Gesellschaft für
Versicherungswissenschaft
und -gestaltung e.V.

Study on the Social Protection Systems in the 13 Applicant Countries

Estonia
Country Study

January 2003

Study financed by the European Commission – Employment and Social Affairs DG

Authors:

Lauri Leppik (Chapters 1 – 4)
Ruta Kruuda (Chapter 5)

Social Protection in Estonia

1. INTRODUCTION: ECONOMIC, FINANCIAL, SOCIAL AND DEMOGRAPHIC BACKGROUND

1.1 Main influencing factors for social protection

1.1.1 Economic and financial indicators

As a result of the transition to a new economic system, Estonia's GDP decreased sharply in the years 1991-1994. By 1995, the recession phase was over. In the following years, the economy recovered quickly. An important stimulus for the Estonian small open economy was the high demand in foreign sector and the economic growth was mainly based on the rapid growth of export to the developed industrial countries, reinforced by the high level of foreign investments. Economic growth was fastest (9.8%) in 1997 (Table 1.1 in Annex 1).

1998 witnessed an economic slowdown due to a crisis in the financial sector and decline in the foreign demand. The same year saw a crisis in the Russian market, and as a result, Estonia's GDP decreased by 0.6% in 1999. In 2000, Estonia's economy rapidly recovered from the crises and posted a strong economic growth, with its GDP up by 7.1%. A rather high rate of growth continued in 2001 and 2002, primarily driven by domestic demand, in spite of the global economic slowdown. The growth rate in 2001 was 5.0%. The Ministry of Finance and the Bank of Estonia have estimated the growth rate in 2002 to be around 4,3%.

Inflation rate, which was very high in the first years of transition, decreased fast in the period 1992-1999 as a result of fixed exchange rate[1], supported by the currency board arrangement and open trade policy. Consumer Price Index (CPI) hit the lowest (3.3%) in 1999 in a situation of decreased domestic demand. Economic revival and the increase of some administratively regulated prices (e.g. electricity, heating, public transportation) increased the inflation rate in 2000 and 2001. The annual inflation in 2001 reached 5.8%, however a general slowdown of the inflation rate was registered since the summer 2001. In 2002 CPI increased by 3.6%.

The Estonian inflation has in recent years followed the dynamics of the Euro area (however, at some percentage points higher level), indicating that

[1] From 1992 the Estonian kroon (EEK) was pegged to the German mark (DEM) at the rate of 1 DEM = 8 EEK. From 2002 the Estonian kroon is pegged to Euro at the rate of 1 Euro = 15.64664 EEK

the Estonian economy is very closely linked with the EU through trade and economic channels.

Keeping the competitiveness of Estonian economy has been a major consideration for all governments starting from early 1990s. The cornerstones of this policy have been the fixed exchange rate (a currency board arrangement), a liberal trade policy, a balanced budget doctrine with very limited state borrowing, far-reaching privatisation and a proportional income tax (the rate is 26%, first 1000 EEK a month are non-taxable). Furthermore, from 2000 the corporate income tax on reinvested profits was abolished.

The overall government sector[2] spending in the second half of 1990s was around 40% of GDP. The total government sector expenditures in 2000 declined to 37.2% of GDP due to a conservative state budget for 2000 following the economic decline in 1999, but also because of a substantial decline in the state revenues as a result of abolition of the corporate income tax on reinvested profits. Decline continued in 2001 (Table 1.2 in Annex 1).

In the years of high economic growth (1997-1998), the Government formed a stabilisation reserve, where it directed the surplus of revenues. The reserve currently amounts to ca 2% of GDP. According to the law, this reserve can be used to finance major structural reforms, e.g. to cover the transition costs of the pension reform, which the Government has undertaken.

State pension insurance and health insurance, which are financed from an ear-marked social tax, have been operating on a 'macro-level defined-contribution' principle, whereby expenditures are determined by available revenues from social tax. Therefore, the level of expenditures of these schemes largely reflects increase in social tax revenues. However, in respect of pension insurance, the timing of pension increases has also influenced annual expenditures. Until 2002 pensions were increased by *ad hoc* political decisions in the absence of any pre-determined rules on the time or size of the increase. In this situation, pensions were increased over 20% from 1 January 1999 ahead general elections in March 1999. While social tax revenues in 1999 increased only by 3.4% as compared to 1998 (against the background of negative economic growth in 1999), pension expenditures in 1999 exceeded social tax revenues over 750 million EEK. The deficit was resolved by the end of 2000, as pensions were not increased in 2000. This was also reflected in the stagnation of expenditure levels (Table 1.3 in Annex 1).

Total expenditures on family benefits have broadly kept pace with inflation. However, the increase of total expenditures hides several important structural changes within the scheme, which have increased

[2] Central government and local municipalities.

targeting on more vulnerable groups within the universal scheme. Child allowance for the first child in the family has remained unchanged from 1 January 1997, while benefits for larger families, single parents and birth grants have been increased. In 1999 none of the family benefits were increased, which resulted in the decline of expenditures as compared to 1998, as the total number of children declined because of the low birth rate. In 2000, the expenditures increased, as a new type of benefit – a child-care fee – was introduced, which increased the number of eligible parents. In 2001, the expenditures on family benefits slightly declined compared to the previous year, against the background that the benefit rates remained unchanged while the total number of children declined because of the low birth rate.

State expenditures on social assistance cash benefits and social services remained largely at the same level in the second half of 1990s. This was largely due to declining expenditures on the social assistance subsistence benefit (the minimum guaranteed income benefit). The subsistence level, which is established by the Government, has remained unchanged at the level of 500 EEK a month from November 1997, i.e. over 5 years. As at the same time incomes from work and some other state benefits (e.g. pensions) have increased, the number of recipients of subsistence benefit as well as the average subsistence benefit per recipient have declined. In 2001 expenditures on this branch increased by over 60% compared to the previous year, since a new scheme of social benefits for disabled persons was introduced.

State expenditures on social protection of the unemployed have been remarkably low, which is mainly due to a very low level of state unemployment allowance, but the provision of labour market services has also been modest. In 1999 expenditures on this branch more than doubled as compared to 1998, explained mainly by the increase of the rate of unemployment allowance from 300 EEK to 400 EEK from 1 January 1999[3], while the number of recipients of unemployment allowance increased as a result of increased unemployment. Higher unemployment explains also the slight increase in expenditure levels for 2000 and 2001.

From 1995 to 1998, the percentage of pensions in GDP was on the level of 7.1 – 7.3%. In 1999, this percentage jumped from 7.1 to 8.5% as the pension expenditures increased in real terms while the real growth of GDP was negative. Since in 2000 pensions were not increased, while the economy had quickly recovered, the share of pensions in GDP declined. In 2001, the percentage of pension expenditure in GDP dropped below 7% (Table 1.4 in Annex 1) as the increase of pensions was below the increase of revenues from social tax. By the end of 2001, the surplus of pension insurance budget was ca 0,6% of GDP.

---

[3] The rate of unemployment allowance remains currently the same.

Health insurance expenditures have been around 5% of GDP, while family benefits account for about 1.5% of GDP. State expenditures on social assistance and social services declined from 1% in 1997 to 0.75% in 2000, but after introduction of the new scheme of social benefits for disabled persons exceeded again 1% of GDP in 2001. Expenditures on social protection of unemployed represent still only about 0.3% of GDP.

Calculations by the author showed that in 1999 public social protection expenditures accounted 14284 million EEK, which was 18.7% of GDP[4]. This means that about 45% of total government expenditures were allocated for social protection. From the total government expenditures on social protection 72.6% accounted for social insurance funds (45.2% state pension insurance and 27.4% health insurance), 21.4% for the general state budget and 6% for local budgets.

Private expenditures are calculated only for the health care sector. In 2000, total health expenditures amounted to 5230 million EEK or 6.1% of GDP. Two-thirds (66.6%) of the total health expenditures were covered by state health insurance, 8.3% from the state budget, 2.0% by local budgets and 23% constituted private expenditures. From the latter, 19.4 percentage points accounted for households, 2.5 percentage points employers and private insurance made up the remainder.

1.1.2 Demographic indicators

The population of Estonia has been decreasing steadily from 1991 because both components of the population change – natural increase and net migration – have been negative[5].

The total number of women has been exceeding the number of men by about 100 thousand, primarily due to shorter life expectancy of men. The proportion of women in the total population is 54% — 117 women per 100 men (Table 1.5 in Annex 1).

The population of Estonian is ageing. The median age has increased from 34.1 in 1989 to 37.9 in 2000, while over the same period the share of

---

4 For the first time, the Statistical Office of Estonia published data on social protection expenditures in July 2002. According to this data, in 1999 the share of social protection expenditure in GDP was 17.0%.

5 In 2002 the Estonian Statistical Office recalculated the earlier population data on the basis of the 2000 Population and Housing Census data. The 2000 Census showed that the average number of the population for 2000 was 4.7% smaller than the number of population based on the 1989 Census data and vital events of the nineties. Compared to the earlier data, a proportionally larger decrease occurred in the number of younger and working-age population. The decrease in the average population to such extent influenced all statistical estimates, which were calculated on the basis of the population number.

population aged 60 or more has increased from 16.9 to 20.3 (Table 1.6 in Annex 1).

Fertility in Estonia rapidly declined over the first period of transition, when annual decrease of live births was 7-16%. The number of births steadily declined from the all time highest of 25,056 in 1987 to 12,228 in 1998. However, in the second half of 1990s the decline in fertility slowed down. The decrease in the number of births that had lasted for more than ten years was replaced by the increase lastly in 1999. 12,545 children were born in 1999 and 13,089 in 2000. In 2001 the number of births slightly declined again to 12,629 children.

The crude birth rate, which was about 16 in 1988 had decreased to 8.9 by 1998. In the next 3 years this parameter increased and was 9.3 in 2001.

In spite of some positive signs in the last years, the total fertility rate remains considerably below the replacement level (Table 1.7 in Annex 1).

As the number of deaths has exceeded the number of births, the natural increase has been negative. However, the situation has improved over the last 5 years.

The average life expectancy at birth declined in the first half of 1990s, reaching the lowest level in 1994, when it was 61.1 years for men and 73.1 for women. However, since then, the average life expectancy has been increasing, reaching 65.4 years for men and 76.1 years for women in 1999. In 2000 and 2001, the average life expectancy for women has remained unchanged, while for men a slight decline has been observed again. (Table 1.8 in Annex 1).

The decline of average life expectancy in mid 1990s was due to raising mortality rates for the age groups 30–49 and 50-69. At the same time the mortality rates for persons aged 70 and over declined, i.e. the life expectancy at higher ages increased.

The difference between the life expectancy of men and women is considerable, nearly 11 years at birth. By the age of 60, this difference declines to 5.5 years.

The net migration has been negative since 1990 as emigration considerably exceeded immigration. A large proportion of non-Estonian population moved mostly to Russia and other parts of the former Soviet Union immediately after Estonia regained independence. Emigration reached the maximum in 1992 and has rapidly decreased since then (Table 1.9 in Annex 1).

The immigration policy of the Government has been quite strict. According to the Aliens Act, the Government annually approves

immigration quota, which shall not exceed 0.05% of the number of permanent residents of Estonia. The immigration quota does not apply to EU, Swiss, Norwegian, Icelandic, US and Japanese citizens and ethnic Estonians, which explains the fact that the actual immigration has been about twice the immigration quota, i.e. 0.1% of the total population.

1.1.3 Social indicators

In 1990s the labour force and employment steadily declined. In the first half of 1990s the labour force participation rate (LFPR) declined rapidly, by 1-2 percentage points a year. From 1995 the LFPR of women has been more or less stable, while the LFPR of men continued to decline. Still, on average, the LFPR of men is about 11 percentage points higher than that of women (Table 1.10 in Annex 1)[6].

In the first half of 1990s the LFPR in rural areas declined more rapidly than in urban areas. However, in the second half of 1990s the situation in rural areas stabilised, while in urban areas the declining trend continued.

For the first time from the beginning of economic transformation the LFPR slightly increased in 2000 compared to 1999. However, this was brought about by the increase of unemployment from the previously inactive people (mainly women), who due to changes in the legislation registered themselves in employment offices.

Economic activity of persons aged 55-64 fell until 1995 and then started to increase, primarily due to gradual increase in the pension age, which was implemented from 1994.

The LFPR of women in age groups 55-64 is considerably lower than the LFPR of men - about 1.5 times in 55-59 age group and 2 times in 60-64 age group). This is explained by the fact that the general pension age for women in 2001 was 58 years (for men the pension age is 63), while possibilities exist for even earlier retirement[7].

Employment rate decreased constantly from 1990 to 2000. The main reason for this lies in the increase of productivity from corporate restructuring and switchover to capital-intensive production. However, the period 1995-1998 was relatively stable, with the employment and unemployment rates remaining at the 1995 level. In 1999 and 2000 both indicators declined again. The number of employed people dropped despite economic growth also in 2000. In 2001, the number of employed persons increased for the first time since 1990, reaching 614,700 persons, up by 8,000 from the year 2000 level (Table 1.11 in Annex 1).

---

6 Labour force data for 1995-1999 are not yet harmonised with the 2000 Population Census data.

7 In 2002 and 2003, the pension age for women is 58 years 6 months, see also 3.1.2.

Compared to most EU countries, employment rate in the age group 55-64 is relatively high (on average 51%).

Noticeable trend in 1990s was the restructuring of the labour force between economic sectors. Employment in agricultural and manufacturing sectors decreased, whereas the service sector grew. Whereas the total employment declined, the number of self-employed persons increased, accounting for 9% of the total employment in 1999. Also the number of part-time employees was growing, accounting for 10% of the total female employment and 6% of male employment.

The unemployment rate rose rapidly in the first half of 1990s due to the release of workforce in the course of economic restructuring. After a period a relative stability in 1995-1998, the unemployment rate began to grow again in 1999, following the economic crisis.

In 2000, in spite of relatively high economic growth, unemployment rate reached the all time high of 13.7%. However, from the second quarter of 2000 the situation in the labour market started to improve and in 2001 the unemployment rate declined to 12.6% (Table 1.12 in Annex 1).

The unemployment rate of men remains higher than that of women. Compared to the average unemployment rate in the EU (8.1%), the unemployment rate in Estonia is considerably higher.

In 2001, the estimated number of households in Estonia was 578,000. The average estimated size of the household was 2.4 members (2.3 in urban areas and 2.6 in rural areas). Households in urban areas are smaller than in rural areas mostly due to a smaller number of children.

About one third (31 %) of all households were single-person households. From single-person households over a half were pensioners, and in turn from them about 75% were female.

The average number of children per household is 0.6. If only families with children are considered, the average number of children per family is 1.6. About 12% of all families with children are single-parent families.

The average birth-giving age has been increasing from 25.6 in 1995 to 27.2 in 2001, indicating postponement of deliveries. The average age of women at first delivery has also increased (from 23.0 in 1995 to 24.2 in 2001).

The share of children born out of wedlock has constantly increased and from 1997 exceeds the number of legitimate births, reaching 56.2% of all new-born children in 2001.

The number of marriages has been fairly stable over the last 6 years at about 5,500 marriages per year. In 2001, 4.1 marriages were registered per 1,000 inhabitants. Also, the divorce rate has been relatively stable. In 2001, 76 divorced were registered per 100 marriages.

1.2 How does the described background affect social protection?

1.2.1 Forecasts and projections

According to the forecasts of the Bank of Estonia and the Ministry of Finance, the GDP is expected to grow by 5 – 5.5% in 2003. It is expected that the main engine of the economic growth of Estonia as a small open economy will continue to be export, which currently accounts for about 90% of the GDP.

With the anticipated annual mid-term economic growth rates about 5-6%, Estonian per capita GDP will amount to 50% of the EU average by year 2010.

It is expected that the CPI growth will decrease in 2003 as compared to 2002. In the next years, the most important influencing factor is expected to be the increase of administratively regulated prices. Also the adoption of the EU tax policy (most importantly the increase of fuel excise) influences Estonian price level, although this influence should remain moderate. However, in the longer term, Estonia's inflation is determined by price convergence and productivity growth exceeding EU average. As the price level of Estonia is approximately 50% lower than in Western European countries (in case of services price differences are even bigger) the price convergence is expected to last for many years. Therefore it is expected that the inflation in the coming years remains some percentage points higher than in the Euro area.

The Government expects that the unemployment rate will decrease in the coming years as a result of economic growth and decreasing tax burden, in particular for the low paid. However, the labour market developments so far do not indicate any clear link between GDP growth and employment rates in case of Estonia, explained by the fact that large part of investments are aimed at increasing efficiency and do not create many new jobs (Table 1.13 in Annex 1).

Population projections indicate that if the current demographic trends continue, the total population will be declining and ageing quite rapidly. The median age is expected to increase to 42.7 years by 2020 and the share of 60+ age group from the current 20% up to 25% by 2020 (Table 1.14 in Annex 1).

1.2.2 Influences of economic, demographic and social developments on the social protection system

Demographic ageing poses standard problems to the Estonian social protection system and the impact can already be seen.

Declining birth rates have reduced the financial burden on the scheme of family benefits. However, in spite of decline in the birth rate, the number of women on parental leave has remained rather stable, indicating that many women either preferred to stay at home with a child as long as possible or are forced to do so because of difficulties to return to labour market.

Demographic factors, like increasing life expectancy, combined with labour market developments have posed challenges for the pension and health insurance systems. Over the last decade the labour market factors have been more important, causing a rapid decline in the number of contributors (employees on whose behalf social tax is paid). Fortunately, high economic growth rates, resulting in increasing social tax revenues have helped to keep the financing on pension and health insurance stable.

In the state pension insurance scheme, the demographic and labour market challenges have been tackled with increase in the pension age. Also, gradual equalisation of pension age of women with that of men has been an important measure to secure sustainability of the pension system, against the background of considerable differences in the life expectancy of men and women. As a positive development, the increase of pension age has been accompanied with increase in the labour force participation rates of the 55-64 age group, while the unemployment rate in this age group is below the average.

Demographic ageing has been also an important driving force for introduction of the compulsory funded pension scheme. However, in the short-run the pension reform will reduce state revenues from social tax and require substitute financing in the amount of about 0.5–1.0% of GDP a year. Since the Government has committed itself to balanced fiscal policy and reduction of the tax burden, any structural reforms would require cutting of other state expenditures. This task would be far from easy, as the demand for financing in several sectors of social protection is only expected to increase. For example, persistence of the high level of unemployment could be partly attributed to the very low level of spending on labour market training, whereby structural elements of unemployment have remained largely un-addressed.

1.3 Annex 1

Table 1.1: Main macroeconomic indicators 1995-2001

	1995	1996	1997	1998	1999	2000	2001
GDP at current prices (billion Euro)	2.7	3.4	4.1	4.7	4.8	5.5	6.2
Real GDP growth (%)	4.3	3.9	9.8	4.6	-0.6	7.1	5.0
GDP per capita at current prices in PPS	5,600	6,100	7,100	7,500	7,700	8,500	n.a.
Inflation rate (CPI)	29.0	23.1	11.2	8.2	3.3	4.0	5.8

Source: Eurostat, Estonian Statistical Office

Table 1.2: Total government sector expenditures 1995-2001

	1995	1996	1997	1998	1999	2000	2001
Total government sector expenditures (% of GDP)	40.3	40.4	37.8	38.6	41.6	37.2	35.8
Budget deficit/surplus (% of GDP)	-1.2	-1.9	2.2	-0.3	-4.6	-0.7	0.4

Source: Ministry of Finance, author's calculations

Table 1.3: State expenditures on main branches of social protection (million EEK)

	1995	1996	1997	1998	1999	2000	2001
State pensions	2,907	3,997	4,649	5,232	6,460	6,504	6,648
Health insurance	2,119	2,829	3,394	3,618	3,919	4,207	4,564
benefits in kind	*1,587*	*2,010*	*2,333*	*2,899*	*3,255*	*3,325*	*3,457*
sickness-maternity cash benefits	*380*	*460*	*552*	*662*	*608*	*726*	*745*
Family benefits	751	817	997	1,229	1,221	1,371	1,323
Social protection of unemployed	55	88	91	96	247	269	289
Social assistance and social services	n.a.	604	652	671	639	647	1,045

Source: Ministry of Social Affairs, Estonian Health Insurance Fund

Table 1.4: State expenditures on main branches of social protection as a percentage of GDP

	1995	**1996**	**1997**	**1998**	**1999**	**2000**	**2001**
State pensions	7.11	7.62	7.26	7.11	8.46	7.61	6.88
Health insurance	5.18	5.40	5.30	4.92	5.13	4.92	4.73
Family benefits	1.84	1.56	1.56	1.67	1.60	1.61	1.37
Social assistance and social services	n.a.	1.15	1.02	0.91	0.84	0.75	1.08
Social protection of unemployed	0.13	0.17	0.14	0.13	0.32	0.31	0.30

Source: Ministry of Social Affairs

Table 1.5: Population of Estonia (thousands) 1995-2001[8]

	1995	**1996**	**1997**	**1998**	**1999**	**2000**	**2001**
Total population	1,437	1,416	1,400	1,386	1,376	1,370	1,364
Male	665	654	646	640	634	632	629
Female	771	761	753	746	741	738	735

Source: Estonian Statistical Office

Table 1.6: Population aged less than 15 years and population aged more than 60 years[8]

	1995	**1996**	**1997**	**1998**	**1999**	**2000**	**2001**
Proportion of population aged less than 15 (%)	20.9	20.5	20.0	19.5	18.9	18.3	17.7
Proportion of population aged more than 60 (%)	18.6	18.8	19.1	19.9	20.1	20.3	21.2

Source: Estonian Statistical Office, author's calculations

[8] The Estonian Statistical Office has revised population statistics for the years 1995-1999 in 2002 on the basis of the 2000 Population Census data.

Table 1.7: Birth rate, fertility rate and net reproduction rate[8]

	1995	1996	1997	1998	1999	2000	2001
Crude birth rate per 1000 inhabitants	9.4	9.4	9.0	8.9	9.1	9.5	9.3
Fertility rate	1.38	1.38	1.32	1.29	1.32	1.38	1.34
Gross reproduction rate	0.67	0.67	0.64	0.62	0.65	0.66	0.65
Net population increase per 1000 inhabitants	-10.3	-9.6	-5.7	-5.7	-4.4	-3.7	-4.3

Source: Estonian Statistical Office, Eurostat

Table 1.8: Life expectancy at birth and at ages 60 and 65

	1995	1996	1997	1998	1999	2000	2001
Life expectancy at birth							
Men	61.7	64.5	64.7	64.4	65.4	65.1	64.7
Women	74.3	75.5	76.0	75.5	76.1	76.0	76.2
Life expectancy at 60							
Men	14.5	14.8	15.2	14.8	15.3	15.3	15.3
Women	19.9	20.1	20.6	20.3	20.8	20.8	21.2
Life expectancy at 65							
Men	12.0	12.2	12.6	12.3	12.6	12.6	n.a.
Women	16.1	16.2	16.8	16.4	16.9	16.9	n.a.

Source: Estonian Statistical Office

Table 1.9: Emigration, immigration and net migration

	1995	1996	1997	1998	1999	2000[9]
Emigration						
total number	9,800	7,200	4,100	2,500	2,000	n.a.
percentage of population (%)	0.66	0.49	0.28	0.17	0.14	n.a.
Immigration						
total number (thousands)	1,600	1,600	1,600	1,400	1,400	n.a.
percentage of population (%)	0.11	0.11	0.11	0.10	0.10	n.a.
Net migration	-8,200	-5,600	-2,500	-1,100	-600	n.a.

Source: Estonian Statistical Office

[9] Starting from 2000, the Estonian Statistical Office has stopped publishing migration data, because of the low quality of administrative data. The main problem is that according to the current legislation, registration of the place of residence is not compulsory and therefore changes to the place of residence are underreported.

Table 1.10: Labour force participation rate (labour force/population aged 15-64, %) 1995-2001

	1995	**1996**	**1997**	**1998**	**1999**	**2000**	**2001**
LFPR	72.6	72.1	72.5	71.9	70.6	70.8	70.4
male	79.3	78.3	78.8	77.8	76.4	76.7	75.8
female	66.3	66.4	66.6	66.4	65.1	65.3	65.4
LFPR 55-59							
male	77.9	n.a	78.5	n.a.	73.9	75.9	74.6
female	43.8	n.a.	52.1	n.a.	52.5	52.0	56.9
LFPR 60-64							
male	38.5	n.a.	43.3	n.a.	47.0	48.4	46.4
female	22.9	n.a.	21.3	n.a.	24.9	25.9	31.3

Source: Estonian Ministry of Social Affairs

Table 1.11: Employment rate (employed/population aged 15-64, %) 1995-2001

	1995	**1996**	**1997**	**1998**	**1999**	**2000**	**2001**
Employment rate	65.5	64.9	65.4	64.7	61.7	60.9	61.4
male	70.9	69.8	70.7	69.2	65.9	65.2	65.8
female	60.5	60.2	60.4	60.4	57.8	56.9	57.3

Source: Estonian Ministry of Social Affairs

Table 1.12: Unemployment rate (unemployed/labour force, %) 1995-2001

	1995[10]	**1996**[10]	**1997**	**1998**	**1999**	**2000**	**2001**
Unemployment rate	9.7	10.0	9.7	9.9	12.3	13.7	12.6
women	8.8	9.2	9.2	8.9	11.0	12.7	12.3
men	10.6	10.7	10.1	10.8	13.6	14.6	13.0

Source: Estonian Statistical Office, Labour Force Survey.

[10] For 1995 and 1996, the unemployment rate is calculated on the basis of the population aged 15-69, from 1997 the population aged 15-74 is taken into account.

Table 1.13: Forecasts on the development of macroeconomic indicators 2002-2005[11]

	2002	**2003**	**2004**	**2005**
Real GDP growth (%)	4.3	5.5	6.0	6.0
CPI growth (%)	4.3	3.5	4.2	3.5
Unemployment rate (%)	11.5	11.3	11.0	10.7

Source: Ministry of Finance.

Table 1.14: Demographic projections (medium scenario) up to 2020

Indicator	**2005**	**2010**	**2015**	**2020**
Population (thousands)	1,316	1,253	1,190	1,127
Percentage aged 0-14 (%)	15.5	13.5	13.7	14.0
Percentage aged 60 or over (%)	20.6	21.7	23.3	25.0
Median age (years)	38.7	40.0	41.3	42.7
Crude birth rate (per 1,000 population)	8.7	9.0	9.2	9.2
Crude death rate (per 1,000 population)	13.3	13.4	13.7	14.1
Total fertility rate (children per woman)	1.20	1.20	1.27	1.40
Net reproduction rate (per woman)	0.57	0.57	0.61	0.67
Life expectancy at birth, males (years)	65.8	67.3	68.3	69.3
Life expectancy at birth, females (years)	76.4	77.2	78.0	78.5

Source: United Nations Population Division, Department of Economic and Social Affairs

[11] Forecasts of the Ministry of Finance, up-dated in July 2002. These forecasts have been based on the continuation of ”normal” economic development, assuming that to achieve the projected economic growth, the resources and institutional base exist, and the main effects of the structural reforms planned by the Government become evident. Up to year 2005, it has been estimated that the positive influence resulting from the domestic demand reaches 0.5%. The forecast assumes that the environment at that time is neutral, i.e. without any smaller or bigger negative or positive shocks. The forecast has not taken into account the possible accession to EU during the forecast period, but resources from the EU structural funds to implement reforms have been taken into account.

2. OVERVIEW OF THE SOCIAL PROTECTION SYSTEM

2.1 Organisational structure

2.1.1 Overview of the system

In accordance with the State Government Act, the field of social protection is within the competence of the Ministry of Social Affairs (*Sotsiaalministeerium*), i.e. only in one ministry. Its functions include:

- policy development;
- drafting of legislation;
- overall co-ordination of activities within the field;
- planning of financial resources necessary to finance benefit systems and other programmes;
- collection and evaluation of relevant statistical information;
- co-ordination and supervision of sub-ordinate institutions responsible for the direct administration of branches of social protection.

The composition of the Ministry includes 4 Deputy Secretary Generals who are responsible respectively for health care, social affairs, employment and European integration.

Within the Ministry, there are 2 specialised departments directly involved with social protection: Social Security Department and Social Welfare Department. Social Security Department is responsible for policy development for the branches of pension insurance, family benefits, unemployment benefits, sickness-maternity cash benefits, funeral grants and subsistence allowance. Social Welfare Department co-ordinates the development of social services and child protection. Other departments (e.g. Statistical and Analysis Department, Financial and Budget Department, Health Care Department, Labour Market Department etc.) fulfil auxiliary or supporting functions.

Within the area of administration of the Ministry there are 2 governmental agencies - the Social Insurance Board and the Labour Market Board - and 2 public legal bodies - the Health Insurance Fund and the Unemployment Insurance Fund -, which are responsible for the administration of the different branches of social protection.

Figure 2.1: Institutions involved in the administration of social protection

2.1.2 Centralisation/De-centralisation of the system

The Social Insurance Board (*Sotsiaalkindlustusamet*) administers the schemes of pension insurance, family benefits, social benefits for disabled persons and funeral grants. The Board maintains a State Pension Insurance Registry, which includes data of all insured persons and the social taxes paid on their behalf, as well as data on beneficiaries. The direct contact with insured persons and beneficiaries is organised through 4 regional Pension Offices with branch offices in all 15 counties, plus some major towns. Pension Offices process benefits applications, grant benefits and arrange the payment through banks or post offices.

The Labour Market Board (*Tööturuamet*) administers the scheme of state unemployment allowances. The Board maintains a Registry of Unemployed Persons and Labour Market Services. Registration of the unemployed persons, processing of the claims, granting and payment of state unemployment allowances is carried out by 16 regional employment offices, which are subordinated to the Board.

The Estonian Unemployment Insurance Fund *(Eesti Töötukassa)* is in charge of the new scheme of unemployment insurance, which was introduced from 1 January 2002. The Fund is a public-legal institution governed by a tripartite Council, which includes 6 members (2 representatives named by the Government, 2 by trade unions and 2 by employers). A representative of trade unions currently chairs the Council. The Fund operates within the area of administration of the Ministry of Social Affairs, but is not subordinated to the Ministry. The Fund is directly responsible for granting and payment of unemployment insurance benefits.

The health insurance scheme is run by the Estonian Health Insurance Fund *(Eesti Haigekassa)*, which is also a public-legal institution within the area of administration of the Ministry of Social Affairs. The Fund has 7 regional branches. The main functions of the Health Insurance Fund include:

- making annual contracts with the providers of medical services and covering the expenses of medical care of insured persons to the service providers under these contracts;
- paying sickness, maternity and care cash benefits to insured persons;
- paying compensations (price differences) of pharmaceutical products to the pharmacies on the basis of prescriptions issued to insured persons.

The Health Insurance Fund is governed by a Council, which includes 15 members:

- 5 representatives of the State (the Minister of Social Affairs, who by position is the Chairman of the Council, the Minister of Finance, the Chairman of the Social Commission of Parliament, Member of Parliament (representing the opposition), the Ministry of Social Affairs);

- 5 members representing organisations of insured persons;
- 5 members representing employers organisations.

While the total expenditures for health insurance are annually allocated by Parliament when adopting the state budget, the Council of the Health Insurance Fund approves the more detailed health insurance budget.

Employers are directly liable for compensations in case of work accident or occupational disease, if they are responsible for the health damage.

