ESPN Thematic Report on Inequalities in access to healthcare

Estonia

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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:
http:ec.europa.eusocialmain.jsp?catId=1135&langId=en

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Summary/Highlights

The Estonian healthcare system is based on compulsory, solidarity-based health insurance, limited co-payments, and universal access to health services made available by providers that operate under private law.

The first factor that influences access to healthcare in Estonia is the financing of the healthcare system. Health expenditure in Estonia makes up a rather small share of GDP (6.51% in 2015), being one of the lowest in the EU. Nearly two-thirds of the total volume of health expenditure is financed through the solidarity-based health insurance system (€916 million in 2016), which is financed through the health insurance contributions of employed (including self-employed) persons. Expenditure through the general central government budget constitutes 9% (€132 million in 2016) of Estonian health expenditure. The system is largely based on social contributions by the economically active population, with roughly half of all people not directly contributing to the system. This weak financing base results in long waiting times and unmet need for care. In 2015, Estonia showed the highest level of unmet need for medical care in the EU (12.7%), mostly due to waiting times. The issue is more prevalent in urban regions compared with rural ones. Although the issue of insufficient financing has been pointed out since 2005, the first steps to improve the system were taken only in 2018 – additional transfers are now made from the state budget to the Estonian health insurance fund (EHIF).

The second factor that influences access is the relatively low extent of compulsory health insurance coverage. The share of uninsured people is around 6%. There are also problems with the continuity of health insurance: for example, 11% of people had health insurance for less than 11 months per year in 2015. Low coverage has multiple causes, including people working abroad, precarious employment and employment income, income not being subject to social tax, and tax evasion.

Thirdly, access to healthcare is influenced by the level of user charges. Household out-of-pocket (OOP) payments amounted to 23% (€320 million) of health expenditure in 2016. Although in principle health insurance covers a wide range of services, cost sharing still influences access to these services. Unmet need for medical care due to cost is lower in Estonia than the EU average according to the EU-SILC data (1.1% vs 1.6% in 2016). The most vulnerable groups are unemployed people and those with reduced capacity for work, given that they have more need for services and medicines, and/or they have lower income.

The most important issues to be solved include increasing health insurance coverage and improving the sustainability and financing of the health insurance system. Insurance coverage is currently being analysed, while sustainability and financing are being tackled by making transfers in respect of non-working pensioners from the state budget to the EHIF's budget. Steps have also been taken to mitigate the problems of OOP payments, by (re-)introducing partial reimbursement of dental care costs for working-age people (and at the same time increasing it in the case of other groups) and changing the system for reimbursing the costs of prescription medicines.

Overall, the available data help to provide a good picture of the situation in relation to healthcare access. However, the age dimension is rather important to highlight when analysing the data for Estonia. An important indicator is also the (estimated) share of those covered by irregular health insurance, which also could highlight problems in the system.

1 Description of the functioning of the country's healthcare system for access

1.1 General description of the healthcare system

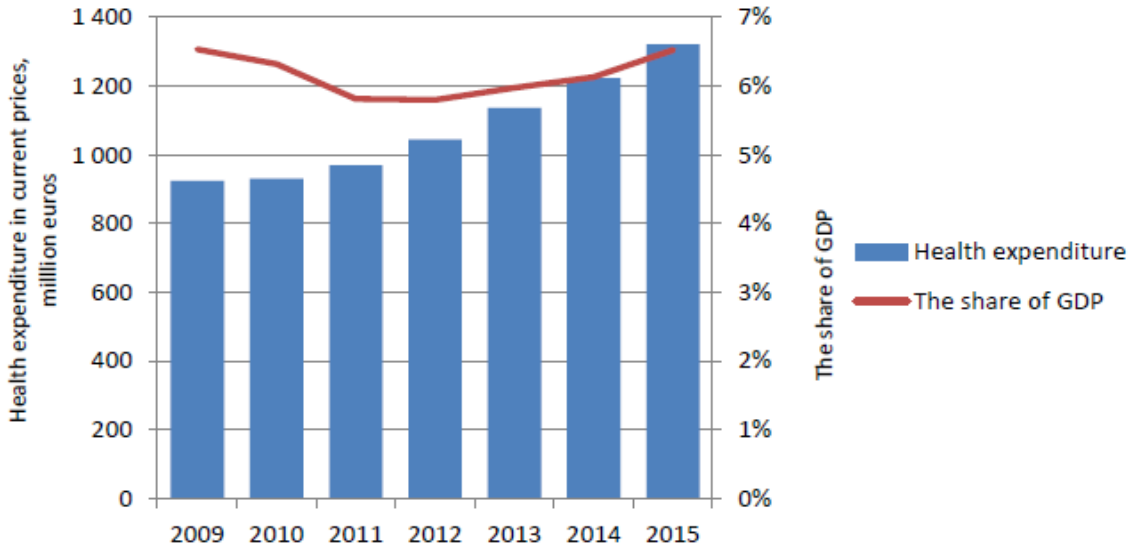
The Estonian healthcare system is based on compulsory, solidarity-based health insurance, limited co-payments, and universal access to health services made available by providers that operate under private law. The Ministry of Social Affairs (MoSA) and its agencies perform the main stewardship role for the Estonian healthcare system. The health system is financed mainly by the health insurance contributions levied on employment income and pooled by the Estonian health insurance fund (EHIF). The role of the EHIF is to act as an active purchasing agency and its responsibilities include contracting of healthcare providers, paying for health services, reimbursing pharmaceutical expenditure and paying for temporary sick leave and maternity benefits. There are also contributions from the state budget or household out-of-pocket (OOP) payments. Local municipalities have a minor, rather voluntary, role in organising and financing health services.

