REPORT 2006

ESTONIAN HEALTH CARE

Health policy of the Republic of Estonia

Health is the most essential individual and national resource. Every person in Estonia has to have the possibility to live in a health supportive environment and make healthy choices, which are the preconditions for the formation of a healthy personality as well as for the successful social and economic development of the society. Enhancement of the socio-economic situation, a decrease in long-term unemployment, poverty and exclusion, and presence and improvement of the social guarantee system are the measures which help the health care policy to serve the interests of every individual.

To implement the mentioned aims, a national health policy has been initiated, which, in turn, has to be integrated with the housing, education and social welfare policies.

The health policy of the Republic of Estonia is based on several legal acts, approved by the state and in conformity with the general trends of the EU. (See Annex 1). According to the Constitution all Estonian citizens shall be entitled to state assistance in the case of old age, inability to work, loss of a provider, and need. The **Social Welfare Act** gives the aforementioned duties to local governments who will guarantee availability of the necessary services for all persons living in the territory of the local government.

According to the Social Welfare Act the persons receiving aid are the permanent residents of the Republic of Estonia. Permanent residents are considered to be the Estonian citizens and foreigners residing in Estonia who have a permanent residence permit. Foreigners with a temporary residence permit should, according to law, receive assistance only if a respective international agreement has been entered into. An exception applies for the foreigners with a permanent address registered before July 1, 1990, who have the right to receive social services and social benefits and other assistance until the end of the legal term in Estonia. A foreign citizen or stateless person of Estonian origin, who has settled in Estonia after August 20, 1991, and their spouse and children are entitled to receive social services and social benefits and other assistance similarly to Estonian residents.

A principal aim of the health policy for the year 2015 is to considerably raise the average life expectancy, which today is one of the lowest in Europe – up to 60 years for men and up to 70 years for women. (See Annex 2).

> *Compared to the average figures of the old EU member states, cardiovascular and cancer morbidity and mortality are significantly higher. The number of avoidable traumatic deaths exceeds the respective figure by more than four times. In Estonia, mortality of children under 14 years of age due to injury and intoxication is higher than in other EU member states. Frequency of incidences of mental and addictive disorders is ever increasing. Suicide has*

become the main cause of death among 15-29-year-olds. What gives reason for concern is the fact that Estonia keeps ranking first in the number of new HIV incidences and every 100th Estonian in the age group 15-49 is estimated to be HIV-infected. Multiresistant tuberculosis is another problem, whereas Estonia is amongst the first in the world as to the spread of the disease. Morbidity of tuberculosis in HIV-infected persons is broadening, the number of HIV-positive pregnant women is also increasing.

Availability of health care services

Being guided by one of the aims of the health policy – to secure the availability of quality health care services to all in need, the **ways to achieve the aim** are the following:

a) to secure the health care services and health insurance prescribed by the state to all Estonian residents;

b) to determine the obligations of the state and employees, and people's self-responsibility for using health care services and paying for these;

c) to reach agreements between the county and local governments concerning guaranteeing health care service provision;

d) to expand and increase the availability of elderly care and medical rehabilitation services, taking into account the share of the aging population and increasing chronic diseases;

e) to enhance operative cooperation between different health care service providers;

f) to make disease prevention and health promotion services considerably more available (regular health examination, systematic screenings);

g) to secure access to special medical care for children with special developmental and educational needs according to their needs.

Availability of health services in Estonia is unevenly spread.
Persons with higher income in general have better availability to health care services than those with lower income. This inequality is increased by the fact that after illness the patient's own proportion in covering the costs related to using health care services is among the biggest in the European Union. Studies have shown that the structures of health care expenditure of the poorest and the richest strata of the population are different. If the expenditures of the poorest households have been made on medications in first order, the richest people can afford to spend on dentistry and other paid services. The vulnerable group also involves persons exclusive of health insurance, who make up about six per cent of Estonian population (ca 80,000 persons) and for whom only unavoidable medical care has been guaranteed today.

When taking a look at the target group of homeless people, we have to take the following circumstances into account:

The number of homeless people in Estonia is estimated to be 3,500, which is approximately 0.3% of the population. A connection between the status of the homeless and health is bi-directional: bad health may be a precondition for staying homeless and being homeless may cause health problems. As health cannot be understood as a medical or biological term only, it should be observed in a broader social, economic, political and cultural context. Good health, thus, depends on a number of factors: income and social status, social support network, education, work conditions, physical environment, genetic features, coping skills and health care services. In case of the majority of the homeless these features are inadequate.