Within the area of social assistance and social services the main responsibilities are on local municipalities (currently 241 municipalities).[12] Municipalities grant social assistance cash benefits and administer social services. In case of statutory social assistance benefits (e.g. subsistence benefit), local municipalities act as a delivery agent, while eligibility rules are fixed by the Social Welfare Act and relevant Government regulations, and finances are allocated from the state budget. However, local municipalities may also grant supplementary social assistance benefits from their own revenues, in which case they are free to determine the eligibility rules. In case of social services the municipalities may decide whether to arrange services themselves, in co-operation with other municipalities or to sub-contract from NGOs or private bodies. The direct role of the state in the field of social services is limited to administration of special care institutions for persons with mental retardation or chronic mental illness, rehabilitation centres for active rehabilitation of disabled persons and school-homes for disabled children.

2.1.3 Supervision

Supervision over the daily work of the implementing agencies is the responsibility of the respective Deputy Secretary General.

The county governments are supervising over the provision and quality of social services and social assistance within their territory.

Financial control and supervision is carried out on 2 levels – internal and external. First, the Internal Controlling Department of the Ministry of Social Affairs controls transactions of the Ministry and subordinate institutions. Secondly, the State Audit Office performs economic and financial control of all public institutions, including public-legal institutions. The State Audit Office also assesses the performance of public institutions in terms of efficiency and effectiveness. The audit reports are published. Annually summary reports are submitted to the Parliament and the Government.

---

[12] In the beginning of 2002, the number of local municipalities was 247. After local elections in October 2002 some municipalities merged and the total number declined to 241.

2.2 Financing of social protection

2.2.1 Financing sources

The schemes of pension insurance and health insurance are financed primarily from a special earmarked tax - social tax. According to the Social Tax Act, social tax is defined as a financial obligation laid on the taxpayer to obtain necessary revenues for state pension and health insurance. The rate of social tax is 33 per cent of the tax base, of which 20 percentage points is allocated for the pension insurance and 13 percentage points for the health insurance.

However, the financing of state pension insurance is not exclusively confined to social tax. National pensions, pension supplements for war veterans and civil servants as well as pensionable service credited for years of political repression and administrative costs are financed from general state revenues. Nevertheless, the earmarked nature of social tax entails that revenues from social tax are kept strictly separate from other state revenues.

While for the health insurance system social tax is the only source of revenues, the state still covers from general revenues certain health care costs outside the health insurance system, e.g. medical assistance to uninsured persons, home care of cancer patients, the costs of ambulance service, preventive and public health programmes etc.

The total expenditures for the state pension insurance and the health insurance are adopted annually by Parliament. The pension insurance budget forms an independent part of the general state budget.

From 1 July 2002, a funded pension scheme (so-called second pillar) is introduced to supplement the state pension insurance. The second pension pillar is financed partly from additional contributions of employees, partly from the reallocation of a share of the current pension insurance part of social tax. Persons, who join the second pillar pay an individual contribution of 2% of the wage, in which case their second pillar pension accounts are credited also with 4% of the wage on the account of social tax paid by the employer.

The new scheme of unemployment insurance, introduced from 1 January 2002, is financed from compulsory unemployment insurance contributions paid by employees and employers.

Family benefits, state unemployment allowances, social benefits for disabled persons, funeral grants, social assistance subsistence benefits and state-provided social services are financed from the general state taxes.

Social services are financed mainly by local municipalities from local revenues. (The main financing sources of local municipalities are: 56% of

the personal income tax paid by individuals living within its territory; subsidies from the state budget and local taxes). However, certain social services for disabled persons (special care institutions for persons with mental retardation or chronic mental illness; rehabilitation centres for active rehabilitation of disabled persons; school-homes for disabled children; technical aids for disabled persons) are financed from the state budget.

Local municipalities finance other social assistance.

In 1999, revenues from social tax accounted for 70% of the total social protection expenditures. General state revenues make up about 24% and resources of local government the remaining 6% of expenditures.

2.2.2 Financing principles

The state pension insurance and health insurance operate on the pay-as-you-go principle. However, according to the law, both schemes shall have cash reserves. The size of cash reserves of state pension insurance is not regulated, but as of 1 January 2002 cash reserves formed 608 million EEK, which was 8% of the pension insurance budget for 2002. By 1 January 2003, the reserves had increased to 1,343 million EEK or 16% of the pension insurance budget for 2003.

According to the Health Insurance Fund Act, the Health Insurance Fund should have cash reserves in the amount of at least 5% of the annual health insurance budget, with the purpose of smoothing financing of expenditures in the case of temporary cash flow problems. In addition, the Fund should have a reserve capital in the size of 8% of the annual budget to reduce the potential effect of macro-economic risks on the health insurance system. The creation of the reserve capital started in 2001 and, according to the law, in the first years each year 2% of the budget is allocated to the reserve capital until the 8% target will be met. In 2001, 113.5 million EEK (2.5% of the budget) was allocated to the cash reserve and 89 million EEK (2% of the budget) to the reserve capital. In 2002, allocations to increase cash reserves and the reserve capital were respectively 80 and 100 million EEK.

Also the unemployment insurance scheme is designed to hold a substantial buffer fund, which makes the scheme partially funded. Unemployment insurance contributions were introduced from 1 January 2002, while benefits are paid only from 1 January 2003. As a result, a reserve capital in the size of one-year contribution revenues is created to smoothen the possible effect of macroeconomic changes, including fluctuations in the unemployment rate. According to the Unemployment Insurance Act, the size of the reserve capital may not be less than 10% of the annual budget.

From 1 July 2002 a compulsory funded pension scheme was introduced (see for more details chapter 3).

2.2.3 Financial administration

Employers and the self-employed shall pay the total rate of social tax into the account of the Tax Office, declaring the amount of social tax paid on behalf of each insured person separately. The Tax Office will further transfer the 20 per cent part of the tax to the Social Insurance Board and the 13 per cent part to the Health Insurance Fund.

The tax base of social tax includes:

1. wages and other remuneration paid to employees in cash;
2. remuneration paid to members of management and controlling bodies of legal persons;
3. remuneration paid to natural persons on the basis of contracts for services or contracts under the law of obligations;
4. fringe benefits within the meaning of the Income Tax Act, expressed in monetary terms, and income tax payable on fringe benefits;
5. income from the entrepreneurship of self-employed persons, subject to deduction of enterprise-related expenditures permitted by the Income Tax Act.
6. benefits paid pursuant to the Unemployment Insurance Act.

In the latter case, only the health insurance part of social tax (i.e. 13%) is payable.

The state pays social tax on a fixed rate on behalf of the following categories persons:

- persons on parental leave with an up to 3-year-old child or receiving child-care fee pursuant to the Family Benefits Act;
- conscripts in compulsory military service;
- carers of a disabled child or disabled adult, receiving caregivers' allowance pursuant to the Social Benefits for Disabled Act;
- disabled persons working in enterprises listed by the Minister of Social Affairs;
- non-working spouse of a diplomat working in a foreign representation;
- non-working persons who have participated in the clean-up of the Chernobyl nuclear disaster.
- persons receiving state unemployment allowance;
- dependent spouse of an insured person caring for a child under 8 years of age or at least 3 children under 16 years of age;
- persons in pension age, receiving a social benefit for ex-patriates pursuant to the Social Welfare Act.

The monthly rate, upon which social tax is calculated, is established in the annual state budget. In 2002, this rate was 700 EEK[13]. Accordingly, the amount of social tax paid by the state is monthly 231 EEK (i.e. 0,33 x 700).[14]

The Social Tax Act stipulates a minimum amount of social tax, which is to be paid by employers on behalf of their employees and by the self-employed. The amount of social tax to be paid per calendar month shall not be less than the amount of tax calculated from the rate established in the annual state budget (i.e. the same 700 EEK).

There is a ceiling on the social tax for self-employed persons – the amount of social tax shall not be higher than the amount calculated from 15 times the minimum wage. There is no ceiling on the social tax paid by employers. In 2002, the minimum monthly wage is 1,850 EEK and accordingly, the ceiling on social tax of self-employed persons is 9,158 EEK per month[15].

The employee's contribution rate for the funded pension scheme is 2%, while the contribution base is the same as for social tax.

In 2002 and 2003, the rate of unemployment contributions for employees is 1%, and for employers 0.5%. For the following years, the contribution rate shall be fixed by the Government, based on the proposal of the (tri-partite) Board of the Unemployment Insurance Fund. The Unemployment Insurance Act stipulates that the contribution rate of employees shall not be less that 0.5 %, but not higher than 2.0%, and the contribution rate of employers not be less that 0.25 %, but no higher than 1.0%. The employers deduct the employees' contributions from their wages and pay the employers share of unemployment insurance contributions together with social tax to the Tax Office.

The contribution base of unemployment insurance contributions includes:

- wages and other remuneration paid to persons working under employment contracts or to public servants;
- remuneration paid to natural persons on the basis of contracts for services or contracts under the law of obligations entered, unless the recipient of the remuneration is registered as a self-employed person.

Since the self-employed persons and members of management and controlling bodies of legal persons are not covered with unemployment

---

13 The same rate applies for 2003.

14 In case of conscripts, only the pension insurance part (i.e. 20%) of social tax is paid, while in case of recipients of state unemployment allowance, dependant spouses and recipients of social benefit for ex-patriates only the health insurance part (i.e. 13%) of social tax is paid.

15 From 1 January 2003 the minimum wage is increased to 2,160 EEK.

insurance, the respective incomes are not subject to unemployment insurance contributions. In case of employees, the contribution base is narrower than the social tax base as unemployment insurance contributions are not paid on fringe benefits.

2.3 Overview of Allowances

2.3.1 Health care

Health insurance covers all residents on whose behalf social tax is paid. According to the new Health Insurance Act, which entered into force from 1 October 2002, the personal scope of the scheme includes employees and self-employed persons as well as certain categories on whose behalf the State pays social tax (see above). Equal rights to health care without payment of social tax are given to all children up to 19 years of age; students up to 24 years of age in daily studies; recipients of state pensions and pregnant women from the 12th week of pregnancy and dependant spouses of insured persons who are within 5 years from pension age. The qualification period for employees is 14 days from the date of entering into employment. For self-employed persons the qualification period is 3 months from the date of registration in the Health Insurance Fund.

The Health Insurance Fund covers the costs of medical examinations, medical treatment and the preservation of the health of an insured person. The costs of services are paid by the Health Insurance Fund to the relevant medical or care institution (which may be a state, municipal and private institution) or private physician on the basis of contracts between the institution or physician and the Health Insurance Fund. The list and prices of medical services compensated by the Health Insurance Fund are set by the Government. The list includes *inter alia*:

- out-patient consultations (including home visits) by general practitioners (family doctors) and specialists;
- laboratory tests;
- preventive health check-ups;
- health tests and procedures both in out-patient care and in hospitals;
- hospital care (including *inter alia* nursing care and necessary pharmaceuticals);
- pre-natal care, confinement and post-natal care.

However, it shall be emphasised that the extent of services available under the scheme depends on the constraints of the health insurance budget.

Insured persons have a free choice of a general practitioner (family doctor), but they must register themselves with a particular family doctor (with a right to change the doctor for the following calendar year). In

general, access to specialists is possible only by referral of the general practitioner.[16]

Patients participate in the cost-sharing through the payment of a visit fee for out-patient visits and a bed-day fee for in-patient treatment. Providers of medical services are allowed to establish visit fees for home visits and out-patient specialist consultations up to a ceiling of 50 EEK. Hospitals may charge a fee for each bed-day for up to 10 days, up to a ceiling of 25 EEK per day.

The health insurance system covers also prescription pharmaceuticals provided to insured persons at discounted price. The Health Insurance Fund compensates to the pharmacies the rate of discount - the difference between the regular price and the amount paid by a patient. The rate of discount varies according to the age, social status and diagnosis of the person.

2.3.2 Sickness

Sickness cash benefit is paid to an insured person in case of temporary incapacity to work, if earnings subject to social tax are not received due to the sick leave.

Sickness cash benefits are paid on the basis of a medical certificate (sick list) issued by the treating doctor in case of illness or injury; rehabilitation; quarantine; and temporary transfer to another job due to the state of health.

The rate of sickness cash benefit is 80% in case of in-patient or out-patient treatment or quarantine and 100% in case of work injury or occupational disease.

The reference earnings upon which the benefit rate is applied, is the average daily income (which was subject to social tax) of the insured person.[17] For self-employed persons the reference earnings are the earnings upon which social tax has been paid in the previous calendar years.

There is no ceiling neither for the amount of sickness cash benefit nor for earnings taken into account for the calculation of the benefit.

Sickness cash benefit is paid from the calendar day following the day, on which an initial certificate for sick leave is issued, i.e. there is a waiting period of 1 day.

---

[16] However, access to psychiatrist, gynaecologist, dermatovenereologist, oculist, traumatologist or surgeon is possible without a referral from the general practitioner.

[17] The average daily income of an employed insured person is calculated by adding together the income subject to social tax paid by employers of the insured person during the six calendar months preceding the calendar month of the day on which the sick leave commenced. The result is divided by the number of calendar days during the period of six months.

In general, sickness cash benefit is paid until the end of the leave indicated on the certificate for sick leave, but for not more than 182 consecutive calendar days per one case of illness. In the case of tuberculosis, the benefit may be paid up to 240 consecutive calendar days.

In case of a temporary transfer to another job for health reasons, the sickness cash benefit amounts to the difference between the previous wage and the new wage, and the benefit may be paid for up to 60 days.

Care benefits are paid to insured persons nursing for a sick family member for up to 14 days. .

Sickness and care cash benefits are subject to income tax (proportional tax 26% of taxable income, in 2002 and 2003 first 1,000 EEK per month are non-taxable).

2.3.3 Maternity

Confinement cash benefits are paid to an insured person in case of temporary incapacity to work resulting from pregnancy or child-birth. Benefit is paid from the calendar day on which the certificate for pregnancy leave was issued, i.e. there is no waiting period.

The rate of confinement benefit is 100% of the reference earnings and the benefit is paid during the pre-delivery and post-delivery period for a total up to 140 days, in cases of multiple birth or birth complications up to 154 days.

If a pregnant woman has to temporarily change her job because of her condition, she is paid the difference between the new wage and the previous wage until the commencement of confinement leave.

Confinement cash benefits are subject to income tax.

2.3.4 Invalidity and disability

According to the State Pension Insurance Act, two kinds of pensions address the risk of invalidity: the work-incapacity pensions and the national pensions on the basis of work-incapacity.

Entitled to work-incapacity pension are residents of Estonia from 16 years to retirement age with permanent work incapacity with the extent of at least 40 per cent, who by the date of granting the pension have a pensionable service[18] of at least one year from the age of 21 to 23. The period increases

[18] The pensionable service comprises of: 1) Pensionable length of service acquired until 31.12.1998, counted as periods of work when the employer was under obligation to pay social tax and certain credited periods (see below section "Old-age"); 2) Pension insurance periods acquired from 1.1.1999, counted on the basis of the social tax paid on behalf of the person (or in case of self-employed persons, social tax paid by

by one year for every three years of age, until it reaches 14 years at the age of 60.

Persons with permanent work-incapacity of at least 40% who lack the required pensionable service are entitled to a national pension on the basis of work incapacity, on the condition that the person has been a resident in Estonia for at least 1 year prior to claiming the pension and does not receive pension from any other state.

Total work incapacity (100%) is defined as a situation where a person is unable earn any income in order to support himself/herself as a result of a serious functional impairment caused by illness or injury.

Partial work incapacity (10-90%) is defined as a situation where a person is able to work and earn income, but due to functional impairment caused by illness or injury, is not able to perform suitable work in the extent corresponding to the general national working time (i.e. 40 hours per week).

Work incapacity is certified by a medical commission. To calculate the work incapacity pension, the higher of the following two amounts is used as a calculation basis:

- the amount of an old age pension calculated from the individual's actual accumulated pensionable service and pension insurance coefficients (i.e. the amount of a standard old age pension)
- the amount of an old age pension for a person with 30 years of pensionable service.

The amount of the work-incapacity pension is the percentage corresponding to the loss of capacity for work of the calculation basis, but not less than the national pension rate (NPR).

In fact, this calculation algorithm creates a 2-level floor for the amounts of work-incapacity pensions depending on the level of work-incapacity. From 1 July 2002, the old age pension for a person with 30 years of pensionable service is 1,395 EEK and NPR is 867 EEK.

National pension on the basis of work-incapacity is calculated as the percentage corresponding to the loss of capacity for work of the NPR. Work-incapacity pension and national pension on the basis of work-incapacity are granted for the duration of work incapacity. Work incapacity may be determined for the periods of 6 months, 1 year, 2 years, 5 years or until attaining the retirement age. Work-incapacity pensioners attaining the retirement age are transferred to the old-age pension. Recipients of national

---

themselves). To obtain pension insurance period of one year, social tax has to be paid at least on 12-times the minimum wage in the course of a calendar year.

pension on the basis of work-incapacity who attain retirement age are transferred to national pension on the basis of old age.

All state pensions (including work-incapacity pensions and national pensions) are, in principle, subject to taxation. However, pensions less than 3 times the non-taxable minimum (currently EEK 36,000 a year, EEK 3,000 a month), which is the overwhelming majority of cases, are not subject to taxation.

Social assistance functions of disability protection are addressed with the scheme of social benefits for disabled persons. The scheme is regulated with the Social Benefits for Disabled Persons Act, which came into effect from 1 January 2001. Entitled to social benefits for disabled persons are residents of Estonia, who have been determined as profoundly, severely and moderately disabled by an expert commission, subordinated to the Social Insurance Board.[19]. A general condition for the entitlement is that the moderate, severe or profound disability has caused additional expenses.

The scheme includes 7 different types of benefits:

- Disabled child allowance
- Allowance for disabled persons over 16 years
- Caregivers' allowance
- Disabled parent allowance
- Study allowance
- Rehabilitation allowance
- Further education grant

The first 5 are regular benefits paid monthly, while the latter 2 are lump-sum benefits. All social benefits for disabled persons are calculated on the basis of the social benefit rate (SBR), which is established by Parliament and currently amounts to 400 EEK a month.

The disabled child allowance is paid until the age of 16 at two different amounts: 255% of SBR for children with a severe or profound disability; and 215% of the social benefit rate (SBR) for children with a moderate disability.

---

[19] Profound disability is defined as the loss of (or abnormality in) an anatomical, physiological or mental structure or function as a result of which the person needs constant personal assistance, guidance or supervision 24 hours a day. Severe disability is the loss of (or abnormality in) an anatomical, physiological or mental structure or function as a result of which the person needs personal assistance, guidance or supervision within every 24-hour period. Moderate disability is defined as the loss of or an abnormality in an anatomical, physiological or mental structure or function of a person as a result of which the person needs regular external assistance or guidance outside his or her home at least once a week.

The disabled adult allowance is paid at three different rates: 160% of the SBR for persons with profound disability; 105% of the SBR for those with severe disability; and 50% of the SBR for those with moderate disability.

Caregivers' allowance is paid to a non-working parent raising a disabled child (3–16 years of age), or to an officially appointed caregiver taking care of a severely or profoundly disabled adult. The amount of the allowance varies (60, 75 or 100% of the SBR), according to the age of the disabled person and the degree of disability.

The disabled parent allowance is paid to a single disabled parent or one of two disabled spouses, and aims to compensate for the extra costs associated with the parenthood of disabled persons. The allowance is paid at the flat rate of 75% of the SBR.

Study allowance compensates for the additional disability-related expenses of disabled students who study in gymnasium, professional school or university. The amount of allowance varies from 25 to 100% of the SBR, depending on the amount of disability-related expenses.

Regular benefits are granted for 6 months, 1 year, 2 years or 3 years, depending on the validity of the degree of disability, and are reviewed accordingly.

Rehabilitation allowance is paid as a reimbursement of the actual costs of rehabilitation, up to a limit of 200% of the SBR. Further education grant is a specific one-off benefit to enable disabled persons to continue their work and covers actual expenses of training courses, up to a ceiling of 24 times the SBR in the course of any three-year period.

Social benefits for disabled persons are not subject to taxation.

In addition to the cash benefits, prosthetic, orthopaedic or other technical aids are provided under the Social Welfare Act, with a partial compensation of the costs of appliances listed by the Minister of Social Affairs.

2.3.5 Old-age

The Estonian old age pension system consists of three pillars:

- state pension insurance scheme;
- compulsory funded pension scheme (introduced in July 2002);
- voluntary private pensions.

The state pension insurance in turn includes two tiers: a service related old age pension and a flat-rate national pension.

Entitled to the old age pension are insured persons who have at least 15 years of pensionable service obtained in Estonia. In 2002 and 2003, the retirement age is 63 years for men and 58 years 6 month for women. By a gradual increase of the pension age of women, the pension ages of both sexes will be equalised at the level of 63 by the year 2016.

The flat-rate national pension is payable to any resident who has attained the age of 63, has resided in Estonia for at least 5 years prior to claiming the pension, but has not completed 15 years of pensionable service in Estonia.

From 1 January 1999, pensionable service is obtained only for the periods when social tax was paid. For the time before 1 January 1999 also certain credited periods are taken into account without payment of social tax.[20]

The old age pension consists of three additive elements:

- A flat-rate base amount, signifying the solidarity element in the system
- A length of service component applying to periods of work through 31 December 1998
- A pension insurance component applying to periods of work after 1 January 1999.

As from 1 April 2002, the base amount is 444.44 EEK. The current values for one year of pensionable length of service and the pension insurance coefficient 1.0 apply from 1 July 2002 and are both 31.69 EEK.

The old age pension shall not be less than the National Pension Rate, i.e. the NPR also serves as the minimum for the old age pension.

Pension insurance coefficients are calculated from the annual social tax registered on the account of the insured person in the Pension Insurance Register. These amounts are summed up and divided by the average amount of social tax in the given calendar year. Accordingly, payment of social tax on the average wage in the course of one year would give an insurance coefficient of 1.0.

Basically, in the pension formula, pension rights acquired before 1 January 1999 are taken into account on the basis of time periods, while from 1 January 1999 onwards all new pensions rights are acquired only on the basis of social tax payments. Accordingly, the pension formula entails a gradual transition from the old rules to the new rules.

---

[20] E.g. time spent as a member of an artistic association or trade union; serving in the armed forces of Estonia or any period equal thereto; in compulsory military service or compulsory alternative service; in full-time study; as the spouse of a diplomat in a foreign mission; receiving unemployment benefit or participating in labour market training working on a farm; raising a child for at least 8 years; fighting for independence; temporarily incapacitated for work etc.

It is possible to take up early retirement up to 3 years before the normal pension age, in which case the amount of pension is permanently reduced by 0.4 per cent per each month of earlier retirement. The old age pension may also be deferred, in which case the pension is increased by 0.9 per cent per each month of later retirement.

The flat-rate national pension amounts to 100% of the National Pension Rate (NPR), which is currently 867 EEK.

It is not possible to combine the flat-rate national pension or the early retirement pension with earnings from professional activity. The normal service-related old age pension may be combined with any work income.

From 2002, pensions in payment as well as the three values determining the amounts of pensions are subject to annual indexation with an index, which with equal weights depends on the increase of the consumer price index and the increase of social tax revenues.

Old Age Pension Under Favourable Conditions are available before the normal pension age (provided the person has at least 15 years of pensionable service) for a number of categories (e.g. raising a disabled child, raising 5 or more children, unlawful imprisoning or exile, working under hazardous working conditions, and others).[21]

From 1 July 2002, a statutory funded pension scheme – the second pension pillar – was introduced. Participation in this scheme is compulsory for young persons aged 18 years entering the labour market in the year 2002 or later. For all other employees participation in the scheme is voluntary (for more details see chapter 3).

First and second pillar pensions constitute a taxable income. However, the sum of pensions, which is less than 3 times the non-taxable minimum (in 2002 and 2003, EEK 36,000 a year or EEK 3,000 a month), are not subject to taxation.

Participation in the supplementary voluntary 'third pillar' pension schemes can take 2 forms: pension insurance policies offered by licensed private life-insurance companies or units of pension funds managed by private fund managers. The state has provided tax incentives, allowing contributions to be deducted from taxable income up to the limit of 15% of the annual income, while benefits, which are paid out as life-long annuities are also non-taxable.

---

[21] Early retirement in the form of a superannuated pension is available for certain professional groups (e.g. pilots, mariners, miners, some groups of artists) whose professional abilities are considered to be declined before the normal pension age, provided they have the required pensionable service (from 15 to 25 depending on the profession).

2.3.6 Survivors

Similar to the situation with old-age and invalidity pensions, two kinds of pensions address also the risk of survivorship: survivors pensions and national pensions on the basis of survivorship. Entitled to survivors' pensions are dependent family members[22] of a deceased insured person, provided the insured person had by the date of death a pensionable service necessary for granting him/her a work-incapacity pension or old age pension.

In case the breadwinner did not satisfy the qualification period, survivors have the right to a national pension on the basis of survivorship, provided the breadwinner resided in Estonia at least 1 year prior to death.

The method of calculation of survivors' pensions is similar to the calculation of work incapacity pension. The higher of the following two amounts is used as a basis for calculating the pension:

- The amount of an old age pension calculated from the deceased insured persons' actual accumulated pensionable service and pension insurance coefficients (i.e. the amount of a standard old age pension)
- The amount of an old age pension for a person with 30 years of pensionable service.

The actual survivors' pension amounts to:

- 100 per cent of the theoretical pension, in the case of 3 or more dependant family members;
- 70 per cent of the theoretical pension, in the case of 2 dependant family members;
- 40 per cent of the theoretical pension, in the case of 1 dependant family member.

National pension on the basis of survivorship is calculated using the same percentages, but these are applied to the National Pension Rate.

Survivors pension and national pensions are not paid in case of working, except for children under 18 years of age or students under 24 in case of

---

[22] 1) Children, brothers, sisters or grandchildren of the breadwinner under 18 years of age (24 in case of enrolment in daily studies). Brother, sister or grandchildren are eligible, if the were maintained by the breadwinner and have no working-able parents; 2) parent of the breadwinner, who is in pension age or permanently incapable to work; 3) pregnant widow from the 12th week of pregnancy; 4) widow, who is in pension age or permanently incapable to work, if the marriage has lasted for 1 years; 5) divorced spouse who reached the pension age or became permanently incapable before divorce or within 3 years from divorce, if the marriage lasted at least 25 years; 6) non-working parents or guardian, who raises an up to 3 year old child of the deceased breadwinner.

enrolment in daily studies. In respect of taxation, the same rules apply as for other state pensions (see above).

2.3.7 Employment injuries and occupational diseases

Social protection in the cases of work accidents and occupational diseases does not constitute a separate scheme in Estonia. Health care costs are covered and sickness cash benefits are provided as a part of the health insurance scheme.

In case of work accident or occupational disease the rate of sickness cash benefit is 100 % of reference earnings, i.e. higher than in other cases (60% or 80% depending on the treatment mode). However, the Health Insurance Fund is entitled to claim the difference from the liable employer. Except this, the same rules apply as for other sickness cash benefits.

In the case of permanent work incapacity as a result of work accident or occupational disease, work incapacity pensions are granted and paid under the state pension insurance. The only difference with the general rules for work incapacity pensions is that the qualification period is not applicable. The same applies for survivors' pension paid for dependent family members in case of death of the insured person as a result of work accident or occupational disease.

In case of permanent work incapacity or death, the victim's employer is obliged to pay additional compensation for health damage to the victim or his/her dependant family members under the civil law. This compensation is equal to the victim's average gross earnings over the twelve months preceding the injury or disease multiplied by the percentage reduction in working capacity, minus the amount of state pension. In case of insolvency or liquidation of the employer, the payment of compensation is taken over by the State. Compensations are indexed annually on 1 March with the consumer price index.

2.3.8 Family benefits

Eligible to family benefits are all residents of Estonia.

The scheme of family benefits includes 10 different types of benefits:

- child allowance;
- child care fee;
- single parent's allowance;
- conscript's child allowance;
- foster care allowance;
- birth grant;

- adoption grant;
- school grant;
- start-in-independent-life allowance;
- supplementary benefit for families with 4 or more children or with triples.

The first five of them are monthly benefits. Birth grant, start-in-independent-life allowance and adoption grants are one-off benefits. School grant is paid once a year. Supplementary benefits to families with four or more children or with triples are paid quarterly.

Benefits (with the exception of the child care fee) are calculated on the basis of the child benefit rate (CBR), which is established by Parliament for each fiscal year and currently amounts to 150 EEK. The rate of the child care fee is established by Parliament separately and is currently 600 EEK.

A child allowance is paid monthly until the child reaches the age of 16. If the child is engaged in full-time studies, the payment is extended up to the age of 19. For the first child, the benefit is equal to the CBR. For every subsequent child, the benefit is 2 times the CBR.

A child care fee is paid to parents caring for children in pre-school age. Entitled is:

- a person on parental leave until the child reaches 3 years of age;
- a parent raising children up to 3 years of age; or
- a parent raising 3 or more children up to 8 years of age.

The amount of the child care fee depends on the age and the number of children in the family. For each child under the age of 3, the fee is 600 EEK. If in addition to one or more children under the age of 3, the family has also children aged between 3 and 8 (or until the finishing of the first grade at school), 300 EEK is paid for each child of this age. For families with three or more children, the child maintenance fee is paid at the rate of 300 EEK for each child aged between 3 and 8 (or until the finishing of the first grade at school). The child care fee is paid on top of the regular child allowance regardless whether the parent is working or non-working.

The conscript's child allowance and single parents child allowance are essentially supplements to the general child allowance. The former is paid for each child of the conscript during his entire term of military service in the amount of 5 times the CBR per child. The latter is paid to children of single parents and amounts to 2 times the CBR per child.

Foster children younger than 18 years receive a monthly allowance of 6 times the CBR.

A birth grant is a lump sum paid for every child born. The birth grant paid to the first child of the family amounts to 25 times the CBR and for each subsequent child the grant equals 20 times the CBR.

Adopting parents receive a lump sum adoption grant at the rate of 20 times the CBR.

Orphans are entitled to a start-in-independent-life grant when they leave a children's home or similar institution. This is lump sum payment amounting to 40 times the CBR.

Each child that receives child allowance and is enrolled in a primary school, secondary school or (full time) vocational school receives a lump sum grant at the beginning of the school year. The grant is 3 times the CBR.

Finally, supplementary quarterly allowance is paid for families with 4 or more children or with triples is equal to the CBR per child.

Family benefits are not subject to taxation.

2.3.9 Unemployment

Social protection against the risk of unemployment includes two tiers:

- Earnings-related unemployment insurance benefits financed from statutory unemployment insurance contributions;
- Flat-rate state unemployment allowances financed from the general state budget.

A precondition for entitlement to unemployment benefits is that the person is registered as unemployed at the employment office.[23]

Eligible for state unemployment allowance are all residents of Estonia who have worked (or have been engaged with certain equalised activities, e.g. caring for a child under 8 years of age; military service; imprisonment) at least 180 days over the last twelve months preceding the registration as unemployed. The state unemployment allowance is income-tested and only unemployed persons with an income below the unemployment allowance rate are entitled to the benefit.

The state unemployment allowance is paid at a flat rate, the current rate is 400 EEK a month.

---

[23] Registered as unemployed can be persons who are: aged between 16 and pension age; not engaged in work or other equivalent activity; ready to take up a job and searching for a job.

There is a waiting period of 7 days, i.e. the benefit is paid from the 8th day of registration as unemployed. For certain categories of unemployed, such as students after graduation or those who were dismissed from their previous job due to a loss of confidence by their employer, the waiting period is extended up to 60 days.