1.2 Financing of healthcare and healthcare coverage

Health expenditure in Estonia makes up a rather small share of GDP (6.51% in 2015), being one of the lowest in the EU (National Institute for Health Development – NIHD – 2017[1], SHA 2011, Eurostat table hlth_sha11_hc).

Although health expenditure increased continuously between 2009 and 2015, from €924 million to €1,324 million, its share of GDP moved in the opposite direction during 2010-2011 – only regaining its 2009 level in 2015 (see Figure 1).

Figure 1. Percentage share of health expenditure in GDP and health expenditure in current prices, 2009-2015



Source: NIHD 2017.

In 2016, total health expenditure in Estonia was €1.4 billion and expenditure per person was €1,071. (NIHD 2017).

Nearly two-thirds of the total volume of health expenditure is financed by the solidarity-based health insurance system through the EHIF (€916 million in 2016). Expenditure through the general central government (paid directly to service providers) constitutes

[1] NIHD Health Statistics and Health Research Database.

9% (€132 million in 2016). Household OOP payments amounted to 23% (€320 million) (NIHD 2017), below the maximum limit of 25% defined in the national health plan 2009-2020 (MoSA 2008). See section 1.4 for more information on OOP payments.

As stated above, the main source of health insurance revenues is health insurance contributions. These contributions give mandatory health insurance coverage. Those covered by the insurance fall into four main categories: employees and self-employed people, whose contributions amount to 13% of their employment income (50.6% of those covered in 2017); those who are eligible for coverage without contributing, such as children, registered unemployed people and pensioners (46%); those who are covered by contributions from the state (3.2%); and those who are covered on the basis of international and voluntary agreements (0.2%) (EHIF[2]). Additionally, if a person does not belong to any of the above groups, it is possible for them to enter into a voluntary insurance contract with the EHIF: however, take-up of the option is negligible (about 555 people in 2016 according to EHIF). The high number of non-contributing individuals (49.4%), i.e. those not in employment or not covered by a voluntary agreement, reflects a strong solidarity element within the system. These non-contributing individuals are eligible for the same in-kind healthcare benefits package as everyone else in the insurance pool.

Despite rather wide possibilities for insurance coverage (i.e. through contributions paid from employment income or through state contributions on behalf of non-working persons), the coverage rate in Estonia is one of the lowest in the EU, being around 94%. Moreover the 94% figure includes those who have health insurance only irregularly; this relates mainly those who work irregularly or have irregularly declared employment income. In 2015, 11% of the population aged 20-64 were covered for less than 11 months per year (MoSA 2016).

The range of healthcare (in-kind) benefits covered by the EHIF is very broad. Overall, the provision of preventive and curative health services as well as pharmaceuticals and medical devices, which may be subject to cost sharing, are covered through the EHIF budget. The few services fully excluded are cosmetic surgery, alternative therapies and optician services.

Over the years, the expenditure structure has remained stable in overall terms. Inpatient care formed the largest share of EHIF expenditure (33%) in 2016 (NIHD 2017), while outpatient general and specialised medical care formed the second largest share (28%); compensation for prescribed medicines amounted to 14%. In the case of central government expenditure, the largest share (30%) in 2016 was made up of ancillary health services expenditure – more precisely, ambulance services and transport of patients. The second largest service group was curative care (24%), which includes the care provided to uninsured persons, health services in prisons and for the Estonian defence forces, and HIV/AIDS treatment. The third and fourth largest groups of services paid for by the government were prevention activities and nursing services, which each constituted 13% of the government's expenditure.

Uninsured people are entitled to emergency care and to some specific healthcare services provided as part of public health programmes (such as those for HIV/AIDS and tuberculosis). For other health services, the uninsured must usually pay out of their own pocket, although some municipalities (e.g. Tallinn) fund a limited range of health services. Furthermore, the uninsured do not always have access to public health services, and uninsured women have not been invited to screening programmes for breast and cervical cancer.

