a chronic disease in 2006, by regions.



Insured having access to specialized medical care within established time limits

The objective of the Health Insurance Fund for 2006 was to achieve that 98% of the insured have a timely appointment with a specialist doctor during his/her regular reception hours. An appointment is timely when the maximum length of a waiting list laid down by the Supervisory Board are not exceeded due to the resources and limited capacity of the health care institution (shortage of specialists, overload of operating rooms and equipment). On the basis of data on waiting lists submitted by health care institutions, 99.6% (0.4% equals ca 18,700 people) of patients had access to outpatient specialized medical care and almost 100% (270 people over the maximum length of the waiting list) had access to inpatient specialized medical care during regular reception hours in 2006.

Owing to the mutual monitoring of agreements concluded between the EHIF and hospitals, waiting lists generated for financial reasons have been eliminated and the number of patients having to wait longer because of the limited capacity of the health care institution has been decreased. Mostly due to the small number of doctors, accessibility problems were bigger in outpatient medical care for ophthalmology, gynaecology and oncology, and in inpatient medical care and day surgery for otology, rhinology and laryngology.

Table 4. Access to specialized medical care under the resources and limited capacity of the health care institution (% of the total number of the insured who had timely access to specialized medical care during regular reception hours; yearly average as at the end of 4 quarters).

Region	Outpatient	Inpatient
Harju	99.4%	100%
Pärnu	99.8%	100%
Tartu	99.8%	100%
Viru	99.8%	100%
Total	**99.6%**	**100%**

For further improvement of accessibility, the EHIF continues to value cooperation with health care institutions, so as to ensure the correct data on waiting lists and together find opportunities for the management of agreements.

1.2. Development of partnerships and performance of obligations by partners

Quality of contract execution

The objective for 2006 was to ensure maintenance of waiting lists in cooperation with partners pursuant to the terms and conditions of the contract. Proper maintenance management of waiting lists enhances the insured people's access to medical care.

The EHIF uses the data on waiting lists as an input in the planning process. Thus, the correct data on waiting lists guarantees the contractual capacities corresponding to the need for treatment of the insured. Upon the maintenance of waiting lists, the EHIF inspected the compliance of the rules for maintaining a waiting list for regular treatment with the law, as well as waiting lists exceeding the maximum length of a waiting list, and the compliance of the waiting list with the actual provision of services. In 2006, a total of 99.5% of all contract partners submitted data on waiting lists in a timely fashion. In 2006, waiting lists were inspected on the basis of documents submitted by the health care institution and on the spot at 204 providers of health care, 95% of whom had submitted correct data to the EHIF. The inspection revealed errors in following the rules for the waiting list and filling in data fields for waiting lists in health care institutions. Health care institutions, who had made errors in complying with the principal terms of the contract and for whom the deadline set by the EHIF for the elimination of shortcomings, had fallen into the year 2006, have eliminated said shortcomings.

Objective 2.
Improve quality of health services

Satisfaction with the quality of health care

For the next few years, one of the priorities of the Health Insurance Fund is quality harmonization and development. To that end, clinical guidelines and standards shall be drawn up in cooperation with professional associations, clinical audits shall be performed and cases inspected at health care institutions. The duty of the EHIF is to motivate providers of health services to monitor, assess and improve the quality of health services.
The objective for 2006 was to achieve an assessment on quality of medical aid on level 'Good' or 'Rather good' among 60% of persons in survey. On the basis of the survey carried out by the research company Turu-uuringute AS, 66% of respondents considered the quality of medical aid to be good or rather good.

2.1 Development of the quality of health services

The objective of the Health Insurance Fund is to encourage, through various quality developing activities, providers of health services to constantly improve the quality of their activity.

- On the basis of common methods and questionnaire prepared in cooperation with regional and central hospitals, a satisfaction survey of persons receiving inpatient medical care was carried out.
- To assess the quality of hospitals' registry offices' telephone service, the Health Insurance Fund carried out a survey using the method of mystery shopping, the results of which were discussed at a meeting with the hospitals' representatives.
- Three long-term prevention projects were assessed in order to improve the quality of prevention activities: the projects for the early detection of breast cancer, prevention of heart diseases and early detection of osteoporosis.
- Clinical guidelines shall be drawn up in cooperation with professional associations.

Clinical guidelines completed in cooperation between the Health Insurance Fund and professional associations

In 2006, the objective was to analyse five clinical guidelines drawn up by professional associations. The following clinical guidelines were completed during the year:

- Clinical guidelines for arterial hypertension in Estonia;
- Guidelines for the rehabilitation of people suffering from heart disease in Estonia;
- Clinical guidelines for Sclerosis Multiplex;
- Guidelines for the diagnosis and treatment of uro-oncological diseases;
- Part I of guidelines for emergency medical care.

Along with professional associations, the EHIF organises the preparation of clinical guidelines, so as to facilitate the use of the best cost-effective practice. The role of the Health Insurance Fund is to motivate and support professional associations in this activity. Introduction and implementation of clinical guidelines is carried out by professional associations among their members.

2.2 Assessment and monitoring of the quality of health care system

In order to assess the quality of services paid for by the Health Insurance Fund and determine whether the provision of services has been justified and on the basis of feedback, motivate the providers of services to provide services of better quality, clinical audits are carried out and quality of recording treatment cases in health care institutions checked.

Number of clinical audits

In 2005, the objective was to carry out 5 audits. During the year, the following audits were carried out:

- Justification of anti-microbial treatment of bronchitis and pneumonia, and quality of diagnosis tactics in family practice;
- Justification of long-term phased treatment (consecutive leave for 20-30 days);
- Justification and quality of echocardiography survey (health service code 6340) in inpatient specialized medical care in general and central hospitals;
- Justification and quality of outpatient specialized medical care in nursing hospitals;
- Justification and quality of provision of level I-III intensive care in general hospitals.

The audits are carried out by professionals renowned for their experience in the field on the basis of laws in force, clinical guidelines, codes of conduct and good practice. Auditors are selected in cooperation with professional associations. The exhaustive results of the executed audits shall be used as an input for improvement of work with quality by the providers of health services, and the Health Insurance Fund shall carry out a follow-up inspection made on the basis of random sampling of treatment records.

Inspected cases

In 2006, the aim was to inspect 10,000 cases; the number of inspected cases amounted to 13,827. The purpose of inspection of treated cases is to ensure that the utilization of health insurance benefits is accurate and justified. By means of inspection of treated cases the Health Insurance Fund shall assign cost-effective treatment tactics, as one of the options, and developed clinical guidelines to the providers of health services for utilization. Inspection of treated cases shall be carried out on the basis of documents (health cards both in general medical care and specialised medical care, dental care cards, health and medical history) certifying the provision of health services.

The main objectives of inspections of cases in 2006 were:

- inspection of coding data quality of all medical bills with DRG in the period of October 2004 to September 2005;
- inspection of issuing prescriptions on the basis of active substances;
- follow-up inspection of prescribing non-steroid anti-pain and anti-inflammatory medicinal products used in rheumatoid arthritis treatment with discount rate of 75% or 90%;
- inspection of medicinal products prescribed for the treatment of chronic hepatitis C (B18.2) with discount rate of 100%;
- inspection of medicinal products prescribed for the treatment of Sclerosis Multiplex (G35) with discount rate of 100%;
- follow-up inspection of issuing recurring prescriptions.

As a result of the inspection, 789 claims for EEK 689.6 thousand were made.

Objective 3. Purposefulness, balance, efficiency and transparency in planning and use of resources of health insurance

Satisfaction with range of services paid by health insurance

The objective for 2006 was to achieve the satisfaction rate of 'Good' or 'Rather good' of at least 46% of the inhabitants with range of services. On the basis of a satisfaction survey a total of 49% of the respondents considered the quality of medical services to be 'Good' or 'Rather good'.

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

Assessment of the insured persons' needs for treatment is the basis for the planning process of the EHIF, and improving its efficiency an important input in enhancing the quality of the planning process of health services as well as their accessibility. To meet this objective, the EHIF assesses the insured persons' needs for treatment by specialities in cooperation with professional associations.

Agreement with professional associations on estimated needs for treatment

The objective for 2006 was to agree upon the need for treatment with two professional associations: with the special committee of general surgery agree upon the need for treatment in general surgery for 2007-2009, and assess the need for medicinal products in nephrology by analysing both the medicinal products used in outpatient care and medicinal product services listed in the hospitals' list of health services. Cooperation resulted in agreements on the need for treatment in general surgery and defined the development perspective for nephrology for the next few years.

3.2. Improve efficiency and transparency of use of resources of health insurance

The objective for the more effective use of health insurance resources is the transition in specialised medical care from activity-based financing to DRG-based financing[1] of service providers, so as to motivate providers of services to use health insurance resources more effectively in the future and increase the proportion of day care in comparison with inpatient medical care. To improve the transparency of resources in health insurance, the Health Insurance Fund has introduced activity-based pricing method[2] for the calculation of reference prices of health services.

Preventing structural rise in price of average cost of a treated case

The objective for 2006 was to reduce the structural rise in price of average cost of a treated case in inpatient specialised medical care to 2.4%. The actual structural rise in the average cost of a treated case in 2006 was 6.5%, which was significantly higher and the set objective was not met.

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1 DRG (diagnosis-related group): a system for grouping treated cases which groups cases that are similar clinically and in their use of resources. DRG-system is the basis for case-based financing.

2 Activity-based pricing is based on the method of activity-based budgeting, where expenses necessary for the provision of a certain service are tied to the activities related to its provision. This approach enables to make the reference prices of health services transparent and all parties shall know what the reference prices of services consist of.

Table 5. Increase of average structural cost of an inpatient treated case (hereinafter ASCITC) in 2004-2006

Year	2004	2005	2006
Increase of ASCTC, %	3.4%	6.4%	6.5%

One of the reasons for the noticeable increase of ASCITC is carrying out simpler operations in day-surgery and out-patient settings, in which case the hospitalised treatment cases are relatively more expensive.
The increase of average structural cost of a treated case is a rise in the cost of ASCITC, fixated for reference prices of health services in specialised medical care. 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 within one treated case. Moderate yearly increase in ASCITC is a natural process, as medical technology develops and new treatment methods are put to use.
However, health insurance funds are limited and a fast increase of ASCITC does not allow ensuring access to health services. Therefore, the Health Insurance Fund has set an objective to impede the increase in ASCITC in inpatient specialised medical care, by using DRG-based financing and upon concluding financing agreements with partners, agreeing upon the average increase in the cost of a treated case.

Development of DRG cost weights

The purpose of developing DRG cost weights is to make DRG pricing more transparent and stable in time. In 2006, the main focus in developing DRG cost weights[3] was on the formation of DRG test base. DRG test base is a database, separate from the operational systems of the EHIF, for treated cases grouped in the DRG of one year. In addition to the Health Insurance Fund, the representatives of medical specialities participated in the revision of DRG test base. On the basis of the test base, the DRG cost weights shall be developed in 2007.

Transition from the reference price calculation of health services to cost-oriented pricing

To improve the transparency of health insurance funds, the Health Insurance Fund has introduced an activity-based pricing method for the calculation of reference prices of health services and plans to start using the activity-based pricing method in all service types. The objective for 2006 was to review the pricing bases regarding laboratory tests and blood products. In cooperation with the representatives of the Estonian Association of Lab Medicine and the Estonian Society for Transfusion Medicine, the structure of laboratory tests was changed and names of tests were brought up to date. New structure and reference prices for laboratory tests took effect on 1 January 2007. Cooperation with the professional association regarding the activity-based description of the prices of blood products shall continue in 2007.

3 DRG cost weights show the relative resource expenses of a separate DRG group for an average treated case, whereas the weight of an average treated case is 1 and treated cases whose weight is more than 1 are on the average more resource-intensive, and vice versa

3.3. Improve efficiency and quality of service and partnership relations

The objective for 2006 was to achieve a summary figure within the range of 85% concerning satisfaction of clients, partners and employers of the Health Insurance Fund.

Satisfaction of partners and employers with collaboration

In 2006, the research firm Klaster carried out surveys among the partners (family physicians, providers of specialised medical care, dentists, pharmacists) and employers of the Health Insurance Fund in order to find out their satisfaction rate with collaboration in the EHIF. Employers' satisfaction rate with the EHIF was 80%, which had decreased by 3% compared to the year 2005. The employers are satisfied with the communication of information by the EHIF and clarity of said information. Dissatisfaction is related to the electronic application provided by the EHIF, through which the necessary data on employees is submitted for the initiation, termination and cancellation of health insurance. Employers' dissatisfaction was also due to availability problems arising with the introduction of the new insured registration system of the Health Insurance Fund. Partners' satisfaction rate regarding the collaboration with the EHIF was 76% (73% in 2005). The partners were satisfied with the inspection of treatment records and providing feedback for said inspection. Collaboration should be improved in the area of clinical guidelines and clinical audits. Partners also mentioned problems regarding the inspection of coverage from the EHIF databases. In the meeting with the representatives of major partners at the end of 2006, the results of the survey were discussed and meetings between all management boards for the development of partnerships were planned.

Satisfaction of insured persons or persons applying for insurance cover

In order to measure satisfaction of insured persons or persons applying for insurance cover with the service quality of the EHIF, the research company Dive Service Quality Development OÜ carried out service level surveys, using the method of inspection purchase (Mystery shopping). As a result of the survey conducted in 2006, the direct service level of the Health Insurance Fund received the rating 'Very good'.

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

The objective for 2006 was to achieve an awareness rate of insured persons of at least 70%. The results of a survey revealed that 71% of 1,500 respondents in the age group of 15-74 responded correctly to the given statements. The statements covered the rights and obligations related to health insurance, rights and procedure for the receipt of various financial benefits, family medicine, and terms and conditions of applying for the European Health Insurance Card.

Comparison of the awareness rate with previous years:

2003	2004	2005	2006
60.5%	66%	70%	71%

The number of people who are aware of their opportunity to change family physicians and of the fact that persons with acute illness must get an appointment with their family physicians within one working day is increasing every year.
In specialized medical care, people are well aware of specialists who do not require a referral from the family physician.
78% of women know that gynaecologists do not require a referral from the family physician. Things are more unclear when appointments with psychiatrists are concerned. Here, only 48% of respondents answered correctly. People are well aware of the right for dental care benefit (77% in 2006 and 74% in 2005) and more than half of the respondents are also familiar with the terms and conditions for supplementary benefit for medicinal products (59% in 2006, 53% in 2005). Statements concerning the scope of health insurance resulted in high awareness rate: over 80%; 82% of respondents were aware of the necessity for the European Health Insurance Card, first required in 2006.
To enhance people's awareness, the EHIF has constantly engaged in information activities. The following publications were published during the year: The Estonian Health Insurance Fund Gazette; information brochure on benefit for medicinal products and European Health Insurance Card; information brochure on in vitro fertilisation; materials covering dental care benefits and work and activities of self-employed persons. In 2006, to improve the provision of information, the EHIF installed common information stands at its contractual partners, medical specialists and dentists as well as hospitals, which provide information on the rights of the insured. More and more people look for answers on the EHIF's website or require specific information in the questions/answers section. People have approved of the services of the EHIF's information line 16363, reorganized in 2006. Increase in the number of calls implies continuous interest and on the basis of asked questions it is possible to prepare a list of topics that the callers have been interested in or that need to be discussed again and should be paid more attention in the course of future notification activities. For the notification of more specific target groups, the EHIF cooperated with internet portals and publications of entrepreneurs, as well as the working environment of accountants and editors of youth portals.
The Advisory Line 1220 service, financed by the EHIF since August 2005, has given good results. The objective of the Advisory Line is to provide people with an opportunity to ask questions related to their health problems 24 hours a day. The Advisory Line operates in Estonian and Russian and provides assistance to both insured persons and those without medical coverage.

Objective 5.
Improve operation of organization

To fulfil the objectives set in the scorecard, the development of the organization must ensure the necessary performance and skills for the development and introduction of respective systems.
To confirm the performance of organization, an objective had been set for 2006 to achieve I-III prize at the Estonian Quality Management Award competition. The work of the EHIF, nominated for the competition, was assessed to be the best in the category of public sector organisations by Enterprise Estonia and Estonian Association for Quality. As the model of Estonian Quality Management Award is completely in compliance with the model recognised and widely used in Europe, the European Foundation for Quality Management (EFQM) acknowledged the EHIF in 2006 as an organization excellently managed on the European level. As a sign of acknowledgment, the EHIF received the R4E certificate from the EFQM. The prerequisite for the development of organization are competent and result-oriented employees, modern information systems and effective work processes.

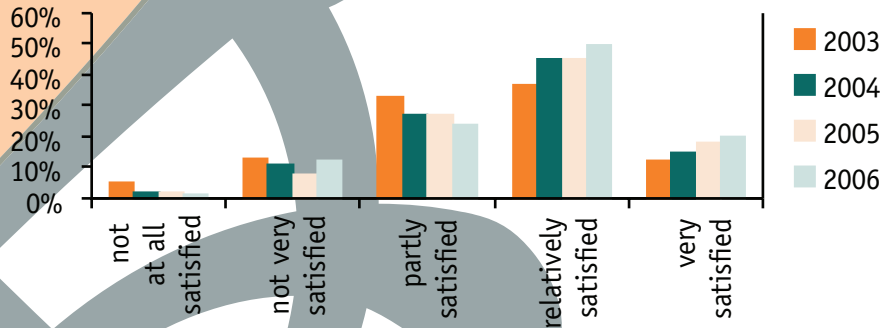
5.1. Develop competence and motivation of employees in a systematic way

The purpose of developing and training the EHIF personnel is to enhance professionalism and motivation through constant improvement of knowledge, skills and attitudes. Personnel training and development is a continuous systematic process, the planning of which is based on the objectives and tasks set in the development plan of the Health Insurance Fund, taking into consideration the individual needs of employees revealed during annual evaluations.
In 2006, the priorities of the organisation of trainings were quality, customer relations and team work.

Satisfaction of employees with corporate governance and organization of work of the Health Insurance Fund

At the end of each year, an internal survey is conducted to find out the employees' opinion of corporate governance and organization of work of the Health Insurance Fund. In 2006, 59.8% of the EHIF's employees took part in the survey (58% in 2005; 64% in 2004; 47% in 2003). The objective for 2006 was to achieve staff satisfaction with corporate governance and organization of work at level 3.5. The objective was 100% fulfilled with the result of 3.5 or 70%.

Chart 2. Staff satisfaction in 2003-2006



The results of the survey shall identify the areas in need of development in order to improve organization of work and enhance employees' satisfaction and motivation through it.

5.2. Use modern information systems

In 2006, the main projects included transfer of the register of insured persons to SAP platform and automation of exchange of data on health coverage between authorities. In cooperation with the Ministry of Social Affairs the introduction of e-prescription is being prepared. Development of the information system for digital prescriptions is an IT development project that includes many interest groups. As a result of its implementation, doctors can issue digital prescriptions, pharmacies spend less time for prescription processing and the patient does not have to worry about the prescription getting lost.