The unemployment allowance is granted for a maximum period of 270 working days. In certain cases however, this period may be extended, i.e. if less than 180 days remain until the pension age; if less than 70 days remain until the date of confinement or if the unemployed person is raising three or more children up to 18 years old.

The unemployment allowance is supplemented while the recipient follows a retraining course. The additional retraining grant amounts to 1.5 times the unemployment allowance.

The state unemployment allowance and the retraining grant are not subject to taxation.

From 1 January 2002, a new scheme of unemployment insurance was introduced. The unemployment insurance covers all employees. Excluded from the scope of unemployment insurance are self-employed persons, members of management and controlling bodies of legal persons, and some categories of civil servants of constitutional institutions. Entitled to unemployment insurance benefits are persons who are registered as unemployed at the employment office and have paid unemployment insurance contributions for at least 12 months over the previous 24 months.

The unemployment insurance benefit amounts to 50% of the individual's previous earnings (maximum 3-times average salary) during the first 100 days of unemployment, and to 40% from 101st to 180th day. The duration of payment is extended for persons with a longer insurance period: up to 270 days in the case of insurance period from 5 to 10 years and up to 360 days in case of insurance period over 10 years. Benefits are paid from the 8th day following the application, i.e. the waiting period is 7 days.

The unemployment insurance scheme also includes indemnities (outstanding salaries, vacation pay and redundancy fees) due to the employees in cases of collective redundancies or employer insolvency. These benefits are funded exclusively by employer's contributions.

Unemployment insurance benefits are subject to taxation.

However, first benefits under the new scheme will be paid only after 1 January 2003 as contribution periods are only counted from 1 January 2002. Under the new two-tier system the current state unemployment allowances maintain a residual role, covering those who are not eligible to unemployment insurance benefits because they lack the necessary

contribution record or have exhausted the maximum period of unemployment insurance benefits.

2.3.10 Minimum resources/social assistance

Minimum incomes are guaranteed under the subsistence benefit scheme. Entitled to subsistence benefit are persons residing in Estonia, whose income after payment of fixed housing expenses (corresponding to the standard living space) is below the subsistence level established by Parliament. The granting of benefit is based on the income of all family members living in the same household.

Subsistence level is currently 500 EEK for the first member of the household and 400 EEK for each following person in the household. The amount of the subsistence benefit is calculated as the difference between the subsistence level and the disposable income of the household.

Subsistence benefit is granted for one month at a time. Each month a new means-test is carried out. The local government has a right to refuse to pay subsistence benefit to working age persons, who do not work or study and who have repeatedly refused offers of suitable work or to take part in relevant social rehabilitation programmes organised by the municipality.

All persons legally staying in Estonia, who lack necessary means of subsistence, have a right to emergency social assistance, which is organised by local municipalities. Emergency social assistance comprises social welfare measures necessitated by the condition of the person concerned and shall guarantee at least food, clothes and shelter.

Social assistance cash benefits are not subject to taxation.

2.4 Summary: Main principles and mechanisms of the social protection system

In terms of eligibility, social security and social assistance rights in Estonia are primarily residence-based. Nationality is not a criterion, which means that Estonia's sizeable non-citizen population is also covered. Residence is the only criteria for receipt of national pensions, family benefits, funeral grants, social benefits for disabled persons and social assistance subsistence benefits, when a contingency occurs, making the coverage of these schemes universal. For old age, work incapacity and survivors' pensions, and unemployment benefits, fulfilment of an additional employment-related qualification period is required, and accordingly, these schemes are designated to cover all economically active persons. The only exception relates to the unemployment insurance scheme, where self-employed persons are excluded from the scope.

Regarding health insurance, individuals are insured firstly on the basis of payment of social tax. However, as a number of large population categories (pensioners, children etc.) are equalised with the insured, the coverage is nearly universal, reaching 94% of population. Emergency social and medical assistance is available to all persons legally staying in Estonia.

As for cash benefits, flat-rate benefits prevail. National pensions, family benefits, state unemployment allowance, social benefits for disabled persons and funeral grants are all flat-rate benefits. Old-age, work-incapacity and survivors' pensions are so far relatively weakly differentiated by former earnings. Sickness and maternity cash benefits are currently the only cases of directly earnings-related benefits. However, with recent reforms, the role of earnings-related benefits is increased. From 1999, pension rights are acquired on the bases of social tax paid on earnings. Also, the introduction of the funded pension pillar will emphasise the link between contributions and future pensions. The unemployment insurance scheme will also provide earnings-related benefits. Means-testing is applied only in connection with state unemployment allowances and social assistance subsistence benefits.

The Estonian social protection system includes 3 contributory social security schemes - pension insurance, health insurance and unemployment insurance. The other schemes: family benefits, state unemployment allowances, funeral grants and social benefits for disabled are non-contributory, being financed from general state revenues. The main financing source for social protection is a social tax, which is paid by employers and self-employed persons, and is ear-marked to finance pension and health insurance. The direct participation of employees in the financing of social security was introduced only very recently, and the 1% unemployment insurance contribution is currently their only direct share. This is supplemented with the 2% contribution for funded pensions. However, the latter contribution is compulsory only for young persons entering the labour market and optional for all current employees.

So far, all social security schemes are financed on pay-as-you-go principle. However, all the contributory schemes have developed (or are currently developing) notable cash reserves and/or reserve capitals. As a result of the ongoing pension reform, a fully funded pension scheme was recently introduced, which in turn creates a necessity for state subsidies to the first pillar to cover for the partial loss of social tax revenues.

Social security schemes are administrated on the national level, either by specialised state agencies (Social Insurance Board, Labour Market Board) or by autonomous public-legal bodies (Health Insurance Fund, Unemployment Insurance Fund). The governing bodies of the public-legal funds include representatives of social partners, but except this supervising function, the role of employers' organisations and trade unions in the social protection administration is relatively modest. The administration of social assistance

and social services lays on local municipalities, who may sub-contract the provision of services from NGOs or private bodies.

In conclusion, the Estonian social protection system is characterised by the following dominating features:

- universal (or nearly universal) coverage;
- substantial role of flat-rate benefits (but these provide relatively low replacement rates);
- relatively few earnings-related benefits (but their role is increasing);
- public administration of schemes with a relatively modest role for social partners;
- great reliance on contribution-based financing.

3. PENSIONS

3.1 Evaluation of current structures

3.1.1 Public-private mix

The new Estonian pension system consists of three pillars:

- state pension insurance;
- compulsory funded pension scheme;
- voluntary funded pension schemes.

The main legal framework of the pension system is established by 3 pieces of legislation, namely the State Pension Insurance Act, Social Tax Act and Funded Pensions Act. The first two acts set the main features of the first pillar, while the latter regulates both the second and the third pillar.

The state pension insurance provides protection against the risks of old age, invalidity and survivorship. In fact, the first pillar comprises of 2 separate tiers:

- residence-based national pensions and
- employment-based old-age, work incapacity and survivors' pensions.

The first pillar is characterised by the following features:

- compulsory coverage of all economically active persons;
- guaranteed minimum pension (national pension) to all residents;
- state administration;
- pay-as-you-go financing principle, the scheme is financed from an ear-marked social tax paid by employers and the self-employed[24];
- defined-benefit on an individual level with partly earnings-related benefits, but vertical redistribution through the flat-rate basic part of pension and minimum pension guarantee.

The first pillar scheme is administrated by the Social Insurance Board, which is a state agency within the area of government of the Ministry of Social Affairs (see 2.1.2).

The economic situation of pensioners currently depends heavily on the state pension insurance as state pensions constitute about 80% of the total net disposable income of persons aged 60 and over (see Table 3.3 in Annex 2).

---

[24] The rate of social tax is 33 %, of which 20 percentage points are to finance pension insurance.

The second and the third pillar are new schemes, where the accumulation phase has started quite recently, in case of the second pillar in 2002, in case of the third pillar in 1998.

The second pillar – compulsory funded pension scheme – was introduced 1 July 2002.

The scheme is characterised by the following features:

- participation is compulsory for new entrants to the labour market and voluntary for current employees;
- participants have to pay an individual contribution of 2% of gross wage;
- individual contributions are supplemented by the state with 4% of gross wage, which is re-directed from the pension insurance part of social tax paid by employers;
- the scheme is fully funded;
- defined-contribution principle applies;
- pension fund assets are managed by private fund managers;
- state supervision.

The second pillar scheme addresses only the risk of old age and does not provide pensions for the risks of invalidity and survivorship. Participants of the second pillar have to choose a pension fund, where their contributions are directed. Pension fund is a pool of assets managed by an asset management company. Currently 6 fund managers operate on the market. Three fund managers (Hansa Asset Management, Ühispank Asset Management and Sampo Asset Management) are affiliated to the 3 biggest banks in Estonia, two are linked to insurance companies (Ergo Asset Management, Seesam Asset Management) and one is linked to an investment bank (LHV Asset Management).

The existing second pillar pension funds can be classified into 3 different categories:

- low-risk funds, which invest only in fixed-interest instruments (bonds, money market instruments and bank deposits);
- medium-risk funds, which invest up to 25 % of assets in equities;
- higher-risk funds, which invest the maximum allowed amount – 50 % – of assets in equities.

According to the Funded Pensions Act, each fund manager is obliged to establish a low-risk fund. In addition, each of the fund managers has set up a higher-risk fund, which invests and 3 fund managers offer a medium-risk fund. Accordingly, altogether there are 15 different second pillar pension funds: 6 low-risk, 3 medium-risk and 6 higher-risk funds.

The second pillar scheme is supervised by the Financial Surveillance Authority, which is subordinated to the Bank of Estonia. The scheme includes a Guarantee Fund, which should cover any losses incurred by scheme participants in case the fund manager has breached investment rules. However, the guarantee system does not cover investment risks.

Participation in the voluntary third pillar can take two different forms:

- pension insurance policies offered by licensed private insurance companies;
- units of pension funds managed by private fund managers.

The third pillar is characterised by the following features:

- voluntary participation;
- individual-centred;
- fully funded financing principle;
- private management;
- free choice between the insurance and the fund instrument ;
- free choice between the defined-benefit and the defined-contribution type schemes;
- tax incentives.

Third pillar schemes may provide protection against the risks of old age and invalidity. To encourage participation in the third pillar, the state has provided very favourable tax treatment, allowing contributions to be deducted from taxable income up to the limit of 15% of the annual income, while benefits, which are paid out as life-long annuities are also non-taxable (for more details see 3.1.2).

5 life insurance companies (ERGO Life Insurance, Sampo Life Insurance, Seesam Life Insurance, Ühispanga Life Insurance and Hansapanga Life Insurance) have a license to sell pension insurance policies under favourable tax treatment. 4 fund managers (Hansa Asset Management, Ühispank Asset Management, Sampo Asset Management, LHV Asset Management) run voluntary pension funds.

In 2002, premiums collected by insurance companies under pension insurance policies amounted to 233 million EEK. The total value of assets of the third pillar pension funds reached 64 million EEK by the end of 2002 (Figure 3.2 in Annex 2).

Figure 3.1: The three-pillar structure of the Estonian pension system

Pillar	Participation	Financing	Adminis-tration	Risks covered	Type of scheme
I	compulsory	pay-as-you-go	state	old age, invalidity, survivor-ship	defined-benefit
II	compulsory for new entrants to the labour market, voluntary for current work-force	fully funded	state/ private	old age	defined-contribution
III	voluntary	fully funded	private	old age, invalidity	defined-benefit or defined-contribution

The multi-pillar structure of the new Estonian pension system recognises the diversity of risk factors influencing the pension system – demographic, labour market, financial market – and aims at maximising the potential benefits of the participant through dividing the risks between various pillars. However, the second and the third pillar are still in their infancy and their role in the benefit provision will emerge only in 10-20 years. The introduction of additional pillars nevertheless clearly underlines the increasing role of individual responsibility and private provision for the old age.

3.1.2 Benefits

The state pension system includes 5 types of pensions:

- old age;
- superannuated;
- work incapacity;
- survivors' and;
- national pension.

Entitled to the old age pension are persons who have attained a pension age and have at least 15 years of pensionable service obtained in Estonia. In 2002 and 2003, the statutory pension age is 63 years for men and 58 years 6 months for women[25],[26].

[25] The pension age has been increased since 1994, starting from the level of 55 years for women and 60 for men. The pension age of men reached the target level of 63 in

The old age pension consists of three additive elements:

- a flat-rate base amount;
- a length of service component applying to periods of work through 31 December 1998;
- a pension insurance component applying to periods of work after 1 January 1999.

In mathematical terms, the pension formula could be expressed as:

- $P = B + s \times V + I \times V$,

where symbols have the following meaning:

B – base amount;

s – pensionable length of service of the pension applicant[27],

I – sum of pension insurance coefficients of the pension applicant,

V – cash value for one year of pensionable length of service and the pension insurance coefficient 1.0.

The flat-rate basic part of pension signifies the solidarity element in the system and provides vertical redistribution from higher-income earners to lower-income earners. The length of service component is also redistributive as it takes into account only on the number of service years, but not the former earnings. However, this component applies only to pre-reform 'old service' up to the end of 1998. From 1999 onwards pension rights are acquired only on the basis of social tax paid. The acquired rights are assessed through annual pension insurance coefficients, which indicate the proportion of the amount of social tax paid on behalf of the person to the average amount of social tax paid in the given calendar year.

Thus, the amount of the pension depends on two individual variables – length of pensionable service accumulated before 1999 and the sum of pension insurance coefficients accumulated thereafter. Longer service before 1999 and higher amounts of social tax paid (i.e. higher legal wages) from 1999 onwards are the factors, which contribute to a higher individual pension.

The pension formula has foreseen a gradual transition from the old rules to the new rules. For the majority of current pensioners who withdraw from

---

2001. The pension age of women will be increased further to be equalised with the pension age of men at the level of 63 by the year 2016.

[26] Statistics on the average effective pension age are not available. It is estimated to be around 60 years as the number of old-age pensioners nearly equals the number of persons aged 60 or over.

[27] On determination of the pensionable length of service see 2.3.5.

work before 1999, pension depends only on the flat-rat base amount and the number of service years. For persons who entered the labour market in 1999 or later, the state pension will also consist of 2 parts: flat-rate base amount and contribution-related insurance component. In essence, the three-part pension formula applies only to the 'transition generations', who have worked both before as well as after 1999.

The real amounts of pensions in payment depend on the values of B (the base amount) and V (the value of 1 service year and pension insurance coefficient 1,0). Until 2002, these values were determined annually respectively by Parliament and the Government on the basis of budget constraints. From 1 April 2002, the values are subject to annual indexation (see below).

From 1 July 2002, the base amount is 444 EEK and the value of a service year is 31.69 EEK[28]. Considering that the average length of pensionable service of old age pensioners is currently 44 years, the average old age pension amounts to 1,839 EEK. Of this, the base amount constitutes about 24%.

To calculate of work-incapacity and survivors' pensions the following method is used. Firstly, the higher of the following two amounts is used as a calculation basis:

1. The amount of an old age pension calculated from the individual's years service and pension insurance coefficients (i.e. the amount of a standard old age pension)[29]
2. The amount of an old age pension for a person with 30 years of pensionable service[30].

The amount of a work incapacity pension reflects the degree of the individual's incapacity. The calculation base, as derived above, is multiplied by the per cent of person's work incapacity. To create a floor below which

---

28 First indexation of pensions was carried out in April 2002. However, the new coalition, which gained power in January 2002, implemented an extraordinary *ad hoc* increase of pensions from 1 July 2002.

29 In case of work-incapacity pension this applies to the applicant, in case of survivors' pension to the breadwinner.

30 The choice of the second component of the floor, as described above – an old age pension for a person with 30 years of pensionable service – bears an indirect relation to the requirements of the European Code of Social Security (see 3.2.1), signed by the Government in January 2000. The Code requires that the old age pension for a standard beneficiary – a person with an insurance period of 30 years – shall correspond to at least 40% of the wage of an ordinary adult male labourer. The same standard – 40% of the wage of an ordinary adult male labourer – also applies for invalidity pension for a person with a total loss of earnings capacity and for survivor's pension for a widow with 2 children. In establishing this particular floor, the Government linked these requirements, so that the pension for a person with total work incapacity must at least equal the old age pension for a person with 30 years of service.

work-incapacity pensions cannot fall, it is further stipulated that the work-incapacity pension may not be less than the rate of the national pension (that is the minimum old age pension). Otherwise, individuals with low degree of work incapacity (40-60%) would end up with very low pensions.

In fact, this calculation algorithm creates a 2-level floor for the amounts of work-incapacity pensions depending on the level of work-incapacity (Table 3.13 in Annex 2).

In practice, most persons under 50 years of age – about two-thirds of all beneficiaries – receive the fixed rate, as their insurance record is relatively short. The standard old-age pension formula has relevance only for persons who are closer to the pensionable age and have an insurance record longer than 30 years.

Survivors' pension depends on the number of dependant family members[31].

The actual survivors' pension amounts to:

- 100 per cent of the calculation base, in case of 3 or more dependant family members;
- 70 per cent of the calculation base, in case of 2 dependant family members;
- 40 per cent of the calculation base, in case of 1 dependant family member.

Again, the floor established in the calculation base – old age pension for a person with 30 years of pensionable service – provides a minimum for the amounts of survivor's pension (Table 3.14 in Annex 2). However, given that many breadwinners with minor children have relatively short insurance records, over half of all survivors' pensions are paid in fixed minimum amounts.

National pension is granted to persons who because of lacking required pensionable length of service or pension insurance period do not have right to old age, invalidity or survivors' pension. National pensions on the basis of old age for persons who lack the required insurance period for entitlement to old age pension are paid at a flat rate, currently 867 EEK. The national pension rate serves also as the minimum pension guarantee for old age pensions. National pension on the basis of work-incapacity is calculated as the percentage corresponding to the loss of capacity for work of the national pension rate (for amounts see Table 3.13 in Annex 2). Different from work-incapacity pensions, there is no second floor established, and as a result,

[31] For definition of dependent family members see 2.3.6.

national pensions for persons with a low degree of work incapacity (40-50%) are really modest, falling even below the social assistance level[32].

National pension on the basis of survivorship depends again on the number of dependant family members and is calculated using the same percentages as in case of survivors' pension, but applying these to the national pension rate (Table 3.14 in Annex 2).

Old age pensions under favourable conditions are paid to workers in occupations that are considered hard or hazardous (e.g. workers in chemical, metal, glass, pulp industry, mining etc.). They may retire 5 or 10 years before the normal pension age, if they have fulfilled qualification requirements - from 15 to 25 years of pensionable service of which at least half in the given profession. Also some other categories (e.g. parent of a disabled child, parent who has raised 3 or more children, unlawfully imprisoned persons etc.) may retire before the normal pension age, provided the person has at least 15 years of pensionable service[33]. In the beginning of 2002, nearly 48 persons thousand (16% of the total number of old age pensioners) received old age pension on favourable conditions under various legal provisions.

According to the Superannuated Pensions Act, early retirement is available for certain professional groups (e.g. pilots, mariners, miners, some groups of artists) whose professional abilities have declined before the normal retirement age, provided they have the required pensionable service, which is from 15 to 25 depending on the profession.

These special regimes in the general state pension system are problematic from a number of aspects:

- The rate of social tax to finance pension insurance is the same for all employers, but in some professions retirement conditions are more favourable, which is questionable from the equity perspective;
- The state accepts that certain branches, occupations and professions are unhealthy, giving a wrong signal to the employers in these sectors and reducing their responsibility to improve working environment;
- The connection of the qualification period to the period of work in unhealthy conditions gives an adverse incentive for a worker to work longer in unhealthy environment;
- These special regimes reduce the average age of retirement.

Starting from 2002, pensions in payment as well as ingredients determining the amounts of newly granted pensions (i.e. B and V) are indexed annually on 1 April. The index is an arithmetic average of the

---

32 Social assistance subsistence level is currently 500 EEK, see 2.3.10.

33 For a complete list of these categories see 2.3.5.

annual increase of the consumer price index and the increase of social tax revenues.

In essence, the indexation formula entails that the increase of pensions will keep pace with inflation, considering that most probably in the coming years the increase of wage bill will continue to exceed the inflation rate. However, from the other side this scenario would mean that the average replacement would decline and discrepancy between living standards of employees and pensioners is going to increase.

Although in principle, state pensions constitute a taxable income, the overwhelming majority of state pensions therefore are not taxed as their level is below 3,000 EEK, which is currently the non-taxable threshold applicable to pension income.

Most old age pensions are currently in a range from 1,000 to 2,500 EEK. The benefit structure is rather flat, as the contribution-related component of the pension plays still quite modest role and the majority of current old age pensions in payment are differentiated only on the basis of years of service.

The average old age pension in 2001 – 1,583 EEK a month, corresponding to 86% of the median disposable income – kept recipients above the poverty line. In 2001, the relative poverty line, determined by the Eurostat indicator of 60% of the median disposable income per household member, was 1,100 EEK.

Data of the Household Income and Expenditure Surveys confirm that most pensioners belong to the second and third income quintiles (Table 3.4 in Annex 2), i.e. to the lower-middle range of the income continuum. At the same time, relatively few pensioners were in the poorest income quintile. The problem of poverty affects more often recipients of national pension and invalidity pensioners since the rates of these benefits do not take the recipients above the poverty line[34].

It could be noted also that low incomes appear less prevalent among old-age pensioners than in families with many children and households with an unemployed member.

The average net replacement rate of the old age pension was around 40-45% during the second half of the 1990s, gross replacement rates varying from 32% to 36% (Table 3.2 in Annex 2)[35]. Although keeping pensioners

---

[34] The national pension, which at the same time is the minimum for old age and work-incapacity pensions in 2001 was 800 EEK.

[35] The replacement rate jumped to over 50% in 1999 as governing coalition increased pensions on average by 20% in January 1999 ahead of general elections in March 1999. However, as in 2000 pensions were not increased, and the increase of pensions in 2001 was on average only 3%, the replacement rate declined to the level of mid 1990s.

out of direct poverty, the replacement rate of 40% means that on average, disposable income of a person decreases by 60% upon retirement. 40% net replacement rate is basically the minimum, which is considered socially adequate by relevant international conventions, like the ILO Convention No.102 and the European Code of Social Security[36].

However, as the earnings-related component of pension was added very recently, the scheme is still strongly redistributive. Individual replacement rates for low-income earners are substantially above 40%, while for higher income earners these decline below 40%. In case of long service years, the replacement rate for a minimum wage earner could be over 100%.

The newly established second pillar is of a defined-contribution type and accordingly second pillar pensions will depend on the value of assets accumulated by the individual over the whole career – the total value of contributions and the rate of return earned. Obviously, in such a scheme, the amount of future pension is linked to the earnings of the person upon which contributions are paid, and to the length of participation in the scheme.

According to the Funded Pensions Act, the following 3 criteria have to be fulfilled to be eligible for second pillar pensions:

- the person has attained pension age, which is the same as in the first pillar;
- the first pillar pension should be granted;
- the person has participated in the second pillar scheme for at least 5 years.

As a rule, pensions are paid by life insurance companies as lifelong annuities. If the value of accumulated assets of the individual exceeds a pre-set amount (3 times the national pension rate), the individual may choose to take additional sums out as a programmed withdrawal from the pension fund (not necessary life-long). However, assets can not be paid immediately as a lump sum. If the insured person dies before the pension age, the units of the fund are inherited. Survivors have the option either to withdraw the accumulated sums in cash or to transfer the units to their own second pillar pension account. After attaining pension age possible left assets from programmed withdrawals are inherited, whereas possible assets left from life-long annuities are not unless a guarantee period is agreed at the time of purchasing the annuity.

However, as already noted, this scheme is only recently established and the benefits will be paid out only in 2009.

---

[36] In fact, according to the ILO Convention No.102 and the European Code of Social Security, the replacement rate of 40% relates not to the average wage in the economy, but to the wage of an ordinary adult male labourer.

Participation in the second pillar will affect the amount of state pension. Since for these persons only 16 percentage points of social tax (instead of former 20 per cent) goes to finance state pensions, the annual pension insurance coefficient, which determines the size of contribution-related component of the first pillar pension, is proportionally (by 4/20, i.e. 1/5) reduced. However, the base amount of state pension (which is, as noted above, about 25% of the average pension) is not reduced, and thus the rules contain a small bonus for persons joining the second pillar.

For persons who do not join the second pillar, pension will develop only from the state pension insurance.

In the voluntary third pillar schemes, the pension age is a matter of contract between the person and the insurance company, except that the minimum age in which case tax privileges apply, is 55 years. Pensions may be withdrawn also in the case of total permanent incapacity to work. Taxation rules applicable to the third pillar are the following:

- contributions (premiums paid on the bases of pension insurance policy or sums paid for purchasing the units of a private pension fund) are deductible from taxable income up to the ceiling of 15% of annual income;
- benefits paid on the bases of a private pension insurance policy or from redemption of the units of a pension fund are taxable at a lower rate (10%), instead of the normal income tax rate of 26% ;
- benefits, which are paid regularly lifelong on the bases of a defined-benefit type pension insurance policy in equal or increasing amounts are not taxable.

As indicated in 3.1.1, there are some pension payments from third pillar schemes, but their role in the overall picture is still insignificant.

3.1.3 Financing of the pension system

The state pension insurance operates on the pay-as-you-go financing principle, current work-force supporting pensioners through the payment of an ear-marked social tax. The 20% pension insurance part of social tax is currently the main source of revenues for state pension insurance, covering over 95% of total pension expenditures (Table 3.5 in Annex 2).

Pension insurance budget receives also allocations from the state budget. These are not however open subsidies. State budget allocations cover legally pre-defined expenditures, which are not related to the insurance principle: national pensions, pension supplements for war veterans, years of service counted for periods of political repressions, administrative costs of pension offices.

Although the pension insurance budget is not autonomous from the general state budget, the earmarked nature of social tax entails that revenues from social tax are kept strictly separate from other state revenues. According to the State Pension Insurance Act, revenues from pension insurance component of social tax can not be used for any other purpose but for payment of state pensions.

The State Pension Insurance Act also stipulates the scheme shall have cash reserves. The size of cash reserves however is not regulated. Although in 1999, following the Russian crisis, the state pension scheme had to struggle with current deficit, expenditures exceeding revenues by over 750 million EEK, the current financial situation is rather good. As of 1 January 2002 cash reserves amounted to 608 million EEK or about 0.6 % of GDP (8% of the pension insurance budget for 2002). By 1 January 2003, the reserves had more than doubled to 1,343 million EEK (Table 3.6 in Annex 2).

In 2001, total expenditures on state pensions exceeded 6.6 billion EEK, which accounts for 6.9 % of GDP (Table 3.8 in Annex 2). In the second half of 1990s, the percentage of pension expenditure in GDP has been around 7.1-7.6%[37]. This is below the EU average, but it should be considered that in contrast with several EU countries, pensions in Estonia are not taxable. Moreover, as demonstrated by Scharpf (1997), social security expenditure levels in the EU Member States are in correlation with GDP per capita levels.

The new second pillar is established using both carve-out and top-up methods. Part of the current pension insurance component of social tax is redirected for the second pillar, while this is supplemented with an additional contribution of employee. The reform is neutral to the overall social tax rate of employers, but affects the distribution of social tax revenues (Figure 3.2 in Annex 2).

From the financing side, the reform has been described with the formula '16+4+2'. Participants of the second pillar have to pay an individual contribution of 2% of their gross wage, which is supplemented by the state with 4 percentage points of the gross wage on the account of social tax paid by the employer.

The individual contribution – 2% – is withheld by the employer. The employer transfers the individual contribution together with the total amount of social tax (33% of wage) to the Tax Office, which operates as the collection agency. The Tax Office then matches the individual contribution (2%) with the part of social tax (4%) and transfers the total 6% to the account of Central Depository of Securities, which registers the amount and

[37] The year 1999 was exceptional, because of the high pension increase. See 1.1.1 and footnote 35.

issues pension units. Thereafter the Depository transfers the amount to the depot bank of the fund manager chosen by the individual. Accordingly, 6% of the gross wage is accumulated on the individual account in the second pillar pension fund. In other words, for participants of the second pillar, 4 percentage points of the pension insurance part of social tax is redirected to their individual pension account on the condition that an individual contribution of 2% of gross wage is paid. For these persons 16 percentage points continue to finance current state pensions and determine the contribution-related insurance component of the state pension.

For persons, who decide not to join the second pillar, nothing will change. Pension insurance component of the social tax remains at 20% and their pension will develop only from the first pillar.

The rules of the second pillar thus provide for the current work-force an opportunity for partial opt-out, but on a condition that the person starts to pay additional contributions.

However, as also the carve-out method is used, introduction of the second pillar will create a typical problem of 'transition costs', i.e. the necessity to finance state pensions in a situation of reduced social tax revenues.

Taking into account the number of persons who joined the second pillar in the first half of 2002, the loss of revenues is expected to be 78 million EEK in the second half of 2002. The Government has announced that existing social tax reserves will be used to cover this deficit.

When the 2003 state budget was drafted, the Government estimated the number of second pillar participants to reach 100-120 thousand persons and consequently the loss of social tax revenues to be around 380 million EEK in 2003. These estimations were based on the results of opinion polls and the rather low number of persons who joined the scheme in the first phase.

Since by the end of 2002 over 200 thousand persons joined the second pillar, reduction of social tax revenues is estimated to be around 600 million EEK in 2003. The Government has announced that it will use the cash reserves of the state pension insurance (surplus of social tax from previous years) to cover the deficit of the first pillar in 2003.

3.1.4 Incentives

Relatively low replacement rates of old age pensions motivate older employees to stay in employment after reaching pension age. This also explains the relatively high labour force participation rates in the 55-64 age group (see 1.1.3). The motivation is even stronger considering that the legislation allows to combine old age and work-incapacity pensions with earnings from work without any limitations. From the other side, the ability to draw old age pension while continuing in employment motivates to seek

pension at the earliest possible date, as granting of pension in this situation would essentially mean increase of disposable income. However, early retirement pensions are not paid in case of working.

To counterbalance the options of earlier retirement, a deferred old age pension was introduced from 1 January 2002. Increase of pension by 0.9 per cent per each month of postponed retirement (i.e. 10.8 percent per year) is considerable more than an 'actuarially fair' adjustment and provides a strong incentive to continue in work without drawing a pension[38]. Continuation of work gives a double interest as the full career is taken into account for calculation of pension and additional working years increase the pension.

The calculation of new pension rights from 1999 on the basis of social tax paid strengthens the link between the payment of contributions and amount of pension to be received. This reduces the degree of vertical redistribution in the state pension system and improves the incentives to contribute to the system especially for the higher income earners. However, for low income earners – persons receiving the minimum wage or less (e.g. working part-time) – the size of actual contributions does not make any difference, as in any case they will end up with minimum pension (Lindell 2001).

3.1.5 Coverage of the system

All economically active persons are covered with the first pillar through the payment of social tax. All residents are guaranteed a national pension. Accordingly, coverage and take-up ratios of the state pension system are nearly 100%.

About two-thirds of all pensioners are women, mainly explained by the lower pension age and higher life expectancy of women (Table 3.11 in Annex 2). However, along with the further increase of pension age of women, the share of male pensioners is increasing. In 2000 and 2001, men outnumbered women among the new retirees.

Differences between average amounts of pensions for men and women have been small – less than 5% – reflecting the relatively flat benefit structure (Table 3.11 in Annex 2). It is obvious that as a result of calculation of all new pension rights on the basis of social tax paid, the benefit structure in the future will increasingly reflect former wage differences. Hence also gender differences are expected to increase, as women's wages are currently on average about 75% of wages of men.