[2] EHIF Health Statistics.

1.3 Availability of healthcare

In 2015, Estonia showed the highest level of unmet need for medical care in the EU (12.7%), which was mostly due to waiting times/waiting lists (EU-SILC, Eurostat table hlth_silc_13).

Based on the Estonian Health Insurance Fund Act,[3] the supervisory board of the EHIF approves the maximum length of waiting lists. As presented in Table 1, the accessibility of primary care is very good, while there are shortcomings regarding other services. For example, in outpatient specialised care, half of patients cannot access services within the maximum time. However, these figures could underestimate the actual situation, as waiting time is measured only from the actual registration of an appointment. However, 33% of people have experienced not being registered on the waiting list at once (mostly as there were no appointment times to offer at that point) (Kantar Emor 2016). This is due to the financing issues of the system, discussed further in section 2.3.

Table 1. Maximum waiting times set by EHIF, and patients with appointments within the maximum waiting time

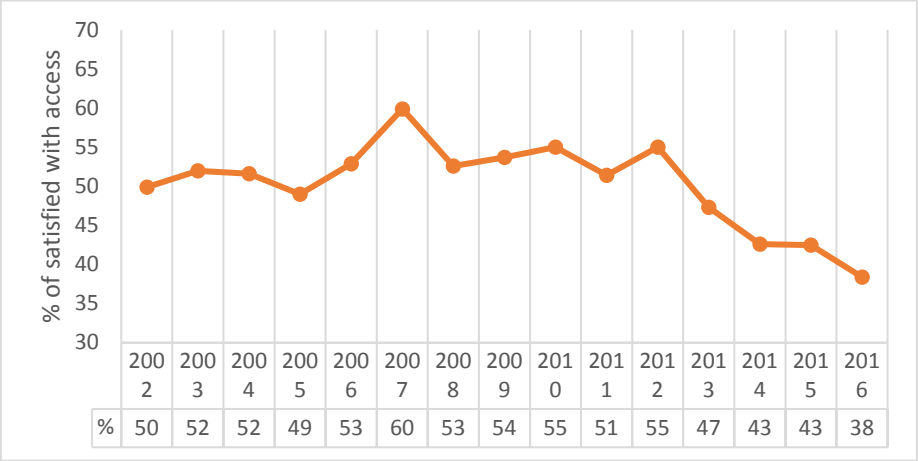
Type of care	Maximum waiting time	% of patients with appointments within the maximum time				
		2013	2014	2015	2016	2017
Primary care: acute cases	1 working day	100%	100%	100%	99%	99%
Primary care: non-acute cases	5 working days	98%	99%	99%	98%	98%
Specialised outpatient care	6 weeks	50%	49%	52%	53%	55%
Day care	8 months	98%	91%	93%	89%	83%
Inpatient care	8 months	90%	89%	88%	85%	73%

Source: EHIF Annual Reports.

The problem is also reflected in perceived access to healthcare. This has been in decline since the peak reached in 2007, when 60% of the population were satisfied (or very satisfied) with access. By 2016, satisfaction had declined to 38% (see Figure 2). Unmet need for care has been rather low and stable in the case of primary care (family doctors) in the past decade, whereas it has increased considerably since 2009-2010 in the case of specialist care (Figure 3).

[3] Estonian Health Insurance Fund Act, passed 14.06.2000.

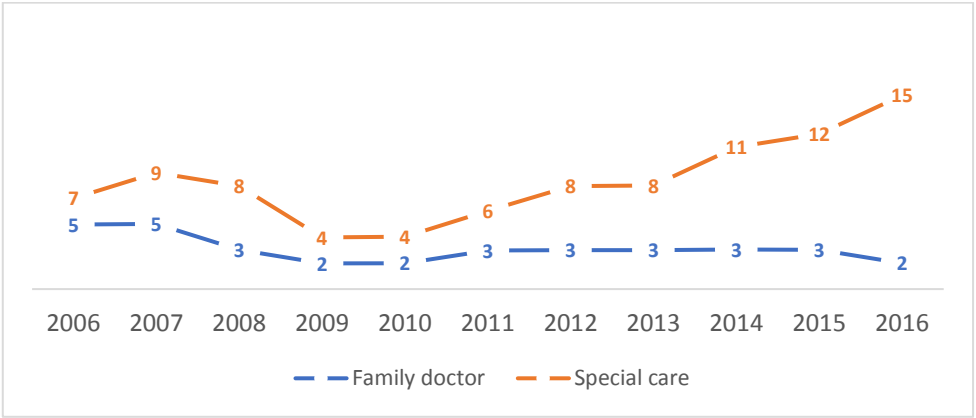
Figure 2. Satisfaction with accessibility of healthcare, 2002-2016



	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016
%	50	52	52	49	53	60	53	54	55	51	55	47	43	43	38

Source: NIHD.