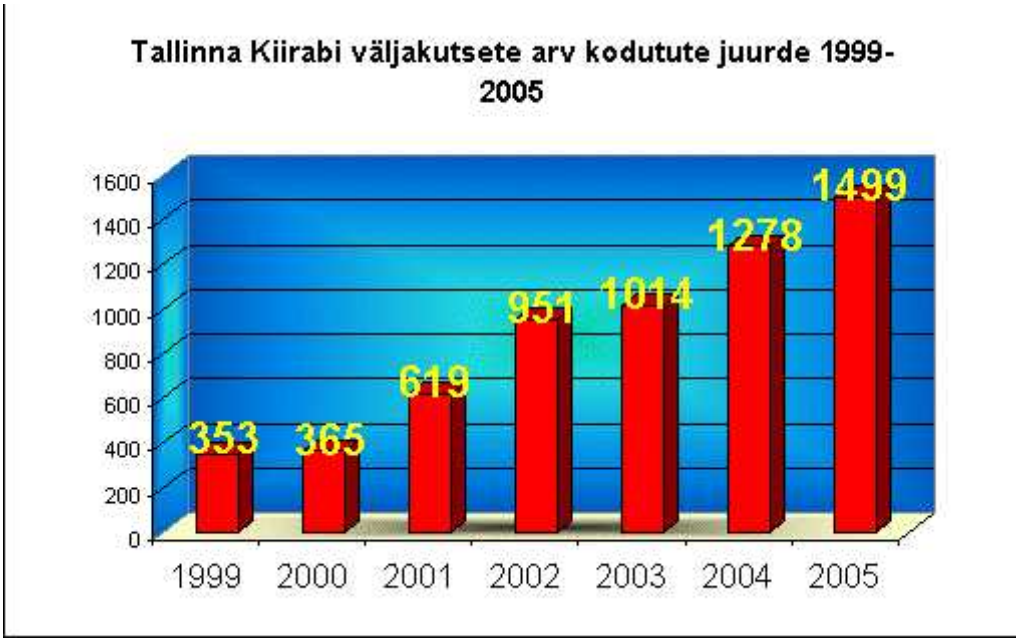
The homeless face several obstacles in their access to medical services. A frequent one is the absence of a valid identification document, absence of health insurance and inability to pay for the prescribed medicines as well as arbitrary termination of treatment in a medical institution, which often relates to addictive behaviour and violation of social rules.

94% of the Estonian population is covered by health insurance, which covers their health care expenses. Therefore, the availability of health care services does not depend on solvency, but the state of health of a person and their need for medical care. Expenditure for the uninsured 6% of the population on unavoidable medical care and, to a certain extent, family health care is covered from the state budget and this expenditure shows a trend of fast growth.

Persons who receive old-age pension or incapacity pension are automatically classified as health insured persons. Thus, the homeless status itself does not exclude health insurance and adequate treatment to go with it. The problem often is the unaffordable cost of treatment. The need for dental care is especially burning. Dental services are for pay, an uninsured person has access to emergency care only if their condition is life-threatening. Problems also occur in sending to specialised physicians, where very long treatment queues exist with regard to planned operations, a lot of medical services have also become paid services, which presumes patient's own share, i.e. paying for the services partially or in full.

Health behaviour of the homeless usually contains no skill to avoid hazardous situations or life styles, therefore, moving to another place of residence often becomes an essential factor of health deterioration. The cold weathers of winter periods constitute a supplementary risk factor for a person whose health is weakened and who is vulnerable to infections, as a result of which the departments of unavoidable medical care departments are often overloaded.

