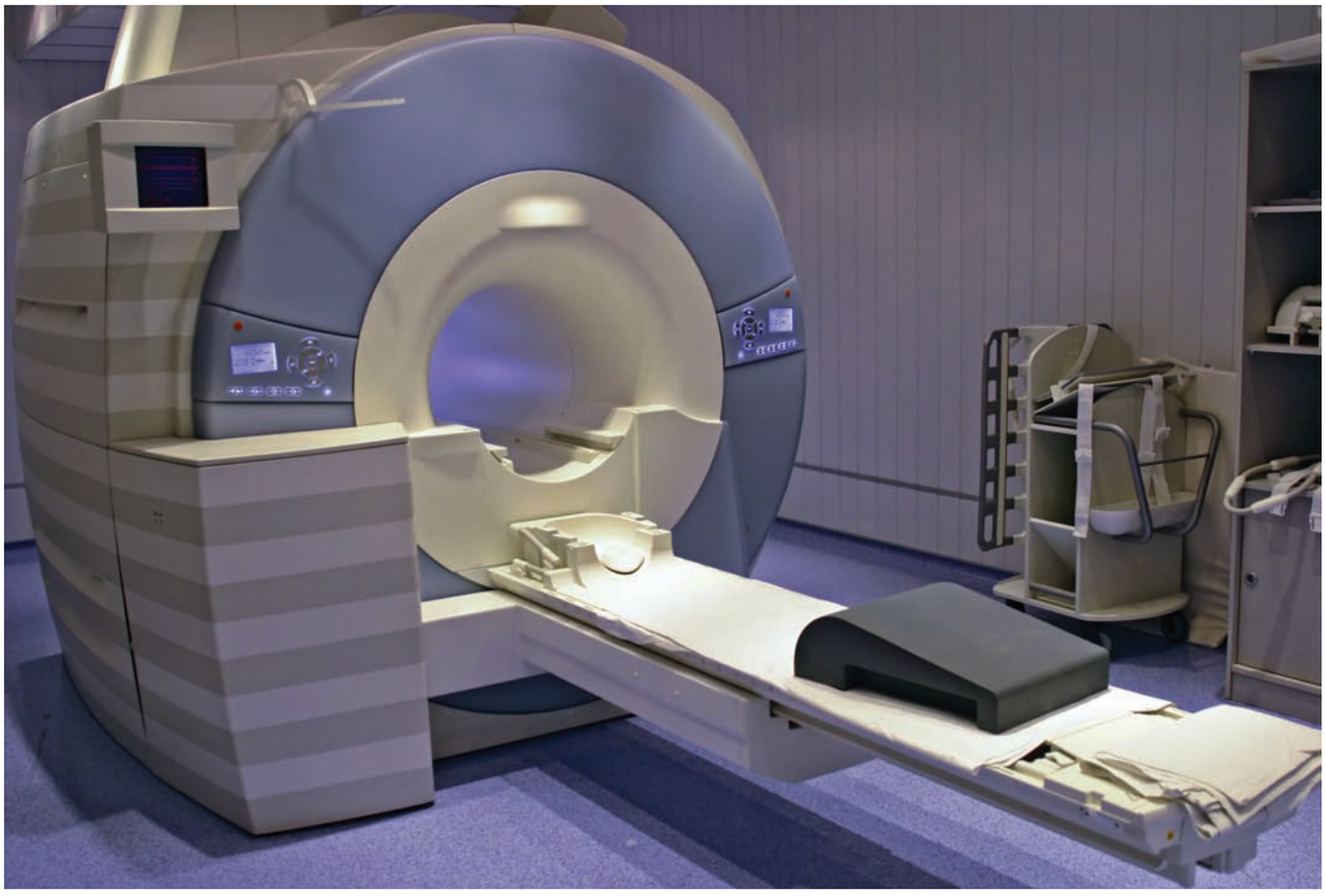

Estonian Health Care Expenditure in 2011

Tervise Arengu Instituut
National Institute for Health Development

National Institute for Health Development

Department of Health Statistics

Health Expenditure in Estonia 2011

Tallinn

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Please note! As normal for statistical analyses, there may be slight corrections possible in this analysis during a year. Please refer to the web versions (analysis at www.tai.ee and data at www.tai.ee/tstua) when using the report and the data.

BRIEF OVERVIEW

1. The share of total health expenditure (THE) comprised 5.9% of gross domestic product (GDP) in 2011.
2. Total health expenditure at current prices comprised EUR 944.6 million in 2011.
3. Compared to 2010, THE increased by 4%, or EUR 36.7 million.
4. Public sector expenditure on health comprised 4.7% of GDP.
5. Public sector expenditure on health comprised 79.3% of THE.
6. The Estonian Health Insurance Fund expenditure comprised 68.6% of THE.
7. Private sector expenditure on health comprised 19.2% of THE.
8. Households out-of-pocket (OOP) expenditure comprised 91.3% of the private sector health expenditure and 17.6% of THE.
9. Expenditure on medical products comprised 60.7% of OOP and expenditure on dental treatment 22.7% of OOP.
10. Rest of the world expenditure comprised 1.4% of THE.

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INTRODUCTION

This analysis is a part of the series “Health Expenditure in Estonia”, published by the National Institute for Health Development. The current analysis provides a brief overview of health expenditure in 2011[1].

The objective of the analysis is to give information about how the health care system is financed through different sources of funding, providers of health services and health care functions, using the methodology developed by the OECD (Organisation for Economic Cooperation and Development) – System of Health Accounts (SHA)[2].