5.3. Improve work processes

Change in the cost of core processes

The objective for 2006 was that the budget of operating expenses shall not exceed yearly increase of consumer price index. Fulfilment of the objective shall be assessed once a year after the end of financial year. The aim of the change in the cost of core processes is to keep the increase of operating expenses under 100 percent as of yearly increase of consumer price index. Implementation of the budget of operating expenses was 89% in 2006.

Health Insurance Fund's explanatory notes to the budget implementation statements and the analysis of the utilization of health insurance benefits in 2006

Introduction

Explanatory notes to budget implementation serve as an explanation of the execution of the 2006 budget of the Estonian Health Insurance Fund and the analysis of the utilization of health insurance benefits.

Table 6. Main indicators for the years 2001-2007 (%)

Main indicators:	2001	2002	2003	2004	2005	2006	2007*
Social tax as a percentage of total revenue	99.5	99.2	98.9	98.9	99.1	98.9	99.0
General medical care as a percentage of total expenditure	7.4	7.9	8.0	7.7	8.1	8.3	8.8
Specialized medical care as a percentage of total expenditure	47.6	45.3	49.9	51.0	51.6	53.0	52.7
Incapacity benefits as a percentage of total expenditure	16.5	16.1	16.2	17.4	17.4	18.8	18,5
Prescription medicinal products as a percentage of total expenditure	14.6	15.2	12.0	13.6	12.0	12.0	10.9
Operating expenses as a percentage of total expenditure	1.7	1.6	1.5	1.3	1.2	1.1	1.1
Reserves/appropriations as a percentage of total expenditure	0	3.7	9.9	10.1	7.8	7.2	8.0
Health insurance benefits as a percentage of GDP	4.3	4.0	4.2	4.4	4.5	4.0	4.6

* approved budget

The insured

As of 31 December 2006, the number of people insured by the EHIF was 1,278,016.

Table 7. Number of the insured

Insured	31.12.2003	31.12.2004	31.12.2005	31.12.2006	Variation % 2006/2005	Proportion of 2006/2005 all insured 2006
Insured persons in employment	584,885	595,734	617,625	651,141	105%	51%
Government insured persons	49,119	43,869	38,538	30,663	80%	2%
Persons covered as insured	631,830	626,438	609,893	592,455	97%	47%
Persons covered by international health agreements	6,217	5,517	5,298	3,757	71%	0%
Total insured	**1,272,051**	**1,271,558**	**1,271,354**	**1,278,016**	**101%**	**100%**

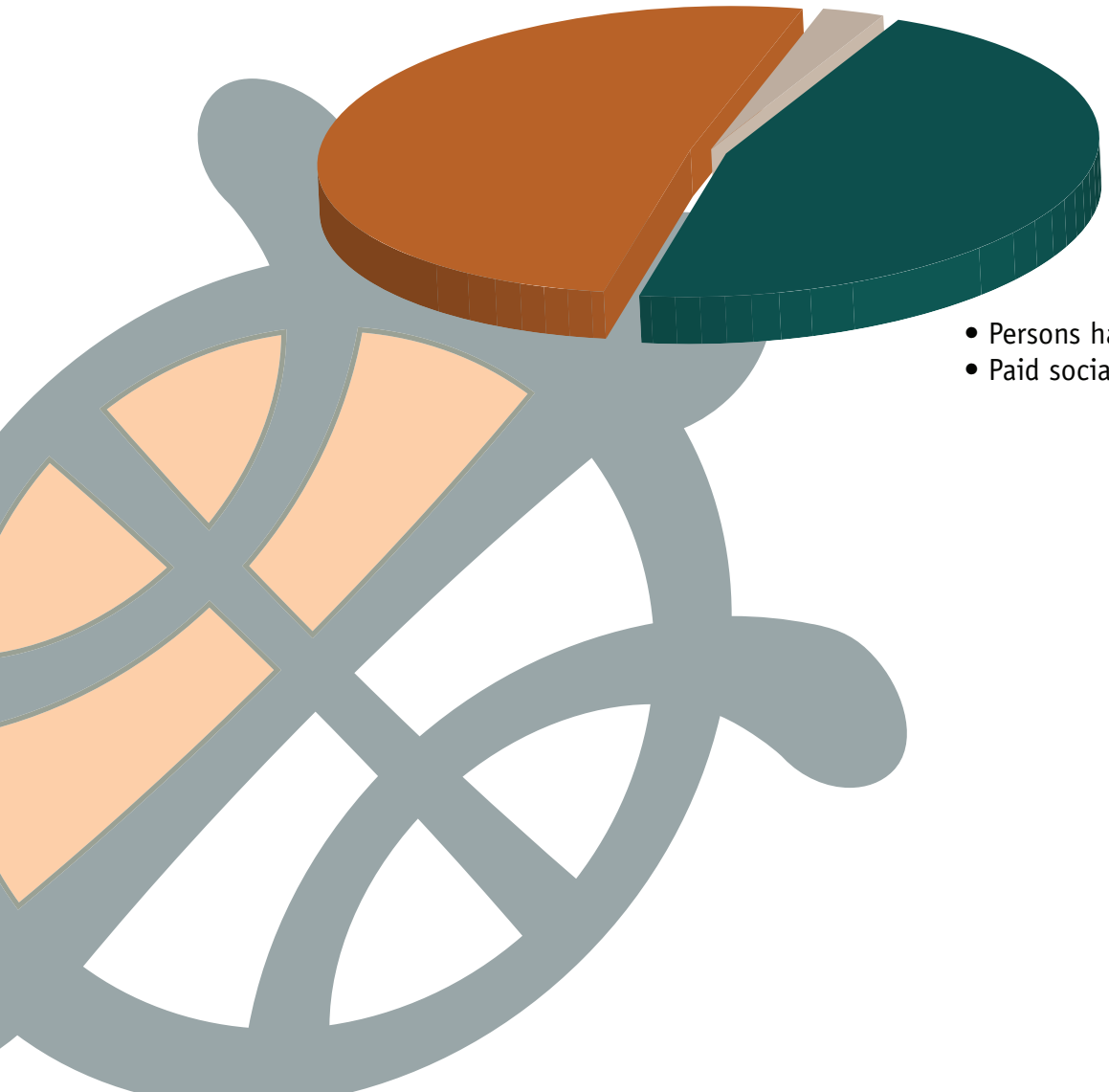
Table 8. Average expenditure in 2006 on health services to a resident of the Republic of Estonia registered with the Health Insurance Fund

Age groups / (years of age)	Number of the insured as of 31 Dec.2006	Expenditure of general medical care in kroons	Expenditure of specialized medical care in kroons	Expenditure of prescription medicinal products in kroons	Total expenditure in kroons
0-9	131,848	562	2,617	336	3,515
10-19	175,880	472	2,122	232	2,826
20-29	173,627	483	2,411	413	3,307
30-39	169,072	495	2,404	443	3,342
40-49	170,088	513	2,712	577	3,802
50-59	164,424	539	4,067	994	5,600
60-69	139,572	538	5,966	1,537	8,041
70-79	108,599	606	7,694	1,985	10,285
80-89	39,564	571	7,284	1,789	9,644
90-99	5,242	532	6,207	1,021	7,760
100-109	100	511	4,224	39	4,774

Chart 3. Proportion of the insured and the social tax paid

- Employed insured persons 51%
- Paid social tax per person EEK 13,155

- Others 3%
- Paid social tax per person EEK 7,997



- Persons having equal status 46%
- Paid social tax per person EEK 0

Review of most important development projects

Family physicians' performance bonus project

Since 2006, the Health Insurance Fund in cooperation with the Management Board of the Estonian Society of Family Doctors have been introducing the family physicians' performance bonus system, whose objectives are as follows:

- Motivate family physicians to actively engage in disease prevention, which would enable to identify at an early stage various malignant diseases or severely progressing diseases and would prevent heavy expenditure on the treatment of said diseases in the future.
- Upon monitoring chronic patients, the main focus is currently on the two most wide-spread chronic diseases in Estonia: type II diabetes and hypertonia.
- Motivate family physicians to provide the insured with a broad health service (monitoring of pregnant women, perform minor surgeries, etc.).

Criteria have been developed to enable the monitoring of said objectives. In 2006, the Health Insurance Fund in cooperation with the Tartu University Department of Family Medicine carried out broad explanatory activities among family physicians regarding the principles of performance bonus. 484 family physicians notified the EHIF of joining the performance bonus system. Summaries shall be drawn up at the beginning of 2007 and additional remuneration assigned for family physicians for work carried out in 2006, if the family physician's activity was in compliance with the established criteria.

Administration of coverage and development of other services of the Health Insurance Fund

The year 2006 saw the implementation of information technology developments related to the register of the insured persons, i.e. the Health Insurance Fund replaced the information technology platform of the register of the insured and developed e-services. Owing to the introduction of the new register, 90% of the exchange of data is carried out electronically and as a result, exchange of information related to insurance coverage between authorities is carried out via X-tee, and citizens' participation in the communication of data is no longer necessary.
The insured person must submit information to the Health Insurance Fund regarding only a few services provided by the EHIF, above all for the applications and invoices for dental care and denture benefits. At the end of 2005, the EHIF expanded the insured persons' opportunities for submitting applications by concluding a cooperation agreement with Eesti Post. As a result, it is now possible to send pre-printed forms directed at insured persons from all post offices of Eesti Post that are connected to the Internet. The service, provided by Eesti Post, has been gaining popularity among the insured. If at the beginning of 2006, approximately 280 forms were issued from post offices, then at the end of the same year the number of forms amount to 1,800 a month. Owing to this, the Health Insurance Fund closed its customer service offices in various regions of Estonia that had engaged mostly in submitting insurance information.

E-prescription

The project of e-prescription is mainly aimed at creating a functioning digital processing system for prescriptions in Estonia. The project of e-prescription is planned as a cooperation project of the Ministry of Social Affairs and the Health Insurance Fund.
As a result of implementation of the project, a prescription, in addition to a paper prescription, can be issued digitally by a physician and purchased in any pharmacy without a paper prescription by the patient. Introduction of e-prescription shall make the issuance of a prescription become more convenient and safe for a physician, improve feedback and analysis, enable the patient to buy the desired medicinal product in a suitable pharmacy without having to worry about leaving the prescription at home or losing it. Additionally, the use of digital prescriptions shall allow saving up on expenses accompanying the printing and usage of paper prescriptions.

Summary of budget implementation

Table 9. Summary of budget implementation, 2004-2006

REVENUE (in EEK thousand)	2004 actual	2005 actual	2006 budget	2006 actual	2006 actual/ 2006 budget %	2006 actual/ 2005 actual %
Social tax	6,276,578	7,277,545	7,940,825	8,808,806	110.9%	121.0%
Premiums paid by persons covered as insured under a contract	27,493	29,492	25,200	30,299	120.2%	102.7%
Amounts due from other persons	11,005	10,073	11,000	12,601	114.6%	125.1%
Financial income	31,078	25,475	30,100	52,489	174.4%	206.0%
Other revenues	3,975	4,307	4,750	5,752	121.1%	133.6%
TOTAL BUDGET REVENUE	**6,350,129**	**7,346,892**	**8,011,875**	**8,909,947**	**111.2%**	**121.3%**
BENEFIT EXPENDITURE (in EEK thousand)						
Health care services benefits	4,059,759	4,716,814	5,407,784	5,329,563	98.6%	113.0%
Disease prevention	60,480	74,436	84,000	77,562	92.3%	104.2%
Primary health care	491,661	592,155	671,153	666,609	99.3%	112.6%
Specialized medical care	3,238,607	3,752,783	4,321,299	4,260,081	98.6%	113.5%
Long-term nursing care	95,177	113,920	130,750	132,386	101.3%	116.2%
Dental care service benefits	173,834	183,520	200,582	192,925	96.2%	105.1%
Health promotion expenses	13,480	8,564	14,000	12,676	90.5%	148.0%
Medicinal products compensated for to the insured	863,847	871,762	965,600	966,796	100.1%	110.9%
Expenditure on benefits for temporary incapacity for work	1,101,980	1,265,063	1,513,480	1,506,355	99.5%	119.1%
Other monetary benefits	72,437	79,761	91,234	77,171	84.6%	96.8%
Other benefit expenses	25,486	41,788	42,303	53,487	126.4%	128.0%
Total benefit expenditure	**6,136,989**	**6,983,752**	**8,034,401**	**7,946,048**	**98.9%**	**113.8%**
OPERATING EXPENSES (in EEK thousand)						
Personnel and administrative expenses	44,773	49,140	54,600	51,259	93.9%	104.3%
Salaries and wages	33,545	36,827	40,960	38,459	93.9%	104.4%
incl. remuneration of themembers of the Management Board	1,699	1,764	1,833	1,908	104.1%	108.2%
incl. remuneration of the members of the Supervisory Board	3	2	5	3	60.0%	150.0%
Unemployment insurance premium	158	160	123	109	88.6%	68.1%
Social tax	11,070	12,153	13,517	12,691	93.9%	104.4%
Management costs	16,236	16,792	18,409	16,867	91.6%	100.4%
Information technology costs	9,096	12,611	13,606	9,885	72.7%	78.4%
Development costs	4,169	3,778	3,692	3,257	88.2%	86.2%
Training	1,756	1,627	1,602	1,455	90.8%	89.4%
Consultation	2,413	2,151	2,090	1,802	86.2%	83.8%
Financial expenses	898	1,699	1,150	1,185	103.0%	69.7%
Other operating expenses	4,940	5,365	6,526	4,591	70.3%	85.6%
Pre-printed forms and publications	1,082	1,148	1,404	1,051	74.9%	91.6%
Supervision of the health insurance system	945	879	1,285	1,060	82.5%	120.6%
Public relations/ public information	914	819	869	860	99.0%	105.0%
Other expenses	1,999	2,519	2,968	1,620	54.6%	64.3%
Total operating expenses	**80,112**	**89,385**	**97,983**	**87,044**	**88.8%**	**97.4%**
TOTAL BUDGET EXPENDITURE	**6,217,101**	**7,073,137**	**8,132,384**	**8,033,092**	**98,8%**	**113,6%**
Earnings of fiscal year	133,028	273,755	-120,509	876,855		320.3%
Provision for legal reserve		-70,000		72,000		
Retained earnings	133,028	203,755	-120 509	804,855		
TOTAL	**6,350,129**	**7,276,892**	**8,011,875**	**8,909,947**	**111.2%**	**122.4%**

Revenue

The planning of revenue of the Health Insurance Fund is carried out on the basis of the Ministry of Finance's official estimates on the indicators for inflation, GDP real growth and receipt of social tax.
In 2006, the revenue of the EHIF amounted to EEK 8,909,947 thousand.

Social tax

Social tax constitutes about 99 percent of the EHIF revenue. Revenue from the health insurance portion of social tax for the 2006 budget was projected to be EEK 7,941 million. The actual inflow was EEK 8,809 million. Revenues received in excess of the budgeted amount account for 10.9 or EEK 868 million. Increase in revenue is triggered by a rise in real wages and the consumer price index, as well as by an increase in employment arising from a more favourable economic environment.

Premiums paid by persons covered as insured under a contract

Persons without medical coverage can insure themselves by making an insurance contract with the EHIF and paying monthly premiums. By 2006, revenue from voluntary insurance contracts was projected to be EEK 23,200 thousand for the non-working retirees of the armed forces of the Russian Federation currently living in the Republic of Estonia, and EEK 2 million for other voluntary insurance contracts. Implementation at EEK 30,299 thousand exceeds the projected revenue, as the number of concluded contracts has been larger than the estimate, and the average salary, taken into account upon the calculation of insurance premiums, has also increased.

Amounts due from other persons

Health Insurance Fund makes claims on third persons liable for causing bodily harm for the insured persons, the treatment costs of which have been paid by the EHIF to the providers of health services. For 2006, revenue was projected to be EEK 11 million. Revenues received amounted to EEK 12,601 thousand, exceeding the estimate by 15%. The number of claims has increased, as cooperation with Public Prosecutor's Office has improved the opportunities to acquire faster and more detailed information necessary for the presentation of claims.

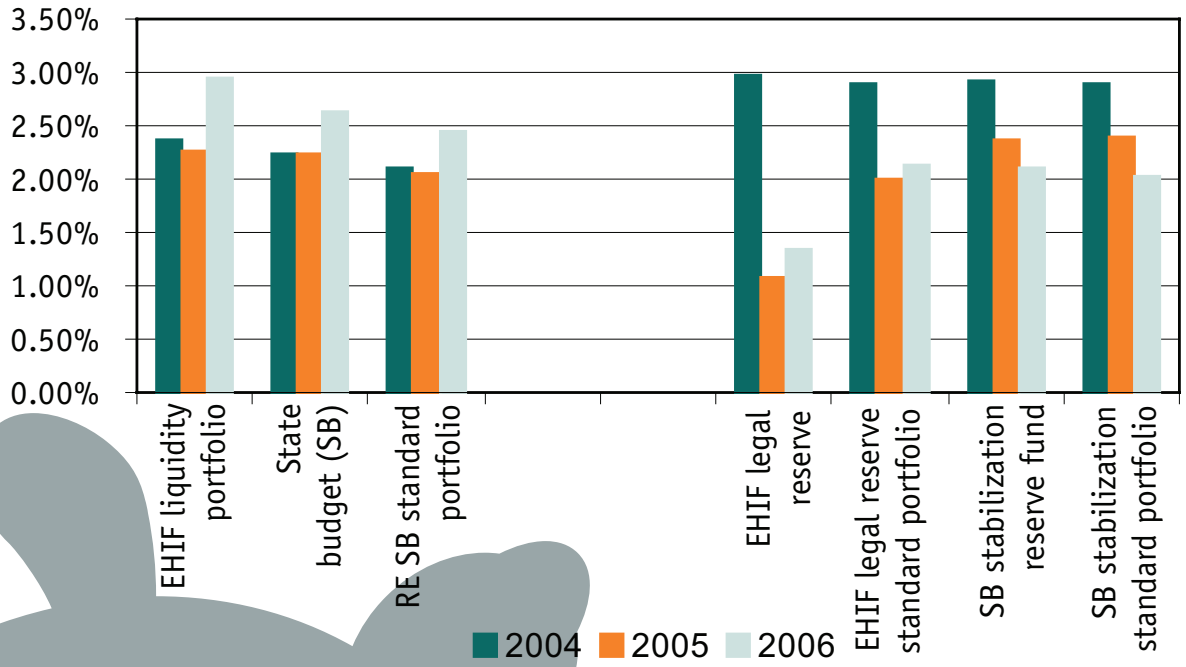
Financial income

Financial income was projected on the basis of the average balance and current rate of return. For 2006, financial income was projected to be EEK 30,100 thousand. The actual income was EEK 52,489 thousand, exceeding the estimate revenue by 74 %. The liquid resources of the EHIF are divided into two: liquidity portfolio and investments in legal reserve. The aims of liquidity portfolio and legal reserve are somewhat different. While the liquidity portfolio aims at ensuring the smooth daily management of cash-flow, the investments in legal reserve are a long-term investment with clear investment limits in order to reduce risks arising from macroeconomic changes.