Figure 3. Unmet need for family doctor and specialist care in Estonia (%), 2006-2016



Source: Estonian Social Survey.

There is a shortage of healthcare workers in Estonia due to the age structure of the workforce, professional migration and inadequate training volumes in the past. However, compared with the EU average, the situation is more worrisome in the case of nurses than in the case of doctors. There were 342.25 practising doctors per 100,000 inhabitants in 2015 in Estonia, while the EU average was 341.3 (Eurostat table hlth_rs_prs1). On the other hand, the number of practising nurses and midwives was 635.32 per 100,000 inhabitants in 2015 in Estonia, while the EU average was 861.6 (Eurostat table hlth_rs_prsns). A particular problem regarding doctors is the ageing workforce: 45% of doctors are older than 55 while among family doctors this share is even higher (58%)(NIHD[4]) Furthermore, 24% of physicians and 16% of nurses working in health institutions were older than 65 in 2015, i.e. past retirement age (NIHD).

1.4 Affordability of health expenditure and depth of coverage

Estonia has a comprehensive system of cost sharing in place, consisting of statutory co-payments for specialist care, co-insurance for some services and a pharmaceuticals cost-sharing scheme. The largest share of OOP payments goes on pharmaceuticals, medical goods and curative care services (i.e. dental care and specialised outpatient medical care). Dental care expenditure makes up the largest share of curative care services (28% in 2016). Prescribed medicines make up 22% of household health

[4] NIHD Health Statistics and Health Research Database

expenses and over-the-counter medicines 16%. A total of 8% of health expenditure goes on long-term care services, 12% on specialised outpatient medical care and 8% on various therapeutic appliances (including glasses) (NIHD 2017).

There are no user charges (except for home visits, €5) in primary care, in order to avoid financial barriers to accessing a family doctor or nurse. Co-payment for specialised outpatient care is €5, while in the case of specialists not contracted by the EHIF (and in the case of uninsured people), patients are charged according to a provider-established pricelist, up to a 'reasonable' cost. In the case of dental care, as of July 2017 the co-payment for adults was 50% with a benefit cap of €40 per year, after which users pay the full price. Co-payment was 15%, with the annual cap of €85, for: insured persons over 63 years of age; pregnant women; mothers of children up to 1 year of age; persons with a greater need for dental treatment because of a particular condition; and persons eligible for a work-incapacity or old-age pension. Dental care for children of up to 19 years of age is free of charge if the service provider is contracted to the EHIF. There is also a reimbursement system for prescription-only medicines. The reimbursement category (100%, 90%, 75% or 50% rate) determines the level of patient co-payment (in addition to a €2.50 base co-payment) and is based on the severity of the disease, the efficacy of the medication and the status of the patient. For example, for chronic diseases, the co-payment is €2.50 plus 0% or 25% of the drug price; in the case of those aged 4–6, receiving disability or old-age pensions, or older than 63, the co-payment is 10%. In addition, there is a system for reimbursing the costs of prescription pharmaceuticals above certain levels: if the cost of the medicines per calendar year is €100-€300, then 50% of the cost is reimbursed to the person; if the cost exceeds €300, then 90% is reimbursed. Reimbursement takes the form of a discount on the medicines being purchased. OOP payments also include direct payments to non-contracted providers, and for services and products that are not part of the EHIF benefits package.

Informal payments have never been common in Estonia and continue to be relatively rare. A corruption survey by the University of Tartu (2011) concluded that the role of informal payments is marginal; 2% of patients acknowledged having paid informally to obtain faster access to care and about 3% paid after getting the treatment. In 2014, the European Commission published a report indicating that corruption in Estonia in general, but also specifically in healthcare, is lower than the EU27 average (European Commission 2014). The proportion of Estonian survey respondents saying that they were asked or expected to pay a bribe for using healthcare services was 1%, below the EU27 average (2%). Overall, informal payments do not appear to be widespread or of a significant magnitude.

2 Analysis of the challenges in inequalities in access to healthcare in the country and the way they are tackled

The previous section highlighted the main challenges in access to healthcare in Estonia – a high share of uninsured or irregularly insured persons; OOP payments, of which those for medicines and dental care make up the greatest share; and long waiting times. These are further analysed in this section.

2.1 Health insurance

The national health plan 2009-2020 (MoSA 2008) set a target for insurance coverage of 99% in 2012 and 2016, and 100% in 2020. However, actual insurance coverage is currently 94%, and there have been no major changes in total insurance coverage in the past decade (fluctuations have been within 2 percentage points).