The following tables prepared by Tallinn Emergency Medicine Service are very informative, reflecting the unavoidable help calls by the so-called homeless persons, and reasons for calls:

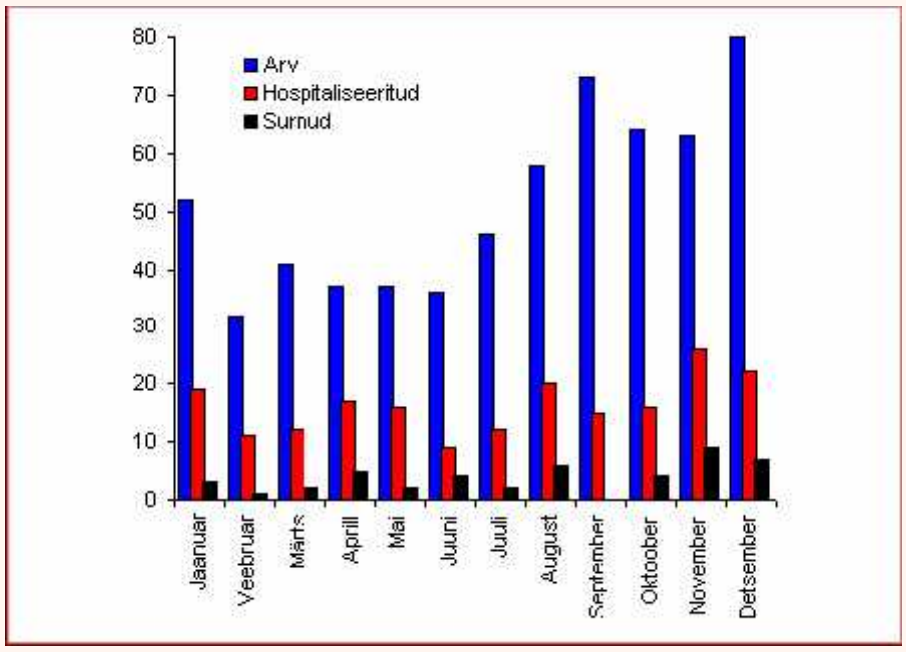


Number of calls by the homeless to the Tallinn Emergency Medicine Service 1999-2005

Statistics of 2001

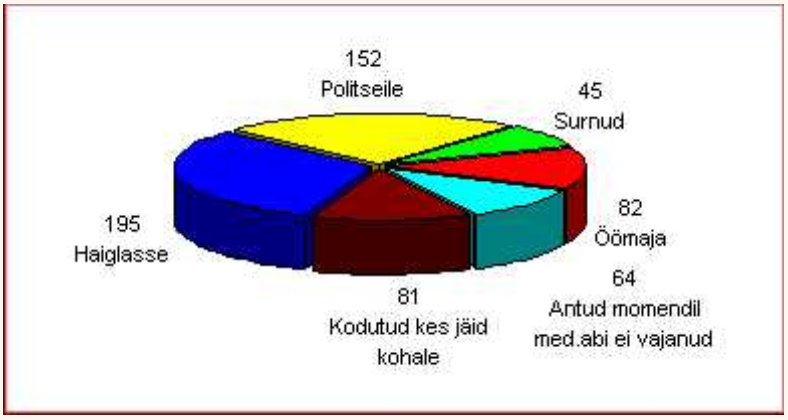
Calls from the "homeless"

	No.	Hospitalised	Dead
January	52	19	3
February	32	11	1
March	41	12	2
April	37	17	5
May	37	16	2
June	36	9	4
July	46	12	2
August	58	20	6
September	73	15	0
October	64	16	4
November	63	26	9
December	80	22	7

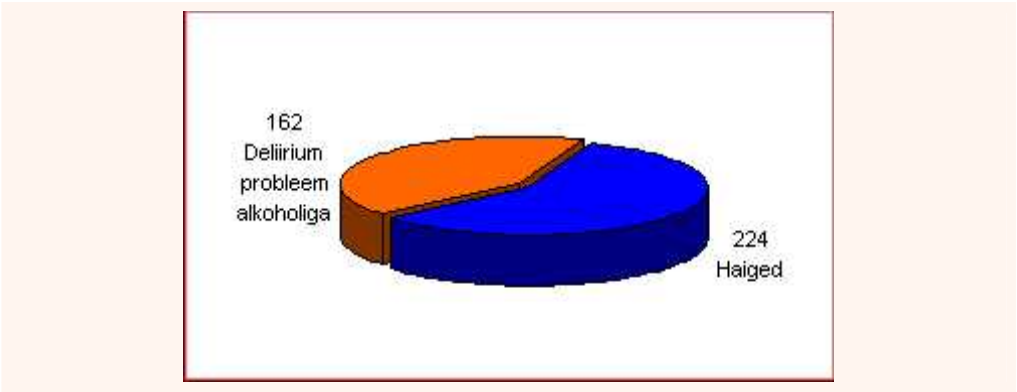


Number
Hospitalised
Dead

January
February
March
April
May
June
July
August
September
October
November
December