Table 10. Main indicators for liquidity portfolio and investments in legal reserve (in EEK), 2006

	Liquidity portfolio	Investment in legal reserve
Fund volume at cost	1,847,653,989	450,279,142
Fund volume at market value	1,857,373,035	443,251,464
Realized gain/loss from beginning of year	38,829,439	9,290,431
Gain/loss on revaluation	9,719,046	-7,027,678
Annualized 30-day yield	3.55%	1.27%
Annualized 90-day yield	3.47%	2.73%
Yield from beginning of year (on a yearly basis)	2.95%	1.35%
Average duration of investment (on a yearly basis)	0.246	0.809

Chart 4. Utility of the EHIF liquidity reserve, the National Treasury reserve and its standard portfolio as well as utility of the EHIF legal reserve, the stabilization reserve and its standard portfolio in 2004-2006



Other revenues

Other revenues comprise revenue from processing and inspection of medical bills for emergency medical care of persons without medical coverage, revenue received from sale of prescription forms to health care institutions and remuneration for medical services rendered to the persons insured by other EU member states.

For 2006, the budget was projected to be EEK 4,750 thousand. The actual revenue was EEK 5,753 thousand, exceeding the projected budget by 21 %.

Expenditure

The EHIF divides expenditure into:

- Expenditure on health insurance benefits
- Costs associated with health insurance administration or the operating expenses of the EHIF.

Table 11. Breakdown of expenditure 2004-2006 (in %)

	2004	2005	2006	Variation 2006/2005
Benefit expenditure	96.64%	95.97%	89.2%	-6.77%
Operating expenses	1.26%	1.23%	1.0%	-0.23%
Appropriations	2.09%	2.80%	9.8%	7.0%

I Expenditure on health insurance benefits

Substantial changes in the expenditure on health insurance benefits of the EHIF in 2006 and their causes:

Expenditure on health services

- In specialised medical care the providers of health services took big steps towards the more effective provision of services: in 2006, the number of outpatient (day cases) surgeries increased by ca 1/5, and the proportion of outpatient and inpatient surgeries of all surgeries is 37% and 63%, respectively.
- Compared to the projected budget, the number of cases of specialised medical care has been exceeded by ca 2%, i.e. 68,000 treated cases, due the number of cases of outpatient and day cases exceeding the estimate. The number of inpatient cases, however, has decreased.
- 2006 was the first financial year that brought along a shortage of doctors in some areas.
- Budgetary expenditure of outpatient and inpatient specialised medical care has therefore been underspent by ca 1%.

Medicinal products

- In 2006, total amount of medicinal products reimbursed for the insured was EEK 966,796 thousand, accounting for 100 % of the annual budget. Compared to 2005, expenditure on benefits for medicinal products grew by EEK 95,034 thousand.
- Increase in the consumption of reimbursed prescription medicinal products through all discount rates was characteristic of the entire year. While the number of reimbursed prescriptions increased by 8% in comparison with the previous year, the expenditure of the EHIF on prescription medicinal products increased by 11%.
- The average expenditure of the EHIF on a reimbursed prescription has increased by 3% and it has happened on the account of two types of reimbursed prescription medicinal products: medicinal products reimbursed at 100% and those reimbursed at 50%. The average cost-sharing of the insured person upon payment for reimbursed prescription medicinal products has decreased by 0.2%.

Benefits for incapacity for work

- In 2006, expenditure on benefits for temporary incapacity for work was EEK 1,506 million, which is 19 % more than in 2005. Increase in expenditure on benefits was caused by increase in the average daily income as well as the number of certificates and days for incapacity for work.

1. Health benefits

Table 12. Implementation of the health benefits budget in 2005-2006

Health benefits (in EEK thousand)	2005 actual	2006 budget	2006 actual	2006 actual/ 2006 budget %	2006 actual/ 2005 actual %
Disease prevention	74,436	84,000	77,562	92%	104%
Health services of general medical care	592,155	671,153	666,609	99%	113%
Specialised medical care	3,752,783	4,321,299	4,260,081	99%	114%
Nursing care	113,920	130,750	132,386	101%	116%
Dental care benefits	183,520	200,582	192,925	96%	105%
Total	**4,716,814**	**5,407,784**	**5,329,563**	**99%**	**113%**

In 2006, a total of EEK 5,329 million was spent on health benefits, which is 1% less than the estimated budget. The main reasons for the underspending of budget funds are the limited capacity of health service providers and arising from that, failure to comply with the capacities of contracts for financing medical treatment. Nursing care is the only health service type, where the projected budget resources were used in full, as the providers of health services have had sufficient capacity to meet the demand. Compared to 2005, expenditure on health services increased by 13%, i.e. by EEK 613 million, whereas the increase was the biggest (16%) in nursing care.

Table 13. Expenditure on outpatient and inpatient health services 2005-2006

Outpatient and inpatient (in EEK thousand)	2005 actual	2006 actual	2006 actual/ 2005 actual %
Disease prevention	74,436	77,562	104%
General medical care	592,155	666,609	113%
Outpatient specialised medical care	1,159,411	1,364,234	118%
Centrally contracted outpatient health services	27,224	40,862	150%
Outpatient nursing care	15,435	19,092	124%
Dental care benefits	183,520	192,925	105%
Total benefits for outpatient health services	**2,052,181**	**2,361,284**	**115%**
Centrally contracted inpatient health services	33,489	19,246	57%
Inpatient specialised medical care	2,435,521	2,738,601	112%
Inpatient nursing care	98,485	113,294	115%
Expenditure on emergency response	97,138	97,138	100%
Total benefits for inpatient health services	**2,664,633**	**2,968,279**	**111%**
Total benefits for outpatient and inpatient health services	**4,716,814**	**5,329,563**	**113%**
Proportion of benefits for outpatient health services	43.5%	44.3%	0.8%
Proportion of benefits for inpatient health services	56.5%	55.7%	-0.8%

Proportion of outpatient health services in the expenditure of health services was 44.3% in 2006, compared to 2005 it has increased by 0.8%.

Disease prevention

Disease prevention is concerned with screening for early detection of pre-disease conditions and application of preventive measures. The cause/effect relationship of prevention activities cuts the EHIF expenditure on the treatment of specific diagnoses. Of EEK 84 million budgeted for disease prevention, the EHIF spent EEK 77,562 thousand, which accounts for 92 % of the estimated amount.

Table 14. Disease prevention projects and other prevention activities 2005-2006

Prevention activities (in EEK thousand)	2005 actual	2006 budget	2006 actual	2006 actual/ 2006 budget %	2006 actual/ 2005 actual %
School health	38,374	42,086	40,553	96%	106%
Reproductive health of young people	6,528	7,804	7,753	99%	119%
Early detection of breast cancer	8,938	10,503	9,874	94%	110%
Screening for phenylketonuria and hypothyrosis	1,061	1,260	1,233	98%	116%
Prenatal diagnosis of hereditary diseases	10,355	9,472	10,077	106%	97%
Early detection of osteoporosis	850	927	829	89%	98%
Prevention of heart diseases	2,449	5,401	2,432	45%	99%
Immunization against hepatitis B	3,145	305	35	11%	1%
Early detection of cervical cancer	1,558	3,570	2,336	65%	150%
Hearing screening for newborns	1,178	2,375	2,034	86%	173%
Other prevention activities	0	297	406	137%	0%
Total	**74,436**	**84,000**	**77,562**	**92%**	**104%**

Need for prenatal diagnosis of hereditary diseases was significantly bigger than planned. This can be explained by increased awareness, coverage level and age of women giving birth.

Lower completion of the project on osteoporosis prevention was due to the specific nature of the target group and the availability of testing opportunities in Tallinn, Tartu and Pärnu.

All family physicians had the opportunity to participate in prevention projects of heart diseases in 2006. The number of family physicians who participated in the project was still moderate, 221 different health care institutions participated in the project, due to that the capacity of actual activities was significantly smaller.

Immunization against hepatitis B was carried out mostly for students of faculty of medicine. Funds were planned for the immunization of students of medical schools.

Underspending on the projects on early cervical cancer detection can be explained by the fact that due to low medical awareness, only 31% of women who received an invitation participated in the project.

Underspending on hearing screening of newborns is due to a decreased need for supplementary testing.

Table 15. Results of the disease prevention programmes in 2005-2006

Prevention activity	Target group covered 2005	Target group planned 2006	Target group covered 2006	% of the covered target group	Results
Health care at schools	193,659	192,700	184,335	96%	By the end of the first half-year, school health council had been formed in 29% of schools, by the end of the second half-year the respective indicator was 34%. At the end of the year, 11 schools did not have a school health contract.
Prevention of cardiovascular diseases (CVD)	12,743	41,150	16,226	39%	CVD risk was observed in one out of every 4 men and in one out of every 5 women; non-medical or medical imposing of risk factors was initiated for 46% of people who participated in the project, reduction of the CVD risk in the course of the project over 4%
Reproductive health of young people and prevention of sexually transmitted diseases (STD)	26,070	26,000	27,763	107%	Proportion of primary appointments was 26% (12% being young men), male patients 5.2% and non-Estonians 22%. SDT screening was carried out in 35% and sexual consulting in 65% of the visits. A STD was detected on 610 occasions (6% of screened patients), incl. two cases of HIV. Pregnancy was detected on 110 occasions and 216 women were referred for abortion in the age group of up to 19 years.
Early detection of breast cancer	20,165	23,000	23,170	101%	589 screened women (2.5%) were referred for differential diagnostics. 87 cases of cancer were detected, of which early-stage cancer accounted for 72%.
Screening for phenylketonuria and hypothyrosis	14,838	15,000	14,081	94%	Phenylketonuria was detected on time on one patient and hypothyrosis on seven children.
Prenatal diagnosis of hereditary diseases	2,174	1,580	1,950	123%	45% of screenings was carried out due to age risk. Fetal chromosome abnormality was detected in) 58 cases (3%
Early detection of osteoporosis	1,385	1,500	1,368	91%	Osteoporosis was detected in 29% and osteopenia in 47% of screened persons. 98% of repeatedly screened persons consumed calcium and vitamin D products.
Immunization against hepatitis B, 2nd half-year	13,311	1,900	364	19%	Mainly carried out among students of faculty of medicine.
Early detection	6,694	16,000	9,410	59%	Pre-cancer condition or cancer was detected in 528 women, i.e. 6% of screened females.
Hearing screening of newborns	7,669	11,000	10,028	91%	13 deviations from the standard were observed in the course of the screening. Three children whose deviation from the standard was observed in the 2005 screening have received inner ear implants.

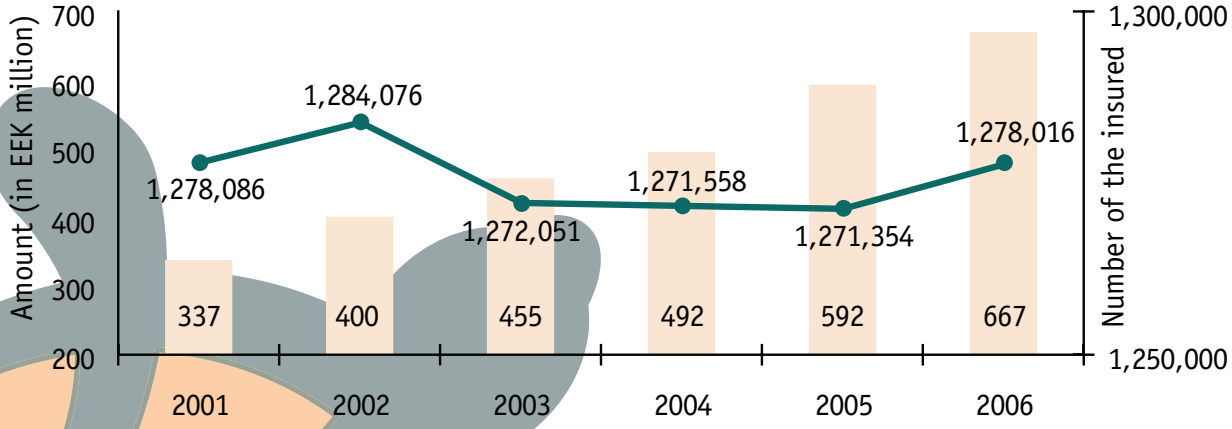
Primary health care

Expenditure on primary health care amounted to EEK 666,609 thousand in 2006. Compared to 2005, the expenditure has increased by 13 % or EEK 74,454 thousand. Increase in the expenditure was due to rise in the reference prices for capitation fees of family physicians, in conformity with wage settlement with medical professionals, as well as due to increase in the funds of the medical tests fund in order to provide family physicians with financial opportunities for the better prevention of diseases and monitoring of chronic patients pursuant to the performance bonus project, launched in 2006.

Table 16. Expenditure on primary health care in 2005-2006

Budget for general medical services (in EEK thousand)	2005 actual	2006 budget	2006 actual	2006 actual/2006 budget %	2006 actual/ 2005 actual %
Base fee	62,525	63,831	63,238	99%	101%
Distance allowance	2,686	2,691	2,662	99%	99%
Qualification allowance	9,384	9,612	9,475	99%	101%
Capitation fee (under age 2)	17,991	22,702	21,175	93%	118%
Capitation fee (aged 2 -70)	355,877	395,650	396,832	100%	112%
Capitation fee (over age 70)	58,579	66,978	67,258	100%	115%
Medical tests fund	82,710	100,302	99,867	100%	121%
General medical care reserve (Advisory Line 1220)	2,403	9,387	6,102	65%	254%
Total	**592,155**	**671,153**	**666,609**	**99%**	**113%**

Chart 5. Number of the insured and expenditure on primary health care in 2001-2006



The distance allowance was paid in 2006 to 197 family practices. The implementation rate of the capitation fee budget in 2006 was almost 100 %, whereby the amount paid as capitation fee increased due to the rising reference price by EEK 52,818 thousand or 12 %, compared to 2005. The medical tests fund budget was implemented 100 %, only EEK 435 thousand of the fund budget remained unused. The reasons for this unused balance are varied and relate to the differences in the location and patient list composition of practices. Compared to 2005, the use of the medical tests fund by family physicians grew by 21 % or EEK 17,157 thousand. Since the price of health care services increased by about 10 %, the growing use of the medical tests fund is largely caused by the greater number of services provided to the insured. In 2006, some 789 physicians or 100% of family physicians maintaining a patient list received the family physician qualification allowance.

Table 17. Primary health care in 2005-2006

Number of family practices and patients	2005 actual	2006 budget	2006 actual	2006 actual/ 2006 budget %	2006 actual/ 2005 actual %
Base fee (practices)	788	803	789	98%	100%
Distance allowance (practices)	196	197	197	100%	101%
Qualification allowance (practices)	782	803	789	98%	101%
Capitation fee (under age 2) (persons)	25,187	26,586	29,000	109%	115%
Capitation fee (aged 2 -70) (persons)	1,093,993	1,096,998	1,095,511	100%	100%
Capitation fee (over age 70) (persons)	153,002	153,087	153,505	100%	100%
Patients (insured) in total	1,271,354	1,276,671	1,278,016	100%	101%
Average patient list (persons)	1,613	1,585	1,617	102%	100%

The average list size per family physician was 1,617 persons in 2006, which has increased by 4 persons compared to 2005. At the end of 2006, there were 47 lists with fewer than 1,200 patients (incl. 7 lists with less than 1,000 patients due to the size of the area) and 177 lists with above 2,000 patients (incl. 47 lists with above 2,300 patients and one list with over 3,000 patients). Most of the biggest family practices with the list of above 2,300 patients are in Pärnu region. Of 789 family physicians, 495 presented the lists of chronic patients to the Health Insurance Fund for the allocation of performance bonus. Therefore, already in the very first year of the introduction of performance bonus, 62% of family physicians have engaged more actively in prevention activities among the patients in their list as well as in monitoring chronic patients.

Table 18. Appointments by family physicians in 2001-2006

Appointments, practices	2001	2002	2003	2004	2005	2006
Appointments by family physicians (total number)	4,338,268	3,987,121	3,935,504	4,194,373	4,513,223	4,828,955
Total family practices	668	813*	820*	783	788	789
Appointments per family physicians per year	6,494	4,904	4,799	5,357	5,727	6,120
Appointments per family physicians per month	546	413	400	446	477	510
Appointments per family physicians per day	25	19	18	20	22	23

* In the annual reports for 2002 and 2003, the number of family practices is given as the number of paid base fee, which is why the given numbers reflect the number of a 1.5-fold base fee.

In 2006, the average number of appointments made by a family physician was 23 (primary, subsequent and preventive), plus 3.6 home visits per week or 0.7 home visits per day. On the basis of information concerning appointments of family physicians in 2006, it should be noted that family physicians have begun to apply the independent work of family nurses. The Family Physicians' Advisory Line 1220 that was launched in the third quarter of 2005 has been operation all through the year 2006. A total of 138,868 calls were received, i.e. an average of 380 calls a day.

Specialized medical care

The expenditure of the EHIF for specialized medical care services amounted to EEK 4,260 million in 2006, of which the EHIF assumed an obligation to pay for 99 % of outpatient and inpatient (incl. emergency response expense) specialised medical care cases and for 1 % of centrally contracted health services.

Outpatient and inpatient specialized medical care (excl. centrally contracted health services)

In 2006, the Health Insurance Fund paid EEK 4,199,973 thousand for outpatient and inpatient specialized medical care services, which is 0.9% or ca EEK 40 million less than the budget projected for this period and 14% more than the 2005 budgetary expenses.

Through contracts for financing health services , 32% of said expenses were directed at financing outpatient (incl. day cases) and 68% for financing inpatient specialized medical care services. Comparing the distribution of outpatient and inpatient expenses to that of previous years (2005 and 2004: 31% and 69%; 2003: 29% and 71%), it can be said that the proportion of outpatient (incl. day cases) expenses has increased gradually, simultaneously with the decrease in the proportion of inpatient expenses. This implies a more effective use of resources as well as effective diagnosis and treatment methods preferably in the conditions of outpatient care or day cases. Financial resources of the budget were spent on financing ca 2.8 million treated cases, 91% of which were outpatient (incl. day cases) and 9% inpatient cases.

The supplementary budget adopted in 2006 directed ca EEK 110 million for the financing of outpatient and inpatient treated cases as well as for the improvement of access to health services. A more detailed expenditure of resources and distribution of treated cases by specialty are given in the two following tables.