Thus, the scale of non-insurance is rather high – 6%. It is estimated, based on different datasets, that the uninsured are mostly found among the working-age population who are economically inactive (58% of all uninsured people) or working abroad (19%). 69% are men and 31% are women. The highest proportion of uninsured persons (30%) consists of males aged 20 to 34. Another issue in Estonia is the continuity of insurance

coverage, which has triggered discussions on expanding coverage and improving the continuity of insurance coverage – including a debate on universal healthcare coverage.

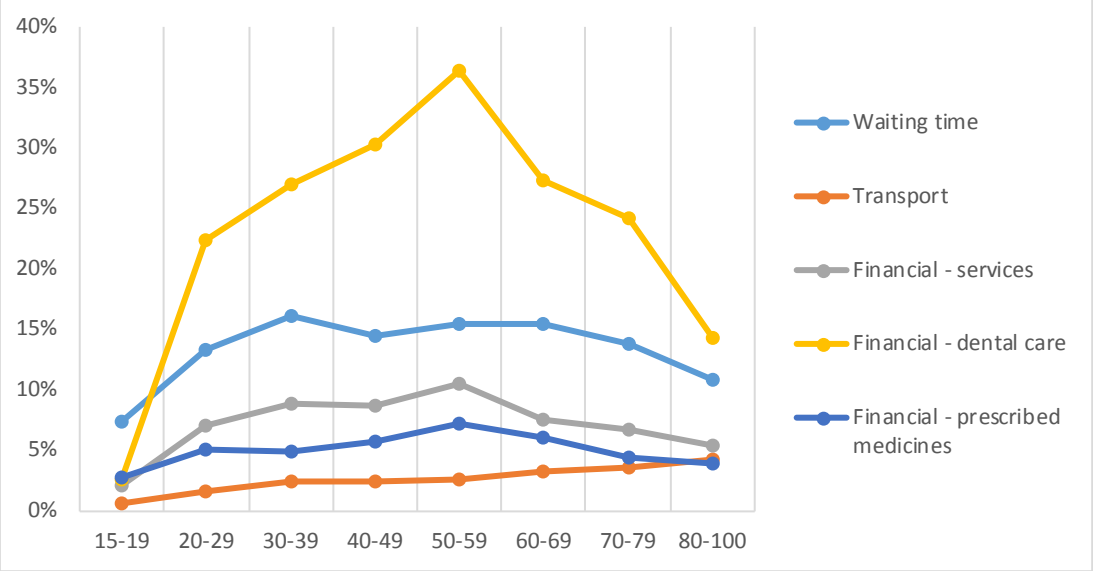
Since the end of 2002, uninsured people have been able to obtain coverage on a voluntary basis – it is possible to enter into a voluntary insurance contract with, and pay insurance premiums to, the EHIF. Voluntary members (about 555 people in 2016 according to EHIF) are entitled to the same benefits as compulsory members. The minimum contract is for one year, and coverage begins a month after the contract has been signed. The person signing the contract must pay an insurance premium equal to 13% of their average salary in the previous year. The premiums must be paid for at least three calendar months at a time. In 2017, this premium amounted to approximately €149 per month. This amount is considered high by Estonian standards, which helps explain why uptake is low.

2.2 Out-of-pocket payments

The OOP payments of households constitute more than a fifth of the total cost of healthcare, with those for dental care and prescribed medicines making up the largest share. In 2014, 41.8% of people reported using prescribed medicines (Eurostat table hlth_ehis_md1e).

An analysis by Võrk (2018) showed that OOP payments are most problematic for women and those aged 50-59. Older people as well as younger people face fewer difficulties regarding OOP payments (Figure 4). Multivariate regression analysis also showed that elderly people are more protected against high medicine and dental care costs. This is so due to somewhat more favourable compensation rates for pensioners compared with those for working-age people (Võrk, 2018).

Figure 4. Share of persons having problems with access to healthcare by age group, 2014