Participation in the second pillar is compulsory for young persons aged 18 (born after 1 January 1983) entering the labour market in 2002 or later. Persons who in 2002 are aged from 19 to pension age (i.e. the current work-force) may join the second pillar voluntarily. However, contributions to the

[38] An actuarially fair adjustment would be about 0.6% per month.

second pillar can not be made on income from self-employment and therefore self-employed persons who do not receive any wage income can not participate in the second pillar.

Over the first period of accepting applications in May 2002, 37,055 persons (or 7.2% of eligible employees) joined the second pillar, starting to accumulate their contributions from 1 July 2002. The second period of accepting applications ended 31 October 2002, adding 170,145 new participants who start to accumulate contributions to their accounts from 1 January 2003.

The total number of second pillar participants has thus reached 207,200 persons, which is 40% of all persons who had the choice. This was considerably more than the earlier public opinion polls suggested. According to the poll carried out by Estonian Surveys Ltd. in April 2002 (i.e. right before the introduction of the second pillar), 6% of working age respondents stated that they intend to join the second pillar in 2002. Further 20% of respondents expressed intention to join the system in the future, 33% were undecided, while 41% stated that they either probably or certainly are not going to join the second pillar.

The high number of persons who joined the second pillar in 2002 indicates thus the success of the Government awareness campaign, advertisement campaign and sales work of pension fund managers, primarily in convincing the formerly undecided persons.

Given that for the current workforce the possibility to join the second pillar remains open[39], participation in the second pillar will likely exceed 50% of employees already in 2003. However, for older workers (born 1942-1956) 31 October 2002 was the last deadline for joining.

Considering that participants of the second pillar have to bear the investment risk, it is somewhat surprising that the majority – 64% – joined higher-risk funds, which invest up to 50% of assets in equities. Only 15% preferred low-risk funds, while the remaining 21% joined medium-risk funds. However, there is a clear age-gender pattern in this respect, older persons and women opting more for low-risk funds. In the 45-60 age group, 38% joined a low-risk fund and 34% a medium-risk fund.

Establishment of the second pillar has increased participation also in the third pillar. In 2002, over 13 thousand new third pillar pension insurance contracts were made. By the end of 2002, about 46,700 persons (ca 8% of all employed persons) had concluded a pension contract with a life insurance company. The number of participants in voluntary pension funds was about 2000 persons.

---

[39] Applications are accepted until 31 October each year in which case collection of contributions starts from 1st of January of the following year.

3.1.6 Public acceptance of the system

According to the Welfare and Health Survey of the Estonian Elderly Population conducted in 2000 by the Tartu University and Estonian Association of Gerontology and Geriatry, 61% of persons over 65-years of age considered their economic situation as satisfactory or better (Table 3.15 in Annex 2). From the other side, about 38% admitted some economic difficulties. Most often encountered difficulties elderly persons living alone in apartment with high housing expenses.

Results of the study show that the majority of pensioners have learned to cope with the rather limited resources available. The evaluation of current employees on the economic situation of pensioners and about their own future prospects as a pensioner, is far less positive. According to the opinion poll carried out by Estonian Surveys Ltd. in June 2001, 82% of working-age respondents considered that the current levels of state pensions do not allow satisfactory coping. 65% of respondents did not believe that the situation could improve considerably in the future. Slightly over 50% of respondents considered that in addition to the state, individuals themselves should take responsibility for their old age provision.

3.2 Evaluation of future challenges

3.2.1 Main challenges

The main challenge for the state pension insurance in the coming years is how to keep the average replacement rate above 40%. From one side, this aim is important in order to maintain the adequacy of state pensions. From the other side, it is an international commitment taken by the Government.

In May 2000, Estonia has ratified Article 12 of the revised European Social Charter (on the right to social security), which requires that the social security system should meet the standards of the European Code of Social Security. In January 2000, the government has also signed the European Code of Social Security, which requires that the old age pension for a standard beneficiary – a person with an insurance period of 30 years – shall correspond to at least 40% of the wage of an ordinary adult male labourer[40].

In October 2000, the old age pension for a person with an insurance period of 30 years amounted to 40.9% of the net wage of the ordinary adult male labourer. Thus the replacement rate was only marginally above the international minimum standard. By October 2001, the replacement rate had declined to 37.4%, i.e. below the minimum standard of the European Code of Social Security.

---

[40] The same standard – 40% of the wage of an ordinary adult male labourer – also applies for invalidity pension for a person with a total loss of earnings capacity and for survivor's pension for a widow with 2 children.

It appears that the aim of keeping the replacement rate above the 40% target level can not be achieved without any further changes to the scheme parameters considering that the current indexation formula will very likely result in the decline of the average replacement rate.

The long-term sustainability of the state pension insurance is jeopardised by the increase of the system dependency ratio.

In the second half of the 1990s the system dependency ratio steadily increased, continuing the trend, which started already in 1992. This was primarily due to the falling number of employees (see also 1.1.3), while the increase of pension age stabilised the number of pensioners. In 2000 and 2001 the system dependency ratio declined again to the 1997 level as a result of increased employment, while the number of pensioners declined with the introduction of the State Pension Insurance Act[41].

3.2.2 Financial sustainability

While the average replacement rate of state pension in Estonia is rather low compared to the other European countries (both the EU and candidate countries), the contribution rate to finance the state pension system – 20% of wages – is higher than in several EU Member States. As the income tax and compulsory social security contributions already place a relatively high burden on labour[42], possibilities to ease the financial pressures of the state pension system through increase of the contribution rate are clearly limited. Given that pensions already account for about half of total social protection spending, attempts to shift financing of the state pension system more towards general revenues would have to compete against similar claims of other branches of social security and public sector.

In this context, a key cost-containment measure has been the increase of statutory pension age. Increase of the pension age has stabilised the total number of pensioners, and as demonstrated in 1.2.2, has been accompanied with increase in the labour force participation rates of the 55-64 age group, while the unemployment rate in this age group has been below the average. Statutory pension age in Estonia is still lower than in the EU countries. However, the statutory pension age has to be weighted against the average life expectancy, which in Estonia is also considerably below the EU average (see Table 1.8 in Annex 1).

Over the period of 1993-2002, the Estonian first pillar basically operated on a principle, which may be called 'defined-contribution on a macro-level'.

---

41 The number of pensioners declined mainly because the former invalidity pensions for child-invalids were replaced by disabled child allowances financed out of general state revenues.

42 The tax wedge on wage income varies from 34% on minimum wage to 43% on twice the average wage.

The level of pensions and thereby the total pension expenditures were adjusted according to the available revenues from social tax (see also 3.3.1). Since as a rule, pensions were increased only after sufficient reserves were developed from incoming social tax revenues, the pension insurance budget could not go into deficit[43]. It could be argued that in principle, such a scheme is always financially sustainable as long as pensions are adjusted only according to financial constraints[44]. Another question is whether the level of pensions would be adequate and subsequently, whether is such a scheme is politically sustainable.

The introduction of indexation from 2002 changed the Estonian first pillar into a typical defined-benefit pension scheme. The total volume of benefits is determined by an index, which depends on the increase of consumer prices and the increase of social tax revenues[45].

In the coming decade, the increase of pension age contributes to the sustainability as the increase of pension age has exceeded the increase of average life expectancy.

Introduction of the funded second pillar will raise the typical problem of "transition costs". Reduction of social tax revenues because of transfers to second pillar accounts is estimated to be around 600 million EEK in 2003, which is about 0.5% of the projected GDP. Over the years, the deficit is expected to increase with the expected increase in participation rate. The Government has announced that to finance the transition it intends to use reserves developed over the last years – the surplus of social tax revenues and the stabilisation reserve. However, considering that the stabilisation reserve currently amounts to ca 2% of GDP, it is clear that these sources are available only for the next few years. Therefore, a longer-term strategy to finance the transition is necessary.

3.2.3 Pension policy and EU accession

Implications of the binding *acquis communautaire* of the European Union upon the Estonian pension system are rather limited (Leppik 1999).

The application of social security co-ordination rules (Council Regulations 1408/71 and 574/72) will to a modest extent increase the costs of the state pension scheme, since the regulations give persons moving

---

43 In practice, these principles were broken in 1999, when pensions were increased over 20% and the increase was not covered with social tax reserves. As a result of economic downturn, the scheme fell in deficit in 1999.

44 At least in theory, the level of pensions could also fluctuate downward. In practice this never happened, as social tax revenues increased due to economic growth and inflation.

45 When calculating the index, the whole pension insurance part of social tax – 20% – is taken into account. The partial loss of social tax revenues due to the second pillar does not therefore affect first pillar pensions in payment.

within the Union certain new rights, which they do not have under the national pension legislation.

According to the State Pension Insurance Act, the payment of pensions is currently limited to persons residing in Estonia. Export of pensions is possible only under a bilateral social security agreement. From the current EU Member States, Estonia has a relevant bilateral agreement only with Finland. From the other applicant countries, Estonia has bilateral agreements with Latvia and Lithuania. With accession, the right to a pension will be extended to the whole territory of the enlarged Union.

However, the addition burden from export of pensions is estimated to be rather modest – less than 1% of the total pension insurance budget. This is explained by the fact that the neighbouring countries, where the movement of persons is obviously highest, are already covered with agreements, emigration to other European countries has been very limited and exported pensions (or parts thereof) are still paid according to the Estonian rates.

Equal treatment of men and women (Directives 79/7 and 86/378) is largely already in place in the Estonian pension system. The last gender-specific provisions in the general state pension scheme (in respect of the pension age and advantages in respect of raising up children) were phased out by the 1998 State Pension Insurance Act even though the directive 79/7 permits derogations from the general principle of equal treatment in these matters.

As noted above, the pension age of men and women will be gradually equalised at the level of 63 by the year 2016. Moreover, as demonstrated in section 3.1.5, differences between average amounts of state pension of men and women have been rather small (less than 5%), indicating that in the state pension system there is currently not only equality of treatment, but to a large extent also the equality of outcomes.

However, the Superannuated Pensions Act and the Old Age Pensions on Favourable Conditions Act are still not yet harmonised with the Directive 79/7. These acts prescribe different qualification periods for men and women, which is not permitted by the Directive (Pennings et al 1998).

Obviously, there will be also indirect implications of EU membership upon the pension policy, e.g. through participation in the Economic and Monetary Union as well as through participation in the open-method of co-ordination in the field of pensions.

3.3 Evaluation of recent and planned reforms

3.3.1 Recent reforms and their objectives

Estonia inherited its benefit systems from the Soviet Union. The pension system of the former Soviet Union had several Bismarckian features – e.g. entitlements based on work and benefits linked to the former wage. However, unlike a typical Bismarckian scheme, pensions were financed from the general state budget. The general pension age under the Soviet Pension Act was 55 for women and 60 for men. The qualification period for the old age pension was gender specific – 20 years for women and 25 years for men. Minimum and maximum pensions made the pension system strongly redistributive, and combined with a relatively flat wage system resulted in a benefit structure that was rather weakly differentiated. The level of pensions remained unchanged for several decades, since the Soviet ideology failed to recognise the notion of inflation, and accordingly there was no need for indexation of benefits (Leppik 2002). A noteworthy feature of the Soviet system was a high proportion of working invalidity pensioners as a result of the full-employment policy.

Early reforms of the pension system in Estonia in the beginning of 1990s may be characterised by the following stages:

1. Financial separation of the benefit system (1990);
2. Benefit liberalisation (1991);
3. Benefit retrenchment (1992);
4. Benefit restructuring (1993).

With the underlying aim of preventing negative effects from economic turbulence caused by price liberalisation, increasing inflation and disturbed cash flows, the government separated the financing of the Estonian pension system from the rest of the Soviet Union even before the formal regaining of independence. At the same time, many people believed that financial separation would allow the provision of better benefits. Therefore, although the Soviet pension system provided rather high replacement rates, the first attempts of the Estonian government to reform the system were partly motivated by a desire to raise the level of social protection even further (Leppik 2002).

The adoption of the Social Tax Act in 1990 introduced a social tax at the rate of 20% of the gross payroll, earmarked for the financing of state pensions[46]. Revenues from the social tax were collected by the Social Fund, which separated pension expenditures from other budgetary expenditures.

The new Pension Act of Estonia, adopted in 1991, had two main objectives – to separate the benefit side of the Estonian pension system from

[46] The act was adopted on 12 September 1990 and came into effect 1 January 1991.

the Soviet system, and to increase coverage and the level of benefits (Leppik and Männik 2002). The new act liberalised eligibility rules broadening the coverage of the pension scheme to all residents and prescribed higher pension rates. The act prescribed a mixed pension formula – a flat rate base amount supplemented with an earnings-related component. Calculation of pensions was based on 2 factors: the minimum wage and the former earnings of the person. The former earnings were calculated on the basis of the five best consecutive years within the 15 years preceding the pension application or the end of the working career.

The new act created a quite typical contribution-financed defined-benefit pension scheme, but high expectations ran up sharply against economic reality and act had a very short life, being implemented for only few months. Because of the total neglect of financial calculations, implementation of the act turned out to be unaffordable.[47] The failure of the first reform was mostly due to a striking lack of qualified staff able to develop policies and legislation in a coherent way, while the situation was further exacerbated by serious economic crisis at the time of collapse of the Soviet Union.

Parliament suspended the Pension Act in February 1992 and pensions were replaced by flat-rate state living allowances. The second reform – introduction of flat rate allowances – should be regarded as a rescue measure to help cope with a situation of deep economic crisis rather than a purposeful change towards egalitarian principles. With flat-rate benefits, payments were easier to administer and calculations easier to make. The levels of pensions were connected to the minimum wage.

In 1992 two important reforms set the broader context for various national policies – monetary reform,[48] and the adoption of the new Estonian constitution.[49] The constitution, *inter alia*, laid down the general principles of social security:

Estonian citizens shall be entitled to state assistance in case of old age, inability to work, loss of provider and need. The types of assistance, its level, eligibility conditions and procedures shall be established by law. Unless otherwise determined by law, this right shall exist equally for Estonian citizens, citizens of foreign states and stateless persons who are present in Estonia.

---

47 Another problem was the need to carry out several recalculations of pensions in an environment of very high inflation in 1991–1992. This had to be done manually, as the level of computerisation of pension offices in the early 1990s was still very low.

48 On 20 June 1992, Soviet roubles were changed to Estonian kroons (EEK) at the rate of 10 roubles per kroon. The exchange rate of the kroon was pegged to the German mark at the fixed rate of EEK 8 = DEM 1. All residents were allowed to change up to 1,500 roubles.

49 The constitution was adopted by referendum on 28 June 1992, and entered into force 3 July 1992.

Notably, social rights were formulated in a rather weak manner in the constitution. The formulation 'state assistance' is used rather than stronger statements such as 'the right to pension'.

Against the background of rather strong public pressure from pensioners' organisations to end the system of flat-rate benefits, the Parliament adopted a State Living Allowances Act in March 1993[50]. The act introduced a gradual increase of the pension age and an important change with respect to old age pensions, differentiating the formerly flat-rate allowances on the basis of length of service. However, invalidity pensions remained paid at a flat rate, depending only on the invalidity group. Invalidity pensions and base amounts of old-age pensions were linked to the minimum wage. From the financing side, the act described a pension scheme that could be classified as a defined-contribution scheme at the macro level. The revenues of the system were pre-defined by a fixed contribution rate, and the benefit levels were adjusted according to the revenues available.[51] This closed-budget approach introduced clear fiscal boundaries to the pension system.

Although amended several times, the State Living Allowances Act remained in force for seven years.[52] Over this period, the benefit formula was actually modified 10 times. Frequent modifications in the formula were made mainly for the purpose of increasing pension levels, the only exception being a change effective from 1 July 1994, when pensions were disconnected from the minimum wage. In the absence of any rules for the automatic indexation of benefits, an *ad hoc* legislative amendment by parliament was necessary for each increase of pensions.

Regardless of rather frequent changes in government in 1992–1997, politicians followed a prudent fiscal approach, whereby pensions were increased only after sufficient reserves were developed in the pension insurance budget from incoming social tax revenues. However, the precise timing of each increase was subject to discretion, and sometimes used for political purposes.

---

50 The Act entered into force from 1 April 1993. The use of the term 'state living allowances' in the title was suggested by politicians who were behind the 1991 pension law, but who landed in opposition after 1992 elections. The use of this term was intended to indicate that the benefit rules of the law were still temporary, and a true 'Pension Law' was missing.

51 The Estonian pension system operated on these principles in 1993–1999. At the micro level, i.e. concerning the benefit calculation rules, the scheme could still be seen as a defined-benefit pension scheme. Although the level of benefits could also fluctuate downward in such a system in theory, in practice this did not happen, as social tax revenues increased due to economic growth and inflation.

52 The State Living Allowances Act remained in force until 1 April 2000, when it was replaced by the State Pension Insurance Act.

In 1997, the Government initiated a major pension reform.[53] A Social Security Reform Commission was appointed with the task of preparing an outline for reform. In June 1997, the government adopted the commission's end product, a policy paper entitled *Conceptual Framework for the Pension Reform*. The paper aimed at establishing a three-pillar pension system, as follows:

- First pillar: state-managed compulsory pay-as-you-go scheme providing defined-benefit pensions;
- Second pillar: privately-managed compulsory funded scheme providing defined-contribution pensions;
- Third pillar: privately-managed voluntary funded schemes providing either defined-contribution or defined-benefit pensions.

The first pillar was to be created by reforming the existing state pension scheme, while the second and the third pillars were to be introduced as new schemes.

The declared social policy objective of the first pillar was to provide a mechanism for protection against poverty in the old age by the instrument of national pension, and an European social security minimum standard, which is understood as 40% net replacement rate, by old-age, survivors' and work-incapacity pensions.

More concretely, the reform of the state pension system had the following primary objectives:

1. Introducing stronger incentives for participation and decreasing labour market distortions, especially the phenomena of 'envelope salaries', by strengthening the insurance principle;[54]
2. Combating an expected increase in the system dependency ratio (beneficiaries to contributors) due to demographic ageing, which could lead to the decline of the relative value (replacement rate) of pensions, by tightening eligibility criteria;
3. Increasing financial transparency by switching the financing of non-insurance pensions or pension supplements to general state revenues;
4. Guaranteeing compliance with the EU's *acquis communautaire* by securing the equal treatment of men and women in all aspects of the pension system and allowing for the pro rata calculation of pensions in applying the EU social security co-ordination system.

---

53 After the general elections in 1995, the government was formed by the centre-right Coalition Party and centre-left agrarian parties. It was headed by the Prime Minister Siimann.

54 The phenomenon of 'envelope salaries' refers to a situation where employers keep books and pay taxes only on a part of the total salary (often only on the minimum wage). The other portion is paid out (and accepted by the employee) 'in an envelope', avoiding taxes.

The reform of the state pension scheme was initiated by a 1999 Social Tax Act, which introduced personal registration of social tax. Most crucial changes were enacted with the State Pension Insurance Act in 1998. The act was adopted in June 1998 and its gradual application was foreseen. The individual recording of pensionable service on the basis of social tax paid was started from 1 January 1999, but the new benefit rules were to be applied only from 1 January 2000.

Firstly, the act aimed at equalising the pension age of men and women at the level of 63 years. The increase of pension age of men reached the target level in 2001, while the pension age of women will be further increased until it reaches 63 in the year 2016. In fact, the pension age was increased already from 1994 according to the State Allowances Act, but the earlier scale of pension age increase maintained different target ages for men and women (respectively 65 and 60).

However, parallel to the increasing of pension age, the new act also provided for a possibility of early retirement up to 3 years before the normal retirement age. In this case, the amount of pension is reduced by 0,4 per cent per each month of earlier retirement.

The act prescribed a single pension formula, which was to serve for the calculation of old age, work incapacity and survivors' pensions, and included three elements[55]:

- A flat-rate base amount;
- A length of service component applying to periods of work before the enactment of the new law (through 31 December 1998);
- A pension insurance component applying to periods of work after the enactment of the new law (after 1 January 1999).

Former invalidity pensions were replaced by work incapacity pensions, limiting the declaration of work incapacity to persons of working age (from 16 through the pension age). Formerly, invalidity pensions could be paid regardless of age, from birth through death. Furthermore, an age-related qualification period was established to work incapacity and survivors' pensions (see 2.3.4).

A new government coalition, which took office in March 1999, introduced several amendments to the 1998 State Pension Insurance Act before the act even took effect[56]. First of all, the application of the State

---

55 The formula did not concern national pensions, which remained at a flat-rate.

56 The new coalition was formed by Isamaa (Pro Patria – national conservatives), the Reform Party (neo-liberals) and the Moderates ('third way' social democrats). It was headed by Prime Minister Laar (Pro Patria). The position of the Minister of Social Affairs is held by Mr Nestor (of the Moderates).

Pension Insurance Act was postponed by 3 months, mainly because all the necessary data to calculate pension points for the previous calendar year were not available before 1 April.

Further amendments clarified the definitions of work incapacity, and modified the calculation rules of work incapacity pensions. The aim was to harmonise the measurement of work incapacity with prevailing practices in other European countries by reflecting work incapacity in percentages, and to fix problems discovered in the rules for benefit calculation. A separate algorithm was established to calculate work-incapacity and survivors' pensions (see 3.1.2).

From 2002, regular indexation of pensions was introduced. From this year also the possibility of deferral of the old age pension was opened, with an increase of 0,9 per cent per each month of postponement beyond the statutory pension age.

Although while recognising the principle of indexation, the new government coalition, which gained power in January 2002, introduced an extraordinary pension increase from 1 July 2002. The value of a service year was increased by 1.50 EEK.

In conclusion, the main elements of the first pillar reform have been:

1. personal registration of the social tax;
2. counting of all new pension rights on the bases of registered social tax payments;
3. introduction of a new pension formula, which includes an earnings-related component for new retirees;
4. continuing the increase of pension age and equalisation of pension age of men and women;
5. introducing mechanisms for flexible retirement by opening the opportunity for early retirement with subsequent reduction of pension and deferred retirement with increase of pension;
6. introduction of qualification periods for work-incapacity and survivors' pensions;
7. financing of expenditures, which are not related to the insurance principle (e.g. national pensions, disabled child pensions, political pension supplements from general state revenues.

The second pension pillar was enacted by a Funded Pensions Act adopted by Parliament on 12 September 2001. The scheme was introduced from 1 July 2002. The aim of introducing the second pillar is to provide supplementary income on top of the first pillar state pension and by this prevent the long-term decline of the replacement rate in the compulsory system.

As suggested by the Government Social Security Reform Commission, the second pillar is focused around the individual rather than the employer to

prevent obstacles to labour market flexibility, in particular considering the small size of the Estonian labour market. Accordingly, contributions to the second pillar are made by individuals and also the main choices in the scheme are to be made by the individual. From the other side, this also entails that the individual is the principal risk-taker in this scheme.

The third pillar is intended to provide voluntary additional pensions. The state encourages the participation in the voluntary pension arrangements by providing tax incentives.

The legal framework of the third pillar was enacted in 1998 by the Pension Funds Act and simultaneous amendments to the Insurance Act and Income Tax Act. However, with the adoption of the Funded Pensions Act in 2001, the 1998 Pension Funds Act was abolished, and the new Funded Pensions Act regulates both the second and the third pillar.

3.3.2 Political directions of future reforms

Despite the controversies related to the pension system, there appears to be a political consensus on continuation of the current pension reform among the four biggest political parties currently represented in Parliament.

While the amounts of state pensions and the mechanism of increasing pensions (i.e. the indexation) continue to be politically debated, there appears to be a broad political consensus that the rate of social tax will not be increased. This position was stressed in the coalition agreement of the previous Government (comprising of the Reform Party, Pro Patria and Moderates), which was in power from March 1999 to January 2002. Also the current coalition (comprising of the Reform Party and Centre Party), which is in power from the beginning of 2002, has stated in their coalition agreement that no principal changes in the tax policy will be made, and accordingly the rate of social tax will remain unchanged.

Considering the size of the pensioner electorate, it is very likely that the issue of adequacy of state pensions will be raised again during the election campaign for general elections in March 2003. However, considering the current positions of the main political parties, major changes to the current state pension system are not to be expected. Campaign proposals are likely to concentrate on possible modifications to the indexation formula and ways to improve the collection of social tax etc.

The introduction of the second pillar has been also supported by the all 4 current biggest political parties represented in Parliament. The adoption of legislation on the second pillar was based on the coalition agreement of the previous 3 party government, while the current coalition has also emphasised in their coalition agreement that they intend to secure the stability of the three-pillar pension system.

The only political party whose leading members have openly criticised the introduction of the funded second pillar and have demanded instead a more rapid increase of spending on the state pension scheme, is the Estonian People's Union, currently in opposition. This criticism was, however, presented before the large wave of joining the second pillar and more recently the party has withheld any further statements on the topic.

3.3.3 Conclusions

In the first wave of reform in early 1990s the Estonian pension system was separated from the Soviet Union. This aim was first implemented through a change in the financing system, from the general state budget to an earmarked social tax. New benefit rules followed shortly. However, the high social expectations of the population ran sharply against harsh conditions during the first years of independence.

The following introduction of flat rate pensions - the second reform - is to be regarded as a temporary rescue measure rather than a purposeful change towards egalitarian principles. The prudent fiscal approach towards the financing of the pension system limited pensions expenditures to available revenues from social tax. This approach is called here a defined-contribution method at the macro level.

A third reform, initiated in 1997, introduced important parametric changes to the first pillar (e.g. equalisation of pension age of men and women, linking pensions to contributions), while even more importantly aimed at establishing a multi-pillar system by adding 2 supplementary pillars based on pre-funding.

The state pension system has managed to keep the majority of pensioners above the poverty level, but the average net replacement rate – about 40% - is still to be considered relatively low, keeping most pensioners in the lower-middle range of the income continuum.

Recent reform measures have been focused on the second pillar funded pensions based on saving in individual accounts. Even though participation in the second pillar requires additional contributions – 2% of wage – from employees, the scheme has turned out to be unexpectedly popular among population. Over 40% of employees have joined the scheme over the first year of operation.

Introduction of the funded second pillar has raised the typical problem of transition costs. The annual deficit is estimated to be around 0.6% of GDP or about 8-9% of the state pension insurance budget. The Government plan to finance transition costs from existing reserves (social tax reserves and stabilisation reserve), will provide a solution only for the next few years. Therefore, a longer-term strategy to finance the transition is necessary.

The main challenge for the state pension insurance in the coming years is how to keep the average replacement rate above 40%. From one side, this aim is important in order to maintain the adequacy of state pensions. From the other side, it is an international commitment taken by the Government in ratifying the European Social Charter. It appears that the aim of keeping the replacement rate above the 40% target level can not be achieved without any further changes to the scheme parameters.

3.4 Annex 2

Table 3.1: Average state pensions by types 1995-2001

	1995	**1996**	**1997**	**1998**	**1999**	**2000**	**2001**
Old-age pension	671	953	1,110	1,247	1,545	1,532	1,583
Superannuated pension	501	689	757	827	986	1,093	1,341
Invalidity pension	536	706	797	902	1,102	1,067	1,026
Survivor's pension	447	559	613	692	840	825	1,080
National pension	375	462	542	630	784	913	913

Source: Social Insurance Board, Ministry of Social Affairs

Table 3.2: Development of the replacement rate of the average old age pension in 1995-2001

	1995	**1996**	**1997**	**1998**	**1999**	**2000**	**2001**
Average gross earnings[57]	2,111	2,644	3,162	3,663	3,760	4,193	4,658
Average net earnings	1,640	2,086	2,479	2,841	2,912	3,311	3,707
Gross replacement rate of average old-age pension	31.8%	36.0%	35.1%	34.0%	41.1%	36.5%	34.0%
Net replacement rate of average old age pension	40.9%	45.7%	44.9%	43.9%	53.1%	46.3%	42.7%

Source: Social Insurance Board

[57] Average earnings upon which social tax has been paid, includes wages of employees and taxable income of self-employed persons. The average wage calculated by the Estonian Statistical Office on the basis of survey data (the sample includes enterprises with 50 or more employees) is about 20% higher. The difference is explained also by the fact that the declared taxable incomes of self-employed (after deduction of business-related expenditures) are lower than the average wage of employees.

Table 3.3: Average monthly net disposable income of elderly households in 2000 (per household member)

	Single person aged 60 or over		**Couple, both aged 60 or over**	
	EEK	%	EEK	%
Wage income	216	11.2%	366	17.9%
Income from self-employment	42	2.2%	78	3.8%
Pensions	1,553	80.8%	1,541	75.3%
Other social policy transfers	87	4.5%	25	1.2%
Other income	24	1.3%	37	1.8%
Total	1,922	100%	2,047	100%

Source: Estonian Statistical Office

Table 3.4: Distribution of pensions by income quintiles (% of the total) according to the 1999 Poverty Study

	I (lowest) quintile	**II quintile**	**III quintile**	**IV quintile**	**V (highest) quintile**
Pensions	12.4	29.2	27.5	17.0	13.9

Source: Tartu University, Ministry of Social Affairs

Table 3.5: Revenues of the state pension insurance 1995-2002 (in million EEK)

	1995	**1996**	**1997**	**1998**	**1999**	**2000**	**2001**	**2002**
Social tax revenues	2,917	3,844	4,637	5,339	5,520	6,297	6,988	7,711
State budget allocations	-	26	19	150	176	254	242	345
Other revenues	214	73	198	38	15	3	6	2
Total revenues	**3,131**	**3,917**	**4,855**	**5,527**	**5,711**	**6,554**	**7,236**	**8,058**

Source: Social Insurance Board

Table 3.6: Total expenditures on state pensions and balance of the pension insurance budget 1995-2002 (in million EEK)

	1995	**1996**	**1997**	**1998**	**1999**	**2000**	**2001**	**2002**
Total expenditures on pensions	2,908	4,067	4,728	5,306	6,460	6,504	6,648	7,325
Balance at the end of the year	769	618	744	965	216[58]	20	608	1,343
Annual change in the balance	+186	-151	+127	+221	-749	-196	+588	+735

Source: Social Insurance Board

Table 3.7: Expenditures on state pensions by types of pension 1995-2001 (in million EEK)

	1995	**1996**	**1997**	**1998**	**1999**	**2000**	**2001**
Old age pensions	2,389	3,322	3,861	4,304	5,285	5,468	5,704
Superannuated pensions	19	24	25	27	32	37	44
Invalidity pensions	341	467	556	664	863	663	578
Survivors' pensions	108	138	161	186	229	229	206
National pensions	7	12	13	14	16	67	77
Total	**2,908**	**4,067**	**4,728**	**5,306**	**6,460**	**6,504**	**6,648**

Source: Social Insurance Board

Table 3.8: Expenditures on state pensions as a percentage of GDP (%)

	1995	**1996**	**1997**	**1998**	**1999**	**2000**	**2001**
State pensions	7.1	7.6	7.3	7.1	8.5	7.6	6.9

Source: Ministry of Social Affairs

[58] From this amount 178 million EEK constituted deposits, which were frozen on the accounts of bankrupt banks.