Table 19. Expenditure on outpatient and inpatient specialized health services by specialty (incl. emergency response expense), 2005-2006

Total specialized medical care by specialty % (in EEK thousand)	2005 actual	2006 budget	2006 actual	2006 actual/2006 budget %	2006 actual /2005 actual
Surgery	785,370	885,850	867,389	98%	110%
outpatient	112,857	127,131	134,028	105%	119%
day cases	27,677	31,028	30,634	99%	111%
inpatient	644,836	727,691	702,727	97%	109%
Othorinolaryngology	111,512	141,056	129,308	92%	116%
outpatient	43,157	51,308	49,450	96%	115%
day cases	12,554	17,157	19,191	112%	153%
inpatient	55 801	72,591	60,667	84%	109%
Neurology	111,877	124,454	126,142	101%	113%
outpatient	49,312	52,951	56,049	106%	114%
day cases	1	0		2	200%
inpatient	62,564	71,503	70,091	98%	112%
Ophthalmology	137,028	155,837	165,585	106%	121%
outpatient	60,695	67,297	74,272	110%	122%
day cases	65,533	71,465	79,542	111%	121%
inpatient	10,800	17,075	11,771	69%	109%
Orthopaedics	320,784	377,226	362,622	96%	113%
outpatient	65,119	66,212	74,897	113%	115%
day cases	16,662	20,055	19,827	99%	119%
inpatient	239,003	290,959	267,898	92%	112%
Oncology	251,918	283,555	262,542	93%	104%
outpatient	100,114	114,398	112,673	98%	113%
inpatient	151,804	169,157	149,869	89%	99%
Obstetrics and gynaecology	398,778	450,229	452,621	101%	114%
outpatient	173,735	190,438	192,270	101%	111%
day cases	24,042	23,903	25,111	105%	104%
inpatient	201,001	235,888	235,240	100%	117%

Total specialized medical care by specialty % (in EEK thousand)	2005 actual	2006 budget	2006 actual	2006 actual/2006 budget %	2006 actual /2005 actual
Pulmonology	97,696	115,830	115,004	99%	118%
outpatient	34,507	44,658	49,974	112%	145%
inpatient	63,189	71,172	65,030	91%	103%
Dermato-venerology	41,085	48,552	48,641	100%	118%
outpatient	31,809	37,260	38,533	103%	121%
day cases	577	604	564	93%	98%
inpatient	8,699	10,688	9,544	89%	110%
Paediatrics	167,965	200,038	184,651	92%	110%
outpatient	36,967	40,120	40,050	100%	108%
day cases	3,863	4,541	4,527	100%	117%
inpatient	127,135	155,377	140,074	90%	110%
Psychiatrics	161,241	195,758	195,905	100%	121%
outpatient	34,874	54,284	47,556	88%	136%
day cases	877	1,397	788	56%	90%
inpatient	125,490	140,077	147,561	105%	118%
Infectious diseases	51,101	58,803	60,777	103%	119%
outpatient	11,747	12,707	14,189	112%	121%
inpatient	39,354	46,096	46,588	101%	118%
Internal diseases	880,692	1,008,776	1,034,625	103%	117%
outpatient	182,910	188,173	217,573	116%	119%
day cases	35,709	59,479	41,248	69%	116%
inpatient	662,073	761,124	775,804	102%	117%
Follow-up care	7,354	9,020	10,835	120%	147%
inpatient	7,354	9,020	10,835	120%	147%
Rehabilitation	64,977	79,366	78,516	99%	121%
outpatient	28,559	32,919	33,614	102%	118%
inpatient	36,418	46,447	44,902	97%	123%
Unspecified specialties	5,554	7,677	7,672	100%	138%
outpatient	5,554	7,677	7,672	100%	138%
Total	**3,594,932**	**4,142,027**	**4,102,835**	**99%**	**114%**
Total outpatient	971,916	1,087,533	1,142,800	105%	118%
Total day cases	187,495	229,629	221,434	96%	118%
Total inpatient	2,435,521	2,824,865	2,738,601	97%	112%
Emergency response expense	97,138	98,213	97,138	99%	100%
Total specialized health services (excl. centrally contracted health services)	**3,692,070**	**4,240,240**	**4,199,973**	**99%**	**114%**

Table 20. Caseload in outpatient and inpatient specialised health services

Cases in specialized medical care by specialty	2005 actual	2006 budget	2006 actual	2006 actual/2006 budget %	2006 actual/2005 actual %
Surgery	341,976	347,996	354,479	102%	104%
outpatient	286,826	290,192	297,457	103%	104%
day cases	6,589	7,030	8,121	116%	123%
inpatient	48,561	50,74	48,901	96%	101%
Othorinolaryngology	190,888	204,222	200,208	98%	105%
outpatient	174,446	183,519	182,005	99%	104%
day cases	3,386	4,466	4,544	102%	134%
inpatient	13,056	16,237	13,659	84%	105%
Neurology	129,494	130,941	130,155	99%	101%
outpatient	122,494	123,340	123,120	100%	101%
day cases	3	0	2	-	67%
inpatient	6,997	7,601	7,033	93%	101%

Cases in specialized medical care by specialty	2005 actual	2006 budget	2006 actual	2006 actual/2006 budget %	2006 actual/2005 actual %
Ophthalmology	284,314	303,535	324,815	107%	114%
outpatient	275,240	292,973	313,893	107%	114%
day cases	7,611	8,164	9,406	115%	124%
inpatient	1,463	2,398	1,516	63%	104%
Orthopaedics	234,656	219,915	249,199	113%	106%
outpatient	219,973	203,255	232,830	115%	106%
day cases	2,732	3,237	3,406	105%	125%
inpatient	11,951	13,423	12,963	97%	108%
Oncology	75,702	81,748	75,923	93%	100%
outpatient	67,006	72,520	67,171	93%	100%
inpatient	8,696	9,228	8,752	95%	101%
Obstetrics and gynaecology	484,206	492,020	489,662	100%	101%
outpatient	433,007	439,307	436,848	99%	101%
day cases	13,691	13,327	15,041	113%	110%
inpatient	37,508	39,386	37,773	96%	101%
Pulmonology	54,527	55,396	57,744	104%	106%
outpatient	51,250	51,940	54,415	105%	106%
inpatient	3,277	3,456	3,329	96%	102%
Dermato-venerology	156,561	159,128	159,893	100%	102%
outpatient	154,595	157,055	158,034	101%	102%
day cases	358	362	292	81%	82%
inpatient	1,608	1,711	1,567	92%	97%
Paediatrics	143,088	146,549	139,234	95%	97%
outpatient	114,875	117,958	109,594	93%	95%
day cases	1 628	1,753	1,690	96%	104%
inpatient	26,585	26,838	27,950	104%	105%
Psychiatrics	187,877	189,822	196,378	103%	105%
outpatient	176,511	178,124	184,929	104%	105%
day cases	261	367	175	48%	67%
inpatient	11,105	11,331	11,274	99%	102%
Infectious diseases	22,118	22,786	25,090	110%	113%
outpatient	12,653	12,924	15,027	116%	119%
inpatient	9,465	9,862	10,063	102%	106%
Internal diseases	351,914	363,558	376,243	103%	107%
outpatient	295,237	303,619	317,358	105%	107%
day cases	2,002	2,648	2,127	80%	106%
inpatient	54,675	57,291	56,758	99%	104%
Follow-up care	1,123	1,268	1,535	121%	137%
inpatient	1,123	1,268	1,535	121%	137%
Rehabilitation	43,598	47,898	52,350	109%	120%
outpatient	38,069	41,528	46,025	111%	121%
inpatient	5,529	6,370	6,325	99%	114%
Unspecified specialties	14,537	14,746	17,093	116%	118%
outpatient	14,537	14,746	17,093	116%	118%
Total cases	**2,716,579**	**2,781,528**	**2,850,001**	**102%**	**105%**
Total outpatient	2,436,719	2,483,000	2,555,799	103%	105%
Total day cases	38,261	41,354	44,804	108%	117%
Total inpatient	241,599	257,174	249,398	97%	103%

Regarding the proportion of expenditure on outpatient and inpatient (incl. emergency response expense) specialised health services in 2006 there has been an underspending of 1%, or ca EEK 40 million. By type of health service there has been an underspending of 3%, or ca EEK 86 million, in inpatient specialised health services , and underspending of 4%, or EEK 8 million, in day care. However, there has been an overspending of 5%, or EEK 55 million, in outpatient specialised health services . Irrespective of the fact that the budget of the Health Insurance Fund contained a sufficient amount of financial resources, the providers of health services could not realise its usage through contracts for financing medical treatment. The main reasons for the incomplete implementation of the budget are the shortage of capacity of providers of health services (this includes both the limited amount of human resources and infrastructure) as well as patients' choices regarding the appointments with certain doctors.
The following table gives an overview of the major implementation indicators for inpatient and outpatient specialised health services .

Table 21. Major indicators for therapeutic services in outpatient (O) and inpatient (I) specialized health services (excl. emergency response expense) in 2005 and 2006

Indicator		2005 actual	2006 actual	2006 actual/ 2005 actual %
Treatment cost (in EEK thousand)	O	1,159,411	1,364,234	118%
	I	2,435,521	2,738,601	112%
Number of cases	O	2,474,980	2,600,603	105%
	I	241,599	249,398	103%
Average cost per case (EEK)	O	468	525	112%
	I	10,079	10,981	109%
Hospital patient days	I	1,677,449	1,579,573	94%
Average length of stay (days)	I	6.9	6.3	91%
Persons treated	O	754,066	772,978	103%
	I	165,756	169,802	102%
Outpatient appointments	O	3,411,785	3,536,036	104%
Ratio of outpatient appointments to treated cases	O	1.38	1.36	99%
Ratio of outpatient appointments to treated persons	O	4.52	4.57	101%
Emergency care as a percentage of treatment cost	O	15.2	15.6	103%
	I	64.6	63.2	98%
Emergency care as a percentage of treated cases	O	15.2	16.6	109%
	I	59.1	58.6	99%
Surgeries	O	47,992	57,137	119%
	I	94,870	97,224	102%

In 2006, the **average cost of a treated case (ACTC)** has increased both in outpatient and inpatient specialised health services, by 12% and 9%, respectively. The increase is mainly due to the new reference prices for health services that took effect in 2006. Additionally, the increase in ACTC has been influenced by the structural increase accompanying the development of medical technology and treatment options.
Compared to 2005, the **average length of stay in hospital** is somewhat shorter in 2006. Upon observing the average length of stay in hospital, it can be said that soon there will be no supplementary resources to noticeably shorten the duration of treatment. Corresponding to this, the number of inpatient bed days has also decreased. Compared to 2005, said number has decreased by ca 6%.

Compared to 2005, the number of persons using outpatient (incl. day care) and inpatient specialised health services has increased in 2006. In the case of outpatient services said increase has also been accompanied by financing of additional treated cases. In the case of inpatient services, the number of treated cases has increased by 3% and the number of persons receiving treatment has increased by 2%. The insured persons have received treatment during a shorter average period than before, which is also implied by the decrease in the number of inpatient bed days and shortening of the average length of stay in hospital.

The number of **outpatient appointments** continues to increase gradually. This is first and foremost due to a rise in the number of outpatient treated cases, which in the comparison of 2006 and 2005 has been 5%. The number of outpatient appointments per one person has increased somewhat.

Compared to the previous calendar year, the **percentage of emergency care** in treatment cost and treated cases has changed differently regarding both outpatient and inpatient specialised health services . The proportion of outpatient emergency care services has increased simultaneously with a decrease in the proportion of emergency hospital care.

The **number of surgeries** also increases by the year. Compared to 2005 the number of surgeries has increased by a total of 8% or by ca 11,500 surgeries in 2006. The proportion of outpatient surgeries (incl. day surgeries) has increased by approximately one fifth. The number of inpatient surgeries has increased by 2%. Most surgeries are still carried out in inpatient conditions but the proportion of outpatient surgeries (incl. day care) constantly changed to the favour of outpatient surgeries. In 2006, 37% of all surgeries were outpatient or day surgeries and 63% were inpatient surgeries. In the past few years, the proportion of outpatient surgeries (incl. day surgeries) has increased as follows: 2001:27%, 2002:30%, 2003:31%, 2004:31%, 2005:34%.

Special cases

To ensure the purposeful financing of certain services and access to said services, the Health Insurance Fund, in the process of budget planning, pays special attention to positions we call special cases. Special cases include surgeries of endoprostheses and cataracts, deliveries and cardiac surgeries. The following table gives an overview of the financing of 2006 special cases in comparison with 2005.

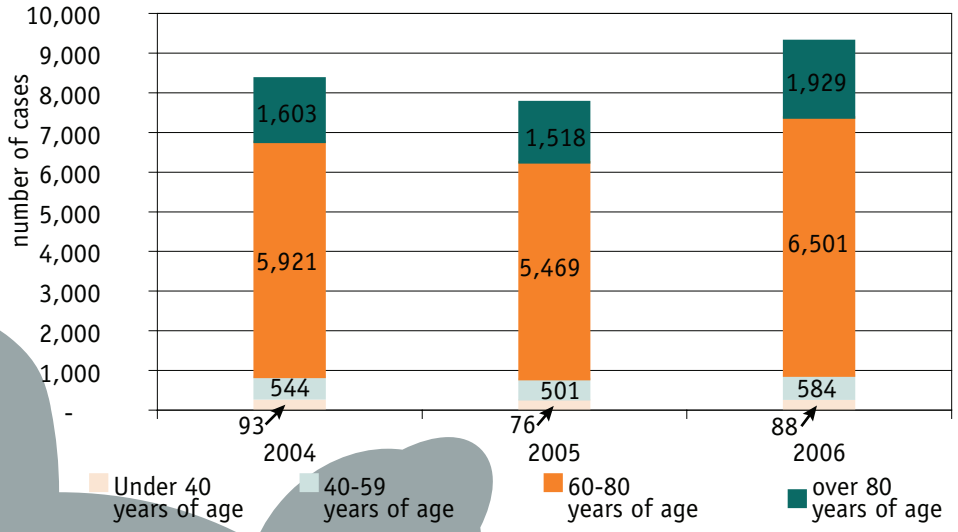
Table 22. Actual use of funds for special cases and the effective caseload, 2005-2006

Special cases	2005 actual		2006 actual		2006 actual/ 2005 actual %	
	treated cases	treatment cost (in EEK thousand)	treated cases	treatment cost (in EEK thousand)	treated cases	caseload
Endoprostheses	2,461	114,975	2,643	128,824	107%	112%
Cataract operations	7,565	66,223	9,102	78,967	120%	119%
Cardiac surgeries	767	87,455	1,062	127,433	138%	146%
Deliveries	12,618	91,427	14,573	126,782	115%	139%

1,062 cardiac surgeries were performed in 2006, which is 38% more than in 2005. Such a big increase is not a trend but caused by the decrease of cardiac surgeries in 2005, compared to 2004. In comparison to 2004, the proportion of surgeries has increased by approximately a quarter in 2006. In 2006, the EHIF paid EEK 127 million for cardiac surgeries. Increase in comparison with 2005 was 46%.

Ca 89-91% of special cases in **endoprosthetic surgery** over the years is related to endoprosthesis of hip and knee joints, 8-10% is related to half-prostheses and 1% to endoprosthesis of the ulna or knee joint. During the past three years, the proportion of hip prostheses has decreased by 1-2%, simultaneously with an increase in the proportion of knee prostheses. If in 2004, the number of knee prostheses surgeries during a year was smaller than the number of hip prostheses surgeries, then in 2006 it was the other way round. The number of upper arm and elbow joint prostheses surgeries is also increasing, exceeding the limit of 1% of the proportion of all endoprostheses in 2006. Upon observing the patients' distribution by age it can be seen that 82-83% of endoprosthetic surgeries are performed on persons 60 years of age or older. Compared to 2005, the number of operated persons who were 80 years of age or older increased by 3%. On the average, five persons in a hundred received more than one prosthesis in 2006. The respective figure for 2004 and 2005 was three persons in a hundred.
The number of **cataract operations** has varied during the years but is still increasing on a longer timeline. Compared to 2004, the number of cataract operations decreased by 600 in 2005. 2006, however, saw the addition of 1,500 operations, which is 20% more than in the previous calendar year. The number of operations has increased in all age groups but mostly in the age groups of 60-80 year olds (19% increase) and over 80 year olds (27%).

Chart 6. Number of cataract operations and distribution by age in 2004-2006.



Centrally contracted health services

In 2006, the Health Insurance Fund paid EEK 60,108 thousand for centrally contracted health services (74 % of the amount projected for the year).

Table 23. Implementation of the budget for centrally contracted health services 2005-2006

Centrally contracted health services (in EEK thousand)	2005 actual	2006 budget	2006 actual	2006 actual/ 2006 budget %	2006 actual/ 2005 actual %
Bone marrow transplants	5,384	8,181	9,499	116%	176%
Elective treatment in a foreign state	13,094	15,300	6,455	42%	49%
Peritoneal dialysis	22,733	24,400	23,077	95%	102%
Emergency transportation of the insured (airplane, helicopter)	1,733	2,500	1,703	68%	98%
Medical check-ups for young athletes	4,491	5,500	4,592	83%	102%
Haematological treatment sessions	9,708	14,000	10,802	77%	111%
Antidotes and serums	200	200	200	100%	100%
Risk balance		0	6,4650	0%	
Artificial urinary sphincters	587	587	587	100%	100%
Cochlear implants	2,783	2,226	2,505	113%	90%
Pathoanatomical autopsy		1,700	688	40%	
Total	**60,713**	**81,059**	**60,108**	**74%**	**99%**

Incomplete implementation of the budget reserved for the services of peritoneal dialysis, medical check-ups for young athletes and haematological treatment sessions as well as elective treatment in a foreign state, is mostly due to lower cost per case than intended. The lower cost of cases of haematological treatment sessions was caused by a delay in the planned expensive treated case (elective surgery and post-surgery treatment of a patient with blood coagulation problems).
Owing to the opportunities to move freely in the Member States of the EU, the EHIF projected a rise regarding the elective treatment in a foreign state in 2006 in both the number of applicants for elective treatment in a foreign state and in the average cost of one case. However, actual need has been modest: in the accounting period the EHIF assumed responsibility for paying for the treatment of 59 persons in a foreign state. Invoices were received for the treatment of 59 persons (incl. 26 children). The EHIF has yet to receive the heart transplantation invoice planned for 2006.
Incomplete implementation of the budget for emergency transportation of the insured and pathoanatomical autopsies in centrally contracted health services is caused by the lower number of treated cases than projected.
Demand for bone marrow transplants and cochlear implants in 2006 proved to exceed the proposed budget, and these services were paid for on the account of unused risk balance funds.

Table 24. Implementation of the caseload of centrally contracted health services in 2005-2006 (CL – caseload, ACPC - average cost per case)

Centrally contracted health services	2005 actual CL*	2005 actual ACPC*	2006 actual CL	2006 actual ACPC	2006 actual/ 2005 actual % CL	2006 actual/ 2005 actual % ACPC
Bone marrow transplants	50	107,680	63	150,778	126%	140%
Elective treatment in a foreign state	53	247,053	59	109,407	111%	44%
Peritoneal dialysis	843	26,966	856	26,959	102%	100%
Emergency transportation of the insured (airplane, helicopter)	76	22,802	84	20,274	111%	89%
Medical check-ups for young athletes	7,508	598	8,922	516	119%	86%
Haematological treatment sessions	243	39,950	274	39,423	113%	99%
Antidotes and serums	2	100,000	2	100,000	100%	100%
Artificial urinary sphincters	7	83,815	7	83,815	100%	100%
Cochlear implants	10	278,307	9	278,307	90%	100%
Pathoanatomical autopsy	0	0	423	1,628	0%	0%

* For the comparison of caseload and average cost per case, the caseload in the 2005 data has been adjusted correspondingly with the definition of 2006 caseload. (In 2005, caseload corresponded to the number of persons treated; in 2006 a single submitted medical bills is regarded as caseload of centrally contracted health services.)

