ESPN Thematic Report on Challenges in long-term care

Estonia

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February 2018

EUROPEAN COMMISSION

Directorate-General for Employment, Social Affairs and Inclusion
Directorate C — Social Affairs
Unit C.2 — Modernisation of social protection systems

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European Social Policy Network (ESPN)

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The European Social Policy Network (ESPN) was established in July 2014 on the initiative of the European Commission to provide high-quality and timely independent information, advice, analysis and expertise on social policy issues in the European Union and neighbouring countries.

The ESPN brings together into a single network the work that used to be carried out by the European Network of Independent Experts on Social Inclusion, the Network for the Analytical Support on the Socio-Economic Impact of Social Protection Reforms (ASISP) and the MISSOC (Mutual Information Systems on Social Protection) secretariat.

The ESPN is managed by the Luxembourg Institute of Socio-Economic Research (LISER) and APPLICA, together with the European Social Observatory (OSE).

For more information on the ESPN, see:
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Responsibilities for long-term care (LTC) provision are divided between the healthcare and welfare systems. The healthcare system provides nursing care, geriatric assessment services and nursing care at home. The welfare system provides LTC in welfare institutions, day-care services, homecare and housing services, as well as other social services.

Provision of LTC can be either formal or informal. Both types of care co-exist, either complementing or substituting for each other, depending on the type of dependency. Formal care is provided in either the public or private sector, by care assistants who are paid under some form of employment contract, and who are mainly lower-skilled caregivers or nurses. In contrast, in order to be considered informal, provision of care cannot be paid for as if purchasing a service; though an informal caregiver may receive income transfers and, possibly, some informal payments from the person receiving care. Informal caregivers usually have an existing social tie to the care recipient.

Population ageing and the associated rise in disability rates are expected to drive up the demand for LTC in Estonia. In the context of limited and inequitable formal coverage, the bulk of LTC is currently provided by informal caregivers. Looking ahead, as Estonia converges with EU norms of living standards and LTC service coverage, the state will face pressure to increase LTC spending, making the fiscal sustainability of LTC a challenge. Although population ageing is largely exogenously determined, the rise in morbidity, frailty and, consequently, severity of LTC needs among the population can be mitigated through effective public policies in LTC.

In Estonia public spending on LTC is lower than in other EU member states, leaving most LTC to be financed out-of-pocket (OOP), and Estonia spent only 0.6% of GDP on LTC in 2013. With public funding for LTC at a low level, coverage of formal LTC is inadequate, inequitable and provides little financial protection. As a result, access to LTC services depends largely on the residence of the beneficiary. Most elderly people finance social services from their state-provided pension, which is often not sufficient to cover the costs of even the least expensive general care home.

In the absence of adequate publicly financed coverage, the burden of care falls disproportionately on informal caregivers, giving rise to significant economic and social costs. The reliance on informal care exacerbates socioeconomic inequalities amongst those in need because caregiver support, like other types of social care discussed above, is allocated at the discretion of local government. The fragmentation between healthcare and social care results in inefficiencies in the provision of LTC.

The main challenges related to LTC concern service access, adequacy and quality; employment issues; and financial sustainability. Access to inpatient nursing care services is uneven between regions, and the coverage of home-based services for the elderly has barely expanded even though unit costs of home-based services are relatively low. Health and social LTC services are also organisationally and professionally fragmented between two separate systems, each with their own cultures and modes of operation. The fragmentation between healthcare and social care results in inefficiencies in the provision of LTC. The fragmentation is multidimensional, existing at financial, organisational, professional and policy levels; and occurring across care episodes, providers, settings and services. Better coordination between health and social care is critical for ensuring effective provision of LTC.

Considering future needs and expenditure demands, Estonia needs to explore new financing models for LTC.

1 Description of the main features of the country's long-term care system(s)

1.1 General characteristics of policies

In Estonia, the Ministry of Finance and Ministry of Social Affairs are both responsible for healthcare budgeting. The share of the state budget for health is prepared by the Ministry of Social Affairs. The Ministry of Finance sets the budgetary ceiling for the Ministry of Social Affairs based on the legislative process and government priorities. In addition, health insurance expenditure (which is managed by the government-funded Health Insurance Fund – EHIF) is determined by the amount of revenue generated by the part of the social tax earmarked for health.[1]

Responsibilities for long-term care (LTC) provision are divided between the healthcare and welfare systems. The healthcare system provides nursing care, geriatric assessment services and nursing care at home. The welfare system provides LTC in welfare institutions, day-care services, homecare and housing services, as well as other social services.[2]

LTC services are divided into health/nursing care and personal care. Healthcare is the responsibility of the EHIF. Nursing care services include nursing healthcare services that are provided as home-based, day-care and institutional services. Personal care services are mainly organised by local government.