According to SHA, health expenditure includes such health-related services as curative care, rehabilitative care, long-term nursing care, occupational health, medicine of the Defence Forces, health care in prisons and administration of health in the public and private sectors. However, total health expenditure (THE) does not include the expenditure of education and training of health personnel, health research and development, environmental health and other services, where the principal activity is not improvement of health. The analysis only includes expenditure on inhabitants of Estonia. It means that THE does not reflect the cost of health services provided to foreigners and the cost of medical goods purchased by foreigners.

The report can be used by all institutions and persons interested in the sphere of health funding, and by the wider public. The author is grateful to all the people who provided information and helped to prepare this analysis.

[1] The terms ‘total health expenditure’ and ‘health expenditure’ are used as synonyms in this analysis. Similarly, the terms ‘expenditure’ and ‘expenses’ are used as synonyms.

[2] The OECD methodology – System of Health Accounts (SHA) or National Health Accounts (NHA) – is used in more than 100 countries.

1. SOURCES OF HEALTH CARE FUNDING

Total health expenditure (hereinafter THE) comprised 5.9% of gross domestic product (hereinafter GDP) in 2011 (Table 1). The share of THE in GDP decreased by 0.4 percentage points compared to the previous year. This drop was due to significantly higher growth rate of GDP than the one of THE.

Table 1. **GDP in current prices and THE, 2000–2011**

Year	GDP, million EUR	THE, million EUR	THE as percentage of GDP
2000	6 159.8	328.9	5.3%
2001	6 970.9	342.2	4.9%
2002	7 776.3	380.8	4.9%
2003	8 718.9	435.4	5.0%
2004	9 685.3	497.4	5.1%
2005	11 181.7	561.6	5.0%
2006	13 390.8	671.8	5.0%
2007	16 069.4	829.1	5.2%
2008	16 235.1	983.5	6.0%
2009	13 761.7	968.7	7.0%
2010	14 322.7	908.0	6.3%
2011	15 951.4	944.6	5.9%

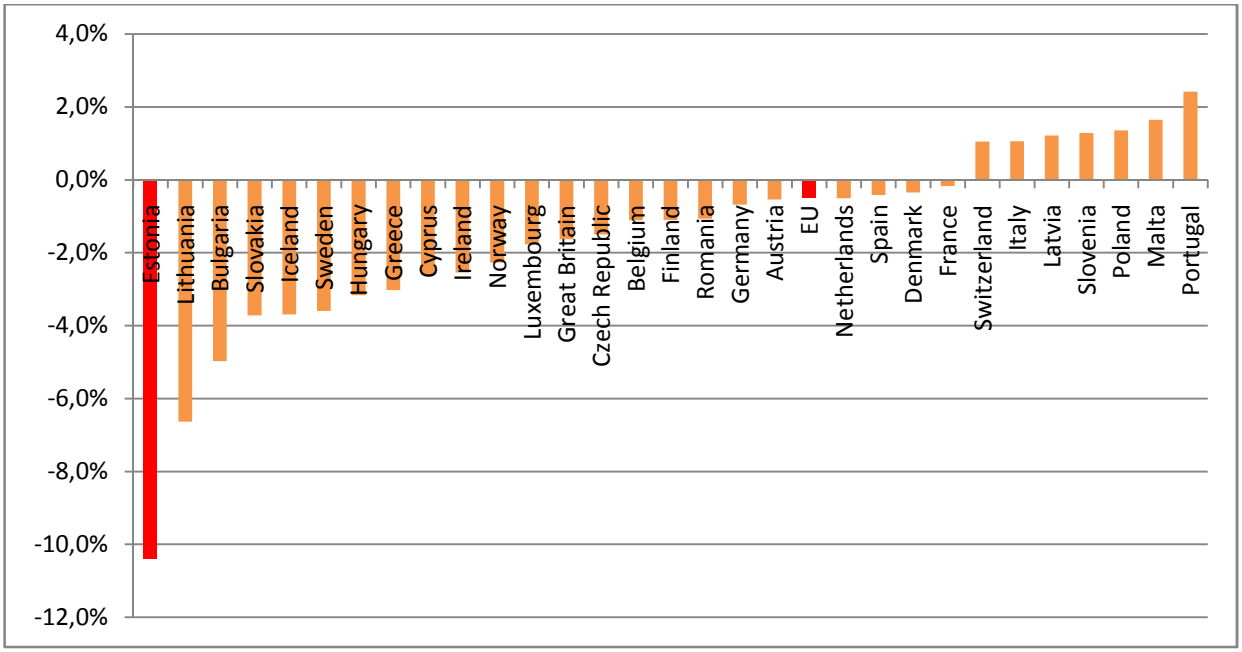
Source: Statistics Estonia, NIHD DHS

Viewing the share of THE in GDP from 2000, it reveals that the share of THE remained within 5% in the first half of the period under consideration. A significant growth took place in 2008, and in 2009 the share reached its peak at 7%; in 2010, the indicator dropped to 6.3% and continued to decrease in 2011. In 2011, the absolute amount of THE increased by EUR 36.7 million and 4% relatively to EUR 944.6 million.

GDP increased 11.4% in 2011. In the first half of the year, economic growth was led by mainly manufacturing industry; in the second half, the fields of construction, information and communication industries started to contribute increasingly more [5].

Health care systems are always accompanied by significant expenditure. Until 2009, health care expenditure grew faster than general economy in the European countries. After the beginning of the economic crisis in 2008 several European countries took various steps to slow down the increase in health care expenditure with an aim to reduce deficit in the budget. At that, the share of THE to GDP decreased in most of the European countries in 2010 (figure 1).

