Peer Review 'The Active Ageing Index at the local level' (Berlin, 14-15 April 2016)

Estonia[1]

Ketri Kupper
Ministry of Social Affairs of Estonia
Tiina Tambaum
Tallinn University

1. **Is active ageing in your country a national, regional or local-level policy?** If necessary, please distinguish between **domains** (employment; participation in the society; independent, healthy and secure living; capacity and enabling environment for active ageing) and **Active Ageing Indicators**.

The size of the Estonian population is 1.3 million. The country is divided into 15 counties and more than 200 municipalities. One third of the population lives in Tallinn. Therefore, NUTS-2 level corresponds to Estonian national level, NUTS-3 (min. 150,000) only to some bigger counties. In the SHARE project, the 5-area division is used, every area includes 2-3 counties (for most of SHARE indicators, the use of these 2-3-counties areas as a geographical division at the local level provides representative results and does not conflict to data protection regulations).

Active ageing policy levels and indicators in Estonia

Active ageing generally is a national level policy in Estonia, but it can vary by different domains.

- Employment is a national level policy. The employment rate is calculated annually with Labour Force Survey, including the regional statistics.
- Participation in society like unpaid voluntary work, care for family members, political participation is a local concern. The participation's indicator is calculated regularly after every four years with European Quality of Life Survey (EQLS). It gives us an indicator on national (for some topics also regional) but not at the local level. According to the Constitution of the Republic of Estonia the family is required to provide care for its members who are in need, that means adult children are obliged to provide care for their fragile parents.
- Indicators for the policy levels relevant to independent, healthy and secure living are different. Health issues (physical exercise, access to health services, excluding dental services), financial security, lifelong learning (mainly limited to (re-)training for labour market), physical safety (police forces) are national level policies or concerns. On the other hand, independent living including physical safety (general infrastructure, adaption of home environments) are local level policies. The indicator at national level is calculated based on several European surveys: EQLS, SILC, ESS, LFS. It gives us an indicator at the national but not

[1] Prepared for the Peer Review in Social Protection and Social Inclusion programme coordinated by ÖSB Consulting, the Institute for Employment Studies (IES) and Applica, and funded by the European Commission.
© ÖSB Consulting, 2016

local level. In wider topics it is also possible to take out regional (county-level) data, but for all counties or municipalities the sample size does not allow this for data protection reasons.

- Capacity for active ageing domain includes: remaining life expectancy, share of healthy life expectancy at age 55, mental well-being, use of ICT, social connectedness and educational attainment. These issues are all national level policies. The indicator is calculated based on several Estonian and European surveys: Annually-Statistics Estonia, EQLS, ICT Survey, ESS, LFS.

2. Are there any programmes, policies, concrete action plans which aim at operationalising the concept of active ageing? To what extent is the AAI used in your country?

Active ageing strategies focus strongly on employment, care burden and health, while other aspects of active ageing receive minimal attention. The strong emphasis of the AAI on the employment domain is dictated by the monetary importance of employment at both macro (higher tax revenues) and micro level (higher pension provisions). The light concern on voluntary activities, non-formal and informal learning, social inclusion and implications of social deprivation is explained by general underestimation of such "soft" activities and their preventive effect on physical and mental health.

In 2012, the first "Active Ageing Development Plan 2013-2020" was drawn up. The document focused on people aged 50 and above. The objective was to create an age-friendly society and ensure quality of life and equal opportunities for older persons. More precise objectives had been set in four areas: 1. Older persons are included in the society and are socially active; 2. Older persons are eager to learn and versatile and active learners; 3. Older persons are active in the labour market and satisfied with their work life; 4. Older persons stay healthy longer and cope well. Unfortunately, the "Active Ageing Development Plan" did not find high level political support by the Estonian Government. By 2016, objectives No 3 and 4 are added into the new national "Welfare Development Plan 2016-2023" but proposals related to objectives No 1 and 2 were rejected as "activities of individual concern related to leisure and hobbies".