Healthcare is managed and financed by the public sector. According to the Health Services Organisation Act there are two types of healthcare services – stationary and ambulatory. Nursing care service is provided to the patient in need of help, either in the nursing hospital (called "long-term care hospital" in the past), at their home, or in a place where they are cared for. A patient is referred to the nursing hospital by the family doctor or a medical specialist from the home, from the hospital and from a care institution. Nursing care service providers need to have a permit from the Health Care Board. The Ministry of Social Affairs regulates nursing services and requirements.

At the current development level, the most appropriate model of integrated care for Estonia is the model of the coordinating network. The coordinating network model implies that the people and institutions in the network have focused their activities clearly on cooperation, but their ties are not necessarily very strong, and the partners may change. In the case of such integration, the relationships are formed based on actions and contracts.

The family doctor is the key person in referring patients to nursing care services. Should a person's needs go beyond just nursing care or welfare services, the organisation of services is death with using case management principles. In this model a case manager, i.e. care coordinator, plays the central role, aiming to guarantee a package of services for people in need that is as suitable and economical as possible. Surveys in several countries have proven the advantages of case management in guaranteeing continuity in providing services; the need for institutional care has shown a decrease by up to 50%.[3]

Ensuring and improving the quality of LTC services has become an important policy priority in Estonia. Dependency on LTC is a significant health-related economic and social risk for individuals and their families. Inadequate social protection against the risk of dependency (through benefits in cash or in kind for the elderly, chronically ill adults and the non-elderly disabled, including disabled children) exposes many families to an

[1] European Commission (2016). Joint Report on Health Care and Long-term Care Systems & Fiscal Sustainability, Institutional Paper 037.

[2] OECD (2011). Estonia: Long-term Care.

[3] Paat, G. and Merilain, M. (2010). The Long-term Care System for the Elderly in Estonia. ENEPRI Research Report No. 75, Contribution to WP1 of the ANCIEN Project.

increased risk of poverty and social exclusion. Increased longevity and associated disability are expected to substantially drive up the demand for LTC services in the context of constrained fiscal resources, a shrinking working-age population, and growing care-dependency ratios.

Given that privately provided care outside of the family is also low, much of LTC care is provided informally by the family – largely, although not exclusively, by older women.

1.2 Principles of governance and system(s) organisation

Responsibilities for LTC provision are divided between the healthcare and welfare systems. The healthcare system (national level) provides nursing care, geriatric assessment services and nursing care at home. The welfare system (mainly local level) provides LTC in welfare institutions, day-care services, homecare and housing services, as well as other social services.[4]

In Estonia, healthcare services are organised at the state level by the EHIF, whereas social welfare services are organised at both the state and local municipality level. This fragmentation in service organisation often leads to a lack of coordination between the two sectors, despite the overlap in target populations.

The county administration is responsible for monitoring the care system (e.g. care services and benefits) and ensuring quality of care services.

1.3 Type of financing

The costs of LTC include both direct costs from public spending on healthcare and social care services, and indirect costs, which mainly result from the caring burden's impact on labour supply and employment.

Public spending on LTC in Estonia is lower than in other EU member states, leaving most LTC to be financed out-of-pocket (OOP) – in the case of elderly, through pensions. In 2014 OOP expenditure comprised 25.3% of the total budget for LTC services. The most common services for which fees are charged by local government are general care homes, followed by housing services, adjustments in housing, and childcare services.[5] In 2013, OOP expenditure made up 68.3% of the total service budget for general care homes (MoSA data). The share of OOP payments for these services has also been increasing. For example, the percentage of the co-payment for general care homes in 2002 was just 39% of total costs. General care homes and special care homes are also the most expensive social services in terms of both private and public expenditure, amounting to EUR 41.4 million and EUR 25.8 million in 2013, respectively. Estonia spent approximately 0.6% of GDP on LTC in 2013. OOP spending has grown rapidly. Although the current absolute level of OOP payments is low (given the low volume of care use), it is relatively large in relation to household income and asset wealth.[6]

With public funding for LTC at a low level, coverage of formal LTC is inadequate, inequitable and provides little financial protection. On the health side of LTC, there is a shortage of nursing care beds. Access to inpatient nursing care services is uneven as between regions, in part a consequence of shortages in home nurses. On the social side of LTC, local government's capacity to provide social benefits and services depends to a large extent on the budgetary resources available. Although local government must follow legal obligations in providing LTC services, they have broad powers and autonomy

[4] OECD (2011). Estonia: Long-term Care.