Nursing care

In 2006, the EHIF paid EEK 132,386 thousand for nursing care, exceeding the projected budget by 1 %.

Table 25. Implementation of the budget for nursing care in 2005-2006

Outpatient and inpatient nursing care (in EEK thousand)	2005 actual	2006 budget	2006 actual	2006 actual /2006 budget %	2006 actual /2005 actual %
Inpatient nursing care	98,485	113,258	113,294	100%	115%
Outpatient nursing care, incl.	15,435	17,492	19,092	109%	124%
home nursing	11,943	13,513	16,470	122%	138%
home care for cancer patients	2,663	3,013	1,769	59%	66%
geriatric assessment	829	966	853	88%	103%
Total	**113,920**	**130,750**	**132,386**	**101%**	**116%**

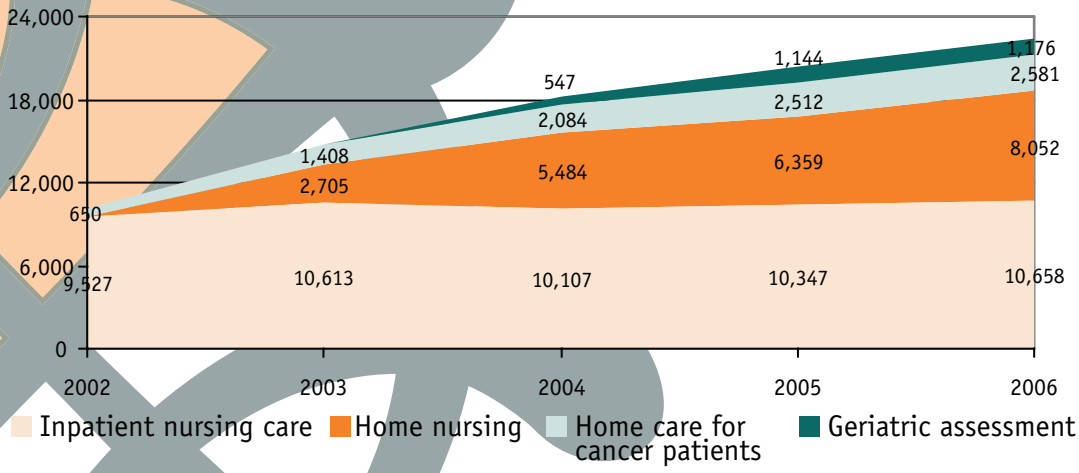
Overspending on nursing care services in 2005 is mainly due to the conditions established in the wage settlement entered into between the Government of the Republic, the Estonian Hospitals Association and the Estonian Medical Association which specified rise in the reference prices, including reference prices of a nursing day by 18 %.
In 2001-2006, the overall expenditure on nursing care has increased by nearly EEK 84,385 thousand, whereas the proportion of out-patient nursing care has developed particularly fast. In 2006, the geriatric assessment service, introduced in 2004, was provided for a total of EEK 853 thousand in total, which is over two times more than in 2004.

Table 26. Caseload (CL) and average cost per case (ACPC) in nursing care in 2005-2006.

Nursing care services	2005 actual CL	2005 actual ACPC	2006 actual CL	2006 actual ACPC	2006 actual/ 2005 actual % CL	2006 actual/ 2005 actual % ACPC
Inpatient nursing care	10,347	9,518	10,658	10,630	103%	112%
Outpatient nursing care, incl.	10,015	1,541	11,809	1,617	118%	105%
home nursing	6,359	1,876	8,052	2,045	127%	109%
home care for cancer patients	2,512	1,060	2,581	686	103%	65%
geriatric assessment	1,144	725	1,176	725	103%	100%
Total	**20,362**	**5,595**	**22,467**	**5,892**	**110%**	**105%**

Increase in caseload in outpatient home nursing service is also due to revising the definition of home nursing case, resulting from the random sampling carried out by the EHIF in 2004.

Chart 7. Caseload in nursing care in 2002-2006



Regarding the average cost per case in nursing care in 2006, the most noticeable is the increase in the cost of inpatient nursing care: in 2005, the average cost per case was EEK 9,518 and in 2006, it was EEK 10,630, thus the expenditure on a treated patient has increased by 12%.

Dental care

Pursuant to the Health Insurance Act, the EHIF covers the cost of dental services provided to the insured persons under age 19 and to adults in case of emergency dental care.
In 2006, the EHIF paid EEK 192,925 thousand for dental care provided for the insured persons. This forms 96% of the projected budget.

Table 27. Budget for dental benefits, 2005-2006

Dental care (in EEK thousand)	2005 actual	2006 budget	2006/ actual	2006 actual 2006 budget %	2006 actual /2005 actual %
Dental treatment in children	146,071	155,734	151,149	97%	103%
Orthodontia	22,885	27,440	27,414	100%	120%
Dental diseases prevention	8,133	8,239	7,340	89%	90%
Emergency dental care to adults	6,431	9,169	7,022	77%	109%
Total	**183,520**	**200,582**	**192,925**	**96%**	**105%**

In dental treatment in children, the number of treated cases has been exceeded by 1%, compared to the projected amount, whereas the implementation of financial resources spent on paying for treated cases has failed by 3%. This has been caused by treated cases with a lower average cost than projected. The situation is similar in orthodontia, where the number of treated cases projected in the budget has been implemented by 101% and the corresponding resources by 100%. The average cost per orthodontia case was somewhat less than projected. In prevention of dental diseases, underspending for treatment expenses was 11% and 9% for treated cases. This was mainly due to smaller participation of the target group in prevention activities. 2006 underspending in expenditure and caseload for emergency dental care to adults was due to a more strict compliance with service requirements. Inspections of case records carried out by the EHIF to see whether the provided services have constituted as emergency care, have contributed to this.

Table 28. Implementation of the budget for dental benefits caseload, 2005-2006

Number of cases in dental care	2005 actual	2006 budget	2006 actual	2006 actual /2006 budget %	2006 actual /2005 actual %
Dental treatment in children	290,523	284,301	288,467	101%	99%
Orthodontia	33,893	36,057	36,327	101%	107%
Dental diseases prevention	55,816	52,677	47,940	91%	86%
Emergency dental care to adults	23,116	22,305	17,901	80%	77%
Total	**403,348**	**395,340**	**390,635**	**99%**	**97%**

The number of cases in 2006 is 1% less than the number projected in the budget. Decrease in the total amount of treated cases is mainly due to the lower level of prevention of dental diseases. In 2006, to ensure purposeful prevention of dental diseases in children, the EHIF and Estonian Dentists' Society finally agreed upon the content and target groups for prevention activities.

2. Health promotion expenses

The EHIF engages in health promotion activities on the basis of the project which specifies the priorities approved by the Supervisory Board of the EHIF, acting in concert with the Ministry of Social Affairs. Of the total EEK 14 million allocated to health promotion, EEK 12,676 thousand (91 %) was put to use. In 2006, the EHIF financed 49 projects, 14 of which shall still be in effect in the first half-year of 2007.

Table 29. Implementation of the budget for health promotion expenditure and comparison of 2005-2006

Health promotion activity	2004 actual in EEK thousand	2005 actual in EEK thousand	2006 budget in EEK thousand	2006 actual in EEK thousand
1. Total health promotion activities targeted at children	5,226	3,515	4,607	4,146
2. Total health promotion activities targeted at adults	8,254	5,049	9,393	8,530
Prevention of cardio-vascular diseases	2,449	723	904	810
Early detection of malignant tumours	414	380	410	328
Prevention of home and leisure injuries and intoxication	2,950	1,225	2,594	2,075
Prevention of damages to the health caused by alcohol	200	873	2,405	2,285
Projects targeted at various priority areas	2,241	1,848	3,080	3,032
Total	**13,480**	**8,564**	**14,000**	**12,676**

Underspending is due to the fact that the activities of several projects targeted at associated groups planned in the second half-year of 2006, were shifted to the first half-year of 2007.

Table 30. Quantitative indicators for the 2006 project activities

Health promotion activity	2004	2005	2006
People participating in sports, training courses and activities meant for the general public	76,720	5,250	25,100
People in personal counselling	13,740	6,680	4,470
Participants in training for health care professionals	1,540	1,000	600
Participants in training for teaching staff	3,830	1,950	3,300
Participants in training for other associated groups (social workers, managers, project groups)	4,130	1,780	2,440
Different publications 82 23 24			
Full circulation of publications	293,000	277,000	346,500
TV and radio programmes/clips	137	81	19

Health promotion activities which were intended to meet the objectives, were mainly aimed at to target groups˘: schoolchildren and adults. Additional target group defined pregnant, parents of infants and patients with chronic diseases. One reaches the target groups directly via the media or associated groups.
Ca 25,000 people participated in projects targeted at the population in 2006, individual counselling was provided in 4,500 occasions. Most of the financed activities were targeted at associated groups, health councils in schools and counties, and members of working groups. A total of 600 health care professionals and ca 3,300 teachers took part in the trainings; over 2,400 people have participated in the meetings of working groups.
Five different information leaflets have been published with a circulation of 19,600 copies. Through family physicians and hospitals, publications issued at the end of 2005 were distributed to risk groups (five different publications with a circulation of ca 40,000). A special health newspaper has been published 18 times in four different Estonian publications, with much attention paid to the prevention of heart diseases. A film "Pregnancy. Delivery. Breastfeeding.", supporting the activity of family schools, and films "Enemy No. 1" and "Let's Talk About Alcohol", designed for handling the alcohol issue in schools, were produced.

In 2006, six social campaigns were carried out:

- "You Are What You Eat?" (visibility 75%);
- "Exercise is a man's best friend" (86%);
- "Sweets don't make life sweet" (77%);
- "What is your child doing at the moment?" (64%);
- "Enjoy life, don't smoke!" (75%);
- "Smoking causes impotence. Tough men don't smoke!" (78%).

In addition to television and radio clips, instructive materials providing practical tips were communicated through the media and the youth could take part in quizzes on related topics.
A health promotion conference "Human Resource in Public Health" with 175 participants was carried out in cooperation between the Health Insurance Fund and National Institute for Health Development. Health promotion projects carried out in 2005 were also assessed. Financial audit was performed on a total of five projects. The projects' financial resources had been used in a purposeful and proper manner. To assess the system of transition to public procurement, eight health promotion projects were substantially analysed. Generally, project activities were in compliance with plans, proposed substantial recommendations shall be taken into consideration upon planning 2007 activities.

3. Expenditure on benefits for medicinal products

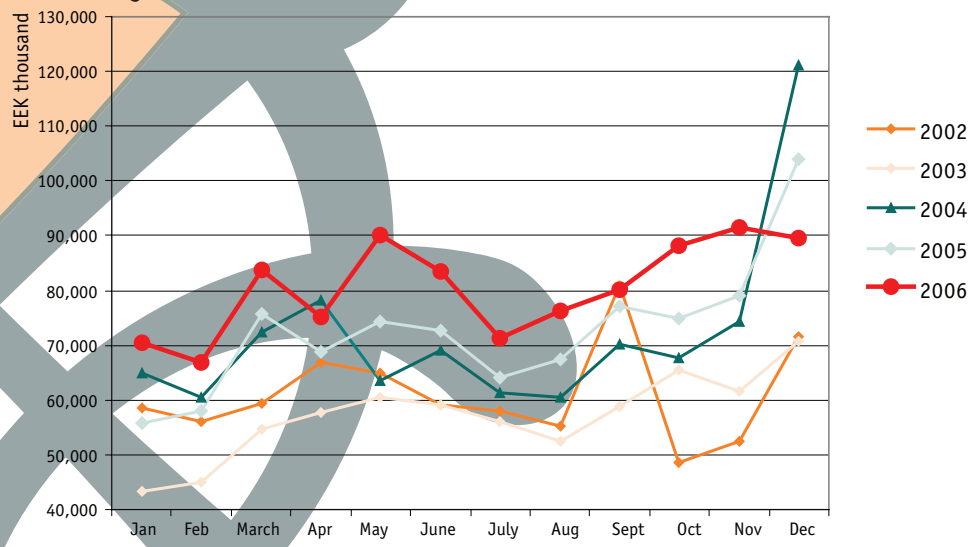
Spending on reimbursed prescription medicinal products is an open commitment for the EHIF. Possible measures for cost-containment, including the lists of illnesses and covered medicinal products, references prices, price agreements, procedure for the prescription and dispense of medicines, mark-up on wholesale and retail, are prescribed by the Ministry of Social Affairs and the Government of the Republic.
In 2006, the overall spending on prescription medicinal products reimbursed for the insured amounted to EEK 966,796 thousand, which exceeds the projected estimate by 0.1 %. Compared to 2005, expenditure on benefits for medicinal products increased by EEK 95,034 thousand.

Table 31. Medicinal products reimbursed for the insured 2005-2006

Percentage of expenditure by reimbursed prescription medicinal products (in EEK thousand)	2005	2006	2006/ 2005 (%)	Medicinal products reimbursed for the insured 2005	2006
Medicinal products reimbursed at 100%	329,540	406,654	123%	37.8%	42.1%
Medicinal products reimbursed at 90%	299,282	289,957	97%	34.3%	30.0%
Medicinal products reimbursed at 75%	69,302	71,239	103%	8.0%	7.4%
Medicinal products reimbursed at 50%	165,954	194,876	117%	19.0%	20.1%
Medicinal products reimbursed under special conditions	7,684	4,070	53%	0.9%	0.4%
TOTAL	**871,762**	**966,796**	**111%**	**100%**	**100%**

Compared to the previous years, increase in the consumption of reimbursed prescription medicinal products is characteristic of the entire year of 2006. Seasonal character, which causes a decrease in the consumption of medicinal products during summer months, was also noticeable in the financial year. However, the amount of medicinal products reimbursed in May is bigger than usual. The probable reason for that is an outbreak of acute virus diseases and treatment of complications in this period, which is confirmed by the fact that the number of certificates of incapacity for work submitted to the EHIF more than doubled in June 2006. In a situation where all medicinal products in the list of medicinal products are reimbursed at 100% for children under 4 years of age, an increase in the number of acute illnesses affects expenditure on reimbursement of reimbursed prescription medicinal products more than prior to the entry into force of the respective amendment to the Act.

Chart 8. Seasonal aspects of expenditure of the EHIF on reimbursed prescription medicinal products by months in 2002-2006



In 2006, the utilization of medicinal products exceeded the previous figures in every way. The reason for the increase due to the fact that the people's consumption habits regarding medicinal products have reached the level of developed countries. Increase in the income of employed inhabitants as well as pensioners due to economic growth also contributes to this situation.
It can be assumed that the number of medicinal products that are not purchased under the prescriptions issued by doctors is smaller than before. Family physicians are of the opinion that the introduction of the system that promotes better monitoring of patients with chronic diseases, has also improved the consistency of treatment. Only in December is the amount of funds spent on the reimbursement of medicinal products less than in 2004 and 2005. This can be explained by the fact that unlike in those years, this December there was no media coverage discussing the increase in the cost of medicinal products and people did not buy in medicinal products but consumed them in a usual manner.
Regularity that prescription medicinal products are used more often in the second and fourth calendar quarter could be also observed in 2006. Quarterly summaries clearly indicate the continuous increase in the use of medicinal products by the population during the past five years. While the expenditure of the EHIF on prescription medicinal products increase by 11%, compared to the previous year, the number of reimbursed prescriptions increased by 8%. The average cost of a reimbursed prescription for the EHIF has increased by 3% and that has happened on the account of two types of reimbursed prescription medicinal products.

Table 32. Number and average cost of reimbursed prescriptions (CP) in 2005-2006

	2005		2006		2006/2005	
Average number and cost of CP	number of CP in EEK	average cost of CP for the EHIF	number of CP in EEK	average cost of CP for the EHIF	number of CP in EEK, %	average cost of CP for the EHIF, %
Reimbursed at 100%	518,992	635	563,593	722	109%	114%
Reimbursed at 90%	1,707,462	175	1,750,253	166	103%	95%
Reimbursed at 75%	398,638	174	433,489	164	109%	94%
Reimbursed at 50%	2,375,510	70	2,645,767	74	111%	106%
TOTAL	**5,000,602**	**173**	**5,393,102**	**179**	**108%**	**103%**

The average cost for the EHIF of a prescription reimbursed at 100% has increased by EEK 87. As the prescriptions concerned are the most expensive, the additional expenses arising from the increase in cost amount to EEK 49 million. Such increase is due to two circumstances: on the positive side the broader use of new and more expensive original medicinal products, and on the negative side the price agreements for expensive medicinal products that have still not been concluded.

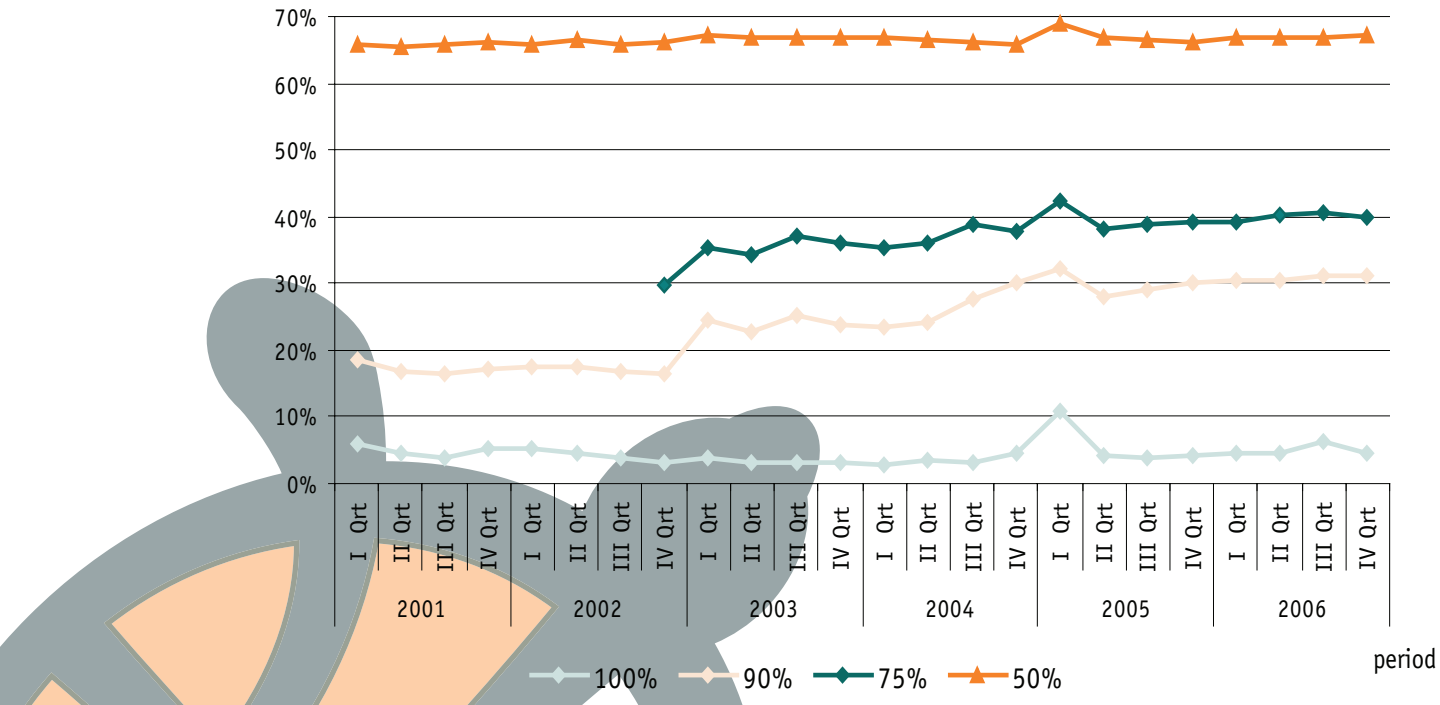
Even though the cost for the EHIF of prescriptions reimbursed at 50% is the smallest, it should be taken into consideration that this type of coverage forms 49% of all reimbursed prescriptions. Thus, the additional expenses arising only from the increase in the average cost of a prescription amount to EEK 10 million. It must be mentioned that through children under the age four, said group of medicinal products also affects the expenditure on medicinal products reimbursed at 100%. For medicinal products reimbursed at 90% and 75% the expenditure of the EHIF remains stable. A positive factor is a decrease in the average cost of a reimbursed prescription, caused by reference prices arising from the wide selection of generic medicinal products. Therefore, the increase in expenditure is only due to the increase in the use of medicinal products. Rise in the number of reimbursed prescriptions in 2005 implies improved access to medicinal products among the population.