195 to the hospital
152 to the police
45 dead
82 accommodation
64 did not need medical aid at the given moment
81 homeless who stayed



162 Delirium, problem with alcohol
224 sick

Source : www.tallinnakiirabi.ee

The last table gives quite an informative picture of the addictive behaviour of the homeless and damages caused by that.

Health care problems of the homeless

Studies prepared for the target group of homeless people have shown the main health care problems: frequent chronic diseases of lungs and respiratory track (incl. refractory or resistant tuberculosis, skin diseases, feet and teeth problems).

Additionally, long-lasting alcohol consumption and food of low nutritional value have resulted in damages of internal organs (liver, stomach) and disorders of the nervous system. Beside this, these are often individuals with an undiagnosed and untreated mental health disorder or a widespread personality disorder.

Such a complex of problems makes it difficult to determine the right treatment for the homeless.

It is also difficult to motivate a homeless person to change their lifestyle and routine, being guided by personal liberty and real situation.

When trying to categorise the homeless according to the so-called ETHOS categories, the health problems of the homeless, in general terms, are as follows:

Category of a homeless person	Health problems

1. **Without shelter** (living in the hostel for the homeless)	Mental disorders, depression, suicidal behaviour
	Contagious diseases, infections, incl. skin diseases
	Personality disorders, criminal behaviour – traumas

	Need for dental care
	Physical disability (legs, frozen limbs)
	Chronic alcoholism and diseases caused by that
	Chronic and seasonally acute diseases/inflammations

2. **Without home** (living in social accommodation places, rehabilitation centres, shelters)	Diseases causing inability to work (documented incapacity for work)
	Physical disability, foot problems (amputated due to freezing), eyesight (eye damages)
	Alcohol-related health disorders
	Narcotic drug addiction-related health disorders
	Chronic diseases, incl. those needing constant medical examination and treatment (liver, stomach, lungs, etc.)

3. **Unstable housing** (living with relatives, friends, acquaintances, living on spaces subject to eviction, incl. persons who illegally use a space, persons released from prison)	Mental disorders
	Alcohol damages
	Chronic diseases needing treatment
	Physical disabilities (legs, eyesight)
	Skin damages

4. **Inadequate housing** (living in deserted houses, inhabitable places)	Diseases resulting from an unhygienic environment, incl. body parasites, skin damages
	Different traumas
	Untreated chronic/acute diseases
	Mental health disorders and other health disorders and intoxications caused by the use of surrogates
	Contagious diseases, incl. tuberculosis

The self-assessment of the homeless concerning their health is usually higher than the objective indicators. The first problem mentioned is a need for dental care, which is followed by concern for feet. There is very little complaining about digestive disturbances, which is inadequate, taking into account the nutrition of the homeless. Such an estimate is related to violation of the requirements of hygiene and nutrition, which refers to the lack of social skills and diverging behaviour as compared to generally acknowledged principles.

Consumption of addictive substances

In Estonia, more than each tenth person happens to abuse alcohol. From year to year expenditures for alcohol abuse related health problems increase.

It has become clear that alcohol abuse relates with high costs on health care, social assistance and crime-related losses. In the countries where losses have been calculated, it has become evident that the amounts are tens of times higher than those of income received from the sale of alcohol. An alcohol policy preventing losses has gained more and more importance among EU member states in the last decades.

In order to prevent losses relating to alcohol consumption, the government of the Republic approved on November 25, 1997, a national alcoholism and drug abuse prevention programme for the years 1997-2007. In this document the government set up the main aim with regard to alcohol – to establish an alcohol policy which is based on programmes and other national documents and is meant to decrease losses resulting from consumption.

The objective of the World Health Organisation (WHO) is to reach a decline in alcohol consumption by 2021, where no more than six litres of alcohol a year would be consumed per person.