[5] Pihor, K., Timpmann, K. and Batueva, V. (2011). Uuringu lopparuanne Kohaliku omavalitsuse poolt isikult ja/voi perekonnalt sotsiaalteenuste eest tasu noudmine Tellija: Sotsiaalministeerium Teostaja: SA Poliitikauuringute Keskus. PRAXIS AS EMOR.

[6] World Bank (2017). Reducing the Burden of Care in Estonia Interim Report.

to define their policies, and their capacities to fund and provide services are highly unequal.[7] Access to LTC services depends largely on the residence of the beneficiary.

In the absence of adequate publicly financed coverage, the burden of care falls disproportionately on informal caregivers, giving rise to significant economic and social costs. The State Audit Office is of the opinion that local authorities should first make sure that the person in need of care, or his or her family, are not capable of providing care themselves before providing assistance involving taxpayers' funds. The reliance on informal care is underpinned by the Constitution of the Republic of Estonia (Art. 27), which stipulates that the family is required to provide care for its members in need.

1.4 Balance between institutional and home care services

Estonia allocates a relatively low proportion of total public spending to in-kind LTC benefits compared with other EU countries, but a relatively large share of its in-kind benefits is for institutional care. Estonia spends only 39% of its total public spending on in-kind LTC services.[8] However, about 90% of Estonia's formal in-kind spending on LTC services is on institutional care, surpassed only by Latvia among other EU countries.[9]

Institutional care absorbs over 50% of the total public budget devoted to LTC in Estonia.[10] In 2014, spending on special care homes,[11] inpatient nursing care and general care homes[12] comprised the largest shares of total public spending on LTC, at 22%, 19% and 13% respectively. In contrast, spending on home care and home nursing care was in each case only 5% of total spending. The data available do not allow a precise estimate of the budget devoted specifically to the LTC since, for example, the inpatient nursing care budget (the second largest category) is spent on both the disabled and non-disabled population.

Home-based care is, however, far less expensive than institutional care per beneficiary. For example, in 2012, the estimated public cost per beneficiary in general care homes was on average EUR 519 per month, while the home care cost per beneficiary was EUR 62. However, use of home care among the elderly remains low, with around 2.6% of the elderly population (65+) receiving the service in 2014, and there appears to be no correlation between use of home-based services and availability of residential care facilities in municipalities.[13]

Due to the limited access to publicly provided home- and community-based services and the high costs of institutional care, many families must resort to informal caregiving.

1.5 Cash vs in-kind benefits

Provision of formal social LTC services includes both in-kind social services and cash benefits. These services (in kind and cash) are provided as needs-based social assistance

[7] The Social Welfare Act actually obligates municipalities to provide eleven social services (among them some LTC services): but not all municipalities do that and, secondly, service standards are very general and allow broad interpretation.

[8] European Commission (2016). Joint Report on Health Care and Long-Term Care Systems & Fiscal Sustainability, Institutional Paper 037.

[9] World Bank (2017). Reducing the Burden of Care in Estonia: Interim Report.

10 Aaben, L., Paat-Ahi, G. and Nurm, Ü-K. (2017) Pikaajalise hoolduse deinstitutsionaliseerimise mõju hindamise raamistik. Tallinn: Poliitikauuringute Keskus Praxis.

11 Retirement-age adults account for the largest proportion of general care home use while working-age adults use special care homes more frequently. This is because a large share of working-age adults who receive social LTC services have mental health issues and thus are clients of special care homes (about 29% of the group, or more than 5000 people in total).

12 General care homes are unable to provide specific services to those with dementia as there is an absence of specialised staff to provide the greater care they need. In addition, general care homes often have open doors, while some older people with dementia require a more secure space.

[13] World Bank (2017). Reducing the Burden of Care in Estonia: Interim Report

to individuals requiring assistance with the basic activities of everyday life as well as those with special care needs. LTC in-kind services provided by the social welfare system are provided by either the local municipality or by the state. Since 2005, most social services have been the responsibility of local government, e.g. municipalities and cities, because they are best acquainted with local life. LTC services provided by the local municipalities include domestic service (or home care), general care services provided outside the home and personal assistant services. Related support services provided at the municipality level include social counselling, curatorship, social transport service, and provision of a dwelling for disabled individuals. Related support services organised at the state level include social rehabilitation services (organised by the Social Insurance Board) and vocational rehabilitation services (organised by the Unemployment Insurance Fund). In 2014, about 68 000 people or 6.1% of the population aged 15 years and over in Estonia received some in-kind social LTC service. This compares with an average of 4.2% in the EU.[14] Cash benefits and benefits in kind may be combined: if the person in need of care only partly claims the benefits in kind, they are entitled to receive a proportionate care allowance. The care allowance is reduced by the percentage corresponding to the claimed benefits in kind. The person in need of care is bound by the decision relating to the ratio between cash benefits and benefits in kind for a period of six months.