Figure 1. **Changes in THE towards GDP, 2009–2010**

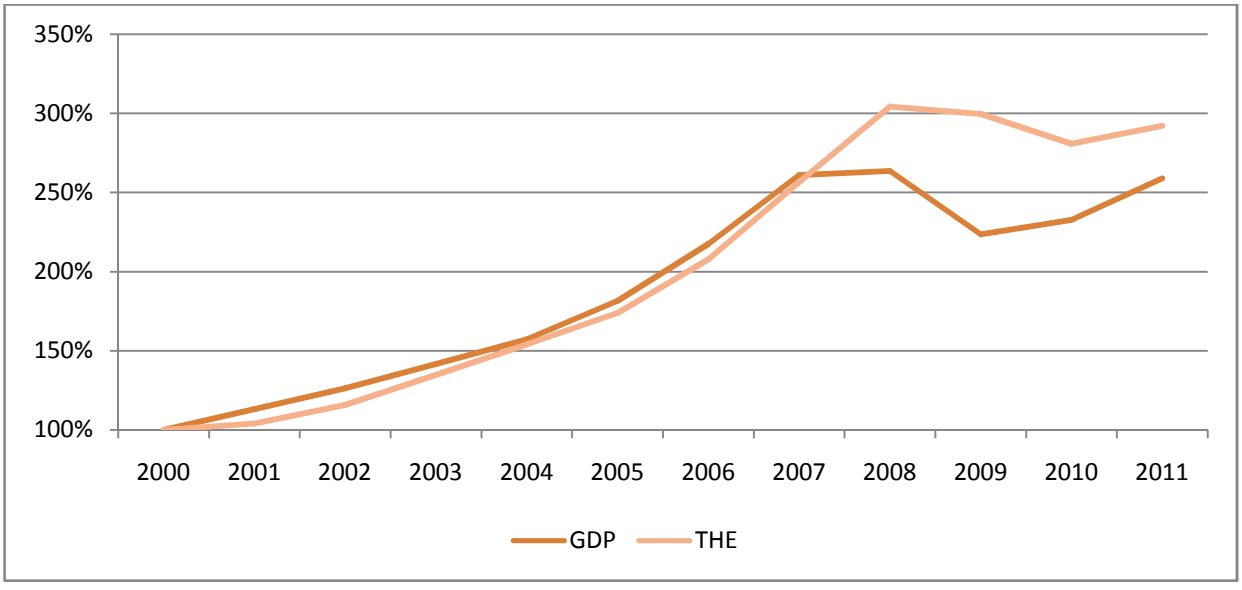


Source: *WHO health for all database*

The largest drop in the share of THE took place in Estonia – 10.4%. In the European Union, the share of THE decreased by 0.5% on average. At the same time, there were countries in which the share of THE towards GDP increased even in 2010.

The share of THE in GDP depends on the absolute indicators of both THE and GDP. When we index both of the Estonian indicators to the level of 2000, it occurs that both THE and GDP increased at a relatively similar pace from 2000 to 2007 (figure 2).

Figure 2. **Indexed values of GDP and THE, 2000=100%, 2000–2011**

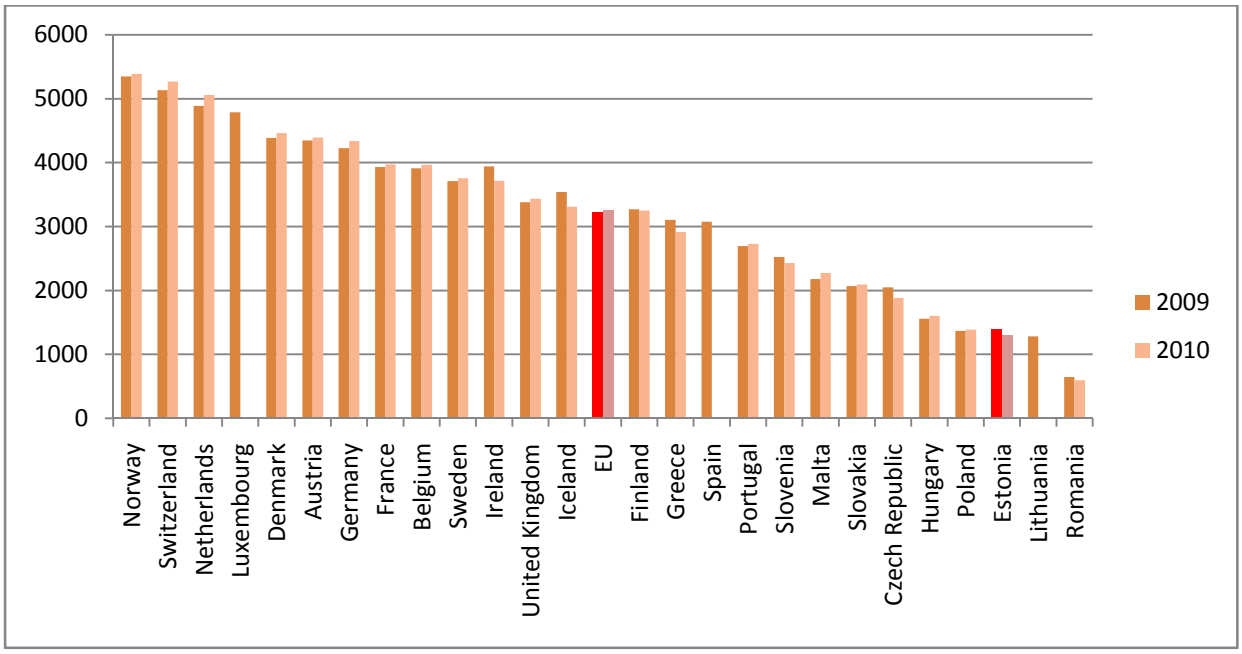


Source: NIHD DHS

An important deviation took place starting from 2008 when the impact of the economic recession significantly slowed down the growth of GDP while THE continued its relatively stable growth. The economic crisis had its effect on health care system in 2009. The following year, THE achieved its lowest level of the short run, caused by the need to mitigate the budget deficit due to significant cuts by the government.