In 2002 there were 21.72 cases of chronic liver diseases and cirrhoses per 100,000 inhabitants. There were 38.34 alcohol-related traffic accidents per 100,000 inhabitants. (Source: WHO)

Sale of vodka grew by 88% in 1999-2002 in Estonia
80% of 15-year-old students have consumed alcohol
12.4 litres of pure alcohol was used by every passport-aged person in 2003
10,191 persons visited a doctor due to mental or behavioural disorder caused by alcohol
75% of convicted criminals were drunk during killing or an attempt to kill
66% of severe bodily injuries have been caused by drunken criminals

(Source: Estonian Human Development report, 2003)

The number of deaths caused by alcohol intoxication is three times higher in Estonia than the European average.

Out of those who died at the consequences of a trauma, 66% had consumed alcohol prior to it, in 28% of cases, alcohol measurements had not been done (Estonian Centre of Medical Forensic Science).

Economic loss due to alcohol-related injuries grew in 2001 by 50%, compared to 2000.

In Estonia, the set of problems connected with narcotic drug abuse is a relatively new phenomenon, growing in the last years of the 20th century into a problem which needs a fast solution. Although the number of drug addicts is in clear minority compared to the number of homeless people, the problem shows an increasing trend and, therefore, needs a solution.

Tuberculosis

According to the World Health Organisation 1/3 of the world population is infected with tuberculosis, 5-10% of these fall ill every year. The total number of people taken ill with tuberculosis every year is 7-8 million. In the years 1993-1996, morbidity with tuberculosis in the world increased by 13%.

According to the estimates of the WHO the success of the tuberculosis mitigation strategy is based on five key factors:
1) government's support to TB prevention and treatment;
2) attention paid to the detection of cases of tuberculosis in risk groups and among people with possible symptoms of TB;
3) use of standardised treatment schemes in the directly checked treatment system;
4) a continuous supply of all diseased people with necessary TB medications;
5) a uniform control system of registration of cases of illness and treatment quality.

In Estonia, tuberculosis morbidity started to grow in the 1990s. In 1997, 51 new TB cases were diagnosed per 100,000 inhabitants, which is nearly 10 times more frequent than in the Nordic countries. The danger of re-emergence of tuberculosis epidemic in Estonia was related to the use of insufficient treatment and incorrect treatment schemes, which in turn resulted from the loss of vigilance over tuberculosis in the society as a whole, first and foremost in the health care system.

Catching TB is facilitated by HIV-infection, which weakens the immunity system. An HIV-positive person is 30 times more likely to fall ill with tuberculosis than an HIV-negative. An HIV-infected person may have tuberculosis without symptoms, which is a reason for delayed diagnosis. Treatment of tuberculosis in HIV-infected and AIDS-diseased persons is more complicated due to the side effects of medications. Treatment of HIV-infection with anti-virus medications does not reduce the risk of falling ill with tuberculosis.

As a result of this, the National Tuberculosis Control Programme for the years 1998-2003 was initiated, consisting in the following:

1) a directly controlled treatment system – ORK – was established (daily administration of TB medication in the presence of a nurse or social worker in a health care institution or at the home of the diseased person) as well as treatment of tuberculosis, taking place in strict conformity with standardised treatment schemes;
2) all TB-diseased persons were secured with free availability of necessary TB medications via national purchases of medications;
3) TB laboratory services were rearranged in order to guarantee preciseness and economy of microbiological diagnostics of tuberculosis;
4) inpatient departments of tuberculosis were rebuilt and supplied with up-to-date ventilation systems to reduce the danger of infection;
5) TB treatment in custodial institutions was rearranged and by today morbidity with tuberculosis has decreased by a half;
6) the tuberculosis register was created, enabling exact monitoring of the dynamics of morbidity and efficiency of the used treatment schemes, and help guarantee that no TB-diseased person would remain without treatment when moving into another place

of residence or after release from a custodial institution. (basis: “National Tuberculosis Control Programme 2004-2007”)

There is a currently functioning extensive tuberculosis prevention campaign in Estonia, in the course of which TB examination was established, obliging all clients of overnight hostels, shelters and social accommodation units to pass a free tuberculosis examination twice a year. Should treatment be necessary, it would be free and obligatory to all persons irrespective of their health insurance.