Table 33. Average indicators of cost-sharing of the insured upon payment for reimbursed prescription medicinal products, 2005-2006

Cost-sharing of the insured,%	2005	2006	Variation
Reimbursed at 100%	5.6	4.7	-0.9
Reimbursed at 90%	29.8	30.5	0.7
Reimbursed at 75%	39.6	39.7	0.1
Reimbursed at 50%	67.1	66.8	-0.3
TOTAL	**38.0**	**37.8**	**-0.2**
Reimbursed at 75%; 90%; 100%	21.7	20.2	-1.5

When in 2005, the average cost for the insured person of a prescription reimbursed at 90% was EEK 75, then in 2006 the respective figure was EEK 73; the respective figures for a prescription reimbursed at 75% are EEK 114 and 108. The graphic overview clearly shows the stability of the cost-sharing of the insured. The only significant change after the implementation of a new Health Insurance Act is the temporary influence of the change in reference price methodology in the first quarter of 2005.

Chart 9. Cost-sharing of the insured upon payment for reimbursed prescription medicinal products in 2001-2006, by quarters



The biggest expenditure upon reimbursement of prescription medicinal products is still related to the diagnosis of hypertension. However, its proportion has decreased. The fact that number of users and prescriptions of medicinal products for curing hypertension is continuously growing can be seen as a positive trend, whereas the expenditure has been decreasing since 2004. The reason for this is continuous increase in the number of generic medicinal products, wide selection and competition between medicinal products for curing hypertension.
The most intense increase of both users and prescriptions takes place in the medicinal products for diabetes mellitus.
The biggest increase in the cost of a prescription is related to the treatment of cancer (26%), amounting to EEK 2,223.

Table 34. Percentage of the most expensive diagnoses of total expenditure on benefits for medicinal products in 2005-2006

	2005		2006			2006/2005			
Diagnosis	Users	Pres-criptions	Re-imbursed in EEK thousand	% of total amount of expenses on benefits	Users	Pres-criptions	Re-imbursed in EEK thousand	% of total amount of expenses on benefits	Users	Pres-criptions
Hypertonia	207,908	1,193,937	190,531	21.9%	216,584	1,234,734	173,689	18.0%	104%	103%
Diabetes	33,037	151,000	102,472	11.8%	39,441	209,654	132,462	13.7%	119%	139%
Cancer	7,880	33,508	59,021	6.8%	8,421	35,696	79,366	8.2%	107%	107%
Bronchial asthma	24,229	113,418	49,803	5.7%	26,137	120,276	59,149	6.1%	108%	106%
Glaucoma	18,582	85,235	37,578	4.3%	21,048	99,853	48,703	5.0%	113%	117%
Primary hyper-cholestero-lemia	17,432	67,970	30,996	3.6%	18,934	63,799	24,467	2.5%	109%	94%

In summary, when analysing the expenditure on benefits for medicinal products in 2006, it can be pointed out that the usage of medicinal products increased in all types of coverage. The average cost for the EHIF of a reimbursed prescription increased as well, and figures of cost-sharing of the insured person decreased.

4. Expenditure on benefits for temporary incapacity for work

In the 2006 budget EEK 1,513,480 thousand was appropriated for the benefits for temporary incapacity for work. The actual expenditure in 2006 remained within the limits of the projected expenses.

Table 35. Expenditure on benefits for temporary incapacity for work in 2005-2006

Expenditure on benefits for temporary incapacity for work in EEK thousand	2005 actual	2006 budget	2006 actual	2006 actual/ 2006 budget %
Sickness benefits	817,636	947,146	957,692	101%
Nursing benefits	127,114	175,544	162,514	93%
Maternity benefits	297,413	362,731	358,758	99%
Work injury benefits	22,900	28,059	27,391	98%
Total	**1,265,063**	**1,513,480**	**1,506,355**	**100%**

Expenditure on the benefits for temporary incapacity for work has grown by 19% in 2006, which somewhat exceeds the increase in expenditure in the previous year but it is exactly the same as the increase in expenditure in 2003-2004. Of all expenditure on benefits for temporary incapacity for work, sickness benefits account for ca 63%, maternity benefits ca 24%, nursing benefits for 11% and work injury benefits for 2%. The proportion of expenditure on maternity benefits and nursing benefits has increased by 1% since 2005 on the account of sickness benefits. The change in the breakdown of expenditure is due to the increasing birth rate of the past few years.

Table 36. Expenditure on benefits for temporary incapacity for work in 2003-2006

Benefits		2003	2004	2005	2006	2004/ 2003	2005/ 2004	2006/ 2005
Sickness benefit	Number of certificates	382,685	412,363	433,944	469,274	8%	5%	8%
	Number of days	4 732,748	5,222,195	5,454,390	5,751,163	10%	4%	5%
	Benefit amount (in EEK thousand)	604,217	723,458	817,636	957,692	20%	13%	17%
	Average income per day (in EEK)	128	139	150	167	9%	8%	11%
	Average length of sick leave	12.4	12.7	12.6	12.3	2%	-1%	-2%
Maternity benefit	Number of certificates	11,241	11,537	11,441	11,903	3%	-1%	4%
	Number of days	1,252,850	1,356,258	1,414,096	1,515,333	8%	4%	7%
	Benefit amount (in EEK thousand)	204,727	253,219	297,413	358,758	24%	17%	21%
	Average income per day (in EEK)	163	187	210	237	14%	12%	13%
	Average length of sick leave	111.5	117.6	123.6	127.3	5%	5%	3%
Nursing benefit	Number of certificates	69,184	73,325	81,850	96,379	6%	12%	18%
	Number of days	585,269	624,096	691,348	797,316	7%	11%	15%
	Benefit amount (in EEK thousand)	91,877	104,890	127,114	162,514	14%	21%	28%
	Average income per day (in EEK)	157	168	184	204	7%	10%	11%
	Average length of sick leave	8.5	8.5	8.4	8.3	1%	-1%	-1%
Work injury benefit	Number of certificates	6,871	5 863	5,996	6,406	-15%	2%	7%
	Number of days	146,411	118,941	125,314	131,508	-19%	5%	5%
	Benefit amount (in EEK thousand)	23,108	20,413	22,900	27,391	-12%	12%	20%
	Average income per day (in EEK)	158	172	183	208	9%	6%	14%
	Average length of sick leave	21.3	20.3	20.9	20.5	-5%	3%	-2%
Total benefits	Number of certificates	469,981	503,088	533,231	583,962	7%	6%	10%
	Number of days	6,717,278	7,321,490	7,685,148	8,195,320	9%	5%	7%
	Benefit amount (in EEK thousand)	923,929	1,101,980	1,265,063	1,506,355	19%	15%	19%
	Average income per day (in EEK)	138	151	165	184	9%	10%	12%
	Average length of sick leave	14.3	14.6	14.4	14.,0	2%	-1%	-3%

The continued growth in expenditure on benefits for temporary incapacity for work from 2003 to 2006 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

A rise in gross wages over the years, on average by 10% per annum in the observed period[4], has increased the average cost of a day of incapacity for work.

Increase in days of incapacity for work

From 2003 to 2006 the number of days of incapacity for work grew on average by 7%.
The increase in days of incapacity for work has been caused by the number of the employed insured persons[5] increased due to a decrease in unemployment rate, as well as changes in the behaviour of people. In the period of 2003-2006 the number of employed insured persons has increased by ca 15 thousand persons. At the same time, the number of persons registered as unemployed in the Labour Market Board has decreased by ca 18 thousand persons. The number of people consulting health care institutions[6] has increased, and certificates for temporary incapacity for work are being used more often than before. In the period of 2003-2006 the number of certificates for temporary incapacity for work has increased by ca 8%. Employers more frequently turn to the EHIF for the confirmation for the substance of certificates for sick leave issued to employees. In the period of 2003-2006 the average length of certificate for sick leave has decreased by a total of 2%. One of the reasons for this are audits organised on said topic by the EHIF.

Table 37. Number of people covered by health insurance and relationship with the number of working insured from 2003-2006

Average number of persons for period	2003	2004	2005	2006	2004/ 2003	2005/ 2004	2006/ 2005
Number of the insured	1,270,671	1,271,919	1,270,601	1,278,680	0%	0%	1%
Insured in employment	581,186	593,769	611,524	643, 261	2%	3%	5%
Insured in employment as a percentage of all insured	46%	47%	48%	50%			

Sickness benefits

The number of sickness benefit days of incapacity for work increased by 5% in 2006, as compared to 2005 and the average cost of a sickness day increased by 11%. Compared to the increase of days of incapacity for work in 2002-2004, the growth of said days has slowed down somewhat in 2005-2006.
The increase in the number of sickness benefit days of incapacity for work has been caused by the increase in the number of working insured by 5%[7] and increase in the number of treatment cases[8]. Average cost of a day of incapacity for work increases based on the increase in the income taxed with social tax.

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4 As the benefit is calculated on the basis of the income of the previous year, the analysis included the rise in gross wages 2002-2005.

5 See Table 37. Number of people covered by health insurance and relationship with the number of working insured from 2003-2006

6 Compared to 2005, the total number of outpatient appointments has increased by 4%.(See Table 21)

7 See Table 37. Number of people covered by health insurance and relationship with the number of working insured from 2003-2006

8 See Table 21.

In the structure of the use of certificates for sick leave, the main reasons for sick leave include illness (89%), household injuries (9%), and transfer to an easier job (1%). Proportion of certificates issued for other reasons (occupational diseases, injuries in traffic accidents, etc.) is marginal and amounts to 1%. Generally, the structure of certificates for sick leave by reasons for leave has remained relatively stable over the past years. There is a discrepancy in 2006, when the proportion of certificates issued because of household injuries increased by ca 2% compared to 2005. This was due to the increase in the number of traumas in 2006[9].

Table 38. Distribution of certificates for sick leave by age groups in 2003-2006

	Under 19	20-29	30-39	40-49	50-59	60 and older
2003	2%	23%	22%	25%	21%	7%
2004	2%	23%	21%	24%	22%	7%
2005	2%	23%	21%	24%	22%	7%
2006	3%	23%	21%	23%	23%	7%

The age structure of the use of certificates for sick leave in 2003-2006 has remained relatively stable. Since 2006, the number of certificates issued to people belonging to the age groups of under 19 and 50-59 age group has increased by 1% and the number of certificates issued to people belonging to the 40-49 age group has decreased by the same amount. Observing the length of sick leave by age groups it can be said that the leave is the longest, 15 days, in the age group of 60 and older. Such tendency has remained stable for years.
Since 1 May 2004 the benefit for temporary incapacity for work is also paid in the case of illness in foreign states based on the certificate issued by foreign state's doctor. In 2006, EEK 1,129 thousand was paid for benefits for incapacity for work based on certificates issued by foreign state's doctors. Compared to 2005, the expenditure on benefits for incapacity for work based on certificates issued by foreign state's doctors has increased by 50%. This is caused by more frequent cases of illness and injuries in foreign states, owing to livelier tourism.

Maternity benefits

Maternity benefit days of incapacity for work have increased by 7% and the average cost of day by 13%, as compared to 2005. Compared to the previous year, the number of certificates for maternity leave has increased by 460 and the average length of maternity leave has increased by 3%.
The continued increase in the number of days of maternity leave per person is caused by increase in the number of cases of taking the maternity leave in time[10]. The latter is caused by the opportunity of the persons giving birth to choose the option economically more suitable for them from both parental and maternity benefit's point of view[11].
Increase in the expenditure on maternity benefits has been influenced by demographical situation: the average age of women giving birth has increased, as has the number of women at the age of giving birth. Decision of the Government to expand the period of issuing parental benefit surely affects the increase in birth rate too.

9 According to the Estonian Society of Traumatologists and Orthopaedists, the proportion of traumas has increased in 2006, compared to 2005.

10 Pursuant to Holidays Act women have the right for a pregnancy and maternity leave at least 70 calendar days before the assumed due date set by the doctor.

11 Pursuant to Health Insurance Act the number of maternity leave days will be reduced if the maternity leave starts less than 30 days before the assumed due date set by the doctor.

The average cost per day of a maternity benefit continues to be higher than the daily average cost of other types of benefits. According to 2006 data, 58% of women having given birth comprised females of 29 years of age or younger, and 42% was comprised females in the age of 30 and older. The average amount of maternity benefits paid to one person was EEK 30 thousand in 2006. Upon analysing the payments of maternity benefit by age it becomes clear that for women over 30 the payable amount of maternity benefit is an average of EEK 10 thousand bigger than the benefits of women in the younger age group.

Nursing benefits

The number of nursing days has increased by 15% in 2006, as compared to 2005. At the same time, the average cost of a nursing day has increased by 11%. The average cost of a nursing benefit day has been on average EEK 32 higher than the cost of sickness benefit day in the past three years. This is due to the increase in the number of maternity benefits applicants with a higher than average income over the last years. From 2003 to 2006, the average cost of the benefit day of the applicants for maternity benefit has been on average EEK 53 higher than the average cost of sickness benefit day. At the same time this indicator increased by an average of 13%. Returning from parental leave, the women who have given birth are the potential users of certificates for care leave, which is why the daily earnings of nursing benefits are expected to increase. On the other hand, there is the parents' opportunity to choose that the parent with higher income will be on parental leave. The analysis of the payment of nursing benefits shows that in the case of almost 18% 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.

The number of nursing days is not only increasing in the age group of children born in the past few years, but in all age groups. Thus the main reason for the increase in nursing days is not only the increased number of births but also the more frequent use of certificates for care compared to previous years

In the structure of certificates for nursing care, the main reasons for leave include nursing a child under 12 years of age (98%), providing care for a child under 3 years of age or a disabled child up to 16 years of age (1%) and nursing a sick family member (1%). In the past three years the structure of certificates for nursing care by reasons for leave has not changed significantly.

Work injury benefits

Compared to 2005, the number of benefit days related to work injury increased by 5% in 2006 and the average cost of sickness day related to work injury increased by 14%. The increase in the average cost of sickness day related to work injury was due to increased wages and the fact that most work injuries of serious nature take place in processing industry.

According to Labour Inspectorate, the number of accidents at work increased by 5% in 2006, compared to 2005. In the structure of certificates for sick leave, the reasons for leave from work include accident at work (95%), work-related injury in traffic (3%). Complications resulting from the accident at work are given as a reason for leave in 2% of certificates for sick leave relating to accident at work. In the past three years the structure of certificates for sick leave relating to accident at work by reasons for leave has not changed significantly.

5. Other monetary benefits

Dental benefit for adults

Overall, the EHIF paid EEK 73,148 thousand for dental benefits in cash in 2006. Compared to 2005, expenditure on dental benefits for adults decreased by 5%, i.e. EEK 3.9 million.
In 2006, the EHIF reimbursed the cost of dental services for the insured according to the following rates:

- EEK 150 for a person aged 19 and over;
- EEK 450 for a pregnant woman;
- EEK 300 for persons with an increased need for dental treatment;
- EEK 300 for a mother with a child under 1 year of age;
- EEK 2,000 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.

Table 39. Dental benefits in 2005-2006

Expenditure on dental benefits in EEK thousand	2005 actual	2006 budget	2006 actual	2006 actual/2006 budget %	2006 actual/2005 actual %
Denture benefit	39,396	40,920	39,950	98%	101%
Dental treatment benefit	37,624	46,464	33,198	71%	88%
Total	**77,020**	**87,384**	**73,148**	**84%**	**95%**

Since 2004, the number of applicants for denture benefit has remained more or less the same, forming 11% of the target group, just as in 2005. The number of applicants for dental benefit, however, has decreased by 3%, compared to 2005. In 2003, 10% of the target group applied for dental benefit, in 2004 18%, in 2005 24% an in 2006 21% of the target group.

Table 40. Number of dental benefit cases

Number of dental benefit cases	2006 target group	2005 cases	estimated cases 2006	actual cases 2006	2006 actual	2006 actual/2005 actual %
Denture benefit	248,000	27,897	27,280	27,471	101%	98%
Dental treatment benefit	968,000	221,072	290,400	206,346	71%	93%
Total	**1,216,000**	**248,969**	**317,680**	**233,817**	**74%**	**94%**

Supplementary benefit for medicinal products

The insured became entitled to and the EHIF became liable to pay supplementary benefit for medicinal products on 1 January 2003. Supplementary benefit for medicinal products is a cash benefit calculated on the basis of expenses incurred by a person on reimbursed prescription medicinal products during a calendar year. The aim of the procedure was to enable the people who spend more than EEK 6,000 per calendar year on buying medicinal products included in the EHIF list of medicinal products, to receive additional monetary benefit. The maximum supplementary benefit per person per calendar year is EEK 9,500.

Supplementary benefit for medicinal products enables to reimburse the cost of medicinal products first and foremost for those who:

- use very expensive medicinal products in their treatment schemes;
- suffer from chronic diseases and must use medication for a prolonged period;
- use several medicinal products in a combination.