In health care expenditure per person in the European countries in 2009 and 2010, two tendencies can be seen. In countries with higher health care expenditure per person the health care expenditure usually continued to increase also in 2010. At the same time, in countries with lower health care expenditure per person there were considerably more occurrences of the 2010 health care expenditure being lower than the one of the previous year. In terms of percentage, health care expenditure per person decreased the most in Czech Republic, Romania, Estonia, and Iceland (figure 3).

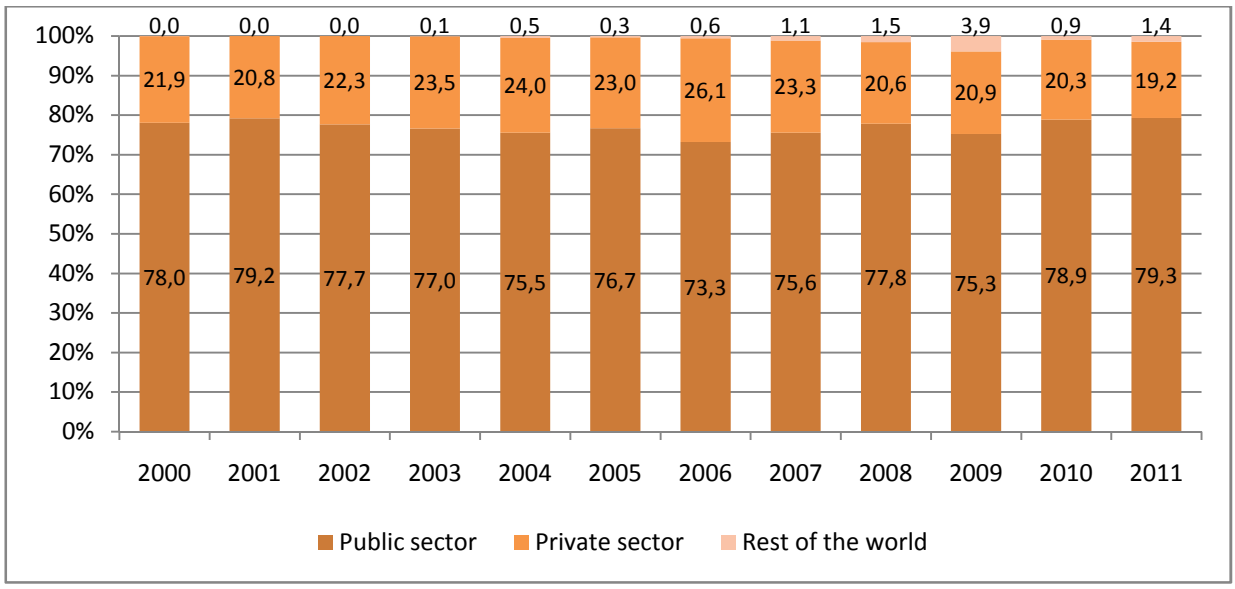
Figure 3. **Health expenditure per capita, PPP, dollar**



Source: WHO health for all database

Public sector expenditure constituted the largest part (79.3%) on THE in 2011 (figure 4). Private sector expenditure made up 19.2% and rest of the world expenditure 1.4%. At that, it is worth mentioning that the share of public sector was at its highest since 2000 in 2011.

Figure 4. **Distribution of THE funding sources, 2000–2011, share**



Source: NIHD DHS

The public sector expenditure was in the absolute sum of EUR 749.3 million, growing by EUR 33.3 million or 4.7% in a year (table 2). Most of the public sector expenditure was compiled by the expenditure of the Estonian Health Insurance Fund (hereinafter HIF) in the share of 86.4%. The EUR 28.8 million increase in the HIF expenditure was largely the reason behind the growth in public sector expenditure.

Table 2. **Public sector health expenditure, 2010–2011**

	2010		2011		Change (%)
	thousand EUR	%	thousand EUR	%	2011/2010
Estonian Health Insurance Fund	618 874	86.4	647 707	86.4	4.7
Central government	85 955	12.0	88 302	11.8	2.7
Local government	11 135	1.6	13 269	1.8	19.2
TOTAL	**715 963**	**100**	**749 278**	**100**	**4.7**

Source: NIHD DHS

Although the number of insured persons remained more or less the same, both the number of medical cases and the medical treatment expenses increased compared to 2010. HIF increased the volume of the outpatient and day care services bought from medical institutions in 2011, which is why the shares of these expenditures increased in the budget of the HIF. At the same time, the average cost of a treatment case increased in both in- and outpatient treatment. In THE framework, the increase in HIF expenditures was reflected in an increase in services of curative care and ancillary services to health care (table 3). [2: p. 45 and p. 53]

Table 3. **Health care expenditure of the Estonian Health Insurance Fund, 2010–2011**