At the moment there are no medical institutions meant specifically for the homeless. Persons without health insurance can receive free treatment in Tallinn Magasini Hospital, which is a care hospital for uninsured persons. An outpatient reception is present in the same hospital.

Knowledge-based social work and health care

Health workers of the Republic of Estonia get in-service training in the **National Institute for Health Development**. The National Institute for Health Development (NIHD) is a national research and development institution, administered by the state, established on May 1, 2003, on the basis of thee institutions: Institute of Experimental and Clinical Medicine, Estonian Centre for Health Education and Promotion, and Centre for Public Health and Social Training, and is the legal successor of these institutions.
The task of NIHD training centre is to improve and enhance the professional and vocational skills of health care and social workers, offering up-to-date high-quality training. Development of training programmes is based on the andragogical model, need for training and the interests of trainees as well as previous experience are monitored.

Training sessions handling the problems of the homeless have either health care of social welfare orientation. Training sessions are usually directed to persons working with risk groups. The sanitary cleaning performed in medical institutions / hospitals is a medical service which is provided by hospitals to persons brought there in the framework of unavoidable medical care. As the medical sphere and social welfare employ specialists of these areas, the professional education of employees of these areas is linked to trainings and courses relating to different risk groups. Therefore, it can be said that the specialised personnel of hospitals, shelters and overnight hostels (social workers with higher education, psychologists, physicians and nurses) are specialists with specialised education and target group aware base education.

Specialised higher education for social workers and medical staff provided by Estonian higher education institutions contains special courses on handling persons who fall into the risk groups of the society.

According to needs and possibilities, the local government has also organised special training courses for non-specialists handling homeless persons, narcotic drug addicts and other risk groups. Training usually relates to the specific features of work, dealing with first aid, primary level counselling and themes related to identifying the

condition of clients with special needs. Training is usually conducted by licensed trainers in co-operation with service providers.

The journal "Sotsiaaltöö" (Social work) constantly reflects the current topics of Estonian social work. The journal gives floor to the specialists of their own areas, introduces new studies and the wide circle of problems related to the target groups of social work. Topical changes in legislation and other necessary additional material for social workers raise their professional competence and give good results in everyday work.

To sum up

Health has to be regarded as a fundamental right of a person, meaning that the society has to guarantee preconditions to all people for achieving a possibly good state of health. The right to health protection, the right to safe life, study, work and psycho-social environment has been established in our Constitution, the Treaty establishing the European Community, European Social Charter and many other international documents. Article 152 of the EU Treaty of Amsterdam places high-level health protection superior in the cases of all decisions, projects and programmes, which may influence people's health.

Every decision (political, economic etc.) **has an impact on the health of the population** and every decision-maker on any level and in any sector has to take responsibility for developing their own and the population's health when planning their activities. In the documents adopted in World Health Forums (Jakarta Declaration, 1997, Adelaide Recommendations, 1988, Bangkok Charter, 2005, etc.) set the theme of responsibility in the centre. Governments and all other decision-makers are responsible for the consequences of their policies or absence of policies, revealing in the health of their people. The national health policy obliges the government to measure the impact of their political decisions on health and report the results in a language that is easily understood by every member of the society. Responsibility for the popular health is joint responsibility that includes all sectors, organisations, groups and individuals of the society.

Equal health possibilities reflect social justice. Social justice prevents systematic and injustice-generated differences in the health indicators between social groups. The activities of all social sectors and levels in implementing the health policy has to be, first of all, directed to the most vulnerable social groups, in order to provide them with access to necessary health information and create them preconditions and facilities to fully develop their health potential. Generation of equal possibilities in terms of education, housing, work, health and health care services, irrespective of gender, nationality and social position, are preconditions for the continuous improvement of the health and quality of life of the Estonian residents.

All persons have uniform rights and possibilities for the availability of health care services irrespective of their age, gender, place of residence, special needs or social background. In the conditions of limited resources one group of population or one person can only be preferred on the basis of their health needs. Availability and quality of health care services is important for each person. Development of the health care system and securing its sustainability are possible, provided that duties are equally divided between the state, local governments, providers of health care services, employers and people.

Health problems of the Estonian population are serious.