The new Welfare Development Plan stresses the need to solve the problems of family care burden by increasing their rate of labour market participation and providing social guarantees to informal carers. The question of family care is one of the government's priorities for the next few years. It foresees several policy initiatives for alleviating caring burden. The main objectives are following: 1. High employment rate and long and high-quality working life; 2. Improved social inclusion through decreased social inequality, poverty and gender inequality. More precise objectives have been set into four goals: 1. The demand and supply of the labour force is in compliance with the aim to increase employment rate and the quality of working conditions supports long-term participation in working life; 2. Adequacy of the social protection system has improved subsistence of people; 3. Assistance need of people is covered with quality assistance which supports active inclusion into the society and community (in sense of enabling people to age in their home as opposed to a nursery house, but not active inclusion like cooperation and contribution in the community) and supports independent coping.

The objective of Estonian health policy is the extension of life expectancy, in particular the increase in healthy life years through reduction of premature mortality and morbidity rates, health promotion, provision of high-quality medical

and nursing assistance. All those objectives are covered by the "National Health Plan 2009–2020"[2]. The general objective of the strategic field is following: by 2020, the health-adjusted life expectancy has extended to 60 years in average for men and 65 years in average for women, and the average life expectancy has extended to 75 years for men and to 84 years for women.

Within two years, Tartu county ran a pilot project "Elderly 2013-2014", which assessed older population health needs in one region of Estonia. The outcome of the project is unique and will be used for developing Estonian social policy at regional level.

In 2015, the Government Office established a Task Force for reducing the burden of care. The duty of the Task Force is to map problems related to caring for family members and develop solutions that make it possible to provide need-based social and health care services by combining financial aids and services. The establishment of the Task Force is scheduled for the Government's Activity Programme for 2015-2019 and the target date for the completion of tasks is November 2017.

The Social Welfare Act provides the organisational, economic and legal bases for social welfare. It has entered into force on January 1st, 2016. It is the first time the state intervenes into local municipalities' autonomy. In order to improve the quality of local social services, the new Social Welfare Act sets minimum standards for 9 types of social services provided by local governments: 1. domestic service, 2. general care service provided outside home, 3. support person service, 4. curatorship of adults, 5. personal assistant service, 6. shelter service, 7. social transportation, 8. safe house service, 9. provision of dwelling.

Lack of finances in local municipalities and regional differences in the access to social services gave rise to a special instrument of the European Social Fund "Welfare services to support participation in the labour market" for 2014-2020. In 2016-2017, local municipalities will have the possibility to apply for funding to develop different social services, i.e. home care-, (temporary-)day care services, social transportation, personal assistant services, also innovative ICT solutions (telecare, alarm button etc.). Municipalities must collaborate with each other to develop services for the extended region (formed by several municipalities). The overall aim of funding is to reduce the informal caregivers' burden of care and support their return to or stay in the labour market.

In 2016, a new Work Ability Reform enters into force, and a new operational support system will be established. The goals of the reform are to help every individual with reduced working ability, having health sufficiently good, to find himself or herself a suitable employment and therefore, cope better on his or her own. The second aim is to change mentality: we will assess ability, not inability to work. Each person with reduced working ability will be approached individually, assessed on his/her ability to be active in the society, and, consequently, helped to find opportunities in the labour market. From 2015 on, new employment support services were extended specially to pensioners. But it is important to mention that the high score in employment rate in older age groups today is still more likely caused by low pensions.

At the moment discussions of pension reform go on in Estonia. There is a need of raise the retirement age, preferably by using automatically adaptive mechanisms.

[2] National Health Plan 2009–2020, https://www.sm.ee/sites/default/files/content-editors/eesmargid_ja_tegevused/Tervis/Aruanded/rta_2009-2020_2012_eng.pdf

It is also necessary to review the pension formula and pension index to avoid future inequality. In addition, Estonia wants to implement more flexible retirement options – such as the option to choose the time of retirement, a chance to receive only half amount of pension or to stop pension payments at the request of the pensioner. By April of 2016, preliminary proposals will be presented to the Government.

In 2017, a new cash benefit for single pensioners will enter into force. The aim of this measure is to improve the quality of life of the pensioners who are living alone. The benefit is paid once a year in September to compensate partly the person's costs for dwelling or other housing expenses.