	2010		2011		Change (%)
	thousand EUR	%	thousand EUR	%	2011/2010
SERVICES OF CURATIVE CARE	423 469	68.4	439 803	67.9	3.9
In-patient curative care	235 313	38.0	241 604	37.3	2.7
Day cases of curative care	16 890	2.7	18 227	2.8	7.9
Out-patient curative care	169 642	27.4	178 400	27.5	5.2
Basic medical and diagnostic services	125 132	20.2	133 173	20.6	6.4
SERVICES OF REHABILITATIVE CARE	8 849	1.4	9 457	1.5	6.9
SERVICES OF LONG-TERM NURSING CARE	14 255	2.3	14 816	2.3	3.9
ANCILLARY SERVICES TO HEALTH CARE	62 444	10.1	72 866	11.2	16.7
Clinical laboratory	37 585	6.1	42 379	6.5	12.8
Diagnostic imaging	24 358	3.9	29 869	4.6	22.6
MEDICAL GOODS DISPENSED TO OUT-PATIENTS	95 243	15.4	96 351	14.9	1.2
PREVENTION AND PUBLIC HEALTH SERVICES	7 724	1.2	7 334	1.1	-5.0
Maternal and child health; family planning and counselling	1 888	0.3	1 577	0.2	-16.5
HEALTH ADMINISTRATION AND HEALTH INSURANCE	6 889	1.1	7 080	1.1	2.8
CAPITAL FORMATION OF HEALTH CARE PROVIDER INSTITUTIONS	0	0	0	0	0
TOTAL	**618 874**	**100**	**647 707**	**100**	**4.7**

Source: NIHD DHS

The expenditure on the curative care services grew by 3.9%. Expenditure on the in-patient curative care increased by 2.7% and on the basic medical and diagnostic services by 6.4%. The basic medical and diagnostic services include financing of family doctor's services. The increase in financing of this field was caused by an increase in the number of visits, replacement of the coefficient of the general medical care, and introduction of the new system of forming capitation fee groups.

In 2011, the former general medical care coefficient 0.94 was replaced by a new coefficient of 0.97 that caused an increase in the HIF expenditure. The change in capitation groups established a system in which the family doctor lists with a larger share of children or the elderly receive more funds.

In-patient curative care and the basic medical and diagnostic services made up 57.9% of the HIF expenditure. Regardless of the low relative growth of these services the expenditures in absolute amounts increased by EUR 6.3 and 8 million respectively.

A significantly larger percental growth was seen in expenditures on clinical laboratory and diagnostic imaging services. These expenditures increased percentally by 12.8% and 22.6%, or in the absolute amounts of EUR 4.8 and 5.5 million.

Out of the largest expenditure types, the only one with a decrease in expenditure was prevention and public health services. This was caused by a decrease in the expenditure on maternal and child health, family planning and counselling. More precisely, the drop in

expenditure was brought about by a lower need than planned for invasive diagnostics and a drop in the number of births. Due to the lower need or a lower rate in participation, there was lower expenditure than expected also on breast and intracervical cancer screening measurements, pre-natal project of hereditary disease, and the project for early detection of heart disease and osteoporosis [2 p. 38].

The largest percental increase in the public sector took place in the local government (hereinafter LG) expenditures (table 2).

Table 4. **Health care expenditure of local governments, 2010–2011**

	2010		2011		Change (%)
	thousand EUR	%	thousand EUR	%	2011/2010
SERVICES OF CURATIVE CARE	4 425	39.7	4 808	36.2	8.7
SERVICES OF REHABILITATIVE CARE	0	0.0	0	0.0	0.0
SERVICES OF LONG-TERM NURSING CARE	3 674	33.0	4 641	35.0	26.3
ANCILLARY SERVICES TO HEALTH CARE	118	1.1	116	0.9	-2.4
MEDICAL GOODS DISPENSED TO OUT-PATIENTS	568	5.1	733	5.5	29.0
PREVENTION AND PUBLIC HEALTH SERVICES	0	0.0	0	0.0	0.0
HEALTH ADMINISTRATION	1 385	12.4	1 943	14.6	40.3
CAPITAL FORMATION OF HEALTH CARE PROVIDER INSTITUTIONS	964	8.7	1 027	7.7	6.5
TOTAL	**11 135**	**100**	**13 269**	**100**	**19.2**

Source: NIHD DHS

The relative growth of local governments was 19.2% and in an absolute sum, the health care expenditure increased by EUR 2.1 million in a year (table 4).

The financing articles of local governments increased in almost all larger service groups, except by the ancillary services to health care. The increase in the local government expenditure was mainly due to increases in the expenditure on services of long-term nursing care that increased by EUR 1 million, and health administration that grew by EUR 0.6 million in a year.

Unlike the public sector expenditure, there was a drop in the private sector expenditure (table 5). The table reveals that this drop was caused by a decrease in the household health care expenditure. However, the volume of other private sector financing sources increased in 2011.

Table5. **Private sector health care expenditure, 2010–2011**

	2010		2011		Change (%)
	thousand EUR	%	thousand EUR	%	2010/2011
PRIVATE INSURANCE ENTERPRISES	2 143	1.2	2 452	1.3	14.4
PRIVATE HOUSEHOLD OUT-OF-POCKET EXPENDITURE	168 604	91.7	165 853	91.3	-1.6
NON-PROFIT INSTITUTIONS SERVING HOUSEHOLDS (other than social insurance)	125	0.1	131	0.1	4.6
CORPORATIONS (other than health insurance)	13 007	7.1	13 254	7.3	1.9
TOTAL	**183 880**	**100**	**181 690**	**100**	**-1.2**

Source: NIHD DHS

The largest growth was seen in the private insurance enterprises expenditure that increased 14.4% in a year. The increase in the insurance expenditure was mainly influenced by increased payments for the basic medical and diagnostic services and over-the-counter medicines. The gross insurance premium payments also increased, meaning that people insured their health via private insurance undertakings in 2011 more than in the previous year [4].

In private sector expenses, the traditionally largest share is held by household OOP expenditure. In 2011, the share of household OOP expenditure in the private sector was 91.3%. Household expenditure was mainly divided between services of curative careand medical goods (table 6). These two types of expenditure made up 86.8% of the volume of household OOP expenditure.