1.6 Balance between and levels of informal and formal care

Formal LTC services and related support services are provided by both the health and social welfare systems. The goal of long-term healthcare services is for the person to improve, maintain or regain health, or to adjust to a health condition. The goal of social LTC services is to maintain, regain or improve capabilities in day-to-day life, while either living at home independently, at home with domestic care or in institutional care.[15]

1.7 Evaluation of needs and eligibility criteria for the various LTC cash benefits and services

In addition to in-kind social services, cash benefits are also provided by local government and by the state. Local government may provide caregiver allowances to informal caregivers, based on eligibility criteria determined by each local authority. As local authorities are not obliged to pay the caregiver's allowance, regional disparities in payments are large. The total spending on caregiver's allowance per capita (used here as a proxy for the level of spending) varied from EUR 0.86 in Saare county to EUR 9.86 in Vôru county. In 49 municipalities and cities, there were in each case fewer than 10 beneficiaries of caregiver's allowance. On average, in 2015, annual caregiver's benefit was EUR 304 per beneficiary (ranging, according to locality and the physical and mental status of the dependent person, between EUR 5 and EUR 100 per month). These disparities indicate that there are no minimum standards in provision of the benefit, which is allocated at the discretion of local government on an ad hoc basis.

The state also provides incentives for employers of disabled people (e.g. social tax incentives, compensation for workplace adaptation or provision of special equipment, and compensation for training costs) and pays eligible caregivers'[16] national insurance contributions and social tax.

14 European Commission (2016). Joint Report on Health Care and Long-Term Care Systems & Fiscal Sustainability, Institutional Paper 037.

15 Paat, G. and Merilain, M. (2010). The Long-term Care System for the Elderly in Estonia. ENEPRI Research Report No. 75, Contribution to WP1 of the ANCIEN Project.

16 National unified criteria for caregiver's allowance do not exist.

2 Analysis of the main long-term care challenges in the country and the way in which they are tackled

2.1 Access and adequacy

With public funding for LTC at a low level, coverage of formal LTC is inadequate, inequitable and provides little financial protection. On the health side of LTC, there is a shortage of nursing care beds. Access to inpatient nursing care services is uneven as between regions, in part a consequence of shortages of home nurses. The main target group for home nursing care consists of patients who no longer need active medical treatment and are discharged from hospital. The most common age group for patients using home nursing in Estonia is 65-85 followed by those over 85. The proportion of patients in different age groups is different as between towns and rural areas. Fewer than half of the patients are functionally independent and manage to take care of themselves, half of the patients are partly dependent and around a tenth of all patients are completely dependent. Hence, a person using home nursing care in Estonia is typically elderly, chronically ill and with no prospect of improving (82.5% of all the patients). Most patients have problems due to a combination of multiple illnesses.[17] In 2015, there were around 90 home nursing centres plus a few self-employed home nurses in Estonia.

On the social side of LTC, local government's capacity to provide social benefits and services depends to a large extent on the budgetary resources available. Although local government must follow legal obligations in providing LTC services, they have broad powers and autonomy to define their policies, and their capacities to fund and provide services are highly unequal. As a result, access to LTC services depends largely on the residence of the beneficiary. In recent years, the coverage of home-based services for the elderly has barely expanded even though unit costs of home-based services are relatively low. The limited supply of home-based services for the elderly has led to a growing demand for general care homes. Most elderly people finance social services from their state-provided pension, which is often not sufficient to cover the costs of even the least expensive general care home. The limited supply of home-based services for the elderly results in growing demand for general care home services as the population ages, though unit costs of home-based services are much lower. The usage of general care home services increases year to year, and from 2009 to 2014 the number of clients grew by a third. While public expenditure on this service during the five-year period increased by only 10.9%, OOP spending went up by 62.0%, comprising 71.9% of the total expenditure. Given that the average monthly payment for the general care home service considerably exceeds the average old-age pension, usage is limited by the income level of the elderly (and of their relatives).