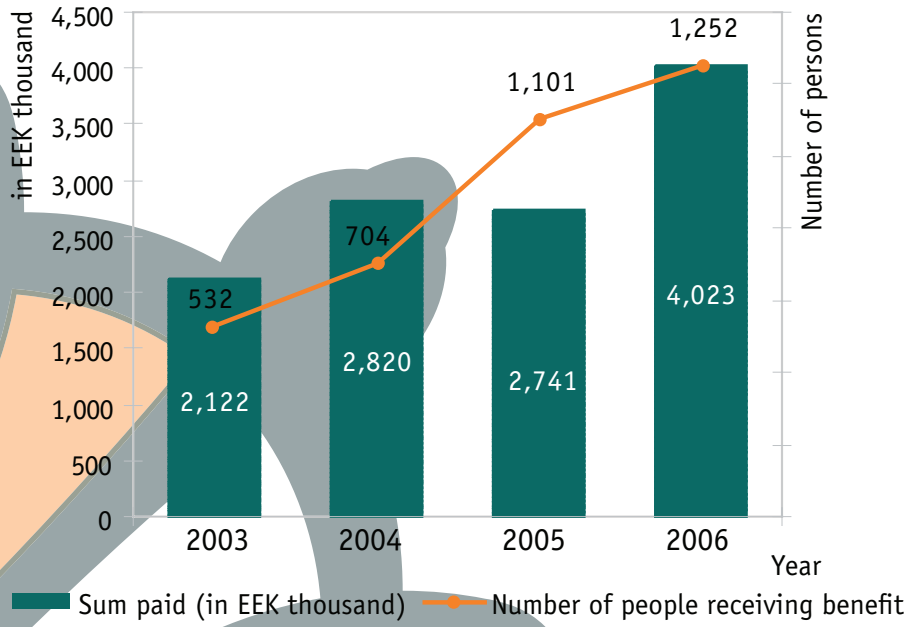
Supplementary benefit for medicinal products allows for a significant reimbursement for those who use medicinal products reimbursed at 50%, where there is an upper limit for reimbursement for one prescription.

Table 41. Supplementary benefit for medicinal products, 2005-2006

Supplementary benefit for medicinal products	2005	2006	2006/ 2005
sum paid in EEK thousand	2,741	4,023	147%
people receiving benefit	1,101	1,252	114%
average sum paid to person in EEK	2,489	3,213	129%

In 2006, the number of persons receiving benefit increased by 14% and the average amount of paid benefit increased by a total of 29%. In 2006, the average sum paid to a person amounted to an average of EEK 3 213. Thus, the total amount of paid benefit also increased significantly. When in 2005, the amount of supplementary benefit for medicinal products transferred by the EHIF to the bank accounts of recipients of benefit was EEK 2,741 thousand; in 2006 the respective amount had increased by EEK 1.28 million. Compared to the first year of the implementation of benefit, the paid amount has nearly doubled and the number of recipients has increased by 720 persons a year. People's awareness of their rights and the existence of supplementary benefit has therefore increased significantly.

Chart 10. Supplementary benefit for medicinal products, 2005-2006



6. Other expenditure on health insurance benefits

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

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

In 2006, EEK 20,833 thousand was spent on health insurance benefits of those insured by the EHIF in other European Union Member States and states of European Economic Area (including Switzerland) and on the expenditure on health services in Estonia of those insured in other European Union Member States and states of European Economic Area (including Switzerland).

Benefits for medical devices

Table 42. Implementation of the budget for benefits for medical devices in 2005-2006.

Benefits for medical devices (in EEK thousand)	2005 actual	2006 budget	2006 actual	2006 actual /2006 budget %	2006 actual /2005 actual %
Primary prostheses and orthoses	9,117	9,200	11,094	121%	122%
Diabetes test strips	9,203	11,898	11,634	98%	126%
Stoma appliances	7,644	8,300	8,846	107%	116%
Spacer devices	35	116	8	7%	23%
Other devices	472	5,000	1,072	21%	227%
Total	**26,471**	**34,514**	**32,654**	**95%**	**123%**

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 during a certain period. The budget for accounting period was exceeded due to a bigger demand for primary prostheses and orthoses, and the bigger average cost of stoma appliances per an insured person. Compared to 2005, the number of persons in need for post-operative or post-traumatic orthosis has increased by 54%. Demand for prostheses has remained stable over the years. The amount of funds spent on diabetes test strips, spacers and other devices was less than the projected sum. Funds available due to the smaller demand for other devices was used in the accounting period to cover the expenses of benefits for medical benefits with a larger demand.

The budget for diabetes test strips for the second half-year included changes in the amounts of test strips (previous amount of 300 test strips a year was replaced with 600 test strips in half-year) for children, pregnant women and, as a new target group, mothers of children under 1 year of age. The amendment to the regulation took effect in November 2006. Compared to 2005, the number of recipients of test strips has increased by 18% in the accounting period, but due to a delay in legislation the implementation remained below the estimate.

II Operational expenditure of the EHIF

The EHIF's operational expenditure on the administration of health insurance benefits in 2006 was EEK 87,044 thousand. The budget for operational expenditure was implemented at 89%.

7. Personnel and administrative expenditure

Table 43. Implementation of the budget for personnel expenditure

Personnel expenditure expenditure (in EEK thousand)	2004 actual	2005 actual	2006 budget	2006 actual 2006 actual	2006 actual/ 2006 budget %	2006 actual/ 2005 actual %
Total salaries	33,545	36,827	40,960	38,459	94%	104%
Basic salary	27,686	30,505	33,248	31,895	96%	105%
Performance pay	4,157	4,556	5,874	4,653	79%	102%
Management Board remuneration (basic and performance-related)	1,699	1,764	1,833	1,908	104%	108%
Supervisory Board remuneration	3	2	5	3	60%	150%
Unemployment insurance premium	158	160	123	109	89%	68%
Social tax	11,070	12,153	13,517	12,691	94%	104%
Total	**44,773**	**49,140**	**54,600**	**51,259**	**94%**	**104%**

In 2006, EEK 51,259 thousand was spent on wages and taxes calculated on wages. The budget was implemented at 94%. Underspending was due to lower disbursements of performance pay and taxes calculated thereon.

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 costing in the course of which the activities/functions necessary for the attainment of the organisational goals are reviewed and the resources (man years) required for the performance of these functions are proposed. Below are a few examples of the volume of services delivered by the EHIF.

Table 44. Examples of service volumes in the EHIF in 2005-2006

	2005	2006	2006/ 2005
Medical bills processed	3,986,961	4,020,332	101%
Reimbursed prescriptions processed	5,000,602	5,393,102	118%
Certificates of incapacity for work processed	533,231	583,962	110%
Treatment records inspected	10,384	13,827	133%
Contract annexes administered	1,586	1,771	112%

The number of inspected treatment records is established in the EHIF scorecard but additional inspections are carried out every year in order to ensure quality provision and proper registration of medical care.

Increase in the proportion of administered contract annexes since 2006 is due to a separate registration of contract annexes for prevention, previously included in the contract annexes of family physicians.

Table 45. Resource required for the implementation of processes/functions of the of the EHIF (in man years) in 2005-2006

Business process and required resource (man years)	2004	2005	2006	Change 2005-2006 (man years)
Health coverage administration	42	39	22	-17
Communication with partners and the insured	39	25	29	4
Management of internal and external communication	4	5	4	-1
Analysis of health insurance benefits	9	11	9	-2
Planning of health insurance benefits	4	4	5	1
Administration of health services contracts	7	9	9	0
Processing of health insurance benefits	43	56	56	0
Processing of covered medicinal products	3	8	9	1
Processing of health services	6	10	9	-1
Processing of benefits for incapacity for work	23	25	28	3
Processing of cash benefits	10	12	9	-3
Processing of other health services	1	1	1	0
Health insurance benefit inspection	41	35	34	-1
Health insurance benefit development	11	13	10	-3
Personnel management and development	2	2	2	0
Management of IT development activities	4	5	6	1
Assurance of availability	8	7	7	0
Business procedures	7	5	5	0
Management of economic activities	16	14	14	0
General management	15	18	18	0
Performance of internal audit	4	4	3	-1
Total required resources	**256**	**252**	**233**	**-19**

Table 45 shows the changes in resources required for the implementation of EHIF functions in 2004-2006. In total, the resource required for the implementation of the EHIF processes decreased by 19 man years in 2006.

In 2005 the EHIF completed the introduction of software supporting the register of the insured. As a result of the project the business procedures of the EHIF were made even more effective. In relation to this, the amount for required resources decreases in health coverage administration. Information was paid to communication with partners and the insured persons, incl. communication preceding information. The number of calls to the EHIF's advisory line 1220 and correspondence with partners and insured persons has increased. Owing to the significant increase in the number of processing certificates for benefits for incapacity for work since 2004 the resource requirements for the implementation of said process have decreased by 3 man years in 2006. At the same time the resource required for processing cash benefits has decreased, as the procedure for reimbursements and processing applications and has been improved and that has resulted in a smaller number of errors which in turn contributes to the more effective process.

Health insurance benefit development process includes development of the price list for services, development of clinical guidelines, harmonization of principles with those of the EU, development of complex prices (DRG), etc. As the bigger development activities regarding the price list for services shall be completed, the amount of required resources shall decrease.

Changes in relation to business procedures contribute to a development process that aims for the increase in the number of highly qualified EHIF employees compared to the implementers of routine tasks.

8. Management expenditure

Table 46. Implementation of the budget for management expenditure

Management expenditure (in EEK thousand)	2004 actual	2005 actual	2006 budget	2006 actual	2006 actual /2006 budget %	2006 actual /2005 actual %
Office expenditure	3,292	3,208	3,327	3,036	91%	95%
Facilities' maintenance	7,650	7,703	8,257	7,669	93%	100%
Supplies and equipment	1,446	1,772	1,759	1,573	89%	89%
Vehicle maintenance	1,703	1,749	1,998	1,822	91%	104%
Business travel	793	821	743	679	91%	83%
Other management expenditure	1,352	1,539	2,325	2,088	90%	136%
Total	**16,236**	**16,792**	**18,409**	**16,867**	**92%**	**100%**

In 2006, the management expenditure amounted to EEK 16,867 thousand, or 92% of the projected budget. Compared to 2005, the expenditure has remained the same or decreased somewhat. Only other management expenditure has changed significantly. Other management expenditure includes expenses on personnel employment, representation, translation services, etc. Increase in expenditure in 2006 (compared to 2005) is due to ordered contractual work pursuant to which as of 2006 it is possible to acquire forms for all applications from all service offices of Eesti Post and nine county governments.

9. Information technology expenditure

Table 47. Implementation of the IT budget

Information technology (in EEK thousand)	2004 actual	2005 actual	2006 budget	2006l actua	2006 actual /2006 budget %	2006 actual /2005 actual %
Personal hardware and software	2,187	2,059	2,251	1,721	76%	84%
Information systems development	1,214	5,223	6,137	3,700	60%	71%
Information systems maintenance	5,196	4,751	4,830	3,949	82%	83%
Other IT expenses	499	578	388	515	133%	89%
Total	**9,096**	**12,611**	**13,606**	**9,885**	**73%**	**78%**

In 2006, information technology expenditure was EEK 9,885 thousand, which was below the estimate and the actual expenditure of 2005. Underspending on IT expenditure was mainly due to the shift of the development of the information system for cash benefits into 2007. Therefore, the objectives for the purchase of services in relation to IT maintenance were not fully met.

In 2006, the main IT related events were:

- The introduction of software supporting the register of the insured was completed.
- Development of electronic certificates for sick leave shall continue in the next few years.
- To improve safety and availability, the EHIF moved its servers into the Estonian Informatics Centre.

10. Development expenditure

Table 48. Implementation of the development budget

Development expenditure (in EEK thousand)	2004 actual	2005 actual	2006 budget	2006 actual	2006 actual/2006 budget %	2006 actual/2005 actual %
Training	1,756	1,627	1,602	1,455	91%	89%
Consultations	2,413	2,151	2,090	1,802	86%	84%
Business consultations	2,048	1,637	1,310	1,356	104%	83%
Legal consultations	365	514	780	446	57%	87%
Total	**4,169**	**3,778**	**3,692**	**3,257**	**88%**	**86%**

In 2006, development expenditure amounted to EEK 3,257 thousand. Budget implementation was 88%.

Upon organizing and ordering trainings, areas of priority in 2006 included automation of work processes, analysis of health insurance benefits and development of planning system. Expenditure on business consultations related to various development projects, for that, consultation services were purchased (mostly committees, expert assessments, advisory committee and working groups). In 2006, EEK 393 thousand of the expenditure on business consultations was spent on the implementation of complex prices of health services, EEK 384 thousand was spent on the development of price lists and EEK 324 thousand on the development of clinical guidelines, EEK 191 thousand on expenses related to health services and EEK 64 thousand on other expenses. Expenditure on legal consultations covers preparation of draft legislation, provision of expert assessments, consultations, and representation of the EHIF in disputes in court if necessary. The budget has not been fully implemented, as expenditure on representation of the EHIF in disputes in court was projected to be larger than required.

11. Financial expenditure

Table 49. Implementation of the budget for financial expenditure

Financial expenditure (in EEK thousand)	2004 actual	2005 actual	2006 budget	2006 actual	2006 actual /2006 budget %	2006 actual /2005 actual %
Banking charges	804	867	1,020	1,032	101%	119%
Reserves administration costs	66	66	66	66	100%	100%
Other financial expenditure	28	766	64	87	136%	11%
Total	**898**	**1,699**	**1,150**	**1,185**	**103%**	**70%**

In 2006, the financial expenditure amounted to EEK 1,185 thousand. Other financial expenditure exceeded the estimate, as due to a significant increase in the volume of transactions concluded with foreign states, the expenses from changes in currency rate have also increased.

12. Other operating expenses

Table 50. Implementation of the budget for other operating expenses

Other operating expenses (in EEK thousand)	2004 actual actual	2005 actual actual	2006 budget budget	2006 actual actual	2006 actual /2006 budget %	2006 actual /2005 actual %
Forms and publications	1,082	1,148	1,404	1,051	75%	92%
Supervision	945	879	1,285	1,060	82%	121%
Public relations/public information	914	819	869	860	99%	105%
Other expenses	1,999	2,519	2,968	1,620	55%	64%
Total	**4,940**	**5,365**	**6,526**	**4,591**	**70%**	**86%**

The cost of the printing of reimbursed prescriptions was included in expenditure on forms and publications. The budget was implemented at 75%, as the cost of printing reduced with a new procurement.
Expenditure on supervision are divided into expenditure on financial audits and expenditure on ordered medical audits on national health services. 2006 expenditure is less than the estimate, as there was no auditor to carry out financial audits on health services development projects.
Publication of health services brochures and leaflets of the EHIF as well as organisation of information days was included in expenditure on public relations and public information. Other expenses cover the cost of internal information, liability insurance of the members of the Management Board and Supervisory Board, expenditure on doubtful receivables and expenditure on fringe benefits. Underspending of the budget for other expenses was due to the decrease in the proportion of the receipt of doubtful invoices.

13. Legal reserve

Legal reserve is a reserve formed from the budget funds of the Health Insurance Fund 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 2006, the legal reserve of the EHIF was EEK 481,363 thousand. Pursuant to the volume laid down by law, the amount of the legal reserve will be EEK 603 million in 2007. Arising from this an appropriation of EEK 122 million has been planned to the legal reserve from the retained earnings of 2006.

14. Risk reserve

The risk reserve equals 2% of the health insurance budget of the EHIF, pursuant to Estonian Health Insurance Fund Act.
As of 31 December 2006, the EHIF risk reserve was EEK 160,148 thousand. Pursuant to the volume laid down by law, the amount of the risk reserve will be EEK 201 million in 2007. An appropriation of EEK 41 million has been planned to the legal reserve from the retained earnings of 2006.

15. Retained earnings

As of 31 December 2006, the accumulated retained earnings of the EHIF constituted EEK 2,023,595 thousand. Since 2003, the retained earnings include excessive inflow of social tax and underspent expenses.
Additionally, the retained earnings were increased by nearly EEK 500 million in 2003, because of a change in the accounting policies of the Tax and Customs Board.
As the receipt of social tax exceeded the estimate by 11% in 2006, the retained earnings of the financial year were EEK 876,855 thousand.
The Management Board of the EHIF shall submit a proposal to the Supervisory Board to allocate EEK 122 million of the retained earnings of 2006 into the legal reserve and EEK 41 million into risk reserve, to fill the reserves by 2007 to the amount required by law.

Annual accounts 2006

Statement by the Management Board

The Management Board declares its responsibility for the accuracy of the Estonian Health Insurance Fund's annual accounts for 2006 as set out on pages 60 to 74 and confirms, to the best of its knowledge, that:

- the accounting principles used in preparing the annual accounts are in compliance with the generally accepted accounting principles;
- the annual accounts present a true and fair view of the financial situation, the revenue and expenditure and the cash flow of the Estonian Health Insurance Fund;
- all relevant circumstances, which have occurred before the completion of the report on 31 March 2007, have been duly recognised and reflected in the annual accounts;
- the Estonian Health Insurance Fund is a going concern.