Table 6. **Household OOP expenditure, 2010–2011**

	2010		2011		Change (%)
	thousand EUR	%	thousand EUR	%	2010/2011
SERVICES OF CURATIVE CARE	48 724	28.9	43 230	26.1	-11.3
In-patient curative care	956	0.6	1 380	0.8	44.4
Out-patient curative care	47 768	28.3	41 850	25.2	-12.4
out-patient dental care	42 465	25.2	37 682	22.7	-11.3
SERVICES OF REHABILITATIVE CARE	7 735	4.6	9 839	5.9	27.2
SERVICES OF LONG-TERM NURSING CARE	8 882	5.3	8 633	5.2	-2.8
ANCILLARY SERVICES TO HEALTH CARE	5 382	3.2	3 502	2.1	-34.9
Clinical laboratory	5 146	3.1	3 172	1.9	-38.4
Diagnostic imaging	237	0.1	330	0.2	39.6
MEDICAL GOODS DISPENSED TO OUT-PATIENTS	97 881	58.1	100 650	60.7	2.8
Prescribed medicines	65 433	38.8	68 028	41.0	4.0
Over-the-counter medicines	22 308	13.2	23 600	14.2	5.8
Glasses and other vision products	5 335	3.2	4 196	2.5	-21.3
TOTAL	**168 604**	**100**	**165 853**	**100**	**-1.6**

Source: NIHD DHS

The drop in household expenditure was due to significant decrease in dental care expenditure. In decreased by 11.3% in a year, in an absolute amount of EUR 4.8 million. Decrease in this expenditure was largely caused by a drop in expenditure on prosthesis; the number of denture receptions also decreased by almost 6% compared to the previous year.

The medical goods expenses that have the largest share in the household budgets historically increased by 2.8% compared to 2010. This is a significant growth after the drastic drop in 2010 when the expenditure on prescribed medicines decreased by 32.9% and on over-the-counter medicines by 33.5% compared to the previous year. However, in 2011, the expenditure on over-the-counter medicines increased by 5.8% and prescribed medicines by 4%. This number can be explained by an increase in doctors' appointments and the number of prescriptions written.

However, the most rapid growth could be seen in the expenditure on in-patient curative care. The share of this expenditure is relatively low in a household budget compared to other health care expenditures, but the relative increase of this article was 44.4% in 2011.

At the same time, we need to consider the fact that the data on household health care expenses is based on a household budget survey carried out by Statistics Estonia. Since the section on health care expenditure makes up a relatively small part of this study and the volume of sample is also low, an assessment of these expenses may vary year to year due to its randomness.

Since the number of hospitalised patients, use and circulation of beds has not increased much in the recent years, the increase of household expenditure on in-patient curative care can be explained by increased prices. At the same time, the expenditure did not grow very much in year 2011. The other assumption may be that people started to value comfort services more (e.g. a separate hospital room, a TV, etc.). Yet, it is unlikely looking at the increase in people's

income in 2011. Thus, this increase should still be explained by a methodology problem in studying household budgets.

Estonian health care system used significantly less expenses financed from rest of the world sources in 2011 than the year earlier. Health care expenditure from the rest of the world increased by 68.8% or EUR 5.5 million (table 7). Regardless of the considerable growth in financing, sustainability of Estonian health care system does not depend on foreign sources – rather, the additional resource enables additional structural development.

Table7. **Health care expenditure from the rest of the world, 2010–2011**

	2010		2011		Change (%)
	thousand EUR	%	thousand EUR	%	2011/2010
SERVICES OF CURATIVE CARE	0	0.0	2	0.0	
MEDICAL GOODS DISPENSED TO OUT-PATIENTS	2	0.0	13.	0.1	442.8
PREVENTION AND PUBLIC HEALTH SERVICES	2 128	26.2	3 275	23.9	53.9
Prevention of communicable diseases	106	1.3	319	2.3	199.8
Prevention of non-communicable diseases	2 021	24.9	2 956	21.6	46.3
HEALTH ADMINISTRATION	42	0.5	33	0.2	-22.2
CAPITAL FORMATION OF HEALTH CARE PROVIDER INSTITUTIONS	5 958	73.3	10 354	75.7	73.8
TOTAL	**8 130**	**100.0**	**13 677**	**100**	**68.2**

Source: NIHD DHS

The growth can mainly be attributed to directing the funds received from the European Regional Fund into capital investments. When interpreting the increase in financing from foreign sources, it should be noted that the capital expenditure was the lowest of the recent years in 2010 due to completion of several objects in 2009.

2. EXPENDITURE ON HEALTH CARE FUNCTIONS AND SERVICE PROVIDERS

As stated in the previous chapter, Estonian current health care expenditure increased by 4% or EUR 36.7 million. In absolute sum, the expenditure on in-patient curative care, basic medical and diagnostic services, and diagnostic imaging increased the most. At the same time, from the abovementioned services, a relatively large growth could be seen in diagnostic imaging expenditure that increased by 23.1% in a year (table 8).

Both the number of diagnostic examinations and the patients needing these examinations increased in 2011. Compared with 2010, the number of functional diagnostic examinations provided as an out-patient service increased by 9.4%, the number of ultrasonography procedures by 3.1%, the one of x-ray examinations and procedures by 10.3%, whereas 6.6% less laboratory examinations were carried out.

2011 is characterised by a continuing increase in the number of day cases of curative care; compared to 2010, the number of these patients per 100,000 citizens has increased by 13%. Use of ambulotary care services has also increased, both as to examinations and curative care services. At the same time, the figures of in-patient treatment have remained relatively stable in the last couple of years. The number of people leaving hospital in the last three years has been stable and the number of bed-days has also remained on the same level.

As to the amount of financing, out-patient health care services increased the most. It is due to increased financing of the Health Insurance Fund with an aim to shorten the waiting lists for out-patient medical services and to increase the availability of services.