In order to support foreign nationals who have migrated to Estonia to settle in and to acquire the primary knowledge and skills, Estonia offers all new arrivals the opportunity to participate in an introductory welcoming programme. The Ministry of the Interior of Estonia offers a welcoming programme in English and in Russian to foreign nationals who have legally resided in Estonia for less than five years in order to support their integration into society. The welcoming programme is offered in the three biggest cities in Estonia as a pilot. All new arrivals meeting the criteria are informed about the programme by the Police and Border Guard Board of Estonia.

In the field of education for older people, the Universities of the Third Age have garnered a lot of attention in Estonia. The University of the Dignified of the University of Tartu has been in operation since 2010 and offers lectures in six cities. The Health and Movement University of Tallinn University was established in 2011. The Third Youth Folk High School of Tallinn has been operating on the premises of Tallinn University of Technology since 1993 and is led by the Estonian Association of Pensioners' Societies. Tallinn University of Technology offers lectures also in Kohtla-Järve (East Estonia). In 2013, the Tallinn City Government also established the Downtown Elderly University. All of these organisations primarily implement the French principles of older adults' learning (as opposite to British principles) by offering lecturers and inviting experts and public figures (e.g. ministers and professors) to give talks. There is always a great deal of interest in the lectures. For example during the 2011-2012 academic year, 1,500 older people participated in studies at the University of Tartu. At Tallinn University, the number of participants has increased from 430 to 1,070 in three years. Despite the positive feedback of this type of older people learning, it must be taken into account that the Universities of the Third Age in Estonia are targeted mainly to elite part of older population, involving more educated participants in towns and cities, and mostly women.

Despite of the fact that the AAI is gaining recognition as a policy-making tool, there is no general coordination for that, particularly on the local level. But at the same time in the above mentioned Welfare Development Plan 2016-2023 there are indicators of employment rate of older workers (in age groups 55-64 and 50-74), the absolute poverty rate in the age group 65+ and the pension dependency ratio (non-working pensioners ratio of the employed persons) which are calculated on the basis of Estonian Labour Force Survey (LFS) and Estonian Social Survey (ESU).

3. Does your country have any examples of analysing active ageing on the local level and is there a link to the AAI (e.g. are AAI indicators used)? Why/why not?

Are there any local initiatives in your country which use the AAI approach (even partly)? (If yes, please describe them.)

According to our knowledge, there are no local initiatives that use the AAI approach. Due to the relatively small size of our municipalities, most of our surveys and studies are regional (equal to national). For example, the focus of The Elderly Survey 2015 conducted by the Ministry of Social Affairs (previous wave in 2009) is more at the national level, but it is possible to make some conclusions on the county level as well.

Also, the Ministry of Social Affairs collects data from local administrations about social services targeted to older citizens. From the county level, the Ministry of Social Affairs collects annual data from service providers about general care, special care and day care centres. From the local governments, the ministry collects annual data about support person services, personal assistance services and other local services. Municipalities collect data related to needs of people for planning social or other public services but this is not a systematic and regular activity. The Elderly Survey 2015 also indicated the untapped needs of older people. Older peoples' expectations clearly indicated that their municipality government should show more initiative by mapping individual needs for support.

Ageing at the local level is partly analysed in Health Profiles of counties and municipalities. These documents are compiled by local administrations. Based on these profiles, various local health promotion activities take place. Some indicators related to ageing are analysed in Health Profiles, but these do not exactly correspond to the AA indicators.

For instance, following indicators are calculated and analysed for counties:

- Dependency ratio (population aged 65+);
- Number of persons aged 65+ who are living alone;
- Possibilities for recreational activities for the elderly;
- Social services for the elderly;
- Life expectancy and healthy life years at the age of 65.

Data from Survey of Health, Ageing and Retirement in Europe (SHARE) is published by NUTS-3 level using a five-area division in which every area includes 2-3 counties (area level). The team of SHARE Estonia recently published the e-book "A look at the grey area. The first proceedings of SHARE Estonia and recommendations for elderly policy making". Physical and mental health issues, retirement and work, social activity and social support issues were expanded upon on the base of SHARE w4 and w5. All main results in this book are also presented on area level. The book is targeted at municipalities and policy makers and available in Estonian: www.tlu.ee/share-esimene. However, results of SHARE Estonia are not given in the theoretical framework of AAI.