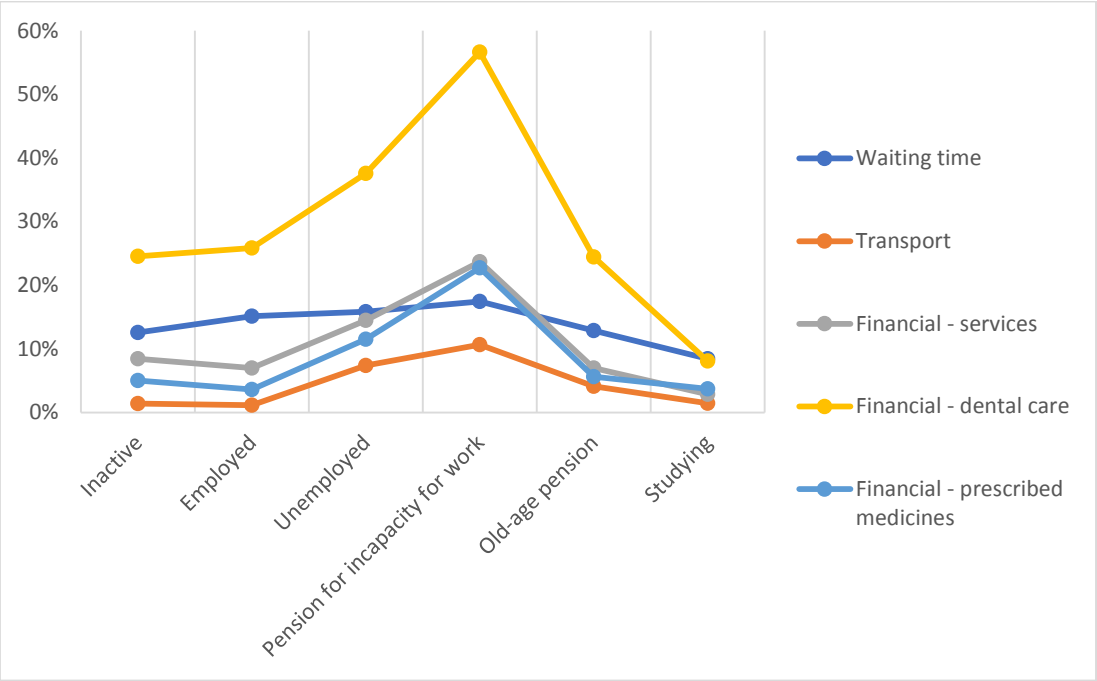


Source: Estonian Health Survey 2014[5], Võrk 2018.

Unemployed people and those with reduced work capacity find it more problematic to share costs with the EHIF, compared with those in employment, in education or on a pension (Figure 5).

[5] Data available here: http://pxweb.tai.ee/PXWeb2015/pxweb/et/05Uuringud

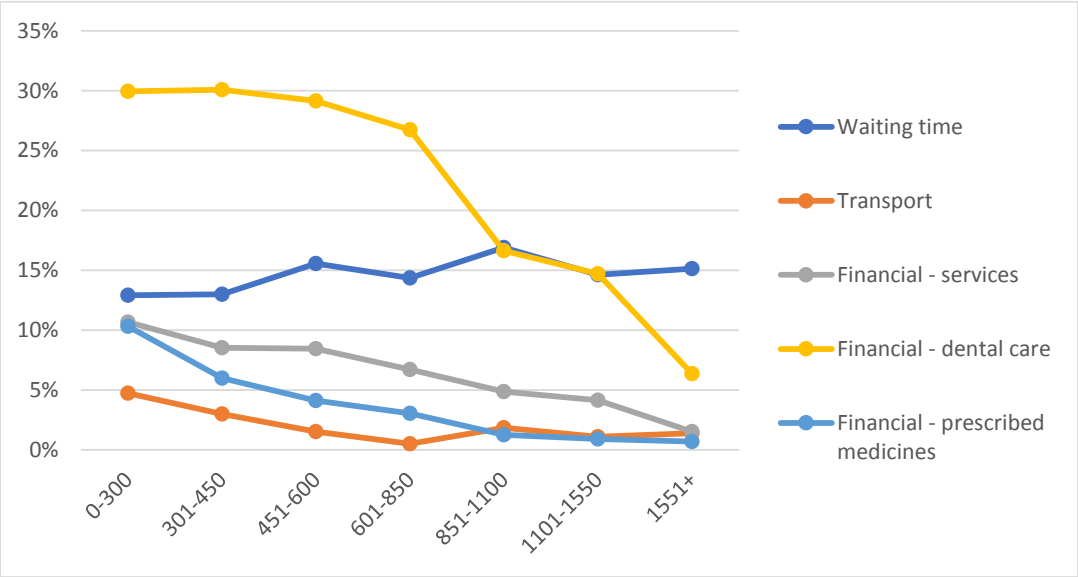
Figure 5. Share of persons having problems with access to healthcare by labour market activity, 2014



Source: Estonian Health Survey 2014, Võrk 2018.

The higher a person's income, the less likely they are in general to report having financial obstacles to accessing health services. The steepest gradient is visible in the case of dental care, although problems drop off sharply at incomes around the level of the national average net wage (around €1,000 in 2017) (Figure 6) (Võrk 2018).

Figure 6. Share of persons having problems with access to healthcare by income (with imputed income values), 2014



Source: Estonian Health Survey 2014, Võrk 2018.