Table 3.9: Recipients of state pensions by type of pension 1995-2002 (at the beginning of the year)

	1995	**1996**	**1997**	**1998**	**1999**	**2000**	**2001**	**2002**
Old age pension	302,099	297,043	291,133	286,198	288,645	284,327	297,363	298,490
Superannuated pension	4,168	3,812	3,783	3,567	3,312	3,240	3,369	3,386
Invalidity pension	52,339	55,250	57,636	59,938	62,522	66,814	43,394	47,140
Survivors' pension	21,283	22,529	22,765	22,476	22,887	23,256	21,936	19,429
National pension	1,787	2,093	2,126	1,906	1,766	1,655	6,816	7,481
Total	**381,709**	**380,727**	**377,444**	**374,085**	**379,132**	**379,292**	**372,878**	**375,926**

Source: Ministry of Social Affairs, Social Insurance Board

Table 3.10: Share of pensioners in total population 1995 –2002 (at the beginning of the year)

	1995	**1996**	**1997**	**1998**	**1999**	**2000**	**2001**	**2002**
Share of pensioners in population (%)	26.4	26.7	26.8	26.9	27.5	27.6	27.3	27.6

Source: Ministry of Social Affairs, author's calculations

Table 3.11: Share of female pensioners and the average pension of women compared to the average pension of men 1995-2002 (at the beginning of the year)

	1995	**1996**	**1997**	**1998**	**1999**	**2000**	**2001**	**2002**
Share of women in total number of pensioners (%)	68.2	67.7	67.6	67.5	67.5	67.3	66.6	66.1
Average pension[59] of women as a percentage of average pension of men (%)	95.4	97.9	96.7	97.0	97.4	102.4	99.4	98.9

Source: Statistical Office of Estonia, author's calculations

[59] The average of various types of pensions payable under the State Pension Insurance Act.

Table 3.12: The numbers of insured pensions and pensioners (average of the year) and the system dependency ratio (the ratio of pensioners to insured persons)

Year	Number of insured persons[60]	Number of pensioners	System dependency ratio (%)
1995	650,146	374,855	57.8
1996	632,569	371,268	58.8
1997	619,659	374,414	60.2
1998	613,832	376,430	61.3
1999	596,500	379,500	63.9
2000	612,400	379,292	62.1
2001	614,218	372,878	60.6

Source : Social Insurance Board, author's calculations

Table 3.13: Pension on the basis of work incapacity (in EEK) as from 1 July 2002

Incapacity for work	Minimum work-incapacity pension	National pension on the basis of work incapacity
100 %	1,395	867
90 %	1,256	780
80 %	1,116	694
70 %	977	607
60 %	867	520
50 %	867	434
40 %	867	347

Table 3.14: Minimum amounts of survivors' pension and the national pension on the basis of survivorship (in EEK) as from 1 July 2002

Number of family members	Minimum amount of survivors' pension	National pension on the basis of survivorship
1	558	347
2	977	607
3 or more	1,395	867

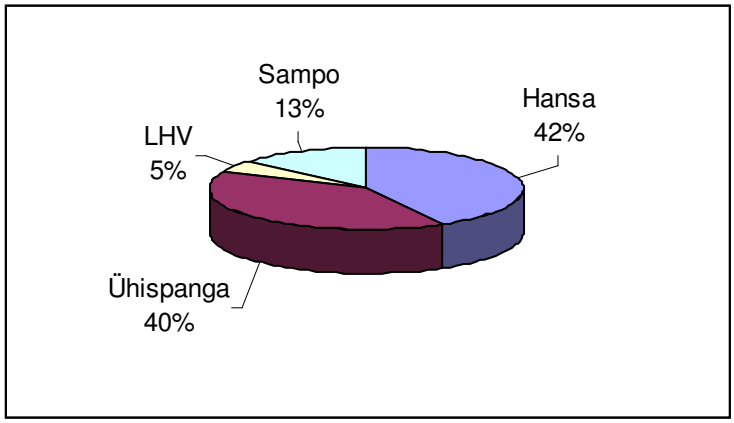
[60] Insured employees and self-employed persons on whose behalf social tax has been paid.

Table 3.15 Self-evaluation of the economic situation of persons aged 65 or over according to the Welfare and Health Survey of the Estonian Elderly Population in 2000

"How do you cope in economic terms?"	Percentage of respondents
Very well	5 %
Satisfactorily	56 %
Somehow	36 %
I am not able to cope	2 %
Can not say	1 %

Source: Tartu University, Estonian Association of Gerontology and Geriatry

Figure 3.2: Market shares of voluntary pension fund managers by the value of managed assets in January 2003



Source: Tallinn Stock Exchange, author's calculations

Figure 3.3: Distribution of social tax after second pillar pension reform

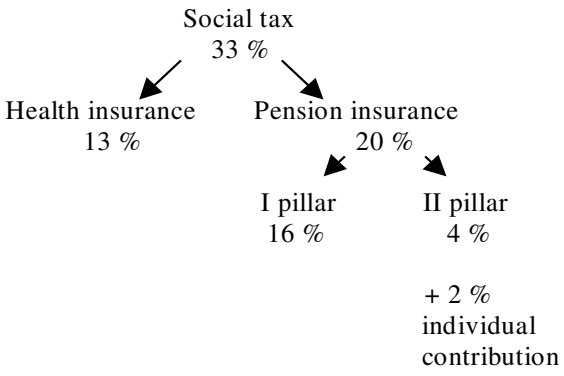
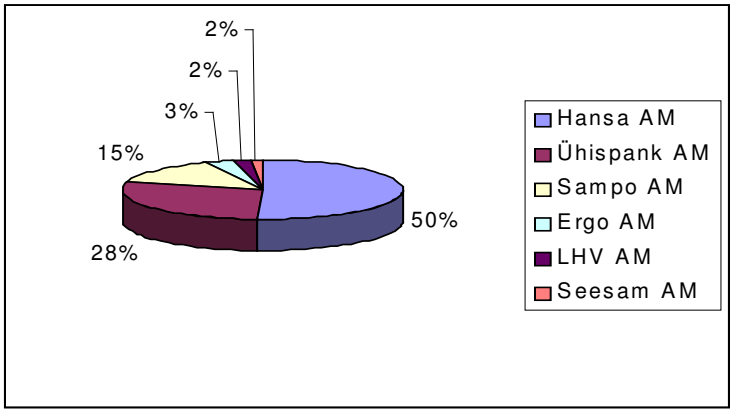


Figure 3.4: Distribution of second pillar participants by fund managers, November 2002



Source: www.pensionikeskus.ee, author's calculations

4. POVERTY AND SOCIAL EXCLUSION

4.1 Evaluation of current profiles of poverty and social exclusion

4.1.1 Social exclusion and poverty within the overall social protection system

The issue of poverty was raised to the public policy debate in Estonia only in 1999 following publication of the results of the Poverty Study, which was undertaken in co-operation of the Tartu University and the Ministry of Social Affairs with the support of the UNDP Poverty Studies Initiative Programme.

Until 1999, the problem of poverty was not directly addressed. It was broadly considered that in a society where the level of resources in general is low, it would be inappropriate to speak about poverty as a specific problem for some groups since the problem of low incomes affects the majority of population. Still the problem was addressed by public and by policy makers in indirect ways, for example, through addressing the issue of the level of state social security benefits (e.g. pensions, family benefits, unemployment allowances).

The 1999 report revealed the patterns of the poverty problem in Estonia and changed the dominant discourse on the subject. In particular, the finding that children (rather than pensioners) are at high risk of poverty influenced strongly public opinion.

The concept of social exclusion is not in the broad use and has been discussed primarily in academic circles. In other words, the problem is still seen mainly as an issue of low income, not that much as an issue of participation in society.

4.1.2 National definitions of poverty and social exclusion

Until now, there is no official definition of poverty or social exclusion, neither a national poverty line.

The official substitute for poverty line is a subsistence level established by Parliament according to the Social Welfare Act for each fiscal year[61]. Subsistence level is the basis for granting social assistance subsistence benefit, aiming to provide a certain minimum guaranteed income, which all residents should have remaining after the payment of housing expenses (see section 2.3.10). When establishing a subsistence level, minimum expenses on consumption of food, clothing, footwear and other goods and services, which satisfy the primary needs, have to be taken into account. For the

[61] Until 2002 the Government had the right to establish the subsistence level.

second and each following household member, equivalence scales 1; 0.8; 0.8 are used, whereby the consumption by the first adult is equivalent to one unit and the consumption share of the remaining household members, including children, is 80% of this.

In reality, however, establishing of the subsistence level has reflected subjective policy decisions of the Government and constraints of the state budget, rather than any objective criteria.

The cost of the minimum food basket alone was 646 EEK a month in 2001 (see below), while the subsistence level has remained unchanged from November 1997 at the level of 500 EEK for the first household member. As a result of inflation, by January 2002 the real value of subsistence benefit had therefore declined about 45% as compared to the 1993 level (Table 4.2 in Annex 3).

In 2001, 70,400 households (12.4% of all households) received subsistence benefit. Compared to 1998, the number of households receiving subsistence benefit has declined by about 15,000, mainly due to stagnation of the subsistence benefit level, while earnings from work and pensions have increased (Table 4.3 in Annex 3).

The Estonian Statistical Office calculates regularly an indicator, called 'the estimated minimum means of subsistence'. This is defined as the smallest amount of means of subsistence needed by a person, to allow him or her to preserve and restore the working ability. In determining the estimated minimum means of subsistence, the Statistical Office has proceeded from the statistically average person and, by relying on expert evaluations, has tried to observe consumption pattern, which is close to the actual consumption, which should cover the person's primary needs (food, clothing, dwelling) and enable to make to a minimal extent also some other necessary expenditures over a 30 day period.

In 2001 the estimated minimum means of subsistence was 1,306 EEK per person, of which the minimum food basket was 646 EEK, i.e. nearly 50% (Table 4.4 in Annex 3)[62].

It should be outlined that the estimated minimum means of subsistence are calculated per person, not per household member, and therefore equivalence scales are not taken into account. Calculation is based on the assumption that all goods and services are purchased with average prices and possible self-production of the household is not taken into account. It should also be outlined that the estimated minimum means of subsistence

[62] Calculated by the Estonian Statistical Office on the basis of suggestions from nutritional scientists, according to which the energetic value of the minimum food basket shall be 2,400 kcal per day. This corresponds to the consumption of food by a man with the moderate workload. WHO recommends for the determination of poverty line the food consumption corresponding to 2,100 kcal per day.

include basic housing costs, whereas the subsistence level established by Parliament indicates income, which should be left after the payment of housing expenses.

In the framework of the 1999 Poverty Study[63], an alternative poverty line indicator was developed, using the expenditure structure of households (equivalence scales 1; 0.8; 0.8), taking into account:

- the cost of a minimal food basket;
- empirically determined housing costs;
- basic clothing, education and transport expenditures.

The study also looked into the layered structure of the poverty problem, defining direct poverty as incomes below 80% of the poverty line and poverty risk as incomes 101 – 125% of the poverty line.

In 2001, the poverty line according to this indicator was 1,488 EEK per household member (Table 4.5 in Annex 3) and 13.1% of households (15.8% of residents) were in direct poverty (income below 80% of the poverty line, i.e. 1,190 EEK a month).

A recent study by the Centre for Policy Studies PRAXIS (Kuddo et al 2002) on the efficiency of Estonian social benefits in alleviating poverty and their impact on work incentives used the Eurostat relative poverty line of 60% of median income per household member.

In 2001, the relative poverty line was 1,,100 EEK.

According to the 1999 Poverty Study, the following types of households were most affected by poverty:

- Households with an unemployed member. From households with an unemployed member, 62% had to cope with direct poverty[64].
- Families with 3 or more children, of which almost 45% of families with 3 or more children had to cope with direct poverty and the risk of poverty was observed to increase with each following child (see section 4.2.4).
- Single-parent households – 37% were in direct poverty.

According to individual parameters, direct poverty affected more often unemployed persons (49% in direct poverty), children up to 9 years of age (35%) and disabled persons (32%).

---

63 Tartu University, Ministry of Social Affairs. *Poverty Reduction in Estonia: Background and Guidelines.* Tallinn 1999.

64 The 1999 Poverty Study distinguished between different poverty strata. Direct poverty was defined as income per household member below 80% of the identified poverty line.

Similar results were revealed by the PRAXIS study, although a different poverty line was used. According to this study, 15.5% of all households were poor in 2000. The groups at highest risk of poverty are:

- Jobless households[65] - 62 % were poor;
- Families with 3 or more children - 37% were poor;
- Single-parent families - 35% were poor.

For comparison, the World Bank in their poverty evaluation in Estonia in 1996, considered poor those households whose consumption expenditure per equivalent adult was less than the minimum pension in the third quarter of 1995, which was 482 EEK. The choice of the minimum pension as the poverty line was driven by two considerations. First, it was observed that the minimum pension reflected closely the cost of attaining a minimum standard of living (defined as the minimum food basket plus an allowance for non-food expenditure), while in the view of the Bank being more widely known in Estonia than the minimum consumption basket. Second, the minimum pension was increased more frequently, and was therefore higher than other potential poverty benchmarks, such as the cut-off level for social assistance or the minimum wage (World Bank 1996).

According to this criteria, poverty affected 8.9% of the Estonian population at the time, or around 130 thousand people. This group included primarily households with little or no formal income – households with unemployed and underemployed members. The incidence of poverty for households with no working members was twice the average. The degree and form of labour market participation among adult household members emerged thus as the key determinant of living standards. The link between poverty and the labour market was observed also in three other ways:

- Poverty indicators were inversely correlated with the education level of the household head.
- Poverty was more prevalent among households with few income earners relative to the size of the household (e.g., households with extended families and many children and households headed by single parents),
- Poverty was more widespread and deeper in rural areas.

4.1.3 18 EU Indicators of Social Exclusion

Most of the indicators, selected by the EU Social Protection Committee for evaluation in the field of poverty and social exclusion are available in Estonia (Table 4.1 in Annex 3). The main sources are Household Income and Expenditure Surveys (HIES) and Labour Force Surveys (LFS), which are conducted annually by the Estonian Statistical Office. However,

[65] Household, were none of the members are working and at least one of the members aged 16 or over is unemployed.

although the source data in principle exist, not all indicators, e.g. breakdowns of low-income rate by age, gender, activity status, household type etc. have been calculated yet. Also, longitudinal data to evaluate the persistence of low-income rate is missing.

There are also some differences in definitions (e.g. HIES considers as household income also revenues from the sale of personal belongings, which are not included by Eurostat definitions) or age groups (e.g. in LFS activity rates and unemployment rates have been calculated for the 15-74 age group), which influence the comparability of data. The Estonian Statistical Office intends to calculate the missing indicators on the basis of 2001 HIES data and is working on harmonisation of definitions.

The authors of the 1999 Poverty Study argued that the relative poverty lines, which are mainly used in international comparisons (e.g. 50 or 60% of median income) are not adequate to characterise the poverty situation in transition economies. This is because incomes are low for a large part of the population, varying relatively little from the median income (see Figure 4.1. in Annex 3), while 50 or 60% of the median income may not be sufficient to meet the basic needs of the household. Instead of relative poverty line it was therefore suggested to use an absolute poverty line, defined through minimum consumption. However, in recent years, the difference between the absolute poverty line (direct poverty – see above) and the relative poverty line of 60% of median income has considerably narrowed. The values of the two indicators in 2001 were respectively 1,190 and 1,100 EEK a month, the absolute poverty line thus being ca 8% higher than the relative poverty line.

The 1999 Poverty Study also revealed that the equivalence scales used by the OECD and the EU – (1; 0.7; 0.5), or even (1; 05; 0.3) – are not adequate for Estonia's situation. The empirical analysis of consumption by Estonian households indicated that the major part of consumption comprises the satisfying of individual basic needs. In countries with a generally higher welfare level the average household uses a large part of its expenditure on the living environment and leisure activities, and accordingly the equivalence scales of household members are relatively lower.

The authors of the study suggested that in order to ensure in Estonia's situation a normal level of individual consumption, it would be optimal to use equivalence scales 1; 0.8; 0.8, which characterise the major and most typical proportions of Estonian household consumption behaviour.

4.2 Evaluation of Policy Challenges and Policy Responses

4.2.1 Inclusive Labour Markets

Unemployment was identified as the major cause of poverty both by the 1999 Poverty Study and 2002 PRAXIS study.

The 1999 Poverty Study showed that unemployment was the main single cause of poverty both on individual and household level. From households with one unemployed member, 62% had to cope with direct poverty. In case of 2 or more unemployed members, the respective figure was already 77%.

According to 2002 PRAXIS study, 62% of jobless households were poor.

As noted in section 1.1.3, unemployment in Estonia steadily increased in 1990s, reaching 13.7% in 2000 (Table 1.12 in Annex 1). Some positive shifts have been observed since then, unemployment dropping to 9.4% in the second quarter of 2002. Nevertheless, a particular concern has been the growth of long-term unemployment. The proportion of the unemployed who have been without work for more than one year raised from 30% in 1995 to 48% in 2001, with the long-term unemployment rate over 6% of the labour force (Table 4.8 in Annex 3). Long-term unemployment is also the main reason of loosing health insurance coverage, as unemployed persons are insured only for the period of receiving unemployment allowances.

Unemployment in Estonia has rather high regional divergence, varying in 2001 from a low of 7.7% in Hiiumaa county (island in West Estonia) to 20.6% in Jõgeva county (in East Estonia). High unemployment rates are also observed in the South-East and North-East of Estonia. Gender disparities of unemployment are relatively small, the unemployment rate of men exceeds that of women by 1-2 percentage points (Table 1.12 in Annex 1). Also the long-term unemployment is higher among men (Table 4.7 in Annex 3).

High poverty risk of unemployed persons is related to the fact that state unemployment benefits have been very low. The state unemployment allowance is 400 EEK, which is only about 7% of the gross average wage. As a result, unemployed persons have to rely mainly on incomes of other household members.

In response to this situation and developments, the Government has attempted to improve the social protection system for the unemployed, but also to initiate some programmes to improve the functioning of the labour market and increase employment.

Changes to Social Protection of the Unemployed Act were introduced from 1 October 2000:

- conditions for registration as an unemployed person were aligned with the ILO criteria, broadening the definition of the category "registered unemployed". With these changes, the long-term unemployed, who could not be registered under the earlier criteria, were brought into the focus of employment offices and most importantly, became eligible for labour market services;
- the period of payment of unemployment allowance was extended from earlier 180 days to 270 days.

A new Labour Market Services Act entered into force from October 2000 with the underlying aim to put more emphasis on active labour market policies, in particular on labour market training and vocational counselling. In the 2001 state budget the expenditures on labour market training were increased by about one-third as compared to 2000 level.

From 2002, a compulsory unemployment insurance scheme was introduced. The scheme is financed from contributions by employees and employers, and is going to provide earning-related benefits – 50% of the previous earnings for the first 100 days, 40% thereafter for the next 80 days (see also 2.3.9). The new scheme will provide better income smoothing in cases of unemployment and is hoped to prevent unemployed persons from falling into poverty. Obviously, as the scheme will apply only to new cases of unemployment, it does not solve the problems of those who already are unemployed or excluded from the labour market.

The Employment Action Plan of 2002 broadly follows the EU employment strategy, being based on four pillars[66]:

- Improving employability;
- Developing entrepreneurship and job creation;
- Encouraging adaptability of businesses and their employees;
- Strengthening equal opportunities policies for women and men.

In the Action Plan, the Government has recognised that since its spending on labour market policies as a percentage of GDP is only about tenth of the EU average, while the unemployment rate is well above the EU average, only well targeted action can give any influence. According to the Action Plan, special attention shall be paid to risk groups whose competitiveness in the labour market is the lowest: the young, the long-term unemployed and the disabled. The Plan focuses on expanding active labour market policy, in particular elaboration of labour market services, implementation of special programmes to integrate risk groups into the labour market as well as increasing the administrative capability of labour market institutions.

---

66 Government of Estonia. *Employment Action Plan 2002*. Tallinn 2001.

In recent years, the following state programmes and projects have been initiated towards these aims:

- A state programme "Increasing employment, preventing long-term unemployment and exclusion of people in the risk groups from work-life" is aiming to decrease unemployment and prevent social exclusion through intensifying active labour market policy.
- To integrate the long-term unemployed into the labour market, a project "Supporting the Employment of the Long-term Unemployed through Labour Market Training and Labour Market Subsidy to the Employer" was launched in all employment offices in 2000 and 2001. In the framework of the project different labour market services were provided to the long-term unemployed, taking into account the specific needs of the target group and individual requirements (individual counselling, labour market training, labour market subsidy to the employers). The unemployed persons participating in the project were provided with an individual action plan to facilitate job finding. The total number of participants in the project was 480 and 272 of them were employed as a result of the project.
- In 2000 and 2001 pilot projects were launched in 9 employment offices, with the aim to decrease unemployment among youth and to increase employment, adapting and implementing the already available measures (vocational guidance, information about training opportunities and labour market situation, labour market training, job mediation). Again, unemployed persons (altogether 282 participants) received an individual action plan to facilitate job finding.
- Another pilot project launched in 5 counties aimed at better integration of disabled young persons in regular and work life by fostering contacts between different parties and enhancing collaboration between representatives of different levels and sectors. The total number of participants in the project was 89 and as a result of the project 45 jobs were created for the disabled young persons.

4.2.2 Guaranteeing Adequate Incomes/Resources

Estonian social assistance and social security schemes provide mostly universal coverage, but benefit rates do not always lift beneficiaries above the poverty line.

A minimum income guarantee is provided under the subsistence benefit scheme, which covers all residents with incomes below a subsistence level (see 2.3.10). Under the same scheme also compensation for housing costs is available up to established limits. However, the subsistence level has remained unchanged from November 1997 at the level of 500 EEK for the first household member, while inflation has deteriorated the real value of the benefit (see Table 4.2 in Annex 3). Although according to legal criteria, the

subsistence level should cover minimum expenses on consumption of food, clothing, footwear and other goods and services, in reality, it does not cover even the cost of the minimum food basket, which was 646 EEK a month in 2001.

Minimum rates of benefits applicable to old age, invalidity and survivors' pensions keep the overwhelming majority of pensioners above the subsistence level. According to the data of the Ministry of Social Affair, pensioners formed only 6% of the recipients of subsistence benefit in 2001. However, the benefit rates of national pensions on the basis of permanent work incapacity and survivorship, which apply in the case the insured person did not have sufficient qualification period, are sometimes below subsistence level (see Tables 3.13 and 3.14 in Annex 2).

Due to the low level of state unemployment allowances (400 EEK a month), about 45% of the recipients apply also for the subsistence benefit scheme, while others have to rely on incomes of spouse or other household members. Long-term unemployed, who have exhausted the right to unemployment allowance, fall also outside the health insurance system, as insurance coverage is connected with the period of payment of unemployment benefits. To uninsured persons (about 6% of the total population) only emergency medical assistance and limited access to the primary care is provided from public funds.

From 2002, a new concept of emergency social assistance was introduced to the Social Welfare Act, whereby local municipalities were made responsible to guarantee to everybody who lacks necessary means of subsistence, at least food, clothes and shelter. At the same time, the principles of payment of subsistence benefit were changed to allow local municipality to refuse to pay subsistence benefit to working age persons who do not work or study and who have repeatedly refused offers of suitable work or to take part in relevant social rehabilitation programmes organised by the municipality.

Over the last few years, there has been considerable public debate on the issue of whether subsistence benefits should be paid to university students. In a situation were only very few public stipends are available, an increasing number of students is hesitating to take a study loan (which has to be repaid) and instead have applied for subsistence benefit. In 2001 students accounted for 11% of all recipients of subsistence allowance. The Government has made a proposal to count students up to the age of 24 (unless they are married or have child of their own) as members of their parents' household, emphasising the family responsibility also during acquisition of higher education.

The Government has also proposed to introduce an asset-test in addition to the current income-test for eligibility to subsistence benefit and to prolong the reference period for evaluation of household income from the current

1 month to 6 months, with the aim to ensure better targeting of the subsistence benefit scheme.

4.2.3 Combating Education Disadvantage

The 1999 Poverty Study showed that low education level was associated with higher individual poverty risk. 31.3% of working age persons[67] with primary education were in direct poverty. For working age persons with basic education the poverty rate was 26.5%, while among persons with secondary or higher education it was 17.9%.

Labour Force Surveys indicate that the lower the level of education, the higher is the risk of becoming unemployed. In 2001, the unemployment rate ranged from 7.4% for persons with tertiary education to 21.1% for those with primary or basic education (Table 4.8 in Annex 3). In 1990s the unemployment rate has increased on different levels of education, but most considerably for persons with only primary or basic education.

According to the Law on Education, school attendance is compulsory from the age of 7 until finishing the basic education or attaining 17 years of age. Secondary education, although not compulsory, is provided free of charge. Students of universities and other institutions of higher education and vocational schools have a right to a state guaranteed study loan.

Free school lunch is provided by state financing for pupils of the first 4 grades. Some local municipalities are additionally financing free school lunches also for older pupils. Several local municipalities have organised a school bus transport.

Educational enrolment rates are close to 100% in the age group of 7 – 15. About 1000 pupils drop out from basic school each year (out of the total of ca 174 thousand pupils in basic education, i.e. about 0.6%). After the age of 16, the enrolment rates decline: 89% in the age group 16 – 18 and 51% in the age group 19 – 22. Enrolment rates are higher among girls: 91.5% against the rate of 86.5 for boys in the age group 16 – 18, and 59.5% for girls against 43.6% for boys in the age group of 19 – 22. One of the problems in this respect has been the low social status of vocational education, only about 25% of pupils after basic school opted for vocational education in 2001.

In May 2002 the Government approved a policy document Education Strategy "Learning Estonia", which was prepared by the Ministry of Education, involving NGOs ("Estonian Education Forum") and social partners. Among other strategic goals, the paper emphasises the principles of life-long learning, equal access to education regardless of gender, age, physical and mental health, social status, economic opportunities and place

[67] In this study, working age was defined as 15-59.

of residence. Also the National Lifelong-Learning Strategy has been developed, with a focus on adult education.

Over the last years, the Government has made efforts to reform the system of vocational education in an attempt to make the system more responsive to the needs of the labour market and thus improving the employment prospects of graduates. An "Action Plan for developing the Estonian vocational education and training system 2001-2004" was adopted by the Government in June 2001. The reform aims to improve the vocational curricula, puts greater emphasis on in-company work practice and increasing the involvement of social partners in co-ordination of the vocational education system. The action plan has set several quantitative and qualitative targets to be achieved by 2004, emphasising access to vocational education, quality and equal opportunities (European Training Foundation 2002):

- Increasing the number of students in the vocational education system by 8% annually. For 2004 it is foreseen that the opportunity to acquire vocational education should be guaranteed for 50% of the age group of the graduates from the basic school, and for 50% of the graduates from general secondary school;
- Decreasing the drop-out rate from vocational schools by one percentage point per year (the current drop-out rate is 13 %);
- To increase the share of vocational education programmes meeting the requirements of vocational standards from 30% to 100%;
- To establish Accreditation Committees at national level by occupational sectors, consisting of representatives of employers, professional unions and other organisations to evaluate the quality of teaching and efficiency.

4.2.4 Family Solidarity and Protection of Children

The 1999 Poverty Study revealed that families with children are at high risk of poverty and the risk increased with each following child[68]. The findings showed that particularly affected are families with 3 or more children. From families with 3 children, the proportion living in direct poverty was 42%. For families with 4 children the respective share was 67%, and in case of 5 or more children already 82%.

The poverty risk was high also for single-parent households of whom 37% were in direct poverty. About 25% of all children are growing in single-parent households, mainly as a result of a very high divorce rate (in 2001, there were 76 divorces per 100 new marriages; see also 1.1.3) and a high share of children born out-of-wedlock. In 2001, 56% of all new-born children were born out of wedlock, up from 44% in 1995 and 27% in 1990.

---

[68] The 1999 Poverty Study was based on 1997 HIES data.

Quite high - 32% in direct poverty – was the risk also for young families (parents under 35 old) with children.

In an attempt to respond to the high poverty risk of families with children, the Government introduced several changes to the family benefit scheme from 1 January 2000, targeting the scheme more towards vulnerable groups:

- The former maintenance benefit (which was paid to non-working parents during the parental leave until the child reached 3 years of age) was replaced by a child care fee. The amount of child care fee depends on the age and number of children in the family and it is paid regardless of the employment status of parents. The parameters of the scheme favour families with many children in pre-school age (see section 2.3.8).
- Supplementary benefits for single parents were doubled (from 150 EEK to 300 EEK).
- Lump sum birth grants were increased by 25%.

Support for large families was further increased from 1 January 2001, when tax advantages for families with 3 or more children were introduced. These families are allowed to deduct additionally from taxable income 12,000 EEK (which is the standard non-taxable threshold) per child a year[69].

At the same time additional quarterly benefits for families with 4 or more children were introduced, with the aim to provide assistance also to those families whose taxable income is too low to take advantage of tax deductions.

The 2002 PRAXIS study indicated that the poverty risk of large families and single-parents families was still high, with poverty rates respectively 37% and 35% (see section 4.1.2). However, as the study was based on 2000 HIES data, the possible effects of measures described above could not be yet fully observed. Furthermore, since the PRAXIS study used a different poverty line, the results are not directly comparable with those of the 1999 Poverty Study[70].

Additional measures in respect of cash benefits for families were implemented in 2002. From 1 October 2002, the period of payment of maternity benefit was extended from 126 days to 140 days (see 2.3.3). From 1 January 2003, child allowance and supplementary benefits for large families are not taken into account as household income for the purpose of means-test for social assistance subsistence benefit. In essence, this implies that the effective subsistence level for families with children is higher than for families without children.

---

69 As the rate of income tax is 26%, the cash value of this tax advantage is 3,120 EEK per child per year.

70 The study used a relative poverty line of 60 % of median income.

In 2001, about 1800 children (about 0.6% of all children) lived in social welfare institutions, the main reason (ca 80% of cases) being lack of parental care. About the same number of children stayed for shorter periods in shelters or social rehabilitation centres because of vagrancy, parental negligence or violence, drug abuse, economic difficulties etc.

The network of social welfare institutions has developed substantially over the last years, new types of institutions (e.g. shelters, rehabilitation centres, youth homes) have emerged, older institutions have improved their facilities and reorganised their activities.

4.2.5 Accommodation

Estonia has experienced liberal housing reforms in the housing sector over the last 10 years. Most of the public housing stock has been privatised (public housing stock has reduced from 61% in 1992 to 6% by 2000) and rent regulations gradually abolished.

Hence, the public sector has few means to intervene in the housing market processes. This has resulted in rapidly increased property prices and rent level, which have, in turn, made many households to face difficulties in access to suitable housing and in meeting the housing costs.

Over a decade, a clear socio-spatial segregation has become apparent, housing quality and size increasingly correlate with household income. The data of 1999 Living Conditions Survey indicated that poor households usually occupy cheap housing while despite this they often meet difficulties in paying for their housing. According to the survey, about half of the households, who considered themselves as poor had tackled problems in paying for their housing during the past year.

The municipalities are required to provide housing for persons or families who cannot afford adequate housing for themselves or their families, and, where necessary, to provide social housing or alternative accommodation. However, the need for financially affordable public housing exceeds the existing supply.

The main policy measure in this respect has been the compensation of normative housing costs under the subsistence benefit scheme. When granting the benefit, expenses for a permanent place of living are taken into account up to limits established for a standard allotted dwelling[71].

Vulnerability in the housing market is not associated only with low income. Vulnerable groups are usually on low-income, but they have also

[71] Standard allotted dwelling is deemed to be 18 square meters per household member and supplementary 15 square meters per household. Some exceptions apply, e.g. for single pensioners.

additional specific features such as old age, disability, family structure etc. that contribute to their exclusion from the housing market. Social-status based segregation is also on increase in larger urban areas.