In the future, data from the Estonian Health Survey can be used for calculating some of the AAI on the county level.

4. What is the level of political support and awareness of using indicators related to the active ageing domains at the local level in your country?

Despite of the fact that political support and awareness of active ageing has increased over the years, at least on modules 1, 3 and 4 of AAI, active ageing still is not on the priority list of local authorities. Thus, local authorities are developing services considering to older peoples' needs, creating infrastructure (roads, public houses, cultural activities, health promotion etc.). However, older peoples' potential is unused in local communities. The initiatives of voluntary work, non-formal learning activities, social and political inclusion need to be improved.

5. What data sources on the situation of older people are widely used in your country (particularly also on the local level) in the policy domains covered by the AAI?

For the employment issues the Estonian Labour Force Survey is used, more at the national than at the county level. Data of older people participation in society is collected in the Estonian Social Survey and Elderly Survey and it is possible (on some issues) to make conclusions also at the county level. In addition, the ministry collects statistics about users of day care centres, by different age groups and service providers. Statistics about independent, healthy and secure living are also collected at the national and county level by the European Social Survey and Elderly Survey. Capacity and enabling environment for active ageing is partly treated in the Lifelong Learning Strategy which is compiled by the Estonian Ministry of Education and Research.

Tambaum: Possibilities of SHARE survey are unused for both at the local and at regional and national level. There are more than 6,500 respondents in SHARE Estonia and the response rate has been close to 90 %, which makes the survey a very representative one. In addition, Estonian data are comparable to other countries which form the context for the local data. The main descriptive statistics are available for public users on websites of Statistics Estonia and The National Institute for Health Development. Why is this data set still underestimated? One the one hand, Estonia joined the survey in 2011 and data has been available for relatively short time. On the other hand, we can see the reluctance of ministries to order reports based on SHARE from R&D institutions (the access to SHARE raw data set is limited to R&D institutions), which means the usage of SHARE data base is relatively inconvenient for officials.

6. What are the key challenges that you face that could limit the use of the AAI in your country at the local level?

The regional AAI has not been calculated for Estonia so far. In Estonia there are 15 counties, 213 local governments (183 rural municipalities, 30 cities). So, one of the key challenges is our small size of local governmental units and different capacities of the local governments. Some of the local governments are small indeed (e.g. 100 inhabitants) in order to get a representative sample for the surveys and studies. Because of the different capacities of the municipality governments, it is also difficult to use the same assessment methods for all of the municipalities.

Secondly, although relevant data is available in different sources, the coordination on national level is insufficient.

At this moment, Estonia is in process of administrative reform, where smaller municipalities will be joining with larger ones. The reforms' general aim is to improve administrative capacity of municipalities to arrange quality of life on local level. After this reform we can see the possibility to adapt AAI calculation on local level.

SHARE results on the base of 5 areas (2-3 counties in each) form also a high-quality data source which covers all issues of AAI: employment, voluntary work, giving and receiving care, physical activeness, access to health care (including access to dental care, where indicators are the worst among SHARE countries), living arrangements, the objective need for care (IADL and ADL limitations), poverty risk, social and material deprivation variables, social activeness as well as personal life expectancy, mental well-being and educational attainment.

7. What kind of support (at local, national and EU level) would be needed in your country to support the development and application of an AAI oriented approach, particularly at sub-national level?

The results (outcomes) we get from AAI should be translated into policy makers "language" to have the strongest effect for taking concrete actions to improve active ageing. Therefore, cross-border learning of good practices from countries similar (first of all by size, but also by socio-cultural background) to Estonia, may be helpful. There is also lack of knowledge how to promote political interest on regional and local level in the field of social inclusion. The AAI gives us an overview of how active older people are, but the causes of non-activeness should also be researched. Support is needed as well on the general coordination process – how to raise stakeholders' awareness and activity on the AAI oriented approach?

8. Further information

Is there any other relevant information which you think is necessary to understand the approach to active ageing in your country that has not been dealt with by this questionnaire?

The share of people aged 55+ suffering from depression (EURO-D) is more than 40 % in Estonia. Taking into account this appalling indicator there is no base for high expectations of older people's own initiative. The implementation of active ageing principles needs policy instruments and initiatives and support from officials and younger citizens.