Other surveys also confirm the fact that dental care is the most costly service for people. Among those who do not visit a dentist at least once a year (58% of the population),

nearly half (45%) find the service to be too expensive (Kantar Emor 2016). This proportion has remained the same during the last six years. Perceived problems are more frequent among women (52%, compared with 39% among men), and among those aged 40-59 (56-58%, compared with around 45% for younger people and 32% for older people). There are not many differences between regions, or in terms of urban vs rural areas.

In 2002, the EHIF's full compensation for adult dental care was replaced by cash benefits with a ceiling, which were further cut during the economic crisis in 2009 and made available only for some adult subgroups. Starting from mid-2017, however, in-kind dental care for all adults has been included in the benefit package again (see also section 2.4). The move from cash to in-kind benefits is expected to result in better price and quality control by the EHIF. Prescription medicines constitute 22% of household health expenses. As seen in the above figures, these are also more challenging to pay for in the case of people with lower income, unemployed people, people with reduced work capacity and those aged 50-59. In the case of older people, again, they have slightly more favourable conditions for buying medicines. Since 2015 a reimbursement system for prescribed medicines has been in place, described in more detail in section 2.4.

2.3 Long waiting times and financing challenges

People experience longer waiting times for specialised care than the maxima established by the EHIF – half of all patients cannot access services within the specified maximum waiting time. The results of analysis, surveys and statistical data all point to the same problem.

Surveys have shown that half of all people have reported waiting for a specialised service for more than a month, and 46% have had to wait for the maximum one month (Kantar Emor 2016). EU-SILC data show that self-reported unmet need for medical care due to waiting time has continuously increased since 2009 (2.9%) and reached 13.5% in 2016. Another survey, the Estonian Health Survey 2014, showed that in 2014, 18.6% of people in need of healthcare (14.1% of the total population) experienced unmet need for service due to long waiting times. It also showed that people in urban areas are more likely to report problems of access to services than in rural areas – e.g. 16% of urban people complained that they had waiting time issues, as against 10% of rural people (quoted in Võrk 2018).

Shortages of healthcare personnel differ across categories and locations. Areas where shortages are acknowledged to be an obstacle in service provision are psychiatrists (especially those specialising on addictions) and family physicians. Shortages are most acute in general hospitals in rural and remote areas, where visiting doctors from regional or central hospitals are being used to fill the gaps. A subsidy has been introduced to motivate young specialist doctors, including primary care doctors, to start their career in locations where it has been difficult to find qualified specialists. After graduation, 20% of University of Tartu medical graduates start by working abroad. Furthermore, the close proximity between Tallinn and Helsinki (two hours by ferry) even enables simultaneous part-time working in Estonia and Finland. Mechanisms or incentives to reduce emigration are lacking. In November 2016 a consensus agreement was reached between stakeholders to increase nurse training capacity to 517 in 2020, up from 350-400.

However, the real concern underlying both long waiting times and personnel shortages is the insufficient financing of the healthcare system, which has been pointed out since 2005. The EHIF has limited resources for paying for the services of insured people; as a result the full capacity of service providers is not covered by the EHIF. Some hospitals exhaust their contract volumes several months before the end of the contract period. As a result, for example, some hospitals only provide emergency care and postpone all

elective care to the next half-year (Õhtuleht, 2016[6]) The EHIF and providers now focus more on adequate contract planning and ex-ante monitoring to avoid this.

The main reason for insufficient funding is that contributions to the system are related to employment, whereas non-contributing individuals (e.g. children, unemployed people, and pensioners) make up more than half of the number of insured people. This has been a longstanding threat to the financial sustainability of the health system, as the narrow revenue base is mostly related to wages, at the same time as the population is ageing. The EHIF's budget has been in deficit since 2013; in 2016 the deficit amounted to €29.6 million, forcing the EHIF to use its accumulated reserves. Steps have been taken to mitigate this issue: see section 2.4.

2.4 Reforms

A number of changes have been introduced during recent years in order to improve access to healthcare. Firstly, some incremental changes have been used to expand health insurance coverage to additional (small) population groups, i.e. the partners of self-employed people who are active in their spouse's business activities (2012), and persons receiving creativity grants (freelance creative persons or artists) (2014).

Secondly, to improve the overall affordability of prescribed medicines, since 2015 additional reimbursement of the costs of prescription pharmaceuticals has been in place; this was widened further in 2018. If an individual's total expenditure on prescription drugs in a year is more than €100, the EHIF reimburses 50% of the OOP cost (from 2018); and if above €300, it reimburses 90% (since 2015). The co-payment (€2.50) is also included in the individual annual cap. The calculation and administration are automatic and take place at the moment of purchase.