For the date there is little reliable evidence and awareness about the housing situation of different social groups, housing-related social exclusion and its impact on individuals. There is lack of information about the different types of exclusion in the housing market as well as the magnitude of persons falling under the different vulnerable groups.

Neither is reliable information on the extent of homelessness available. The number of homeless people is estimated to be about 5,000, which is ca 0.4% of population. The problem is obviously more apparent in larger cities.

Responsibility to arrange social services, incl. homeless shelters, lies with local municipalities. The capital city of Tallinn has ca 150 places in 3 homeless shelters. In 2001, the total number of shelters in Estonia was 35. The number of persons who used the services of these institutions was 5,218, main reasons linked to lack of dwelling, vagrancy, release from prison, economic difficulties.

Main factors contributing to the emergence of homelessness have been the sharp change from the former Soviet strongly state-controlled housing policy to a largely non-interventionist approach in respect of housing relations, while the offering of public rental housing is scarce.

In 2003 a study on access to housing for vulnerable groups is being carried out in Estonia under the supervision of the Ministry of Social Affairs and within the Community Action Programme on Combating Social Exclusion. The study aims at specifying vulnerable groups and examining processes that lead to social exclusion in the housing market as well as proposing new mechanisms to improve accessibility to a decent housing in a good environment for all social groups.

The research project is expected to increase awareness of housing and social exclusion issues among policy-makers, policy-planners and general public. Main findings and recommendations will serve as a basis for identifying key challenges for achievement of social inclusion regarding housing, agreeing upon priority objectives and measures in the area of housing and social exclusion when outlining the Joint Inclusion Memorandum in co-operation with European Commission.

The Ministry of Economics and Communications has drafted the Housing Sector Development Strategy for 2003-2008. The policy document is currently being discussed within the Ministries and other relevant authorities and institutions. However, the strategy appears to be mainly concerned with the issues of renovation and maintenance of the housing stock and falls short

proposing integrated measures to improve the access to housing and housing situation of different population groups.

4.2.6 Ethnicity

The 1999 Poverty Study did not reveal any considerable differences between poverty rates of Estonians and non-Estonians (which is mostly Russian-speaking population). From non-Estonians 22.6 % were in direct poverty, while among Estonians the rate was 21.0%.

However, the unemployment rate among non-Estonians has been considerably higher than among Estonians, respectively 18.1% and 11.2% in 2000[72].

Integration policies of the Government have mainly concentrated on teaching the Estonian language, which *inter alia* facilitates also access to the labour market.

4.2.7 Regeneration of Areas

In spite of a relatively small territory, regional discrepancies in Estonia are relatively high[73]. In 2001, the net disposable income per household member varied from 2,735 EEK a month in Harju county (North Estonia) to 1,588 EEK in Valga county (South Estonia). In the 4th quarter of 2001, the average wage varied from 7,036 EEK a month in Harju county to 4,025 EEK in Põlva county (South Estonia). In 2001 the labour force participation rate (in the 15-74 age group) varied from 68.3% in Harju county to 52.6 in Võru county (South Estonia). The unemployment rate varied from 11.0% in Central and West Estonia to 18.0% in Ida-Viru county (North-East Estonia).

These disparities reflect the varying degree of success in the structural conversion of the economy over the transition period. In the course of economic transition, most rural areas have encountered difficulties caused by the restructuring and decline in agriculture[74]. On the other hand, adjustment to the new economic environment has been more successful in larger cities and towns, except industrial towns in Ida-Viru county (North-East Estonia). The key to the success of larger towns (Tallinn, Pärnu, Tartu) has been the growth of the service sector and reorientation of production to

---

72 At the same time, the labour force participation rate is higher among non-Estonians – 65.4 % (for the population aged 15-74) against 63.0% for Estonians.

73 For the purpose of measuring regional cohesion according to Eurostat criteria, Estonia forms a single statistical region at NUTS 2 level, but at NUTS 3 there are 5 regions: North-Estonia (Harju county, incl.Tallinn), Central Estonia (Järva, Lääne-Viru and Rapla counties), West-Estonia (Hiiu, Lääne, Pärnu and Saare counties), North-East Estonia (Ida-Viru county), South-Estonia (Jõgeva, Põlva, Tartu, Valga, Viljandi and Võru counties).

74 The share of agriculture in GDP declined from 9.2% in 1993 to 3.3% in 2001.

export markets. A number of former monofunctional industrial settlements in different regions of Estonia and industrial towns in Ida-Viru county, have however been caught in the restructuring crisis, reflected in high unemployment. Also the counties, which have a substantially declined agricultural sector and have not been able to create enough alternative jobs, are lagging behind: Jõgeva, Põlva, Valga and Võru counties (South Estonia). Low income levels and relatively high unemployment rates take these counties in the most disadvantaged situation[75].

The Government adopted a Regional Development Strategy (see footnote 75) in November 1999, focusing in particular on the development of 'problem regions'.

Seven regional development programmes are operating:

1. Programme for the Agricultural Areas – focusing on the diversification of the economic structure with alternative fields of activities, promotion of SME sector, improvement of the competitiveness of enterprises and the qualification of the labour force. Target regions are Jõgeva, Põlva, Valga and Võru counties (South Estonia).
2. Programme for the Industrial Areas - aiming at stopping the increase of unemployment through support to economic restructuring, favouring new investments, promotion of SME sector, development of technical infrastructure and retraining of labour force and increasing its mobility, as well as the improvement of the quality of the living environment. Target regions are Ida-Viru county and the former monofunctional industrial settlements in Lääne-Viru, Pärnu, Rapla and Viljandi counties.
3. Programme for the Islands - directed to maintaining of permanent settlement of islands through the reduction of isolation and development of communications as well as stimulating the development of tourism and other viable sources of living and maintaining of unique cultural peculiarities. Target region includes all main islands of Estonia.
4. Programme for the Network of Centres – aiming at the development of a balanced network of centres to counterbalance the predominant growth of the capital region. The programme is targeted at the county centres to achieve a spatially co-ordinated development of public educational, research, cultural and development institutions and communications.
5. Programme for the Local Initiative – aiming at the development of initiative of NGOs in rural areas.
6. Programme for the Cross-border Co-operation - promoting the cross-border co-operation of counties, municipalities and NGOs.
7. Programme for the Setomaa Region – directed to the development of infrastructure and maintaining of unique cultural peculiarities of the municipalities of historical Setomaa territory (South-Eastern Estonia).

---

75 Regional Development Strategy of Estonia. http://www.erda.ee/english/pdf_english/Estonian_Regional_Development_Strategy.pdf

All programmes are project-based, providing financing to suitable projects presented by counties, municipalities or NGOs. The Estonian Regional Development Agency administrates the programmes.

It is difficult, for many reasons, to assess the effectiveness of regional development programmes to date. Many of the projects initiated in recent years have been directed at the modernisation of infrastructure and broader development conditions and as such their effects are not yet reflected in the decline of regional discrepancies.

4.2.8 Other factors influencing poverty and social exclusion

The 1999 Poverty Study indicated that risk of poverty was rather high also among disabled persons – 32% in direct poverty.

To improve the social protection of the disabled persons and to facilitate their integration into society, a new scheme of social benefits for disabled persons was introduced from 1 January 2001 (see section 2.3.4)[76]. These benefits in particular aim to compensate disability-related costs: i.e. costs, which disabled persons have higher than other members of the society, such as for medical and social rehabilitation; special educational needs, vocational training, retraining and employment needs; the need for personal assistance or special technical aids; use of transport, communication and other public services. The benefits should thus contribute to better social integration/inclusion of disabled people.

As a supplementary anti-poverty measure, social benefits for disabled persons are not taken into account as income when the means-test for subsistence benefit is carried out. This implies that in fact, the subsistence level applicable to disabled persons is higher than for non-disabled persons.

In 2001-2002 the Government has approved an Action Plan for implementation of the Disability Policy Concept Paper, largely based on the United Nations Standard Rules on the Equalisation of Opportunities for Persons with Disabilities. The Action Plan is mainly focusing on improvement of rehabilitation and supporting services, advancing accessibility of environment and enhancing education and employment of disabled persons.

In 199-1999 2 Phare Consensus projects were implemented on the development of social protection and prevention of social exclusion of persons with disabilities. In 2003 these will be followed up by a Phare project "Enhancing Employment Opportunities for People with Disabilities" aiming to increase the competitiveness of disabled persons and widen the

[76] Some types of benefits for disabled persons were established already from 1 January 2000.

scope of job opportunities by providing rehabilitation and labour market services and workplace adaptation.

A number of initiatives have been taken to enhance social cohesion in the field of information and communication technologies (ICT). Estonia is well advanced in the field of ICT. Almost a third of the population have direct access to the Internet and the majority of employees have web access at work. To broaden the access to Internet, over 200 Public Access Internet Points have been opened (many in public libraries). Considerable amount of public information is available on Internet as the majority of public institutions have developed their own web pages. Increasing number of public services are available on-line (e.g. possibilities to present tax declarations, obtain and submit various application forms for documents, benefits etc.)

In 1996-2000, in the framework of a Government-supported project "Tiger Leap", all schools in Estonia were computerised and connected to Internet. Public-private partnership project "Look@world" initiated in 2001 is aiming at avoiding the Digital Divide and providing equal opportunities through broadening the access to Internet and web-based private and public services. More concretely, the project aims at providing possibilities to use Internet and e-services for people who are not able to pay for current services. The main objectives of the project are to double the current number of Public Access Internet Points and to train 100,000 persons (current non-users) basic computer and Internet skills, targeting older population (50-74 years old) and blue-collar non-office workers.

An emerging social problem for Estonia is the increasing number of HIV positive people, closely connected to the widening of the drug abuse problem, in particular among youth. While in 1999 there were only 9 new HIV+ cases, the number of new cases exploded in 2001, reaching 1474 mainly due to the spread of HIV among injecting drug abusers. In 2002 the number of new cases declined to 899, as a result of increased awareness and needle-exchange programme. Nevertheless, stigmatisation of HIV victims and costly treatment options are new challenges for the Estonian society to tackle.

4.2.9 Administration, Access to and Delivery of Services

Following the publication of the 1999 Poverty Study, a number of measures indeed have been implemented by the Government, which directly or indirectly address the problems outlined in the study. However, up to now, the Government has not been able to formulate a coherent strategy or action plan in respect of poverty alleviation.

Several functions relevant for social cohesion (e.g. housing, social services, and social assistance) have been placed on local municipalities.

The problem is however that most of the Estonian local municipalities are rather small[77] and accordingly their fiscal base is modest, which does not allow them to carry out properly the functions, which are expected from them.

The role of non-governmental organisations is on increase, in particular as advocacy groups for integration of marginalised groups, e.g. disabled persons, formerly imprisoned persons etc. Several NGOs are also providing social services for the target groups.

4.3 Evaluation of Future Challenges

4.3.1 Main challenges

Poverty studies indicate that the main drivers of poverty and social exclusion are unemployment and family breakdown. While unemployment has started to decline over the last year, it still remains at a relatively high level of over 9%, above the EU average. Breakdown of the traditional family model, expressed in the high divorce rate and the high share of children born out of wedlock, has led to the high share of children growing in single parent households. Poverty of single-parent households and large families (with 3 or more children) has often a common denominator – only one wage-earner in the family (or none at all).

A growing concern is increasing inequality and stratification of society. The difference between incomes of the highest and lowest income deciles is over 6 times (Table 4.10 in Annex 3), highest among the Central and Eastern European candidate countries and well above the EU average. The Gini coefficient – 0.36 in 2001 (Table 4.9 in Annex 3) – is also highest among the CEE candidate countries. Regional disparities are also considerable in spite of the relatively small territory.

Combating unemployment requires simultaneously increasing the demand and supply of labour. While possible interventions to increase the demand of labour are mostly outside the scope of social policy, increasing the employability and support to the economic adaptation are challenges for the labour market policy in the coming years. A key role in this respect will play the adaptation of the vocational training system and a systematic advancement of life-long learning systems.

Combating the negative effects of family breakdown requires from one side more targeted redistribution through the family benefit scheme, but more importantly, the development of a complex system of family support services.

---

[77] After local elections in October 2002, there are 241 local municipalities in Estonia.

4.3.2 Links to other social protection policies

The pension reform undertaken since 1999 is gradually strengthening the link between former contributions and the amount of pension (see chapter 3). This reduces the degree of redistribution in the pension system and increases differentiation of pension incomes. Nevertheless, there is a minimum pension guarantee for persons with low contributions and/or short working career. The pension indexation formula basically guarantees the increase of the real value of pension, while not necessarily preserves the relative position of pensioners to wage-earners.

Recent reforms in the field of health insurance have increased the individual responsibility of patients by increasing direct out-of-pocket payments on pharmaceuticals as well as increasing co-payments on specialist care (visit fees and payments for hospital services). These additional payments, although subject to ceilings, will inevitably increase economic hardship to low-income chronic patients.

4.3.3 Political directions of future reforms

The main ideological separation line in respect of state interventions and redistributions runs between the centre-left Centre Party and the liberal Reform Party, who are, however, the current coalition partners. The Reform Party has strongly criticised the current system of social benefits and is opposing the increase of current benefit levels. The Centre Party, at least in rhetoric, is more pro-welfare-state. Other major political parties hold moderate positions between the two extremes.

However, in the upcoming election campaign (Parliament elections in March 2003) poverty and social exclusion have not been raised as major issues. Both coalition parties have decided to focus their campaigns on the reform of income tax system. The Centre Party is advocating for an introduction of progressive income tax (with tax rates of 15, 26 and 33%) instead of the current proportional income tax (26%). The Reform Party is strongly opposing the progressive income tax, and campaigns for reduction of the income tax rate from 26% to 20%. However, both plans would substantially reduce state revenues (by 1.5 – 2 billion EEK a year), although their impact on individuals would be different, depending on the earnings level[78]. Reduction of state revenues would in turn tighten the already very tight competition between different fields of the public sector for state financing and would impose very strict boundaries for the further development of safety net.

[78] The proposal of the Centre Party would reduce the tax burden for low- and middle-income earners, while only a rather small number of high-income earners (4-5%) would face tax increase.

Against the background of missing consensus across major political forces, political directions of future reforms in field of social inclusion are difficult to predict.

4.3.4 Social exclusion, poverty and EU accession

The Government has recently indicated its commitment to draft a Joint Social Inclusion Memorandum (JIM) in co-operation with the European Commission. This policy document aims at measuring poverty and social inclusion and identifying key challenges and immediate and long-term actions for social inclusion. The process of drafting the JIM in itself is expected to contribute to building up and strengthening the network between governmental agencies and other relevant stakeholders and hopefully will result in a more integrated set of measures to tackle poverty and social exclusion.

The extent of the future EU influence on social inclusion policies is again difficult to foresee. On one hand, as this domain in the EU is primarily within the competence of Member States, it may be expected that the development of domestic political and policy discourse on the topic will be the most crucial determinant. On the other hand, financial support from the EU Structural Funds and participation in the open method of co-ordination are expected to have positive influences. As it appears, against some of the EU social inclusion indicators (e.g. distribution of income, Gini coefficient), Estonia is lagging behind not only of the current EU Member States, but also the other candidate countries. These comparisons in turn are very likely to be reflected in the future policy debates in Estonia.

4.3.5 Conclusions

The issue of poverty has been raised to the public policy debate only relatively recently, at the end of 1990s. However, until now, there is no national poverty line. The official substitute is a subsistence level, approved by the Parliament and serving as a basis for social assistance subsistence benefit. The subsistence level is not however based on any objective criteria and has reflected subjective policy decisions of the Government and constraints of the state budget. As a result, the subsistence level does not cover even the minimum food basket. The subsistence minimum calculated by the Estonian Statistical Office on the basis of the minimum consumption needs could be titled as the semi-official poverty line.

In academic circles both an absolute and a relative poverty line has been used. The authors of the 1999 Poverty Study (mainly researchers of the Tartu University) came to the conclusion that the relative poverty line of 50 or 60% of median income is not adequate to characterise the poverty situation in Estonia, because these income levels may not be sufficient to meet the cost of basic commodities. Instead, using of absolute poverty line,

based on minimum consumption necessary to satisfy basic needs, was suggested. Recent data from 2001 and 2002 indicate however, that the gap between the absolute poverty line developed in 1999 and the relative poverty line of 60% of median income has been narrowing with the increase of median income. Consequently, the two measures give nearly the same results on the extent of poverty.

Different strategy documents and action plans adopted in recent years – e.g. Employment Action Plan; Regional Development Strategy; Education Strategy; Conceptual Framework of the Pension Reform; Disability Policy Action Plan; Concept of Child and Family Policy – as well as the programmes implementing them, have addressed also social inclusion aspects of these sectoral policies. However, until now, the different sectoral policies are relatively loosely connected and do not form a coherent strategy. The Government therefore needs to develop a comprehensive strategy and a plan of action for prevention and alleviation of poverty and social exclusion.

Recent safety net policy responses of the Government have included the following measures:

1. Development of more inclusive labour market policies, with increased emphasis on active measures (e.g. alignment of conditions for registration as an unemployed person were with the ILO criteria, bringing also the long-term unemployed persons into the focus of employment offices and making them eligible for labour market services);
2. Introduction of a new scheme of unemployment insurance;
3. Introduction of a new scheme of social benefits for disabled persons to compensate disability-related costs;
4. Introduction of a new concept of emergency social assistance making local municipalities responsible to guarantee everybody at least food, clothes and shelter;
5. Increased targeting of the scheme of family benefits to groups in higher poverty risk (large families and families with small children).

These policy measures have concentrated on the development of cash benefit schemes. At the same time, the nature of problems behind main drivers of poverty and social exclusion suggests that in addition to cash benefits, more emphasis on social services could be appropriate.

Notable positive initiatives have been taken in the area of E-inclusion, where public-private partnership projects are aiming to prevent the digital divide.

4.4 Annex 3

Table 4.1: The values of EU social cohesion indicators for Estonia.

	Indicator	**Value**
1.	Low income rate (percentage of individuals living in households where the total household income is below 60% national median income)	Total: 19.9 % Breakdowns not available *ESO 2000*
2.	Distribution of income (ratio between the income of the top 20% to the bottom 20%)	6.8 *MoSA 2000*
3.	Persistence of low income	Not available
4.	Relative median low income gap	52.1 % *PRAXIS 2000*
5.	Regional cohesion (coefficient of variation of employment rates ate NUTS 2 level)	Not applicable[79]
6.	Long term unemployment rate (population unemployed for over 12 months as proportion of total labour force)	Male: 6.9 % Female: 5.4 % Total: 6.2 % *ESO LFS 2000*
7.	Persons living in jobless households	Not available
8.	Early school leavers not in education or training	Not available
9.	Life expectance at birth	Male: 65.1 Female: 76.0 *ESO 2000*
10.	Self defined health status by income level (proportions of population aged 18 and over who characterise their state of health as bad or very bad: lowest and highest income quintile, gender breakdown)	Male: 13.3 % Female: 19.0 % Total: 16.4 % Lowest quintile: 14.5 % Highest quintile: 6.8 % *MoSA 2000*
11.	Dispersion around the low income threshold (persons living in households where the total household income was below 40, 50 and 70% median national income)	Below 50%: 13.7 % *ESO 2000*
12.	Low income rate anchored at a moment in time	Not available
13.	Low income rate before transfers	Not available
14.	Gini coefficient	0.360 *ESO 2000*
15.	Persistence of low income below 50% of median income	Not available
16.	Long term unemployment share (population unemployed for over 12 months as proportion of total unemployed population)	Male: 46.7 % Female: 41.3 % Total: 44.3 % *ESO LFS 2000*
17.	Very long term unemployment rate (population unemployed for over 24 months as proportion of total labour force)	Male: 4.2 % Female: 3.0 % Total: 3.6 % *ESO LFS 2000*

[79] Estonia constitutes a single statistical region at the NUTS 2 level.

Table 4.1 continued: The values of EU social cohesion indicators for Estonia.

	Indicator	**Value**
18.	Persons with low educational attainment (educational attainment rate of ISCED level 1 or less by age groups)	Aged 25-34 Male: 10.3 % Female: 5.8 % Total: 8.1 % Aged 35-44 Male: 10.4 % Female: 6.1 % Total: 8.2 % Aged 45-54 Male: 17.1 % Female: 14.8 % Total: 15.9 % Aged 55-64 Male: 35.4 % Female: 33.9 % Total: 34.5 % *ESO LFS 2000*

Remarks: ESO – Estonian Statistical Office
LFS – Labour Force Survey

Table 4.2: The development of social assistance subsistence level in Estonia, 1993 - 2002

Date of changing the subsistence level	**Subsistence level**	
	Nominal value, EEK	**Real value (1993 = 100), EEK)**
2.09.1993	280	100
1.10.1994	320	75
1.01.1996	320	55
1.02.1996	390	64
1.01.1997	460	70
1.11.1997	500	69
1.03.1998	500	65
1.01.1999	500	63
1.01.2000	500	61
1.01.2001	500	58
1.01.2002	500	55

Source: Kuddo et al. 2002, author's calculations

Table 4.3: Households receiving subsistence benefit in 1998 – 2001 (in EEK)

	1998	**1999**	**2000**	**2001**
Households receiving subsistence benefit (thousands)	85.1	81.1	65.4	70.4
Share of all households (%)	13.9	13.7	11.4	12.4

Source: Ministry of Social Affairs

Table 4.4: The development of subsistence minimum in 1998 – 2001 (in EEK

	1998	**1999**	**2000**	**2001**
Subsistence minimum	1,177	1,172	1,229	1,306
minimum food basket	*599*	*579*	*593*	*646*

Source: Estonian Statistical Office

Table 4.5: The development of the poverty line developed by researchers of Tartu University, 1997 – 2001 (in EEK)

	1997	**1998**	**1999**	**2000**	**2001**
Poverty line	1,250	1,330	1,360	1,428	1,488

Source: Ministry of Social Affairs

Table 4.6: The development of relative poverty line of 60% median household income per household member 1996 – 2001 (in EEK)

	1996	**1997**	**1998**	**1999**	**2000**	**2001**
Median income	1,200	1,338	1,539	1,695	1,750	1,833
60% of the median	720	803	923	1,017	1,050	1,100

Source: Ministry of Social Affairs, Estonian Statistical Office, author's calculations

Table 4.7: Long-term (over 12 months) and very long-term (over 24 months) unemployment, 1997 – 2001 (annual average, in percentages)

	1997	**1998**	**1999**	**2000**	**2001**
Long-term unemployment rate (%)	4.4	4.6	5.6	6.2	6.1
Long-term unemployment rate for men (%)	4.4	4.9	6.4	6.9	6.8
Long-term unemployment rate for women (%)	4.5	4.3	4.8	5.4	5.4
Long-term unemployed from total unemployed (%)	45.7	47.1	45.9	45.4	48.3
Very long-term unemployment rate	2.6	2.5	3.2	3.6	3.9

Source: Estonian Statistical Office, Ministry of Social Affairs

Table 4.8: Unemployment rate by education level, 1997 – 2001 (annual average, in percentages)

	1997	**1998**	**1999**	**2000**	**2001**
Primary or basic (ISCED level 1 or less)	15.8	16.6	21.5	23.8	21.1
Secondary (ISCED level 2)	10.6	10.8	13.3	14.6	13.6
Tertiary (ISCED level 3)	5.1	5.1	6.1	7.3	7.4

Source: Estonian Statistical Office

Table 4.9: Gini coefficient 1996-2001

	1996	**1997**	**1998**	**1999**	**2000**	**2001**
Gini coefficient	0.34	0.37	0.38	0.38	0.37	0.38

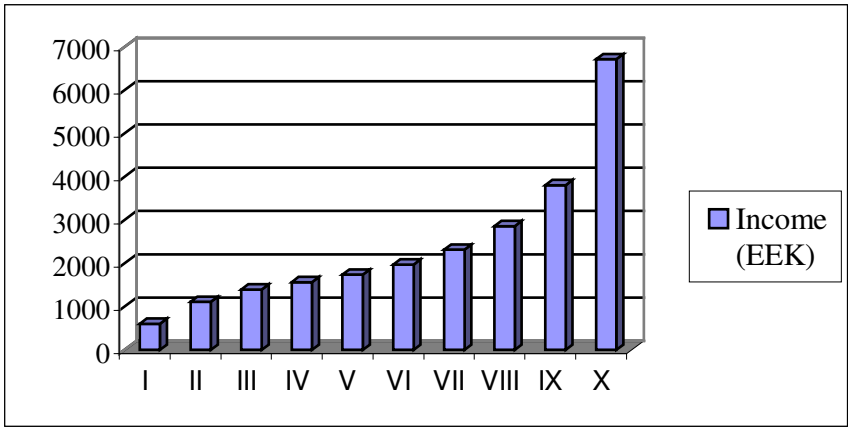
Source: Ministry of Social Affairs

Table 4.10: Income differences between the 20% households with the highest and 20% households with lowest income 1995-2001

	1995	**1997**	**1998**	**1999**	**2000**	**2001**
S80/S20	7.7	5.6	5.4	5.5	6.7	6.1

Source: Ministry of Social Affairs

Figure 4.1: Average monthly disposable income per household member in income deciles in 2001



Source: Estonian Statistical Office

5. HEALTH CARE

5.1. Evaluation of current structures

5.1.1 Organisation of the health care system

General administration of health care

The general administration of health care and health policy in Estonia is the responsibility of the Ministry of Social Affairs (MSA)[80]. According to the State Government Act and the Statute of the Ministry, the responsibilities of the Ministry in the area of health care include:

- policy formulation and development;
- general co-ordination of disease prevention, health promotion, health protection, diagnostics and medical care;
- ensuring equal access to care and provision of high quality of health services;
- ensuring the quality and safety control of pharmaceutical products;
- collection and analysis of health statistics.

Subordinated to the Ministry there are different agencies responsible for various administrative tasks related to health care: the Health Care Board, the State Agency of Medicine, the Health Protection Inspectorate and the Centre for Health Education and Promotion[81].

Health Care Board, established in January 2002, is responsible for registering health care workers, issuing activity licences, supervising of health care service providers, arrangement of ambulance services and evaluation of the quality of care.

State Agency of Medicine is responsible for import and export authorisation, marketing authorisation and quality control of medicinal products, inspection of pharmaceuticals and supervision over medical devices.

Health Protection Inspectorate organises and executes state supervision of health protection and applies relevant enforcement powers. The Inspectorate

---

[80] The Ministry of Social Affairs was formed in 1993, when 3 former ministries (the Ministry of Health, the Ministry of Labour and the Ministry of Social Welfare) were merged.

[81] Under the Ministry of Social Affairs are also other agencies, e.g. Medical Library, Institute of Experimental and Clinical Medicine and Centre of Occupational Health. These institutions are not described in this study. For details please see MSA web-site www.sm.ee

organises the supervision of foodstuffs, drinking and bathing water, carries out relevant laboratory tests, registers communicable and parasitic diseases, investigates the circumstances of infection transmission and works out measures for prevention and control of communicable diseases, supervises the organisation of immunisation of population and monitors immunisation coverage[82].

The Centre for Health Education and Promotion is responsible for initiating, developing and implementing health promotion and disease prevention programs. The Centre is also training and supporting a network of health promotion co-ordinators in all counties as well as the development of counselling and resource centres at the local level and the network of auditors to improve quality and professionalism in health promotion.

The main legal framework of the current health care system is established in 3 pieces of legislation: Health Insurance Act, the Estonian Health Insurance Fund Act and Health Services Organisation Act.

Health insurance system

A system of compulsory health insurance to cover the costs of preventive and curative health services of insured persons as well as for compensation of pharmaceuticals and technical aids, and payment of cash benefits in case of temporary incapacity to work is established by Health Insurance Act[83]. According to the law, the Estonian health insurance system is based on the following main principles:

- solidarity between insured persons;
- limited cost-sharing;
- services provided according to the needs of insured persons;
- equal access to health services in different regions;
- rational use of health insurance funds.

Estonian Health Insurance Fund Act provides the objective, functions, competence, legal status and management of the Estonian Health Insurance Fund, which is the body in charge of practical administration of the health insurance scheme[84].

The Estonian Health Insurance Fund is a public-legal institution, which is governed by a Council, which includes 15 members:

---

82 http://www.tervisekaitse.ee/tkuus.php?msgid=958. Accessed 06.05.2002

83 The current version of the Act was passed 19 June 2002 and entered into force 1 October 2002.

84 The Act was passed 14 June 2000 and entered into force 1 January 2002.

1. 5 representatives of the State (the Minister of Social Affairs; the Minister of Finance; the Chairman of the Social Commission of Parliament; Member of Parliament representing the opposition and 1 representative of the Ministry of Social Affairs);

2. 5 members representing organisations of insured persons;

3. 5 members representing employers organisations.

The Fund operates within the area of administration of the Ministry of Social Affairs, but is not directly subordinated to the Ministry. However, the Minister of Social Affairs is by position the chairman of the Fund Council.

The Health Insurance Fund has 7 regional offices, which cover from 70 to 500 thousand insured persons in their respective region.

The main functions of the Health Insurance Fund include:

- making annual contracts with the providers of medical services and covering the expenses of medical care of insured persons to the service providers under these contracts;
- paying sickness, maternity and care cash benefits to insured persons;
- paying compensations (price differences) of pharmaceutical products to the pharmacies on the basis of prescriptions issued to insured persons.

The Health Insurance Fund contracts most of the health care providers. Services are compensated according to a price-list, established by the Government[85]. While only few years ago, contracts with health care providers were made according to the historical data based on service-use and regional needs, the new legislation[86] establish precise criteria for service providers to be eligible for contract with the Health Insurance Fund. The same rules apply for all providers. The quality of contracts has increased, contracts setting down the amount of services to be provided, patient numbers and average cost per case. The average length of contracts has increased from 2 pages to 30 pages. Contracts have been re-negotiated every year (Jesse 2002).

The objective of the Health Insurance Fund is to purchase high quality services for insured persons at reasonable cost and to manage existing resources efficiently. The new Health Insurance Act has established additional requirements for contracts, including quality criteria (e.g. criteria on access to services and maximum length of waiting lists) and is also taking into account regional needs and differences.

---

85 Government Regulation No 302 from 24 September 2002.

86 I.e. Health Insurance Act, Health Services Organisation Act, Decision No.32 of the Council of the Health Insurance Fund from 30 November 2001 on Basic Principles of Contracting Health Care Service Providers and the Hospital Master Plan (on the latter see 5.3.1).

Provision of health care

Health Services Organisation Act provides the organisation of and the requirements for the provision of health services on various levels, and the procedure for the management, financing and supervision of health care[87].

All people residing in Estonia are eligible to choose a family doctor. For access to specialist care and hospital treatment patients, as a rule, should obtain a referral from their family doctor. Referral from the family doctor is a prerequisite for reimbursement of the visit to a specialist by the Health Insurance Fund. Thus family doctors operate as gatekeepers of the health care system. However, access to several outpatient specialists, like gynaecologist, TB specialist, ophthalmologist, otorhinolaryngologist and dermato-venerologist is possible without a referral of the family doctor. The same applies also for patients with chronic illness, which requires continuous monitoring of the health status according to the generally recognised treatment guidelines. Other patients seeking specialist care services without a referral of the family doctor shall pay the full cost of services.

Persons registered with a family doctor are inserted into the list of patients of the family doctor. According to the Decree No. 113 of the Minister of Social Affairs from 29 November 2001, the number of patients in the list of a family doctor should be in a range of 1,600±400 persons.