2.2 Quality

Due to the composition and characteristics of informal caregivers and their dependants, the care burden costs are high, and quality is threatened. Most informal caregivers are elderly and have their own health problems. Moreover, many may lack the means and knowledge to provide the assistance necessary. Combining paid work and caring activities may prove difficult for working-age informal caregivers, particularly if they also care for children. To address care needs, they may decide on part-time work, or to drop out of the labour market. The lack of training and support for informal caregivers increases the risk of admission into institutional care.[18] Given that wealth is limited for

17 Estonian Nurses Union and EHIF (2015). Koduõenduse tegevusjuhend 2015 (Home nursing code of conduct). Retrieved 1 April 2016, from http://www.ena.ee/koduoed/koduoenduse-tegevusjuhend-2015.

18 Polluste, K., Marcinowicz, L. and Chlabicz, S. (2016). Is home care an issue for primary health care? Expert views from Poland and Estonia. Family Medicine & Primary Care Review; 18, 4: 455-459.

much of the population aged 50 years and over,[19] to what extent will those in need of care have to rely on family support or state support in the coming years?

Health and social LTC services are also organisationally and professionally fragmented between two separate systems, each with their own cultures and modes of operation. Thus, although healthcare and social care services coexist within the community (e.g. home nursing care and home help with daily activities) and within institutional settings (e.g. hospital-based nursing care and social welfare institutions), they often lack adequate protocols for cooperation. The organisational separation also involves separate administrative procedures as well as IT/communication infrastructures. Similarly, at the professional level, there is fragmentation between healthcare and social care in terms of differing professional norms and cultures, social statuses and prestige, as well as employment terms and conditions, and working time/shift patterns and training. As most social care providers are informal, there is little training and skills development or actual planning of human resources. Finally, at a policy level, responsibility for the management of service provision and financing differs between healthcare and social care. Healthcare LTC services are managed at the state level, while in social care this responsibility is decentralised to the municipalities. Because municipalities have a wide degree of flexibility to determine the extent of services provided and how eligibility is determined, access to social LTC services is not equal across the country. Since the beginning of 2017 the EHIF has incorporated a common needs assessment for healthcare and social care services in its health service list; however, practical implementation by primary care providers remains to be accomplished over the next few years. There is thus no common, nationally standardised needs assessment instrument currently available to accurately reveal whether the right level and type of care is being prioritised.

This fragmentation of LTC between the healthcare and social care systems contributes to inadequate coordination and continuity of patient care, which leads to a deterioration in patient outcomes. Effective coordination between healthcare and social care services is essential for not only improving outcomes and quality of LTC, but also for ensuring value for money in both the health and social LTC sectors.

It is important to actively promote multidisciplinary teams and service integration, as payment reforms alone would not achieve this. Important elements of this reform would include: regular contact between medical professionals and institutional/social care providers; joint clinical and care guidelines helping to coordinate care through different pathways and reduce avoidable variations in both medical and social care; joint care coordinators, care planning systems, etc; specialised care providers to address complex health problems; and intermediate care services, coupled with appropriate quality assurance systems. This could pilot and eventually scale up reforms to promote professional and services integration.[20]

2.3 Employment

Provision of LTC can be either formal or informal. Both types of care co-exist, either complementing or substituting for each other, depending on the type of dependency. Formal care is provided in either the public or private sector, by care assistants who are paid under some form of employment contract, and who are mainly lower-skilled caregivers or nurses. In contrast, in order to be considered informal, provision of care cannot be paid for as if purchasing a service, though an informal caregiver may receive income transfers and, possibly, some informal payments from the person receiving care. Informal caregivers usually have an existing social tie to the care recipient. Most informal

[19] European Commission (2015). The 2015 Ageing Report: Underlying Assumptions and Projection Methodologies. Joint Report prepared by the European Commission (DG ECFIN) and the Economic Policy Committee (AWG).

[20] World Bank (2017). Reducing the Burden of Care in Estonia: Interim Report.

LTC is delivered by families and friends – mainly spouses, daughters, sons and stepdaughters.[21]

Given that the extent of privately provided care outside of the family is also low, much of LTC care is provided informally by the family – largely, although not exclusively, by older women.[22] Recent time-use data for Estonia show that although men and women are equally likely to participate in paid work before midday, as the day progresses women are less likely to return to paid work, focusing more on household production and care activities.[23] Such care activities peak in the evening hours. As the number of younger entrants to the labour market diminishes, keeping older women full time in the labour force – if that is their wish – will become ever more important.