Expenditure on treatment of in-patient curative care and the basic medical and diagnostic services increased considerably less, by 3% and 5.5% respectively. The volume of in-patient curative care and the basic medical and diagnostic services has not increased. The increase in expenditure is due to an increase in the price of the service (see p. 10).

Table 8. **Expenditure on health care services, 2010–2011**

	2010		2011		Change (%)
	thousand EUR	%	thousand EUR	%	2011/2010
SERVICES OF CURATIVE CARE	484 969	53.4	497 443	52.7	2.6
In-patient curative care	244 817	27.0	26.7	26.7	3.0
Day cases of curative care	16 916	1.9	18 261	1.9	8.0
Out-patient curative care	221 612	24.4	23.9	23.9	1.7
incl. basic medical and diagnostic services	132 129	14.6	139 451	14.8	5.5
incl. out-patient dental care	65 724	7.2	60 897	6.4	-7.3
SERVICES OF REHABILITATIVE CARE	16 711	1.8	19 514	2.1	16.8
In-patient rehabilitative care	12 293	1.4	14 670	1.6	19.3
SERVICES OF LONG-TERM NURSING CARE	40 147	4.4	40 814	4.3	1.7
ANCILLARY SERVICES TO HEALTH CARE	94 262	10.4	103 112	10.9	9.4
Clinical laboratory	43 058	4.7	45 761	4.8	6.3
Diagnostic imaging	24 689	2.7	30 395	3.2	23.1
MEDICAL GOODS DISPENSED TO OUT-PATIENTS	220 554	24.3	224 624	23.8	1.8
Prescribed medicines	156 406	17.2	159 873	16.9	2.2
Over-the-counter medicines	35 577	3.9	37 050	3.9	4.1
PREVENTION AND PUBLIC HEALTH SERVICES	24 655	2.7	26 051	2.8	5.7
Prevention of non-communicable diseases	6 570	0.7	8 124	0.9	23.7
HEALTH ADMINISTRATION AND HEALTH INSURANCE	19 352	2.1	21 220	2.2	9.7
CAPITAL FORMATION OF HEALTH CARE PROVIDER INSTITUTIONS	7 323	0.8	11 867	1.3	62.1
TOTAL	**907 973**	**100**	**944 645**	**100**	**4.0**

Source: NIHD DHS

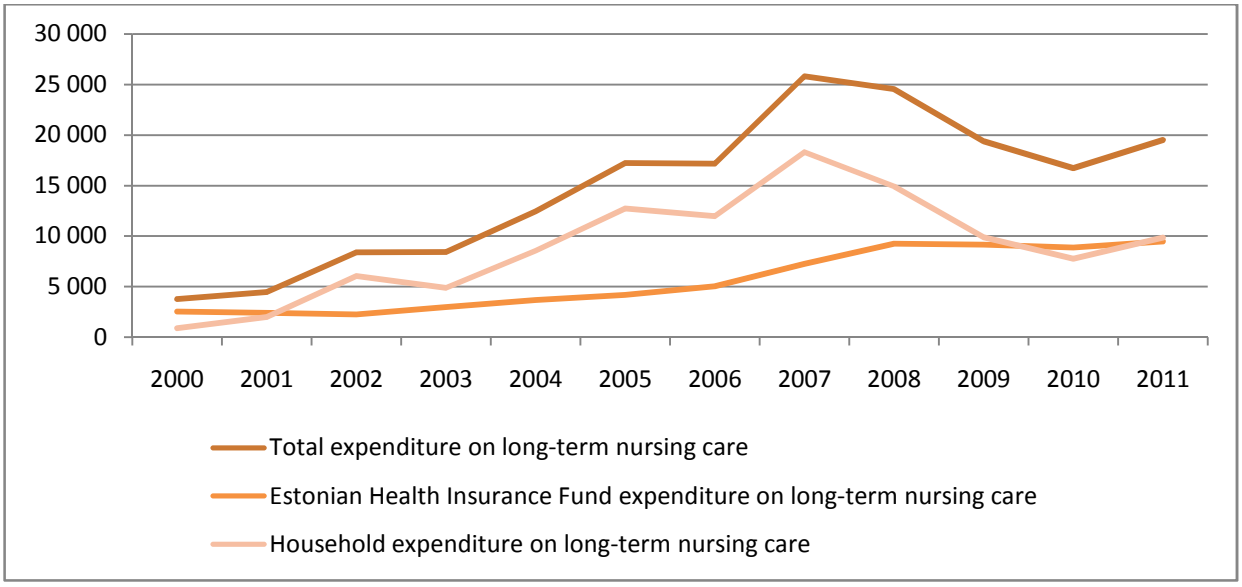
Large relative changes also took place in expenditures on in-patient rehabilitative care, prevention of non-communicable diseases, and capital formation of health care provider institutions. As stated in the previous chapter, the high relative growth of capital expenditure was due to the low absolute expenditure of 2010 as a reference year. High increase in the expenditure on prevention of non-communicable diseases was mainly caused by an increase in the central government and foreign financing of the programme „Measures Supporting Healthy Choices“.

This programme is used to implement actions with an aim to improve the health condition of the population. The aim of the programme is to increase qualified labour force and improve work life quality by decreasing the share of people who are inactive on the labour market for health reasons, as well as prevention of dropping out of the labour market because of health [1].

The expenditure on long-term nursing care increased mainly due to an increase in the self-financing of households. A more precise illustration of the long-term nursing care expenditure dynamics in 2000–2011 can be seen on figure 5. For the first time after 2007, there was an increase in the long-term nursing care expenditure in 2011 compared to the previous year. That

number of long-term nursing care procedures dropped by 5.2%; at that, there were 28.1 procedures per 100 patients in 2011. However, the number of long-term nursing care cases funded by the HIF increased by 9.1% [2: p. 85].