In 2001 the Health Insurance Fund had contracts with 562 family doctors. Most of the family doctors are self-employed. The main financing mechanism of family doctors is capitation, which is adjusted to the age of patients[88].

In 2001 the number of hospitals in Estonia was 67. According to the Health Services Organisation Act, hospitals may be owned by joint-stock companies or foundations, which hold a relevant activity licence. Most of these companies are still in public (either state or local municipality) ownership. The main source of financing for hospitals is contracts with the Health Insurance Fund. Public and private providers have the same criteria of eligibility for a contract with the Health Insurance Fund, and services are compensated according to the same price–list.

---

87 The current version of the Act was passed 9 May 2001 and entered into force 1 January 2002.

88 Different rates apply in respect of the following age groups: children under 2 years of age, persons from 2 to 70 years of age, and persons over 70 years of age.

Private sector has been most active in the field of dentistry, providing almost 75% of services, and is also developed in the areas of gynaecology, otorhinolaryngology, ophthalmology and urology.

Public health

The public health system is organised through the Department of Public Health at the Ministry of Social Affairs, the Health Protection Inspection and the Centre for Health Promotion and Disease Prevention.

The Department of Public Health in the Ministry of Social Affairs is responsible for developing and managing public health programmes, environmental health issues and health protection. The Department has prepared several national programmes in the area of health promotion and disease prevention:

- a national programme for the prevention of tuberculosis until 2003;
- a national programme for the prevention of alcoholism and drug addiction until 2007;
- a national development plan for the prevention of HIV/AIDS and other sexually transmitted diseases until 2001;
- a national health programme of children and adolescents until 2005;
- a national environmental health action plan of Estonia;
- a national programme of research and development in public health for the years 1999-2009;
- a programme for preventing high blood pressure until 2009;
- a programme for preventing cancer until 2009;
- a programme for preventing accidents until 2009.

The last three programmes are approved by the Minister of Social Affairs, but financing is not yet confirmed.

The Centre for Health Promotion and Disease Prevention is a leading institution to implement and monitor several national public health programmes and health promotion projects, including:

- The national programme for the prevention of alcohol and drug abuse 1997 – 2007;
- National health programme for children and adolescents 2000-2005;
- National project "Get rid from tobacco!";
- PHARE Twinning Project on smoking prevention in Estonian schools.

The Centre is a member of the European Network for Health Promotion Agencies (ENHPA) and participates in the ENHPA project "Tackling inequalities in health".

The Centre has also organised several national and international conferences, seminars as well as press-events on various health promotion matters[89].

5.1.2 Benefits

According to the Health Insurance Act, which entered into force from 1 October 2002, benefits of the health insurance system are divided into benefits in-kind and benefits in-cash.

Benefits in-kind include:

- medical services;
- pharmaceuticals, and
- technical aids.

Cash benefits include:

- benefits in case of temporary incapacity to work;
- compensations for dental care of adult persons;
- supplementary compensations for pharmaceuticals[90].

The costs of medical services are paid by the Health Insurance Fund to the relevant medical or care institution or private physician on the basis of contracts between the service provider and the Health Insurance Fund.

The medical services compensated by the Health Insurance Fund are listed in the Government Regulation No. 302 from 24 September 2002. The list includes over 1200 different codes *inter alia*[91]:

- out-patient consultations (including home visits) by general practitioners (family doctors) and specialists;
- laboratory tests;
- preventive health check-ups;
- health tests and procedures both in out-patient care and in hospitals;

---

89 http://www.tervis.ee/locate_eng.php3 Accessed 07.05.2002

90 The new law describes also a fourth type of cash benefits – travel expense compensation for reimbursement of costs incurred in connection with travel to medical institutions. However, this benefit will be available only from 1 January 2005.

91 Over the last few years, more and more complex prices have been introduced to cover different health care services.

- hospital care (including *inter alia* nursing care and necessary pharmaceuticals);
- pre-natal care, confinement and post-natal care.

As a rule, patients should obtain a referral from their family doctor for access to specialist care and hospital treatment. However, access to some outpatient specialists is possible without a referral of the family doctor (see 5.1.1).

Only few services are excluded from the list of services compensated by the Health Insurance Fund, e.g. cosmetic surgery and alternative therapy. However, implementation acts of the new Health Insurance Act defined more clearly patients' co-payment levels for some services (e.g. induced abortions, certain rehabilitation services).

Patients participate in the cost-sharing also through the payment of a visit fee for outpatient visits and a bed-day fee in case of hospital treatment. Providers of medical services are allowed to establish visit fees for home visits and outpatient specialist consultations up to a ceiling of 50 EEK[92]. Hospitals may charge a fee for each bed-day for up to 10 days, up to a ceiling of 25 EEK per day.

According to the new Health Insurance Act dental care is fully covered by the Health Insurance Fund only for children up to 19 years of age. Starting from 1 January 2003, adult persons have to pay for dental care out-of-pocket, but are entitled to annual reimbursement of incurred costs, subject to a ceiling – 150 EEK a year – established by the Minister of Social Affairs[93].

The health insurance system covers also prescription pharmaceuticals provided to insured persons at discounted price. The list of pharmaceuticals compensated by the Health Insurance Fund is established by the Minister of Social Affairs in Regulation No 112 from 24 September 2002. The Health Insurance Fund compensates to the pharmacies the rate of discount - the difference between the regular price and the amount paid by a patient. The co-payment of the patient (either first 20 or 50 EEK per prescription) and the rate of discount (100%, 90%, 75% or 50% of the remainder) varies according to the diagnosis and age of the person.

The Government has established lists of diseases for which drugs may be inserted into the list of compensated pharmaceuticals with the discount rate of 100% or 75%[94]. The 100% discount rate applies to 25 medical conditions

---

92 Before 1 October 2002, visit fees were established by the Minister of Social Affairs and were respectively 5 EEK for outpatient visits and 15 EEK for home visits. Several categories of persons (e.g. children, pensioners, and pregnant women) were exempted from the payment of the fee.

93 Regulation of the Minister of Social Affairs No 145 from 16 December 2002.

94 Government Regulation No 308 from 26 September 2002.

(incl. AIDS, cancer, syphilis, organic mental illnesses, epilepsy, Parkinson disease, diabetes, glaucoma, sclerosis multiplex etc.) and the 75% discount rate to 41 different conditions (e.g. cardiovascular insufficiency, bronchial asthma, peptic ulcer, ulcerative colitis, chronic nephritis, chronic C-hepatitis, rheumatoid arthritis, trigeminal neuralgia etc.).

The Minister of Social Affairs may establish reference prices for pharmaceuticals included in the list. To be eligible for inclusion in the list, the manufacturer or distributor of the pharmaceutical may also be required to conclude a price agreement with the Ministry of Social Affairs.

The 90 per cent discount rate applies to children under 10 years of age, persons receiving a pension for incapacity to work on the basis of the State Pension Insurance Act, and insured persons over 63 years of age.

All other prescription pharmaceuticals included in the list are compensated with the 50% discount rate up to a ceiling of 200 EEK per prescription.

5.1.3 Financing of the health care system

The health care system is financed from different sources – public and private.

Most of the resources come from the public sector, 76,9% of the total in 2000, while the share of private sector was 22,9%. Health care expenditures of the public sector are divided between the Health Insurance Fund and allocations of the state budget and local municipalities.

The major share – about two-thirds – of total health care expenditures is financed by the health insurance system. State budget allocations count for about 8-9% of total expenditures, while the share of local municipalities has been around 2%. From private expenditures, the direct expenses of households are the most important source, counting for ca 20% of total health expenditures (Table 5.1 in Annex 4)[95].

The main source of revenues of the Health Insurance Fund is earmarked social tax. The rate of social tax is 33 per cent of the tax base (comprising primarily of the payroll), of which 20 percentage points is allocated for the pension insurance and 13 percentage points for the health insurance (see also 2.2.1 – 2.2.3).

---

[95] The Ministry of Social Affairs introduced National Health Accounts from 1998. For 1998 data, the methodology of Harvard University was used. Since 1999 the Ministry is using OECD methodology "A System of Health Accounts for International Data Collection".

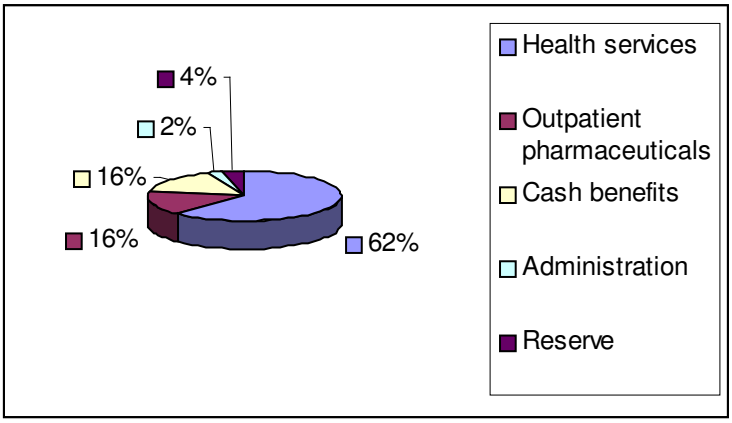
In 2001, revenues from social tax constituted 99.5% of the total revenues of the health insurance budget. Remaining residual sources of income were bank interests, regress payments from private insurance companies for costs incurred in cases of motor accidents, regress payments from employers, fees for issuing duplicate membership cards etc.[96]

The annual health insurance budget is drafted primarily on the basis of the macroeconomic prognosis on the development of total payroll, presented by the Ministry of Finance. The Government approves the figure and finally the Parliament approves allocations from social tax to the Health Insurance Fund as a part of the annual state budget. The Council of the Health Insurance Fund thereafter approves the more detailed health insurance budget, distributing available resources between various types of benefits and other foreseen expenditures.

The main types of expenditures of the Health Insurance Fund are expenses for health services, drug compensations and sickness/maternity cash benefits (see Table 5.3 in Annex 4).

In 2002 the total health insurance budget is 4.98 billion EEK or 318 million Euro. The major part, 62% of the health insurance expenditure goes to finance health services (Figure 5.1). Equal proportions from the budget – 16% for each – are allocated for the outpatient pharmaceuticals and sickness-maternity cash benefits. Administrative expenses are relatively small, comprising only 2% of the total budget. Reserves count for 4% of the budget.

Figure 5.1: The division of health insurance budget in 2002



Source: Health Insurance Fund 2002

According to the Health Insurance Fund Act, the Health Insurance Fund should have cash reserves in the amount of at least 5% of the annual health insurance budget, with the purpose of smoothing financing of expenditures

[96] http://www.haigekassa.ee/aruanded/HK_majandusaruanne.pdf

in the case of temporary cash flow problems. In addition, the Fund should have a reserve capital in the size of 8% of the annual budget to reduce the potential effect of macro-economic risks on the health insurance system. The creation of the reserve capital started in 2001 and, according to the law, in the first years each year 2% of the budget is allocated to the reserve capital until the 8% target will be met. In 2001, 113.5 million EEK (2.5% of the budget) was allocated to the cash reserve and 89 million EEK (2% of the budget) to the reserve capital. In 2002, allocations to increase cash reserves and the reserve capital were respectively 80 and 100 million EEK. The reserve capital may only be used as an extraordinary measure by an order of the Government on the proposal of the Minister of Social Affairs.

Over the last years the increase of total expenditures of the Health Insurance Fund on health care services has been lower than the annual inflation rate. In 2001 and 2000, health service expenditures were basically stagnated on 1999 level (Table 5.3 in Annex 4). At the same time, the Ministry has been trying to adapt the price list of services according to the inflation rate. The prices for health services increased 10% in 1997 and 20% in 1998. An average increase in 1999 was 15%, while in the same year there were serious shortfalls in revenue collection due to changes in the Social Tax Act[97]. As a result, in 1999 the Health Insurance Fund had to spend more than 300 million EEK from its reserve funds to cover health service expenditures. In 2000 prices of the main health services were not changed. The price increases in 2002 were between 3-8%.

From the total expenses for health services, 74% are distributed for inpatient specialist care services, including also specialised ambulatory visits (Figure 5.2). Primary health care receives 14% of total expenses. This might seem to be a relatively small proportion as compared to other countries. It should be taken into account that this number doesn't contain some visits to the specialists where patients have a direct access without family doctor's referral[98].

Over the last years there has been a slight decrease in visits to specialised ambulatory care, which may indicate the results of the primary health care reform (see 5.3.1).

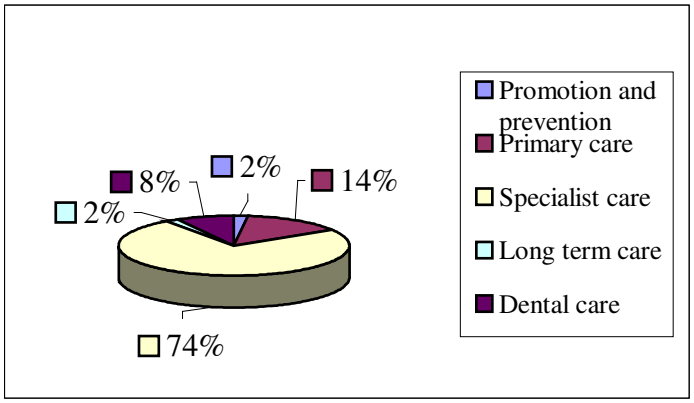
The expenses for dental care form about 8% of the total expenses and are showing a declining trend over the last years. Relatively small share goes to finance different health promotion and disease prevention activities as well as long term care – 2% of the total for each.

---

97 From January 1999 the date of payment of social tax was changed and as a result, companies had a legal possibility to pay social tax in the year 1999 only for 11 month.

98 For the list of those specialists see 5.1.1

Figure 5.2: The division of expenditures of the Health Insurance Fund on various health care services in 2002



Source: Health Insurance Fund 2002

For reimbursement of pharmaceuticals, the Health Insurance Fund has 2 payment schemes:

- pharmaceuticals for out-patients through pharmacies (see 5.1.2);
- pharmaceuticals for hospital use – the cost of pharmaceuticals is included in the price of health services.

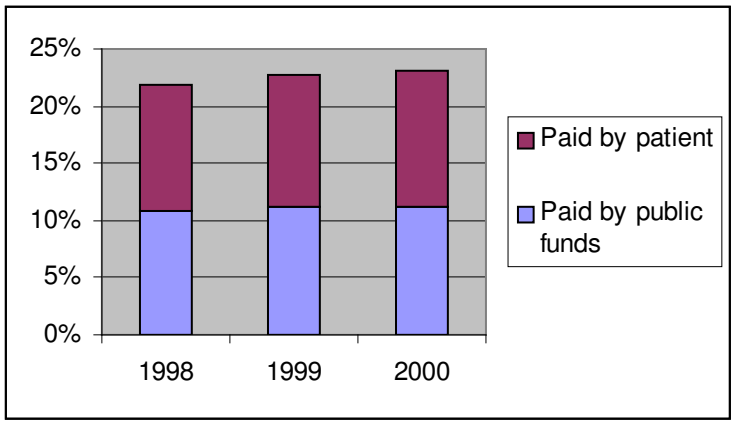
Expenses of the health insurance system for compensated drugs have been increasing rapidly (see Table 5.3 in Annex 4). When the 2001 budget was drafted, it was expected that the expenses for drug compensations should be around 500 million EEK. The actual expenses in 2001 were however 666 million EEK or 33% higher than expected.

The increase of expenditures is matched with the increase of the sale of medicinal products in Estonian retail and hospital pharmacies. In 1998 the increase was 29%, in 1999 18% and in 2000 24% on a year-to-year bases. In 2000, the total number of prescriptions was 3,4 million.

The increase of drug costs has three main reasons. Firstly, the amount of medication used in Estonia has increased. Secondly, older drugs are replaced by medication, which is more effective, but also more expensive. And thirdly, new pharmaceuticals have been introduced for the treatment of diseases, which had no medical treatment before or the existing treatment was not available in Estonia. The last two major qualitative changes in the choice of pharmaceuticals allow the prescribing physician to use more effective and safe medicines than ever before. In volume terms, the amount of prescription pharmaceuticals used per capita has doubled over the 1990s, but is still less than one-half of the European level.

Persons over 65 years of age use 42% of costs on reimbursed pharmaceuticals of the Health Insurance Fund (Kiivet and Harro 2002).

Figure 5.3: Expenditures on pharmaceuticals as a percentage of total health care expenditure and as divided between the patient and public funds.



Source: Health Insurance Fund, presentation by Dr. Lambot, K.

Total expenditures on pharmaceuticals comprise about 22-23% of the total health expenditures (Figure 5.3). Half of the total pharmaceutical expenditures are paid by the public sector, the other half being paid directly by patients. In most of the EU countries the total pharmaceutical expenditure as a percentage of total health expenditure has been between 10-20%. At the same time the percentage paid by the public sector in the EU countries is higher than in Estonia[99].

Public health programmes are financed through the Health Promotion Fund, state budget and international donors, in smaller proportions by local municipalities. The major part of the resources for health promotion comes from the Health Promotion Fund[100]. The Health Promotion Fund operates as a sub-fund of the Health Insurance Fund and is governed by a Board of 5 members. Once a year, different organisations and non-profit institutions may present their projects for funding. The Board makes a selection of projects according to pre-determined criteria and presents the list of the projects for approval to the management of the Health Insurance Fund. The annual average number of applications is approximately 300 and the annual budget for 2002 was 12,9 million EEK.

---

99 Lambot, K., presentation at conference in Riga, December 2001

100 The Fund was formed in 1995 within the health insurance budget. Until 2001, the Fund subordinated to the Ministry of Social Affairs and governed by a board of 13 members from Parliament, representatives from NGOs and universities. From 2001, the Health Promotion Fund is under the Health Insurance Fund.

Health care expenditures financed from allocations of the state budget are defined in the Health Services Organisation Act. According to the Act, the following services shall be covered from the state budget:

- ambulance services;
- emergency care for patients without health insurance;
- investments into the hospital infrastructure according to the Hospital Master Plan;
- strategic reserve for drugs and medical equipment;
- unexpected public health emergencies at national level;
- expertise ordered by the health care quality commission;
- national health programs;
- health care research and development.

In 2001, state budget allocations to finance different health care functions amounted to 508 million EEK (see Table 5.4 in Annex 4).

Municipalities may finance the provision of health care services or other health care costs from local budgets on the basis of a decision of the local government council. However, in practice, the role of local municipalities in the overall health care financing has been rather modest.

Private health expenditures are divided between households, employers and private insurance (Table 5.3 in Annex 4). Expenditures of households account for user charges, direct payments for medical services (e.g. dental care), over-the-counter expenses for pharmaceuticals etc. Private medical insurance is basically limited to travel insurance.

The total health expenditures as a percentage of GDP have been around 5-6% over the last decade (Table 5.2 in Annex 4). In 2001, 5.5 % of GDP was spent on health care. The percentage is slightly below the relevant share in the EU Member States (from 7 to 10%). Since a large share of revenues for health care comes from a payroll tax, the development of health expenditures largely depends on the development of the payroll as a percentage of GDP. From the other side it shall be kept in mind that the GDP per capita in Estonia is only about one third of the EU average.

In nominal terms health expenditures have increased more than 10 times over the last decade, illustrated by the increase of the health insurance budget from 439 million EEK in 1992 to 4.4 billion EEK in 2001.

5.1.4 Incentives

Coming from the centrally planned system, Estonia started with a major decentralisation in early 1990s hoping that those who are at the local level are closer to the needs of population and therefore could plan more efficiently the health care system.

Health care system during Soviet times was heavily hospital and specialist care oriented. This type of system had a very strong fiscal pressure and was difficult to maintain. Over the last ten years the number of hospitals was reduced from 120 to 67. The number of hospital beds has reduced from 18,000 in 1990 to 9160 in 2001. The number of hospital beds per 1,000 population was 6.0 in 1998, which is only 0.2 percent higher than the CEEC average. Compared to the other CEECs, decrease of the number of hospital beds in Estonia was most rapid, 38 percent during 1990-1998. Inpatient utilisation and performance of acute hospitals in Estonia is comparable to Germany and Austria, but less than in Nordic countries. Decrease of hospital beds has not influenced the number of patients in in-patient care. This can be explained by the decrease in the length of stay by one half. This became possible due to the use of more efficient outpatient treatment opportunities and patient-friendly medical technologies (Kiivet and Harro 2002).

The number of health care personnel has decreased during the last ten years. According to the statistics there were 3.08 physicians per 1;000 inhabitants in Estonia in 2000, which is lower than in most developed countries. As the number of medical students decreased in 1990s and assuming approximately 10-year circle to train new qualified staff, Estonia could expect deficit from qualified medical personnel in the near future. The number of qualified nurses has decreased as well, which makes the system even more difficult to sustain.

The number of physicians has decreased during the last 10 years by 15 per cent (Kiivet and Harro 2002). At the same time, the number of dentists has increased about the same proportion, which is the only increase among the groups of specialists. As mentioned earlier, 75% of the dentists are working in private practice. Increase in the number of dentists affects out-of-pocket expenditures, which increased almost 50 per cent in 2000 as compared to 1999 statistics[101].

5.1.5 Coverage of the system and access to care

As of 1 January 2001, the number of persons registered as members of the Health Insurance Fund was 1,277,690. While the total population of Estonia as of 1 January 2001 was 1,366,723, the number of insured persons constitutes 93,5% of the total number of residents.

---

[101] Ministry of Social Affairs National Health Account System 2000.

According to the Health Insurance Act and Social Tax Act, as a general rule, coverage with health insurance derives from the payment of social tax. Insured persons are:

- all employees for whom the employer has paid (or has a duty to pay) social tax;
- self-employed persons who pay social tax themselves.

In addition, the state insures some categories of persons by paying social tax on their behalf (e.g. recipients of child-care allowance, caregiver's allowance and state unemployment allowance)[102].

Furthermore, the following categories of non-working persons are equalised to insured persons under the Health Insurance Act without payment of social tax:

- children under 19 years of age;
- students up to 24 years of age enrolled in daytime studies;
- pregnant women from the 12th week of pregnancy;
- recipients of state pensions granted in Estonia;
- dependent spouse of an insured person who is within 5 years from pension age.

From 1 October 2002, under the new Health Insurance Act it is possible to enter into a voluntary insurance contract with the Health Insurance Fund. The persons qualifying for voluntary insurance of the contract are those, who have been insured by the Health Insurance Fund for at least 12 months immediately preceding entering into a voluntary contract or persons who are dependent upon the insured person. Also, persons receiving pension from a foreign country are eligible for a voluntary contract. The minimum contract period is 1 year. The monthly insurance premium is equal to 13% of the average salary in the previous calendar year. The premium changes every year according to the development of the average salary in Estonia[103].

As illustrated by Figure 5.4, 45% of all insured persons are active contributors to the system: employees and self-employed persons who are insured through the payment of social tax, whereas 52% of all insured persons are covered without the payment of any contributions. 3% of all insured persons are insured through the payment of social tax by the state[104]. Considering the negative natural increase and ageing of population, the high system dependency ratio may become a serious threat to sustainability of the solidarity-based health insurance.

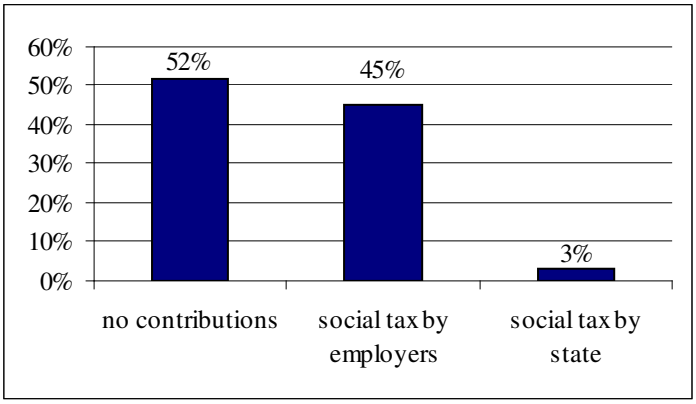
---

[102] For a complete list of these categories of persons see 2.2.3.

[103] http://www.haigekassa.ee/in_english/health_insurance.htm#voluntary Accessed on 20.01.03

[104] See also Table 5.4 in Annex 4.

Figure 5.4: Solidarity in financing the Estonian health insurance system



Source: Health Insurance Fund 2002

The problem is also that self- employed persons tend to evade paying social tax. As seen from Table 5.5 in Annex 4, in 2001 the average annual contribution of self-employed persons was over 3 times smaller than the average contribution received on behalf of employees. The Government has taken steps to improve tax collection, in particular through strengthening the administrative capacity of the Tax Office and introducing a stronger link between contributions paid and cash benefits of the health and pension insurance. However, the payment of social tax by self-employed persons has not yet improved substantially.

In respect of access to care, waiting lists exist for certain treatments. In order to regulate access to care and existing waiting lists, the Health Insurance Fund has set quality criteria for primary health care providers and other contractors. For example, the contract requirement of the Health Insurance Fund for primary health care doctors is that the patients in acute conditions shall get appointment or home visit for the same day or in case of chronic conditions within 72 hours. For appointment to specialists, the maximum allowed waiting period is 4 weeks, whereas in emergency situations care should be provided immediately.

In principle, men and women have equal rights to health care. In practice, the evidence shows that women tend to use more health care services (visits to general practitioners and specialists, hospitalisation, use of prescription drugs) compared to men. However, the gender differences are not pronounced in all age groups, being largest in middle age groups (25 to 44 years old) (Kunst et al 2002).

Persons who are not covered with health insurance (about 70 thousand in 2001) are entitled to emergency medical assistance. In 2002, 62.4 million EEK is allocated for this purpose from the state budget.

The market of voluntary health insurance is very small and consists mainly of travel insurance. This has been mainly explained by the absence of any specific tax incentives and the extensive package of services provided by the public health insurance. Following the adoption of the new Health Insurance Act, which extended patient's co-payments and increased individual responsibility for dental care, some insurance companies have announced about their plans to develop new products of private health insurance.

5.1.6 Public acceptance of the system

Estonian health care system has been changed radically during the last ten years. People can freely choose their family doctors and change the doctor if not satisfied, co-payments have been relatively small, hospitals equipped with high tech equipment and information about the latest possible treatment options in the world available.

In order to evaluate public opinion on the health care system and reforms, the Health Insurance Fund and Ministry of Social Affairs have conducted several patient satisfaction surveys. According to the latest patient satisfaction surveys, 95% of the population is in general satisfied with the health care system[105]. The 5% of dissatisfied patients were mostly complaining about the lack of information, impolite attitude of doctors and doubted competence of the doctors. However, surveys also indicated that the public awareness about the role of the health insurance system and about patients' rights and responsibilities was rather low. According to the results, people were more satisfied with private health care providers then with public providers[106].

During the last year health care issues have become a very disputable and hot topic in the media. This can be explained by an increased interest among population on health issues, improved access to the information on health care, and recent and ongoing health care reforms. Particular attention in the media received the draft of the new Health Insurance Act.

In contrast with the public opinion surveys, the articles and editorials of newspapers reflect mainly dissatisfaction with the current health care system and planned reforms. However, it is positive that the public discussion has tackled issues, which are crucial for the future development of health care system, e.g. the principles of solidarity; how to reorganise the health care system to respond better on people’s needs, to become more transparent and sustainable; the role of government in organising health care services; the role and responsibilities of the individuals regarding their own health.

---

105 Health Insurance Fund, Patient satisfaction survey 1999

106 Health Observatory HIT Estonia 2000, Health Insurance Fund

5.2. Evaluation of future challenges

5.2.1 Main challenges

Health sector development has not been a top priority area during the transition period in Estonia. Most of the focus and support in the first years of transition was given to the economical development expecting that once the financial stability and economic growth are ensured, there will be time and opportunities to deal with social issues. However, in spite of economic growth, inequalities in respect of health status have emerged and are increasing within and between different socio-economic groups (Kunst et al 2002). One of the main challenges for future development therefore will be to diminish social inequalities in respect of health and the Government should develop a comprehensive strategy in this respect.

Another challenge is to cope with the poor general health status of population. Average life expectancy of men is about 9 years shorter than the EU average, for women about 4 years shorter. In spite of some positive changes in the population health behaviour, smoking, increased drug abuse, HIV/AIDS, tuberculosis and the high suicide rate require more serious efforts.

Simultaneous implementation of several reforms in the health care sector is complicated task from itself. Decentralisation of the health care system started already in 1991, the primary health care reform was initiated in 1997 and hospital sector reform in 2001. Each reform requires strong administrative and analytical capacity to plan, manage and evaluate progress. At the same time resources, both financial and human, are very limited in Estonia. Therefore there is a strong need to invest in the human resources and to strengthen the analytical capacity in all institutions to support the ongoing processes.

There is also a strong need to modernise organisational and financial management of the hospitals. Currently, hospital managers are mainly doctors without special training on financial and economic issues. There have been also attempts to politicise hospital management during the last year. Several recently appointed hospital managers who were elected through open competition were later replaced with politically affiliated managers. Many doctors have also become members of political parties in order to keep their positions or to influence on political decisions relating to health care.

One of the future challenges will be how to motivate qualified doctors and nurses to remain in Estonia. A low salary of doctors and nurses has been under the discussion during the last 5-7 years. Stagnation of the wage level of doctors and nurses is linked to the stagnation of expenditures on health services. Most of the doctors and nurses are salaried by hospitals. Salaries

vary considerably among different regions and hospitals. Over the last two years the nurses association and hospitals association have not been able reach agreement on increase of nurse's minimum hourly rate. Nurses require an increase by 25%, from current 20 EEK to 25 EEK. A special commission is formed at the governmental level to mediate ongoing negotiations.

There is a strong need to strengthen the capacity of the Ministry of Social Affairs to develop, monitor, analyse and manage the health care system in Estonia. Salaries in the Ministry are low, which makes it very difficult to attract and keep highly motivated and qualified staff to work in the Ministry. The Ministry should invest in human resource management and develop comprehensive strategy to attract and keep highly qualified staff. One option for the future is therefore to support establishment of institutions whose responsibility will to be prepare and provide different types of policy analyses, epidemiological studies and to evaluate health system performance.

Most of the Estonian hospitals are in serious need of capital investment. Until 2003, investment grants for hospitals came from the state budget, but since January 2003 capital costs will be included in the complex prices of health services. From the one hand it assures stable funding for hospitals and allows them to develop long term investment and renovation plan for future. According to the Estonian Master Plan, hospitals will need about 5 billion EEK to build and renovate the hospital infrastructures according to the EU standards.

5.2.2 Financial sustainability

Comprehensive forecasts on the financial sustainability of Estonian health care system are currently missing. The Ministry of Finance has projected the development of social tax revenues in 2003-2030 using a static model developed in co-operation with Callund Consulting Ltd (UK consultancy firm). The model takes into the account demographic and economic developments. According to these projections the increase of revenues from social tax to the health insurance remains on average between 5.8 - 6.2% a year over the projection period[107]. Projections are obviously sensitive to demographic and economic scenarios. According to demographic forecasts the number of taxpayers is expected to decrease substantially over the next 30 years (see 1.2.1), resulting in an increase of system dependency ratio (beneficiaries to contributors ratio).

Pressure on the financial sustainability of the system also arises from higher expectations and increased health care demand, while obviously scientific developments in the medical science increase supply. People demand the best possible pharmaceuticals and the best possible treatment in

[107] Personal communication with the CEO of the Health Insurance Fund Dr. Jesse in May 2002.

available in the world to be compensated by the health insurance system. The increase in the use and prices of the medicinal drugs is an important source of financial pressure (see 5.1.3).