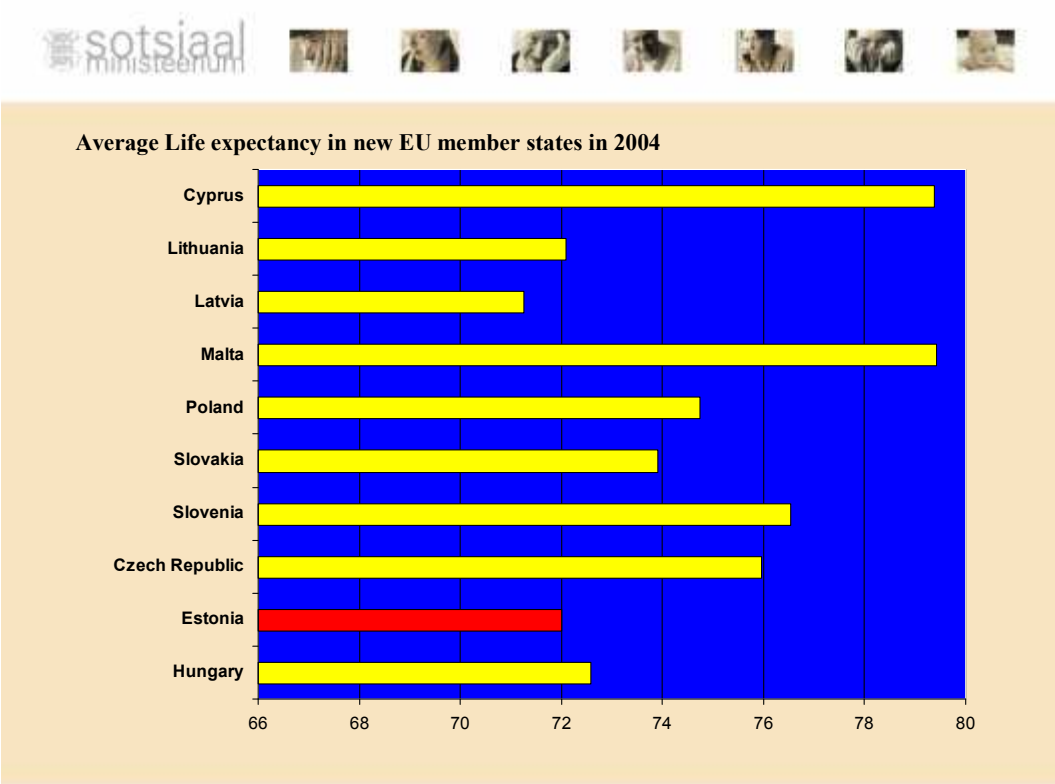
The health policy is no more one option out of several. This is a duty of the whole society, requiring commitment of every sector and level. The reasoned health investments and joint activities of all of us for applying the health policy may bring about positive changes in the public health and well-being already in near future. The reasonability of our today's decisions and activities will be evaluated by the health and well-being of future generations.

Annex 1 Implementing acts of the Health Policy

Implementing acts of the Health Policy

- Child Rights Protection Strategy
- National Programme of Research and Development in Public Health for the Years 1999 - 2009
- National Tuberculosis Control Programme 2004 – 2007
- National HIV/AIDS Prevention Programme 2020
- National Strategy on the Prevention of Drug Dependence 2012
- National Heart Disease Prevention Strategy 2005-2020
- National Cancer Strategy (under preparation)
- Development Plan "Estonian Food" („Eesti toit", under preparation by Ministry of Agriculture)
- Physical Activity Strategic Governmental Action Plan 2006-2010 (under preparation by Ministry of Culture)
- National Sustainable Development Strategy
- Environment Strategy 2030 (under preparation by Ministry of Environment)
- Chemical safety strategic action plan (under preparation)
- Mental Health Policy Basic Document
- Primary Health Care Development Plan (under preparation)
- Hospital Master Plan
- Estonian Long-term Care Development Plan 2004 - 2015
- Rehabilitation Medicine Development Plan
- Medical and Nursing Specialities Development Plans
- Estonian Emergency Services Development Plan 2000-2010
- National Action Plan for Social Inclusion 2004-2006
- Action Plan for Growth and Jobs 2005-2007
- Implementation Plan of the Lisbon Strategy

Annex 2 Average life expectancy in new EU members states in 2004



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