Figure 5. **Expenditure on long-term nursing care, 2000–2011, thousand euro**



Source: NIHD DHS

Long-term nursing care expenditures of households have been varying on different years. A significant reduction took place after 2007 when the long-term nursing care expenditures of households were the highest of the viewed period. The reason for reduction of the long-term nursing care expenditures of households may be due to the impact of the economic crisis to people's income, causing them to spend less on long-term nursing care. It may be assumed that long-term nursing care services are not primary as to people's health and they are often given up or postponed due to lack of money.

When viewing the current health care expenditure[3] by service providers it can be seen that current health care expenditure made abroad increased significantly (table 9). The increase of this expenditure was mainly due to an increase in the planned expenditure on health care services abroad by the Health Insurance Fund. At that, the increase in expenditure was due to both an increase in the number of planned treatment cases from the 129 cases in 2010 to 166 cases in 2011, and an increase in the cost of the average treatment case.

51 people were directed abroad for planned treatment in 2011, 85 persons were sent abroad for examinations and 30 people were seeking for bone marrow donor via the Red Cross blood service of Finland. The most patients were treated in Finland and Germany, and the most examinations were made in Netherlands and Belgium [2: pp. 75–76].

[3] Current costs is total health care expenditure minus capital expenditure.

Table 9. **Current health care expenditure by service providers, 2010–2011**

	2010		2011		Change (%)
	thousand EUR	%	thousand EUR	%	2011/2010
HOSPITALS	407 565	45.3	435 909	46.7	7.0
NURSING AND RESIDENTIAL CARE FACILITIES	25 799	2.9	25 938	2.8	0.5
PROVIDERS OF AMBULATORY HEALTH CARE	203 646	22.6	199 479	21.4	-2.0
Offices of dentists	61 352	6.8	56 581	6.1	-7.8
RETAIL SALE AND OTHER PROVIDERS OF MEDICAL GOODS	220 554	24.5	224 634	24.1	1.8
PROVISION AND ADMINISTRATION OF PUBLIC HEALTH PROGRAMMES	22 531	2.5	23 579	2.5	4.7
GENERAL HEALTH ADMINISTRATION	19 352	2.1	21 220	2.3	9.7
OTHER INDUSTRIES (rest of the economy)	229	0.0	245	0.0	7.0
REST OF THE WORLD	973	0.1	1 774	0.2	82.3
TOTAL	**900 650**	**100**	**932 778**	**100**	**3.6**

Source: NIHD DHS

The increase in expenditures in hospitals was largely caused by an increase in the Health Insurance Fund funding. Compared to 2010, the Health Insurance Fund spent EUR 25 million more in hospitals.

Table 9 reveals that the only expenditure to drop from the types of institutions were the ones made in providers of ambulatory health care. It was mainly caused by reduction of expenditure made in offices of dentists mainly due to reduction of the amount spent on dental services by households in 2011.

DATA SOURCES

The data sources used for THE calculations are listed below. Depending on source, data was presented on standard forms or in a custom format.

1. Estonian Health Insurance Fund – expenditure on health insurance benefits.
2. Ministry of Finance – 2011 report on local government budget implementation.
3. Health expenditure of ministries: Ministry of Education and Research, Ministry of Justice, Ministry of Defence, Ministry of the Environment, Ministry of Culture, Ministry of Economic Affairs and Communications, Ministry of Agriculture, Ministry of Finance, Ministry of Internal Affairs, Ministry of Foreign Affairs.
4. Statistics Estonia:
    a. Household Budget Survey;
    b. The report “Rehabilitative care” is the source of data on rehabilitation expenditure incurred by people.
5. Data on health expenditure from private insurance companies.
6. State Agency of Medicines – turnover of medicines in hospital and retail pharmacies.
7. Health Board – date related to hygiene, drinking water and environmental health control.
8. Institutions of occupational health – data on mandatory medical examinations of employees.
9. Database of the State Treasury – 2011 State Budget Execution Report is the source of data on the health expenditure incurred by the Ministry of Social Affairs.
10. Departments of the Ministry of Social Affairs:
    a. Finance and Property Management Department– specified data on medical treatment expenses of uninsured persons, foreign aid projects, foreign loans; projects financed through the Ministry of Finance from gambling tax;
    b. Social Policy Information and Analysis Department – institutional reporting on social welfare.
11. National Institute for Health Development – health promotion projects and programmes.
12. Estonian Red Cross – expenditure on prevention and public health services.

REFERENCES

1. „Tervislikke valikuid toetavad meetmed 2010–2011“. – National Institute for Health Development. http://www.tai.ee/et/instituut/koostooprojektid/loppenud-projektid (07.11.2012)
2. Annual Reports of the Estonian Health Insurance Fund, 2011. http://www.haigekassa.ee/uploads/userfiles/EHK_Aastaaruanne2011_EST_.pdf (08.11.2012)
3. Health for all database, WHO (26.11.2012) http://data.euro.who.int/hfadb/
4. Consolidated data of insurance undertakings (from 31.03.2008). – Financial Supervision Authority. http://www.fi.ee/index.php?id=3271 (14.11.2012)
5. Möödunud aastal kasvas majandus jõudsalt. – Statistics Estonia. http://www.stat.ee/57509 (08.11.2012)

HOW TO RECEIVE HEALTH STATISTICAL DATA AND INFORMATION?

Health statistics and health studies data base of the National Institute for Health Development
http://www.tai.ee/tstua

Data inquiry from the National Institute for Health Development
tai@tai.ee

Data base of Statistics Estonia
http://www.stat.ee/