Since caregiving is time-consuming and can be mentally and physically draining, it can negatively affect the caregiver's health and ability to participate in the labour market. Employed people many need to reduce their working hours temporarily because of their child's or parent's care needs. They may also permanently move to a part-time job or withdraw from the labour market completely.[24]

In addition to age effects, there are strong educational and ethnicity effects on employment status among women with care obligations. Women with higher education are more likely than other women to be employed part time, and less likely to be inactive, because of caring responsibilities. One possible explanation is that women with higher education have more flexible work options. In general, Estonians with higher education complain less (to a statistically significantly extent) about the lack of care services, suggesting that more educated people have access to more flexible work arrangements or have better access to care services because they can afford private services. In addition, non-Estonian women in Estonia are less likely to look for a job because of caring responsibilities and less likely to be employed part time, compared with Estonian women.[25]

Not surprisingly, informal care responsibilities curtail family members' (especially women's) ability to participate actively in the labour market (for example, the average monthly allowance for caregivers of working-age adults and elderly people with official severe disability status is about EUR 21, while for profoundly disabled status this is increased by EUR 11-12). A conservative estimate of the opportunity cost of time spent providing informal care was EUR 23.9 million in 2015 (confidence interval of 16.0-31.7 million) or about 0.12% of GDP. Besides the economic costs, informal carer responsibility incurs social costs associated with the psycho-social impact of providing care to sick, disabled family members (see also Figure below).

[21] European Commission (2012). Long-term care: need, use and expenditure in the EU-27.

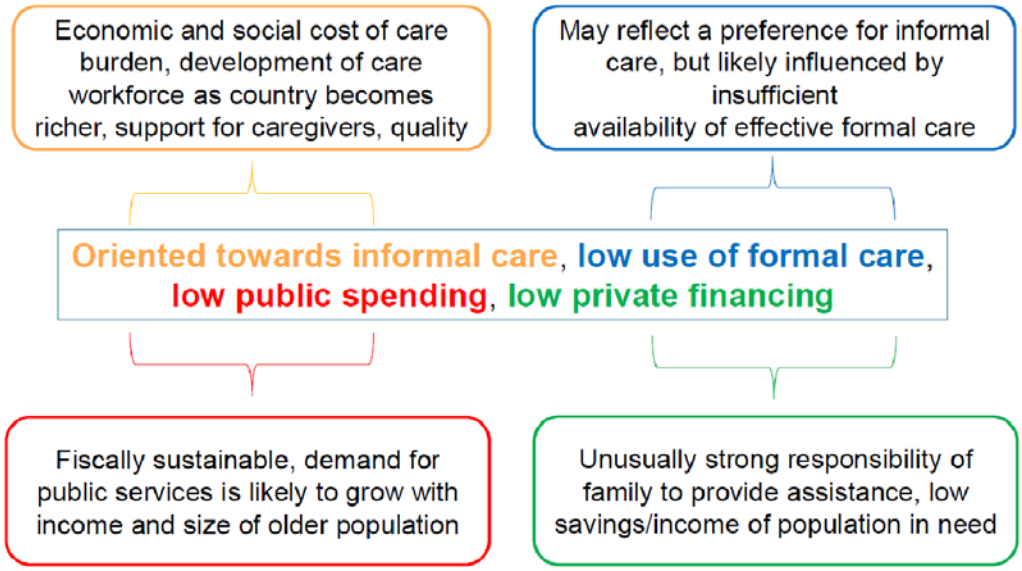
22 European Commission (2015). The 2015 Ageing Report: Underlying Assumptions and Projection Methodologies. Joint Report prepared by the European Commission (DG ECFIN) and the Economic Policy Committee (AWG).

[23] Levin, V., Munoz-Boudet, A. M., Rosen B. Z., Aritomi T. and Flanagan J. (2015). Why Should We Care About Care? The Role of Informal Childcare and Eldercare in Aging Societies. Washington DC: World Bank.

[24] Võrk et al. Estimates of the Economic Costs of Informal Care, forthcoming.

[25] World Bank (2017). Reducing the Burden of Care in Estonia: Interim Report.

Figure 1. Estonian long-term care system centred around informal care



2.4 Financial sustainability

At the financial level, fragmentation arises from the separation of funding streams between the state and local government levels. Long-term healthcare services, such as inpatient and home-based nursing care, are financed at the state level by the EHIF through an earmarked social payroll tax. In turn, long-term social care services, such as help with daily activities in the home or in social welfare institutions, are financed primarily through local government taxes with limited equalisation payments from the state for lower-income municipalities. Other social care services such as special care services and childcare services are financed directly by the state.