Thirdly, since July 2017 adult dental care has been subject to a partial co-financing scheme in the form of an in-kind benefit. A new dental care benefit package includes the most essential dental services. For adults, a 50% co-payment applies, capped at €40 per year. A 15% co-payment capped at €85 per year applies to: persons over 63 years of age; pregnant women; mothers of children up to 1 year of age; persons with a greater need for dental treatment because of a particular condition (like diabetes); and persons eligible for a work-incapacity or old-age pension (previously they received cash benefits of €19.18 or €28.77 per year, depending on the target group).

Fourthly, to improve the sustainability of the healthcare system and tackle the EHIF's deficit, in April 2017 the government decided to expand the revenue base for the EHIF and to start making transfers for non-working pensioners. Transfers by the state will gradually increase from 7% in 2018 up to 13% of the state guaranteed pension in 2022. The additional revenue is expected to form around 11% of the EHIF's budget and provide around €200 million extra. The scheme does not involve an additional tax on pensions, but rather a state transfer calculated by reference to the actual total amount of pensions paid to non-working pensioners every month. This scheme ensures the necessary stability and should cover rising costs due to rapid population ageing. In addition, health services that were previously state-financed will become the responsibility of the EHIF, in order to reduce fragmentation and increase efficiency in purchasing. This means that state financing will be gradually transferred to the EHIF, and the EHIF will become responsible for financing emergency care for uninsured people, ambulance care, and HIV and drug dependency treatment, as well as other drugs and services that are currently financed from the state budget (Explanatory note, 2017[7])

[6] RAHAD OTSAS: Juuni lõpuni tuleb paljudel eestlastel suu planeeritud ravist puhtaks pühkida, *Õhtuleht*, 16.06.2016.

[7] Explanatory note for the draft act amending the Estonian Health Insurance Fund and other associated Acts 512 SE (2017).

2.5 Conclusions

Overall, it can be concluded that the main aspects that influence access to healthcare in Estonia are: firstly, the financing of the healthcare system; secondly, the rather low rate of insurance coverage; and thirdly, OOP payments by households.

Regarding financing, the issue has its roots in high levels of solidarity within the system, whereby roughly half of all people are not directly contributing to the system. Lack of funding results in long waiting times and unmet need for care. The problem is even worse in urban areas compared with rural ones. Although the issue of insufficient financing has been pointed out since 2005, the first steps to improve the system are only now being taken – with the state starting to transfer additional funds to the EHIF related to the number of non-working pensioners.

The incidence of non-insurance is around 6% and of irregular insurance around 11%. The first mainly concerns young men and the economically inactive population. Their capacity to pay for services by themselves is usually low; thus steps should be taken to find ways to give them insurance cover, either by changing the rules regarding health insurance contributions and widening the scope of residents considered equal to insured persons, or moving to universal healthcare coverage. A related analysis commissioned by the MoSA is currently in process.

Although in principle health insurance gives equal access to a wide range of services, cost sharing still influences the availability of these services. Unmet need for medical care due to cost is lower in Estonia than the EU average according to the EU-SILC data (1.1% vs 1.6% in 2016), but the data show more difficulties accessing dental care due to the high cost of the service. The cost of dental care is fully reimbursed for children and partially reimbursed for pensioners, leaving working-age people in the most vulnerable position. Working-age people also find it harder to afford prescription medicines than pensioners do, the latter having slightly higher reimbursement rates. The most vulnerable groups are unemployed people and those with reduced capacity for work, especially given that they have more need for services and medicines and/or they have lower income. The lower a person's income, the more difficult it is for them to share costs with the EHIF. Steps have recently been taken to mitigate these problems, by (re-)introducing partial dental care compensation for working-age people (and at the same time increasing it in the case of other groups), and changing the reimbursement of the costs of prescription medicines. Close monitoring is necessary so see whether these measures improve access and reduce income-related inequality in healthcare utilisation.

3 Discussion of the measurement of inequalities in access to healthcare in the country

The extent of unmet need for health services gives a good indication of the situation in Estonia with regard to accessibility. Although some surveys show slightly different results from the EU-SILC data, the overall proportion of people experiencing access problems is similar and it is therefore possible to make cross-country comparisons. The age dimension should be highlighted when presenting the data. For example, pensioners in Estonia have rather low incomes, and thus OOP payments should be challenging for them: however, they experience fewer difficulties than those aged 50-59, partly because they have slightly higher compensation rates for services like dental care and medicines.

The income quintile gap in healthcare access captures the situation rather well in the case of Estonia, as national studies (e.g. Võrk 2018) show that the higher a person's income, the fewer access problems persons perceive.

Figures for insurance coverage should be accompanied by estimates of those with only irregular cover.

The old-age dependency ratio (those aged 65+ to those aged 15-64) captures well changes in the burden under the solidarity-based system.

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