As noted in section 5.1.3, health expenditures in Estonia have been around 6% of GDP, which is only slightly below the EU average, but this percentage has been declining in recent years to 5.5% in 2001. However, the share of health expenditures in GDP has to be evaluated against the background that the prices of pharmaceuticals and medical equipment are determined by the EU and world markets, while GDP per capita in Estonia remains substantially below the EU average. Therefore, in absolute terms resources available to health care are very limited compared to the current EU member states. At the same time morbidity follows a pattern similar to the developed countries and people set their expectations about the system according to the systems of the EU countries. This makes the situation prone to political conflicts. Health care issues have become highly political in Estonia and the constant temptation for politicians has been to give more promises than the system can afford. Therefore a strong regulation and political commitment is required from the Government to keep the financial equilibrium of the system.

Against this background it is likely that the individual responsibility and out-of-pocket payments will continue to increase in the future. In particular this will be caused by the increase of prices for pharmaceuticals, exacerbated by doctor's prescription habits. Direct out-of-pocket payments will also increase due to extra charges for commodities in hospitals allowed by the new Health Insurance Act and due to the increasing number of private practitioners in certain fields (dentists, gynaecologists etc.).

Another political controversy relates to the matters of ownership and operation principles of hospitals. Some politicians like to declare that hospitals should operate on for-profit business principles. The impact of increasing market principles should be more evaluated before any final decisions are taken in this respect. Situations where hospitals are interested to provide only those services which are more profitable and diminish the provision of services which are less attractive and economically less profitable (for example treatment of infectious diseases), should be avoided.

An important related issue concerns capital investments of hospitals. According to the Hospital Master Plan, the required amount of capital investments to hospitals will be around 5.4 billion EEK over the next 12 years. In legal terms, capital investments are the responsibility of the hospital owners, while most of the hospitals are currently owned by the state and local municipalities. In the state budget and budgets of local municipalities capital investments of hospitals however have to compete with other claims on public spending, which is likely to result in considerable delays in implementation of the investment plans. Due to the difficulties of receiving budget allocations, a growing number of providers

are taking loans from banks and pay them back from income they receive from the Health Insurance Fund[108]. The recent discussion is mainly based on the assumption that in the future most of the investments will come into the system through private sector. However it is going to be a real challenge to attract private investors to invest into the hospitals.

5.2.3 Health Care Policy and EU accession

The process to prepare Estonia for the EU accession has been a high priority for the Estonian Government.

Health issues in the *acquis communautaire* are divided between many different fields: free movement of persons; free movement of goods; environment and health; consumer protection and health protection; health and safety at work; quality of food; research and information technology.

In the process of EU accession negotiations, the Ministry of Social Affairs is co-ordinating the following chapters[109]:

- Free movement of persons (Chapter 2);
- Environment (Chapter 22);
- Consumers and Health Protection (Chapter 23).

In respect of free movement of persons, Estonia has negotiated on the recognition by EU member states of diplomas and qualifications of:
(a) persons who completed education during the time when Estonia was part of the Soviet Union (diplomas issued in the Soviet Union);
(b) persons who began to study a profession listed in the Sectoral Directives (medical doctors, dental practitioners, pharmacists, nurses of general care, midwives, veterinary surgeons) before the harmonisation of the Estonian curricula and duration of training with EU requirements.

The general EU system for the mutual recognition of diplomas and professional qualifications (89/48/EEC, 92/51/EEC) is harmonised by the *Recognition of Foreign Professional Qualifications Act* and *Professions Act*. *Health Services Organisation Act* has been harmonised with the Directives 77/452/EEC, 77/453/EEC, 78/686/EEC, 80/154/EEC, 80/155/EEC, 81/1057/EEC, 89/595/EEC, 89/594/EEC, 93/16/EEC on free movement of health care workers (doctors, dentists, nurses, midwives). The *Medicinal Products Act* has been harmonised with the Directives 85/432/EEC, 85/433/EEC on free movement of dispensing chemists. There are no limitations in the Estonian legislation as regards foreign dispensing chemist planning to work in Estonia.

---

[108] Health Observatory HIT Estonia 2000

[109] All Estonian positions are described more thoroughly in Ministry of Foreign Affairs home page, and at http://www.sm.ee/gopro30/Web/gpweb.nsf/pages/Social Accessed 07.05.2001

The Health Care Board, which according to the new Health Service Organisation Act started to operate from 1 January 2002, will be responsible for registering health care professionals, issuing licenses, and keeping register of health care professionals and activity licenses[110].

In the area of environmental health, the Ministry of Social Affairs is responsible for quality requirements for drinking water and bathing water; dangerous substances; contained used of genetically modified micro-organisms.

In respect of the environment chapter, Estonia has declared that it is prepared to adopt and implement the *acquis* in full on the date of accession, with the exception of the following directives where transitional periods were requested:

1. Volatile Organic Compounds (VOC) Directive (94/63/EEC): Estonia requests transitional periods until 2004 and 2007 for the construction of petrol vapour regeneration systems taking into account the throughput of stations and terminals;
2. Urban WasteWater Directive (91/271/EEC): Estonia requests a transitional period until 2010 for the renovation construction of sewerage systems and wastewater treatment facilities;
3. Directive on Nitrate Pollution from Agricultural Sources (91/676/EEC): Estonia will establish an Action Program by the date of accession, but expects understanding and confirmation by the EU that the implementation of the Program will be completed by 2008;
4. Drinking Water Directive (80/778/EEC): Estonia has promised to ensure adequate monitoring of the directive by the date of accession, provided that there is an understanding and confirmation by the EU that Estonia the implementation of the directive will take place over a transitional period by 2013;
5. Directive on Discharge of Dangerous Substances into Surface Water (76/464/EEC): Estonia requests a transitional period until 2006 for elaboration and implementation of emission reduction programs for list 2 substances;
6. Directive on the Landfill of Waste (99/31/EC): Estonia requests transitional periods:

- until 16 July 2013 to close the existing landfills that do not meet the requirements of the Directive after creating a network of new landfills;
- until 16 July 2009 in order to develop and implement new methods of disposal of oil shale ash derived from the generation of energy.

In respect of the consumers' and health protection Estonia is prepared to accept the *acquis* in full by the date of accession and has not requested any transitional periods or derogations.

[110] NPAA 2002-2003 Part III Chapter 2, Free Movement of Persons

The impact of EU accession on the health care system has not been very thoroughly discussed and evaluated. The recent rulings of the European Court of Justice, e.g. Kohl/Decker, Smith/Peerboms cases are showing that there is a common need for co-ordination of health care systems within the EU.

The system of social security co-ordination is currently governed by EC Regulations 1408/71 and 574/72. It is an important to make a distinction between two different situations, which are regulated by Article 22 of Regulation 1408/71:

- Immediate benefits during a temporary stay (Art. 22.1.a)
- Planned care (Art.22.1.c)

In the first case, the person who stays in another Member State either on professional or personal reasons a right to attain should receive immediate benefits in kind (emergency medical care) at the cost of the competent state. The reimbursement by the competent state will be made in accordance with the tariffs applicable in the state where treatment was provided[111]. This implies that upon accession, Estonian nationals travelling in EU Member States will no longer be obliged to buy a private travel insurance, but are insured out of the public purse. In case of sickness or injury the expenses of the treatment have to be reimburses by the Estonian health insurance system. Also in the case of migrant workers from other member states whose dependent family members did not transfer their residence, Estonia would have to refund to the competent state the cost of the medical care provided to those family members in the country of their residence, as Estonia will be the competent state according to the *lex loci laboris* principle.

From the current 15 EU Member States, Estonia has bilateral agreements (covering the provision of medical care for temporary visitors) with Finland and Sweden. From the EU applicant countries Estonia has bilateral agreements with Latvia and Lithuania.

The financial burden arising from application of the EU social security co-ordination provisions in the health care field is expected to be about 3 % of the total expenditures of the Estonian health insurance system on medical treatment[112].

According to the Statistical Office of Estonia, the total number of Estonian tourists to the 15 EU Member Sate was 210,534 (of them 115,107 to Finland, 45,150 to Sweden and 50,277 to the other EU countries) in 1999. The average duration of stay in the EU Member State was ca 3.5 days. The share of visits of Estonian tourists to the countries covered with existing

---

111 http://europa.eu.int/comm/employment_social/soc-prot Accessed 24.04.02

112 Leppik, L. Memo on the increase of health care costs when applying Regulation 1408/71

bilateral agreements, i.e. Finland, Sweden, Latvia, Lithuania was ca 70%. Taking into account the predictable increase in the living standards it may be expected that the total annual number of Estonian tourists visiting EU Member States will be increasing. It can also be expected that the average duration of the stay will increase from 3 to 5 days, which would increase the incident rate roughly by 50%. Under the Estonian/Finnish bilateral agreement in 1999 there were 125 cases when Estonian residents were provided emergency care in Finland, with the total costs around 1,8 million EEK. The average incident rate was ca 0.11%, which is lower than in other European countries. The average cost per case was approximately 14,000 EEK. We may assume that upon EU enlargement there will annually ca 500,000 visits by Estonian tourists to the EU Member States and current applicant countries, the incident rate would be about 1% and the average cost per case would be 14,000 EEK. In this case, the total expenses of the Estonian health insurance system to reimburse for the medical care of tourists and other temporary visitors would be around 70 million EEK annually which is ca 2.4% of annual expenditures on health services according to the 1999 prices.

Possible negative implications may arise in case of planned care. It is relatively less likely that patients from the EU countries will seek medical care in Estonia than the other way around. It is more likely that Estonian patients will seek health care in other Member States and hope for cover of the costs by the Estonian health insurance system. There is also a possibility that patients will attempt to bypass waiting lists by using private health care services aboard.

In order to prevent possible negative implications to our health insurance system, the Government must clearly define:

- the basic health care package which is covered by health insurance;
- terms of entitlement;
- groups of authorised providers and suppliers under the health insurance system.

The new Health Insurance Act has clarified the situation in this respect considerably.

In the field of public health Estonia has established good co-operation with the European Commission. Participation in the EU public health programmes enables Estonia to move faster towards improving the health situation of the population, as the co-operation:

- gives access to information necessary to work out national strategies and activities;
- enables to use the practical experience of EU countries;

- enables to provide corresponding administrative staff with necessary training[113].

In respect of the possible phenomenon of brain drain of health care personnel upon EU accession there are different views in Estonia. Concrete estimations and projections are however missing. One of the arguments here is that to some extent the health care personnel is already moving to different EU countries even without accession. The reasons are not only economical, more importantly possibilities to gain new knowledge and to work in international environment. The potential size and implications of the brain-drain problem need to be more thoroughly analysed in the nearest future.

5.3 Evaluation of recent and planned reforms

5.3.1 Recent reforms and their objectives

The health care system inherited from the Soviet Union was based on central planning and financing. Free access to health care was a constitutional right for every citizen. In the reality however, access to and quality of care varied between regions and socio-economic classes. For example, there was a special health care system for *nomenklatura*, for military and railways. The system was characterised by excessive hospital capacity and high number of specialists, weak and underdeveloped primary health care, declining health status of the population and lack of considerations of the cost of health care.

Health care reforms undertaken in 1990s have encompassed the following major measures:

- establishing of a social health insurance system
- developing primary health care;
- reorganising and strengthening of public health system;
- decentralising administration of health care system;
- initiating hospital sector reform;
- initiating the reform of drug policy;
- reforming nursing care system.

Health insurance system was introduced in January 1992. The main objective was to secure funding for health care and to introduce a clear purchasing/provision split. An earmarked tax of 13% on salaries was introduced to finance health insurance.

Over the last 10 years the health insurance system has gone through several administrative and structural reforms. In 1992 there were

[113] Ministry of Social Affairs, Health Policy http//:www.sm.ee Accessed 09.05.2002

22 independent sickness funds in Estonia, which were co-ordinated by an Association of Sickness Funds. In 1994, the Central Sickness Fund was established under the Ministry of Social Affairs to supervise over the 17 local sickness funds. Although the number of the sickness fund diminished over the years and the organisational structure was improved, the system had still inefficiencies and was considered by several actors to be too vulnerable for political changes[114]. According to the new Estonian Health Insurance Fund Act, which entered into force in 1 January 2001, the Health Insurance Fund became independent public-legal body with tripartite governing council.

The Health Insurance Fund has recently also prepared a development strategy for the years 2002-2004. The strategic objectives are of the Fund are:

- to assure client satisfaction,
- to keep access to the health services, waiting lists and incidence rate at the level of 2001
- to become the best client-oriented organisation within the public sector;
- to manage organisation efficiently keeping the increase of the overhead cost half from the annual increase of inflation level.

By and large, the health insurance system has proved to be a relatively stable and sustainable solution for financing health care. The system provides coverage to the majority of population (over 93% in 2001), while persons without health insurance are entitled to emergency medical assistance. However, changes in the population structure, higher demands from patients, changes in the health care utilisation and expenditures (e.g. increasing expenditures for compensating pharmaceuticals) pose a complex of factors, which require to pay more attention to cost containment and macro- and microeconomic efficiency in order maintain sustainability and to keep the system efficient.

Administrative reforms undertaken in early 1990s focused on decentralisation of provision to the county level and devolution of power to the newly elected local governments. Ownership of hospitals and health facilities was largely decentralised. It was argued that the county level shall be the extension of the state power in regions, while having a wider opportunity to manage health care system according to the local needs. Country doctors, appointed by the County Governors in agreement with the Ministry of Social Affairs for the term of 5 years, were responsible for the planning of health care services, health promotion, disease prevention and disease surveillance activities. However, from legal and financial perspectives there was a controversial situation where county doctors had the responsibility to develop health care at the regional level, but did not

[114] Between 1991 to 1995 there were four different Ministers of Social Affairs in Estonia.

have financial instruments and appropriate legal power to implement those policies. There was also a tendency to have over-capacity in secondary care hospital beds and emphasis on high technology treatment that was not economically feasible and put pressures on the overall financial management. Therefore, after some years of experience, the general planning of health care was again partially re-centralised at the state level within the Ministry of Social Affairs and the Health Insurance Fund. The new Health Services Organisation Act, which entered into force on 1 January 2002, transferred the responsibilities of county doctors to the newly established Health Care Board and left to the county level only the responsibility for supervision of primary care (family doctors) and public health services.

During the Soviet period, primary health care was based on a system of policlinics and ambulatory centres. The need to reform this system was recognised already in early 1990s and among first changes a postgraduate training programme for family medicine was established at the Tartu University[115]. However, because of frequent changes in the Government and political unwillingness to initiate reforms, the process was delayed and a broad-scale reform of the primary care system was enforced only in 1997.

The objectives of the reform were to introduce family doctors as gate-keepers of the health care system, to establish a new financing mechanism of primary care, to improve overall efficiency and effectiveness of the system and to shift balance from secondary and tertiary care to primary care[116].

In the beginning of the reform it was estimated that to cover the whole population Estonia will need approximately 800 family doctors, based on the assumption that on average there will be 1900±400 persons in the list of one family doctor. Only those doctors who had passed a special training program for family doctors (or were officially registered in the program) and had the required number of patients (1900±400) in their list, were eligible for a contract with the Health Insurance Fund[117]. In the first year of the reform the Health Insurance Fund contracted about 390 family doctors. In 1999 the Health Insurance Fund had contracts with 493 family doctors and by 2001 the number had increased to 562 contracts[118]. Financing of primary care was shifted to a capitation system in 1998 conducive to patient choice and clearer family doctor responsibility for patients.

By 2002, the reform has been almost completed in all regions of Estonia with the exception of Tallinn where the number of policlinics is still high[119].

---

115 WHO 2000

116 WHO 1999, 2000

117 Regulation No 113 of the Minister of Social Affairs from 29 November 2001 shortened the size of the list of a family doctor down to 1600±400 patients.

118 Health Observatory HIT Estonia 2000

119 The Ministry of Social Affairs estimated that the reform is implemented in 5 years.

To develop the system further, different incentive mechanisms have been discussed, e.g. to establish a special bonus system for family doctors for good immunisation coverage etc., but not yet introduced.

The population is generally satisfied with the new system, however about 60 per cent of the population would still prefer to go directly to specialists without referral (Thetloff 2000).

In the beginning of 1990s there were 120 hospitals in Estonia. By 2001, the total number of hospitals has decreased to 67. In May 2000, the Government approved the Estonian Hospital Master Plan. The Master Plan envisages consolidation of specialised health care in order to increase the efficiency and quality of services. According to the Plan, the current 17 catchment areas for acute care hospitals shall be reduced to 4 and the hospital structure accordingly revised, with a central or regional/university hospital in each of the regions. The number of acute care hospitals shall be reduced from 27 to 13 by 2015 and the number of beds also reduced down to about 3100. One of the conditions when restructuring the catchment areas is that most people in Estonia should live within 70 km (or one hour of transportation) from an acute care hospital.

The underlying idea of the Hospital Master Plan is that by concentrating care of acute patients to fewer hospitals it will be easier to make necessary investments in medical equipment. It is also believed that the average length of stay will become shorter and a significant part of the care will with time be transferred to and outpatient setting. The Master Plan also envisages an expansion of long-term nursing care and restructuring of some of the current acute care hospitals into long-term care institutions. The Government is currently negotiating with the World Bank to have a loan to support these reforms (World Bank 2001) [120,121].

The general objective of the nursing care reform is to shift the provision from a low-quality stigmatised institutional system to an open care system with greater reliance on home care, support to families and greater emphasis on social adaptation and community integration. Sharing of responsibilities between the social protection system and the health care sector still requires further elaboration. In principle, social services are a responsibility of local municipalities, while the long-term nursing care remains a responsibility of the health sector.

The main objective of the pharmaceutical reform is to ensure safety, efficacy and quality of drugs. The State Agency of Medicines was established in 1993 to administer the new regulations in this field.

In the first years, the reform created some resistance from primary care doctors, especially in Tallinn.

120 European Observatory HIT Estonia 2000

121 Ministry of Social Affairs, Health Policy

Manufacturing, wholesale and retail distribution of pharmaceuticals was privatised.

The increased demand for health care from patients and the increased costs of medical technology and drugs pose a real threat that current sources of revenues will not be sufficient to cover the demand in the future. Expenditures on medicines in the Nordic countries have been rising at a rate of 8-10% a year, while in Estonia 13%-20% a year[122]. The continuous increase of drug expenditures forced the Health Insurance Fund to propose measures for cost containment. The proposals presented in 2001 and 2002 in the draft of the new Health Insurance Act were quite radical and were estimated to save approximately 100 million EEK in the annual budget. Some of these proposals were adopted in the new Act, but some rejected by the Parliament. As an attempt to contain the increase of expenditures on pharmaceuticals at the expense of stagnation of health service costs, the new act has set a ceiling whereby in the annual health insurance budget the expenses of the Health Insurance Fund on compensation of pharmaceuticals shall not exceed 20% of the expenses for health care services[123]. One of the key measures to keep expenditures on pharmaceutical under control is reference pricing. From the other side, this also implies increase of patient's out-of-pocket payments. From the total out-of-pocket expenditures of patients approximately 50% comprise expenditures on prescription pharmaceuticals[124]. Over-the-counter pharmaceuticals are paid fully by patients.

According to the new Health Insurance Act, co-payments of patients are increasing also for inpatient and outpatient care. Under the previous version of the act, patients had to pay a relatively small visit fee for attending specialist care at outpatient level (5 EEK= 0,32 Euro). Even though the fee was modest, several groups of patients were exempted. According to the new act, providers of medical services are allowed to establish visit fees for home visits and out-patient specialist consultations, and hospital may charge a fee for accommodation services (see 5.1.2). However, family doctors cannot charge fees for ambulatory visits. The objective for introducing co-payment system was to influence service utilisation patterns and to get additional revenues for the health care system. Private providers may charge extra fees.

Public health system has been reformed since 1993 when the Department of Public Health was formed within the Ministry of Social Affairs. The objective of the Department of Public Health was to develop strategies for disease prevention and health promotion activities to improve the health of

---

122 Lambot. K., presentation at conference in Riga, December 2001

123 As seen from Table 5.3 in Annex 4, in 2001 expenditures on drug compensations amounted to 23.4% of expenditures on health services.

124 Health Observatory HIT Estonia 2000

population. This organisational change shifted focus from old sanitary epidemiological system to the new public health institutions and programs.

Several measures have been undertaken to modernise the public health system:

- earmarked resources for health promotion projects within the Health Insurance Fund;
- expanding range of disease prevention and health promotion programmes financed from the state budget;
- establishment of the National Centre for Health Promotion and Education;
- establishment of the Public Health Department and public health specialisation within the Medical School of the Tartu University;
- pre-EU accession activities and harmonisation of legislation on health protection and occupational health.

5.3.2 Political directions of future reforms

Two parties - Reform Party and Centre Party currently form the Government. Before coming to the Government in the beginning of 2002, the Centre Party was in opposition over the last 5 years and is therefore using every opportunity to introduce and implement their strategies regarding social policy before the next parliamentary elections. The most difficult questions for the new Minster of Social Affairs coming from the Centre Party have been to tackle with the access to and affordability of innovative pharmaceuticals and to continue the ongoing hospital sector reform.

Considering the approaching parliamentary elections (in March 2003), two possible scenarios might appear.

First, the current government may take advantage of the current public debates and make promises to increase the benefits provided under the health insurance system to increase their political popularity, which at the same time would increase the burden of the health insurance system. Secondly, the government may continue the public discussion and take the difficult decisions to continue with the reforms. For the moment it is difficult to predict which scenario will take place.

As noted above, the Health Insurance Fund has suggested a strategy to cope with the increase of expenditures on pharmaceuticals by introducing a reference pricing system. These proposals however have met a strong resistance from some lobby groups (mainly from companies selling original drugs), and these groups have been successful in influencing some political forces.

Individual patients and patient organisations want to have better access to cheaper drugs in one hand but from the other to have also access to the new innovative drugs, which have become available but are not included in the list of the drugs compensated by the Health Insurance Fund. In order to meet the desires of population, the idea to allow import to Estonia drugs, which are more affordable, but with uncontrolled quality, has gathered some political support.

Hospital Master Plan has met very strong opposition from local municipalities who resist closing or reorganising some of the hospitals within their territory. The resistance of municipalities is explained by uncertainties in respect of how the access to health care will be influenced as well as concerns about the decrease of working places in their territory.

5.3.3. Conclusions

The biggest challenge for the health care sector over the transition period has been to compete for public financing with other sectors, which require support for successful restructuring. It seems, however, that the government strategy to prioritise economic development without comprehensive social policy has created a situation where serious social inequalities in respect of health of population have emerged.

Regarding population health problems, Estonia is comparable to other developed countries. The main cause of morbidity is cardio-vascular diseases followed by cancer. From the other had the high rate of communicable diseases, suicides and HIV/Aids epidemic requires very serious long-term efforts and investments from the Government to eliminate and to keep those serious public health threats under control.

While health care expenditures as a share of GDP are comparable to the EU average, the system is still under serious financial constraints as GDP per capita in Estonia is only one third of the EU average, while the prices of pharmaceuticals and medical equipment are determined by international markets. Therefore even in spite of high economical growth rates the resources to tackle with the challenges of the health care system are very limited.

In response to the current problems, the Government has in 2001 and 2002 revised the main legislation in the health care sector, in particular the Health Insurance Act, Health Insurance Fund Act and Health Services Organisation Act. The new legal framework has defined a more detailed legal framework for operation of health care providers, focuses on increasing economic efficiency, improvement of quality of care, patients' rights and responsibilities and revised the cash benefit system and compensation mechanisms for pharmaceuticals. From the other side, the new legislation will increase the individual responsibility of patients by

increasing direct out-of-pocket payments of patients on pharmaceuticals as well as on specialist care by allowing the increase of visit fees and co-payments for hospital services.

5.4 Annex 4

Table 5.1: Trends in health care expenditure as percentage of GDP 1992 - 2001

	1992	**1993**	**1994**	**1995**	**1996**	**1997**	**1998**	**1999**	**2000**	**2001**
Health care expenditures (% of GDP)	4.5	5.5	6.3	6.2	6.1	5.5	5.9	6.5	5.9	5.5

Source: Ministry of Social Affairs, European Observatory HIT Estonia 2000

Table 5.2: Financing sources of health care in Estonia 1999 - 2001[125]

Financing sources (%)	**1999**	**2000**	**2001**
Public sector	76.8	76.4	77.8
health insurance	*66.0*	*66.0*	*67.0*
state budget	*8.7*	*8.4*	*8.2*
local municipalities	*2.2*	*2.0*	*2.6*
Private sector	19.6	23.3	22.2
households	*14.0*	*19.7*	*18.8*
employers	*4.8*	*2.6*	*2.3*
private insurance	*0.8*	*1.0*	*1.1*
Foreign assistance and loans	3.5	0.3	-
Total (%)	100.0	100.0	100.0
Total health expenditure (mln EEK)	4,950	5,146	5,354

Source: Ministry of Social Affairs, National Health Accounts 2000.

[125] National Health Accounts were introduced in 1998.

Table 5.3: Expenditures of the Health Insurance Fund by types in 1995 - 2001 (million EEK)

	1995	**1996**	**1997**	**1998**	**1999**	**2000**	**2001**
Total expenditures	2,119	2,829	3,393	3,618	3,919	4,207	4,331
Expenses for health services	1,477	1,836	2,074	2,530	2,833	2,851	2,842
Drug compensations	110	187	259	368	412	474	666
Sickness/maternity cash benefits	380	460	522	662	607	726	745

Source: Health Insurance Fund, Estonian Statistical Office

Table 5.4: Health care financing from state budget 1998-2001 (million EEK)

	1998	**1999**	**2000**	**2001**
Emergency medical assistance to uninsured persons	42.3	62.9	72.0	77.1
Forensic psychiatric expertise and coercive treatment	7.4	7.4	9.2	8.3
Sanatorium vouchers	14.3	12.0	5.7	1.0
Nursing care of cancer patients	-	0.3	0.3	0.3
Support to ambulance services	111.6	130.6	122.5	139.5
Other supporting services	0.7	0.8	3.5	1.9
Pharmaceuticals and technical aids	15.5	18.1	26.3	28.1
Preventive and public health programmes	11.9	28.5	23.5	31.4
Health care administration	54.2	64.6	62.1	76.5
Related functions (Estonian Health Project; food, hygiene and water inspection; compensations in case of work accidents etc.)	31.9	67.4	110.6	95.1
Capital investments	63.3	80.0	76.6	43.4
Total expenditure	355.0	473.8	518.6	508.4

Source: Ministry of Social Affairs

Table 5.5: The number of insured persons and average annual contributions in 2001.

Categories of insured persons	**Number of insured**	**Average contribution per person (EEK)**
Economically active persons	574,284	7,909
Employees	*553, 431*	*8,114*
Self-employed persons	*20,853*	*2,489*
Insured by the state	38,144	2,400
Equalised with the insured	665,429	0
Total	1,277,857	

Source: Health Insurance Fund

BIBLIOGRAPHY

Bank of Estonia. *Monetary Developments & Policy Survey*, Tallinn, March 2002.

Estonian Statistical Office. *Living Conditions*, Tallinn 2000.

Estonian Statistical Office. *Household Living Niveau 2000*, Tallinn 2001.

Estonian Statistical Office. *Labour Force 2000*, Tallinn 2001.

Estonian Statistical Office. *Population 2000*. Tallinn 2001.

Estonian Statistical Office. *Social Trends 2.* Tallinn 2001.

European Observatory. *Health Care Systems in Transition – Estonia 2000.*

European Training Foundation. *Estonia: Review of progress in vocational education and training reform 2002.*

Government of Estonia. *Pre-Accession Economic Programme*. Tallinn 2001.

Government of Estonia. *Employment Action Plan 2002*. Tallinn 2001.

Government of Estonia and European Commission. *Joint Assessment of Employment Priorities*. 2001.

Jesse, M. *Estonian Health Insurance – the first 10 years.* Paper presented at the USAID conference "Ten Years of Health systems Transition in Central and Eastern Europe and Eurasia", Washington 2002.

Kiivet, R.-A. and Harro, J. (eds.) *Health in Estonia 1991-2000*. Tartu 2002.

Kuddo, A., Leetmaa, R., Leppik, L., Luuk, M. and Võrk, A. *Social Benefits in Estonia: efficiency and work incentives.* Tallinn 2002.

Kunst A., Leinsalu M., Habicht J., Kasmel A. *Social inequalities in health in Estonia*. Tallinn 2002.

Leppik, L. Social protection system of Estonia facing the EU enlargement. In Tulva, T. (ed.) *Estonian Social Welfare at the Threshold of the Millennium*. Tallinn 1999.

Leppik L. Memo on the increase of health care costs when applying Regulation 1408/71. Tallinn 2001.

Leppik, L. and Lindell, C. Neighbours look at each other: Estonian and Finnish Pension Systems. The Central Pension Security Institute Reports 2001:25. Helsinki 2001.

Leppik, L. Disability protection in Estonia. In Fultz, E. and Ruck, M. (eds.) *Reforming Worker Protections: Disability Pensions in Transformation.* ILO-CEET, Budapest 2002.

Leppik, L. and Männik, G. Transformation of old-age security in Estonia. In Schmähl, W. and Horstmann, S. (eds.) *Transformation of pension systems in Central and Eastern Europe*. Edward Elgar Publishing Ltd. 2002.

Ministry of Finance, Ministry of Economic Affairs. *Overview of Estonian Economy 2001.* Tallinn 2002.

Ministry of Social Affairs. *Estonian Health Statistics 1992-1999.* Tallinn 2000.

Ministry of Social Affairs. *Social sector in figures - 2001*. Tallinn 2001.

Ministry of Social Affairs. *Social sector in figures - 2002*. Tallinn 2002.

Ministry of Social Affairs, Estonian Statistical Office, Tartu University, Institute of Applied Social Research FAFO. *Living Conditions Study in Estonia 1999: Baseline Report.* Tartu 2000.

Ministry of Social Affairs, Estonian Statistical Office, Tartu University, Institute of Applied Social Research FAFO. *Living Conditions Study in Estonia 1999: Additional Tables.* Tartu 2001.

Palm W., Nickles J. et al. *Implications of Recent Jurisprudence on the co-ordination of health care protection system*. Brussels 2000.

Pennings, F., Leppik, L., Vitsur, J., Karotam, N., Vansteenkiste, S. and Nelissen, J. *The consistency of Estonian social security law with EU legislation on equal treatment of men and women.* Final report of the Phare Consensus Programme. Tilburg 1998.

Põlluste K. *Eesti Rahva Tervis*. Tartu 1998.

Scharpf, F. *Balancing Positive and Negative Integration. The Regulatory Options for Europe.* Policy Paper RSC No. 97/4. Robert Schuman Centre, European University Institute, Florence 1997.

Tartu University, Ministry of Social Affairs. *Poverty Reduction in Estonia: Background and Guidelines.* Tallinn 1999.

Thetloff, M. Health care utilization and patient satisfaction survey in 1999. *Eesti Arst* 3, 2000 p.163-169.

United Nations Population Division, Department of Economic and Social Affairs. *World Population Prospects: The 2000 Revision.* New York 2001.

World Health Organisation. *Health in Transition*. Copenhagen 2001.

World Health Organisation. *Highlights on Health in Estonia.* Copenhagen 2001.

World Bank. *Estonia - Living Standards During the Transition: A Poverty Assessment.* Washington DC 1996.

World Bank. *Estonia – Health Sector Development*. Washington DC 2001.