LTC costs are expected to put pressure on Estonia's public budget over the next decades. The projections for LTC expenditure in the latest EC ageing report (European Commission, 2015) are that public spending on LTC in Estonia is due to increase from 0.6 to 1.3% of GDP over the period 2013-2060 due to purely demographic effects. These projections cover in-kind public spending on health and social LTC, including: formal care in institutions and at home; informal care; and LTC-related cash benefits. If the country's living standards converge towards the EU average, , LTC in Estonia is projected to climb to 3.3% of GDP by 2060. Adding to this, a convergence by LTC formal/public coverage rates with the EU average would bring spending in Estonia to 4% of GDP by 2060.

2.5 Recent or planned reforms

Reforms in the healthcare system have close linkages to the social welfare system. Many social care home residents also need LTC, but the amount of care provided is constrained by the limited resources of municipal budgets. As the target groups for LTC and welfare services are largely overlapping, integration and better coordination of services are required to respond more effectively to the varying needs of elderly and chronically ill people.

To alleviate the problem of the shortage of LTC facilities and home care services, the government has allocated additional funds from the EU structural funds in the next planning period 2014-2020. The government has decided that EUR 49 million will be used to relieve the burden of family members who currently take care of disabled people. Additionally, EUR 28.3 million from the European Social Fund and EUR 5.3 million co-financing from the government was allocated to local government for developing social

services in 2016[26] and EUR 1 million was allocated from the state budget to support families with children with a severe disability. At the end of 2014, the new development plan for special LTC was approved for 2014-2020, under which EU structural funds will be used to reorganise the network of LTC facilities.

The EHIF is pursuing many reforms in the next few years. For example, one strategic priority of the EHIF for the next few years is conducting thorough analyses of payment models, and developing strategic purchasing arrangements that incentivise high-quality care and effective coordination of care between different care settings, including between the healthcare and social care systems. Another priority for the EHIF will be to develop the availability of post-acute services – including rehabilitation and nursing care in hospitals as well as home nursing care – through strategic planning and contracting. In addition, the EHIF intends to support holistic reforms of LTC in Estonia, including the possibility of combining general care homes and inpatient nursing care facilities into one integrated care unit.

The multidisciplinary teams within primary care centres are expected to improve the access to, and coordination of, services needed across the healthcare and social care sectors. According to the EHIF, primary care centres should provide family doctor and family nurse services (a minimum of three doctors and three nurses in a centre), as well as physiotherapy, midwifery and home nursing services. Providing home nursing care through primary care centres with the support of the family doctors' professional team would allow for improved access to the service, as well as a more comprehensive and adequate needs assessment, since family doctors and nurses are likely to be particularly familiar with the insured persons on their lists. Indeed, with the development of these primary healthcare centres, the EHIF is committed to support the implementation of a case management programme within these primary care centres to comprehensively assess patients' conditions/needs and adequately coordinate healthcare and social care services accordingly.

The EHIF is currently piloting a preliminary case management model as part of a separate project with the World Bank. This programme identifies eligible participants using an algorithm which draws on current administrative data on patients' health and social status, as well as the family physician's intuition. After conducting a comprehensive healthcare and social care needs assessment, family physicians and patients develop care plans together, outlining the patient's key healthcare and social care goals as well as contingency plans in case the patient's health or social situation deteriorates. Family physicians and nurses are responsible for coordinating the patient's care as needed (providing referrals, setting up appointments, etc.) and routinely following up on the patient's care status, adjusting the care plan as needed.[27]

2.6 Policy recommendations to improve the access and adequacy, quality and sustainability of the LTC system(s)

Good coordination between health and social care is critical for ensuring effective provision of LTC. The experience of several European countries shows that there is considerable scope for improving care outcomes and quality by managing the interactions between these sectors more effectively. In Estonia, LTC is fragmented across care episodes, providers, settings and services. Considering future needs and expenditure demands, Estonia may need to explore new financing models in the future for LTC. Despite a great variety in approaches and coverage levels of public LTC across countries, recent developments suggest that financing models are converging and that countries are increasingly moving towards 'targeted universalism'. In addition, many countries are striving to improve the sustainability of funding sources for LTC, with an

[26] Rahandusministeerium. State budget strategy 2017 – 2020. file:///C:/Users/gerli/Downloads/res-2017-2020-eng.pdf

[27] World Bank (2017). Reducing the Burden of Care in Estonia: Interim Report.

eye on unburdening the working-age population. Supporting informal caregivers and improving their chances of participating in the labour market is equally critical in the context of Estonia, where informal caregivers will continue to form the backbone of the LTC care system in the short to medium term.