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

Balance sheet

ASSETS

(in EEK thousand)	31.12.2005	31.12.2006	Note
Current assets			
Cash and bank accounts	419,876	538,014	2
Shares and other securities	915,539	1,580,886	3
Claims and advance payments			
Trade receivables	3,186	4,759	
Other short-term receivables	15,120	11,705	4,8
Interest receivable	395	738	
Social tax receivable	752,805	942,873	
Prepaid expenses	1,889	1,873	
Total	**773,395**	**961,948**	
Inventories			
Goods for resale	323	247	6
Total current assets	**2,109,133**	**3,081,095**	
Fixed assets			
Long-term financial investments			
Shares	90	90	3
Long-term securities and bonds	188,957	185,545	3
Other long-term receivables	14,262	9,689	7,8
Total	**203,309**	**195,324**	
Tangible fixed assets			
Land and buildings (residual value)	1,424	1,831	
Other inventories (residual value)	7,116	5,721	
Total	**8,540**	**7,552**	**9**
Intangible fixed assets			
Purchased licences	731	1,915	9
Total fixed assets	**212,580**	**204,791**	
TOTAL ASSETS	**2,321,713**	**3,285,886**	

LIABILITIES AND EQUITY CAPITAL

(in EEK thousand)	31.12.2005	31.12.2006	Notes
Liabilities			
Current liabilities			
Loan commitments			
Repayments of long-term loan commitments	193	0	10
Debts and advance payments			
Supplier payables			
Accounts payable for medical care services	373,203	449,994	
Accounts payable for medicinal products subject to discount	87,219	81,338	
Supplier payables for health insurance benefits	34,287	47,612	
Other supplier payables	1,899	2,493	
Total supplier payables	496,608	581,437	
Taxes payable	29,637	29,430	11
Employee-related liabilities	6,620	6,788	
Other debts	403	652	
Received advance payments	0	2,472	
Total	**533,268**	**620,779**	
Total current liabilities	533,461	620,779	
Total liabilities	**533,461**	**620,779**	
Equity capital			
Reserves	569,512	641,512	
Net surplus/deficit for previous periods	944,985	1,146,740	
Net surplus/deficit for financial year	273,755	876,855	
Total equity capital	**1,788,252**	**2,665,107**	
TOTAL LIABILITIES AND EQUITY CAPITAL	**2,321,713**	**3,285,886**	

Statement of revenue and expenditure

(in EEK thousand)	2005	2006	Note
Revenue from the health insurance part of social tax and claims collected from other persons	7,287,618	8,821,407	12
Expenditure on health insurance	-6,983,752	-7,946,048	13
Gross surplus/deficit	303,866	875,359	
General administrative expenditure	-82,321	-81,268	14
Other operational revenue	33,799	36,051	
Other operational expenditure	-5,365	-4,591	
Operating surplus/deficit	249,979	825,551	
Financial revenue and expenditure			
interest and financial revenue	25,475	52,489	
financial expenditure	-1,699	-1,185	
Total financial revenue and expenditure	23,776	51,304	
Net deficit/surplus for financial year	**273,755**	**876,855**	

Cash flow statement

(in EEK thousand)	2005	2006
Cash flow from operations		
Social tax received	7,143,848	8,618,341
Payments to suppliers	- 6,910,550	- 7,893,987
Personnel expenses paid	- 36,664	- 38,509
Taxes paid on personnel expenses	- 13,418	- 13,531
Other revenue received	61,025	76,977
Other expenses paid	- 502	0
Total cash from operations	**243,739**	**749,291**
Cash flow from investment		
Purchase of fixed assets	- 6,114	- 3,849
Proceeds from disposals of financial assets	1,504,655	2 167 188
Purchase of financial assets	- 1,716,508	- 2,794,492
Total cash flow from investment	**- 217,967**	**- 631,153**
Net change in cash and bank accounts	25,772	118,138
Bank accounts at beginning of period	394,104	419,876
Change in cash and cash equivalents	25,772	118,138
Cash and cash equivalents at end of period	419,876	538,014
incl. short-term deposits	381,587	490,795

Statement of changes in equity

(in EEK thousand)	2005	2006
Reserves		
Reserves at beginning of year	639,512	569,512
Increase/decrease of reserves*	- 70,000	72,000
Reserves at end of year	569,512	641,512
Net surplus/deficit for previous periods		
At beginning of year	874,985	1,218,740
Increase/decrease of legal capital*	70,000	- 72,000
Net surplus/deficit for financial year	273,755	876,855
At end of year	**1,218,740**	**2,023,595**
Equity at beginning of year	1,514,497	1,788,252
Equity at end of year	**1,788,252**	**2,655,107**

* Pursuant to the decision of the EHIF Supervisory Board, EEK 72 million was allocated to the legal reserve in 2006.

Notes to the Annual Accounts

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

General principles

The annual accounts for 2005 of the EHIF have been drawn up in accordance with the accounting principles generally accepted in Estonia based on internationally recognised accounting and reporting policies. Basic requirements of generally accepted accounting principles have been established with Accounting Act and supplemented by instructions issued by the Accounting Committee. The financial year began on January 1, 2006 and ended on December 31, 2006. The figures in the annual accounts have been given in 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 with the structure of its entries adjusted to accommodate the specific features of the activities of the EHIF.

Financial assets and liabilities

Regarded as financial assets are monies, short-term financial investments, customer receivables and other current and long-term receivables. Regarded as financial liabilities are supplier payables, accruals and other short and long-term loan commitments.
Financial assets and liabilities are initially registered in their acquisition cost, which is the just 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 adjusted acquisition cost.
Financial assets 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 met, terminated or expired.
The purchase and sale of financial assets are 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 sold financial assets.

Foreign exchange accounts

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

Financial investment accounts

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

Accounts for securities acquired for short-term holding

Securities and bonds acquired for short-term holding are recorded on the balance sheet proceeding from their just value. The assessment of the just value is based on the market value of the financial investment of the day of drawing up the balance sheet.

Long-term financial investment accounts

Long-term financial investments are recorded on the balance sheet according to the just value method. Profits and losses arising from the changes in value are recorded in the statement of the revenue and expenditure on the financial year.

Receivable and loan accounts

Receivables and granted loans are assessed individually and reflected on the balance sheet on conservative basis in view of the amounts collectible. Receivables and granted loans, which are uncollectible, are expensed for the period and shown on the balance sheet with a minus. Receivables and loans, which do not justify any recovery measures for practical or economical reasons, are deemed irrecoverable and written off.

Stock accounts

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

Tangible fixed asset accounts

Tangible fixed assets are assets having an expected useful life of more than one year and an acquisition cost of more than EEK 30,000. Assets, which have a shorter expected useful life and a smaller acquisition cost, are expensed at the time of acquisition.
Tangible fixed assets are recognised at their acquisition cost and depreciated on a straight-line basis in accordance with their expected useful life. Land is not subject to depreciation.
The following depreciation time limits (in years) are applied:

- buildings 10-20
- inventories 2-4
- cars and other vehicles 3-5
- equipment 3-5
- intangible fixed assets 2-4

Intangible fixed assets

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 EEK 30,000.
Intangible fixed assets are recognised at their acquisition cost and depreciated on a straight-line basis in accordance with their expected useful life within 3 to 5 years.
Expenditure on tangible and intangible assets incurred after acquisition are, as a rule, expensed for the period. Additional expenditure are added to the cost of intangible fixed assets, if it is likely that this expenditure allows the asset to generate more economic benefits in the future than expected and if this expenditure can be reliably assessed and related to the asset.

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 downwards 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 Health Insurance Fund is the reserve formed from the budgetary funds of the Health Insurance Fund in order to minimise the risks arising for the health insurance system from the obligations assumed.
- The risk reserve equals 2 percent 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 Health Insurance Fund.

The health insurance fund has the obligation to establish a risk reserve as of 1 October 2002 with regard to the entry into force of the new Health Insurance Act. The said Act amended the Estonian Health Insurance Act by adding § 39¹ to it.
The amount transferred to the risk reserve shall be specified with the decision of the supervisory board after the approval of the audited annual report.

Legal reserve

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

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

Pursuant to the decision of the EHIF Supervisory Board, 70 million kroons from the legal reserve will be utilised in 2005.
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 Accounts include significant circumstances affecting the assessment of assets and liabilities, which were identified between 31 December 2005, 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 Accounts

Note 2. Cash and bank accounts

(in EEK thousand)	31.12.2005	31.12.2006
Deposits at call	38,289	47,219
Fixed term deposits	381,587	490,795
Total cash and bank accounts	**419,876**	**538,014**
Fixed term deposits:		
due within 1 month	241,587	334,795
due within 1 to 3 months	140,000	156,000
Total	**381,587**	**490,795**

Note 3. Shares and other securities

Short-term investments

(in EEK thousand)	Date of acquisition	Maturity date	Underlying currency	Acquisition cost	Just value	Rate of return
Bond of the Government of Germany	16.08.2006	14.02.2007	EUR	153,941	155,843	3.25%
Bond of BCP Bank	16.10.2006	16.02.2007	EUR	154,591	155,699	3.55%
Bond of BCP Bank	29.09.2006	28.02.2007	EUR	77,097	77,754	3.49%
Bond of the Government of the Netherlands	24.04.2006	30.03.2007	EUR	30,426	31,031	3.02%
Bond of Sampo Pank	13.04.2006	13.04.2007	EEK	31,946	32,634	3.25%
Bond of FIH Bank	16.11.2006	15.05.2007	EUR	61,438	61,696	3.74%
Bond of BKIR Bank	30.11.2006	31.05.2007	EUR	76,796	76,983	3.70%
Bond of SEB Eesti Ühispank	14.06.2006	14.06.2007	EEK	10,641	10,812	3.33%
Bond of Sampo Pank	15.12.2006	15.06.2007	EEK	34,330	34,369	3.86%
Bond of the Government of Belgium	15.11.2006	12.07.2007	EUR	50,417	50,642	3.64%
Bond of the Government of France	31.08.2006	2.08.2007	EUR	75,799	76,558	3.44%
Bond of the Government of Germany	30.11.2006	17.08.2007	EUR	62,924	63,889	3.68%
Bond of Sampo Pank	5.09.2006	5.09.2007	EEK	38,548	38,944	3.72%
Bond of NRWBK Bank	16.11.2006	28.09.2007	EUR	141,904	143,380	3.79%
Bond of Sampo Pank	17.11.2006	19.11.2007	EEK	19,225	19,286	3.96%
Bond of Sampo Pank	15.08.2006	15.08.2008	EEK	20,000	20,080	3.32%
Bond of Hansapank	19.10.2004	19.10.2009	EUR	31,278	31,674	2.41%
Bond of General Electric KP	10.05.2004	4.05.2011	EUR	15,603	15,763	2.24%
Bond of Citigroup	3.11.2004	3.06.2011	EUR	24,974	25,170	2.34%
Bond of ING Group	26.06.2006	18.09.2013	EUR	46,874	46,955	3.57%
Bond of HSBC	23.11.2006	28.10.2013	EUR	31,307	31,528	3.89%
Bond of General Electric KP	28.01.2005	28.07.2014	EUR	31,209	31,611	2.37%
Bond of Goldman Sachs	23.11.2006	2.02.2015	EUR	31,622	31,861	3.96%
Bond of Barclay	23.11.2005	23.11.2015	EUR	7,796	7,826	2.92%
Bond of General Electric KP	17.03.2006	22.02.2016	EUR	31,215	31,369	2.88%
Bond of ING Group	11.04.2006	11.04.2016	EUR	31,212	31,532	2.99%
Bond of Sampo Pank	13.04.2006	13.04.2007	EEK	16,457	16,811	3.25%
Bond of SEB Eesti Ühispank	14.06.2006	14.06.2007	EEK	18,380	18,676	3.33%
Bond of Sampo Pank	15.12.2006	15.06.2007	EEK	18,636	18,657	3.86%
Bond of KWF	29.03.2005	20.06.2007	EUR	46,931	47,346	2.64%
Bond of the Government of France	3.08.2006	5.07.2007	EUR	68,279	69,109	3.34%
Bond of the Government of Germany	17.11.2004	17.08.2007	EUR	32,861	31,945	2.58%
Bond of Sampo Pank	17.11.2006	19.11.2007	EEK	13,938	13,983	3.96%
Bond of the Government of Germany	21.04.2006	14.12.2007	EUR	29,479	29,470	3.28%
Total				**1,568,074**	**1,580,886**	

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 2007 are recognised as short-term investments.
The revenue and expenditure of the revaluation are reflected in the statement of revenue and expenditure.

Long-term investments

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

(in EEK thousand)	Shares of AS Viimsi Haigla (at cost)	
	2005	2006
Balance at the beginning of year	90	90
Balance at the end of year	90	90

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

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

(in EEK thousand)	Date of acquisition	Maturity date	Underlying currency	Acquisition cost	Just value	Return rate
Bond of the Government of Germany	16.11.2006	4.07.2008	EUR	47,262	48,056	3.67%
Bond of Sampo Pank	15.08.2006	15.08.2008	EEK	20,000	20,080	3.32%
Bond of the Government of France	25.10.2006	25.04.2009	EUR	31,530	32,225	3.67%
Bond of Dexia Bank	29.09.2006	21.09.2009	EUR	31,158	31,198	3.65%
Bond of Rabobank	15.07.2005	15.07.2015	EUR	31,074	22,180	6.65%
Bond of Citigroup	15.08.2006	9.02.2016	EUR	15,619	15,737	3.44%
European Investment Bank KP	6.06.2005	24.03.2020	EUR	16,967	16,069	3.14%
Total				**193,610**	**185,545**	

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)	31.12.2005	31.12.2006	Note
Claim to Tallinn Diagnostic Centre	9,541	6,577	
Short-term part of loans granted	5,252	4,933	8
Advance payment of wages	0	19	
Claims for reimbursement of maintenance costs	200	32	
Contractual claims against insured persons	153	154	
Allowance for doubtful receivables	-26	-10	
Total	**15,120**	**11,705**	

The principal amount of claim to Tallinn Diagnostic Centre as of 31.12.2005, of EEK 9,541 thousand, was received pursuant to court judgment in 2006. The claim to Tallinn Diagnostic Centre as of 31.12.2005 has been filed pursuant to court judgment: fines in the amount of EEK 5,789 thousand, state fee in the amount of EEK 484 thousand and costs for legal assistance in the amount of EEK 304 thousand.

Note 5. Social tax receivables

Social tax receivable in the amount of EEK 942,873 thousand (as of 31.12.2005: EEK 752,805 thousand) is comprises a short-term claim to the Tax and Customs Board for the health insurance part of social tax.

Note 6. Inventories

As of 31.12.2006, the Estonian Health Insurance Fund has in stock unused prescription forms costing EEK 247 thousand (EEK 323 thousand as of 31.12.2005). Inventories belonging to the EHIF are deposited into storage with liability with other persons with balance sheet value of EEK 126 thousand (EEK 35 thousand as of 31.12.2005).

Note 7. Miscellaneous long-term receivables

(in EEK thousand)	31.12.2005	31.12.2006	Note
Long-term part of loans granted to health care institutions by the EHIF	8,330	3,397	8
Long-term tax claim against the Tax and Customs Board	121	518	
Long-term part of the amount paid to the Social Insurance Board for renovating the premises of the Pärnu Department and the Rapla Office	5,811	5,774	
Total	**14,262**	**9,689**	

Note 8. Loans granted by the Estonian Health Insurance Fund

(in EEK thousand)

Health care institution	Loan balance as of 31.12.2005	incl. the short-term part of the loan	incl. the longterm part of the loan
SA Põhja-Eesti Regionaalhaigla	12,880	4,550	8,330
incl. under previous contracts			
Mustamäe Haigla	5,833	2,750	3,083
Estonian Oncological Centre	7,047	1,800	5,247
AS Ida-Tallinna Keskhaigla	702	702	0
Total	**13,582**	**5,252**	**8,330**

Health care institution	Loan balance as of 31.12.2006	incl. the short-term part of the loan	incl. the longterm part of the loan
SA Põhja-Eesti Regionaalhaigla	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**

The average interest rate of granted loans is 5%, the loans have been granted in Estonian kroon, maturity dates of repayments are November 2007 and August 2008.

Note 9. Fixed assets

Tangible fixed assets

(in EEK thousand)	Land and buildings	Other inventories	Total
Acquisition cost			
31.12.2005	3,581	21,374	24,955
Purchase of fixed assets	589	1,450	2,039
Written off	0	- 647	- 647
31.12.2006	4,170	22,177	26,347
Accumulated depreciation			
31.12.2005	2,157	14,258	16,415
Calculated depreciation	182	2,839	3,021
Written off		- 641	- 641
31.12.2006	2,339	16,456	18,795
Residual value			
31.12.2005	1,424	7,116	8,540
31.12.2006	1,831	5,721	7,552

Intangible fixed assets

(in EEK thousand)	Purchased licences
Acquisition cost	
31.12.2005	7,627
Purchase of fixed assets	1,809
Written off	-4,653
31.12.2006	4,783
Accumulated depreciation	
31.12.2005	6,896
Calculated depreciation	625
Written off	-4,653
31.12.2006	2,868
Residual value	
31.12.2005	731
31.12.2006	1,915

Recording of intangible fixed assets covers the licences for SAP and user of Oracle databases.

Note 10. Leased assets

Financial lease

In 2006, financial lease payments for servers amounted to EEK 202 thousand.
As of 31.12.2006, there are no valid financial lease contracts.

Operating lease

The profit and loss account for 2006 includes operating lease payments in the amount of EEK 5,780 thousand, EEK 591 thousand of that was paid for the lease of means of transport, EEK 151 thousand for operational leasing of computer equipment, and EEK 5,038 thousand has been paid pursuant to commercial lease contracts of premises.

Expenditure on lease in future periods shall be divided as follows:

(In EEK thousand)	Means of transport	Computer equipment	Premises	Total
Due date of up to a year	386	2	5,044	5,432
1-5 years	641	0	25,224	25,865
more than 5 years	0	0	18,780	18,780

Note 11. Taxes payable

(In EEK thousand)	31.12.2005	31.12.2006
Individual income tax	25,833	25,615
Social tax	3,597	3,624
Income tax from fringe benefits	62	58
Unemployment insurance premium	81	63
Mandatory funded pension premiums	64	70
Total	**29,637**	**29,430**

The individual income tax arrears include individual income tax in the amount of EEK 24,459 thousand (as of 31.12.2005: EEK 24,657 thousand) deducted from the benefits for incapacity for work paid by the Health Insurance Fund to the insured.
The social tax arrears include social tax in the amount of EEK 634 thousand (as of 31.12.2005: EEK 660 thousand) calculated from the holiday pay not disbursed to the employees.

Note 12. Revenue from principal activity

(In EEK thousand)	2005	2006
Health insurance part of social tax	7,277,545	8,808,806
Amounts due from other persons	10,073	12,601
Total	**7,287,618**	**8,821,407**

Note 13. Expenditure on health insurance

(In EEK thousand)	2005	2006
Health service benefits, incl.	4,716,814	5,329,563
Disease prevention	74,436	77,562
General medical care	592,155	666,609
Specialised medical care	3,752,783	4,260,081
Long-term nursing care	113,920	132,386
Dental care	183,520	192,925
Health promotion expenses	8,564	12,676
Expenditure on benefits for medicinal products, incl.	871,762	966,796
centrally acquired medicinal products	4,172	4,070
Expenditure on benefits for temporary incapacity for work	1,265,063	1,506,355
Other monetary benefits	79,761	77,171
Other expenditure on health insurance benefits	41,788	53,487
Health service benefits arising from international agreements	15,317	20,833
Benefit for medical devices	26,471	32,654
Total expenditure on health insurance benefits	**6,983,752**	**7,946,048**

Note 14. General administrative expenditure

(In EEK thousand)	2005	2006
Personnel and administrative expenditure	49,140	51,259
remuneration	36,827	38,459
incl. remuneration of the members of the Management Board	1,764	1,908
incl. remuneration of the members of the Supervisory Board	2	3
unemployment insurance premium	160	109
social tax	12,153	12,691
Management costs	16,792	16,867
Information technology costs	12,611	9,885
Development costs	3,778	3,257
Total general administrative expenditure	**82,321**	**81,268**

Note 15. Transactions with related parties

Related parties include the Members of the Management Board and of the Supervisory Board as well as businesses connected with them. No transactions have been made with the Members of the Management Board and of the Supervisory Board or with businesses connected with them. Remuneration paid to the Members of the Management Board and of the Supervisory Board in 2006 is indicated in Note 14.

Signatures to the Annual Report

The Management Board of the Estonian Health Insurance Fund has prepared the annual report for the financial year 2006.
The annual report of 2006, which comprises the management report, notes to the implementation of the budget and the annual accounts, 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 Estonian Health Insurance Fund.

	Date	Signature
Management Board:		
Chairman of the Management Board Hannes Danilov	.....	.....
Member of the Management Board Arvi Vask	.....	.....
Member of the Management Board Maigi Pärnik-Pernik	.....	.....

Supervisory Board:	Date	Signature