Some recommendations for policy-makers are set out below.[28]

- Develop a shared vision for integrated healthcare and social care at an early stage, with the goals of introducing care delivery processes centered on addressing the needs of people who rely on them, independently of who is providing care.
- Review the legal framework set by the various health and social care acts, to identify any regulatory blocks to integration. Lack of detail in social care legislation (e.g. on where the responsibilities for medical treatment end and where social care begins) can lead to competing goals, with poor alignment of professionals across healthcare and social care. Putting a roadmap in place for modifying the legislation appropriately can start now. This includes a review of legislation to permit sharing of electronic data between healthcare and social care.
- Establish detailed requirements for the objectives and content of all social welfare services. Regulations should establish minimum standards in the provision of relevant services to be adhered to by local government.
- Raise awareness of the rights of patients and their families, and the services available to them.
- Develop legislative and policy frameworks to guide and sustain integrated care arrangements between healthcare and social care providers. Programmes should include medium- to long-term financial strategies that are realistic about costs, as well as sound governance arrangements and accountability mechanisms to ensure providers are held responsible for stated goals and quality targets.
- Increase access to end-of-life care at home.
- Ongoing monitoring and evaluation systems should be put in place, underpinned by a periodic (annual) review of LTC within the national monitoring framework. Local government would be responsible for providing information on service delivery to the national government, which would then analyse the quality and adequacy of provision (according to state regulations/law). Incentives could be provided for local government/LTC providers who meet quality/quantity indicators for LTC provision. Here the LTC strategy is dependent on the outcome of the future subnational administrative reform, which is intended to increase municipality size and provide high-quality public services to all residents.

3 Analysis of the indicators available in the country for measuring long-term care

In Estonia and in many other European countries, there is a problem with a lack of data and/or with the quality of data relating to LTC. Many services are provided at the local level, and this means that data should be collected by local registers. To improve the health and social welfare information systems, it is important to determine which data should be collected, at what level and by whom. Indicator data is essential at regional and service level, to support planning for further activities and controlling the performance of services and activities.

It is important that data is available at all levels and is of sufficiently high quality. If the situation with the national registries is generally improved every year, the collection of relevant survey data is still a challenge (for example, household surveys and studies on service use).

[28] World Bank (2017). Reducing the Burden of Care in Estonia: Interim Report.

In Estonia there are about 300 database and information systems, most of which are personalised. The population register is the state's database for holding basic information about each person living in Estonia. It contains their name, ID code, date of birth, place of residence, and other statistical data such as nationality, native language, education and profession. Each resident can review and correct their data in the register. The register is connected to other systems via X-Road, and a variety of other state systems depend on its data for their services. For example, when individuals apply for child support, study allowance or concessionary status for public transport, data is retrieved from the register. The same is true when a person uses i-Voting. The system retrieves the information automatically – no extra documents have to be submitted or online forms filled out. The state also benefits because statistics are kept up-to-date, and functions such as voter registration and tax filing, which are based on place of residence, can be handled properly. In relation to LTC, the most important databases are the STAR (*sotsiaalteenuste- ja toetuste andmeregister*), the Social Protection Information System, S-Web, H-Web, TETRIS (*töövõime hindamise ja töövõimetoetuse andmekogu*), the Health Information System, and the health insurance database.[29]

At present, no national or local-level quality indicators are measured in Estonia. However, there are considerable frameworks and developments around quality assurance, including internationally recognised LTC indicators, which should be adopted in Estonia.

In the social sector, some national-level indicators have been introduced to measure the quality of services starting from 2011 (Development Plan of MOSA 2011-2014). In Estonia, general patient satisfaction has been measured annually since 1999, but information on the quality of nursing care is hidden in the data on primary and specialist care, as specific LTC questions are not asked.[30]

The government has approved the development plan of Statistics Estonia for 2018-2022. The greatest change in the new strategy period is transforming Statistics Estonia into a national data agency – an office that offers data from different sources, and support for those using data, as well as classic official statistics. The main task of Statistics Estonia in the coming years is to make necessary information easily and conveniently available for enterprises and state authorities. The aim is to decrease administrative burdens because of the reforms – enterprises and institutions will then be able to focus more on their main activity. Central to the strategy of Statistics Estonia is offering personalised statistics and data sources to users.

[29] Aaben, L., Paat-Ahi, G. and Nurm, U-K. (2017). Pikaajalise hoolduse deinstitutsionaliseerimise mõju hindamise raamistik. PRAXIS.

[30] Koppel, A. and Paat-Ahi G. (2012). Quality assurance policies and indicators for long-term care in the European Union. ENEPRI Report.

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