World Health Organization

Country Cooperation Strategy at a glance

Estonia

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Indicator	Value
Total population (millions, 2008)[1]	1.34
% population 0–14 years old (2005)[2]	15.3
% population 65 years and older (2005)[2]	16.6
Life expectancy at birth (years, 2006)[3]	71.3
Infant mortality (before 1 year of age) per 1000 live births (2007)[1]	5.0
Total health expenditure as a % of GDP (2005)[2]	5.0
Per capita total expenditure on health at international dollar rate (US$ purchasing power parity, 2005)[2]	789
General government health expenditure as a % of general government expenditure (2005)[2]	11.5
Physicians per 100 000 population (2006)[2]	329
Human Development Index rank of 179 countries (2006)[3]	42
GDP per capita (US$ PPP) (2006)[3]	19 155
Adult (15+ years) literacy rate (2006)[3]	99.8%

Sources

[1] *Eesti Statistika aastaraamat 2006/Statistical yearbook of Estonia 2008.* Tallinn, Statistics Estonia, 2008.

[2] European health for all database [online database]. Copenhagen, WHO Regional Office for Europe, 2007 (http://www.euro.who.int/hfadb, accessed 17 April 2009).

[3] *Human development report 2007/2008. Fighting climate change: Human solidarity in a divided world* New York, United Nations Development Programme, 2008 (http://hdr.undp.org/en/reports/global/hdr2007-2008/, accessed 17 April 2009).

Estonia has an area of 45 227 km² and is located in the Baltic region. It borders on the Russian Federation to the east and Latvia to the south. Estonia is divided into 15 counties representing the national government and around 227 municipalities including 33 cities. Estonia is a independent parliamentary democratic republic and since 2004 a member of the European Union. Estonia has a unicameral parliament (Riigikogu) with 101 members directly elected for four years. The last regular elections were in March 2007. The Government exercises executive power led by the Prime Minister and including 14 ministers. Governments usually comprise a coalition of political parties. The President is elected for five years. Toomas Hendrik Ilves is the elected President since October 2006.

HEALTH AND DEVELOPMENT

Disease pattern changed, with new challenges ahead. The infant mortality rate has decreased substantially (from 15.7 in 1992 to 5.0 in 2007) and has remained very low in recent years. The main disease burden challenge is premature mortality caused by external causes and lifestyle-related risk factors. The working-age population bears more than half of the disease burden (60% among men). Similar to other industrialized countries, the main causes of mortality are diseases of the circulatory system (50%), cancer (20%) and external causes of death (10%). Mortality differs between men and women due to differences in mortality from external causes. Mortality from circulatory diseases is higher among men than among women. The lifestyle risk factors causing the disease burden are alcohol consumption, use of tobacco, low physical activity and low intake of fruits and vegetables. A growing challenge is the increasing prevalence of obesity. In the past decade, a new challenge of tackling communicable diseases such as HIV and multidrug-resistant tuberculosis has emerged. Estonia has one of the highest HIV incidence rates in the WHO European Region. Estonia has kept other communicable diseases under control with broad vaccination programmes implemented with high coverage.

Estonia has rapidly and successfully reformed the health system during the past 18 years. The reforms started with health system financing, followed by organizational changes in service delivery and overall governance. During the transition, Estonia's economy developed rapidly and sequential health system reforms were implemented.

Health system financing. In 1991, Estonia established a mandatory social health insurance system financed by income-related contributions and covering almost the entire population. The health insurance system went through various changes from decentralization to recentralization. Currently, a single health insurance fund is responsible for collecting contributions, pooling and purchasing health care services. Discussions are ongoing as to whether a similar active purchasing function should be established for public health services. System-wide cost containment and improving the efficiency of the health system have always been driving forces of the reforms of health care financing. The financial protection of the population has remained an important objective, but private funding from households has increased over the years and is currently at the level of the western European countries.

Health care services. Health care was reshaped around family physicians at primary care, who have a partial gatekeeping with direct access for few selected specialists and coordinating role. Currently, the whole population is covered by a network of family physicians and enrolled with individual family doctors. In parallel to primary care reforms access to essential and modern medicines has been improved over last decades. Restructuring of the hospital sector has complemented reform of primary health care. Estonia has succeeded in significantly reducing the excess capacity of acute care hospitals to the average level of the EU. The ongoing challenge is developing a network of long-term care providers and improving collaboration between the levels of care. The public health system has been decentralized, and several networks have been created to empower citizens. Standardizing public health services and strengthening coordination are ongoing. Several organizational models have been applied to improve risk management in health protection. On disease prevention and health promotion, links have been applied to primary care and empowerment of the third sector (nongovernmental organizations) to increase the possible service delivery networks.

Stewardship. The Ministry of Social Affairs has exercised stewardship through various policy documents, strategies and regulations. An institutional framework includes various agencies and institutions under both public and private regulation. The EU accession has increased the need to improve coordination at country and international level. Further the need for health sector leadership has increased to exert influence on other sectors influencing health. For this, new leadership and management practices need to be developed and clear performance measurement applied to achieve the health system goals. In 2008 the Government approved the National Health Plan 2009-2020, which aims to increase the health status and quality of life of entire population through various activities.

Human resources. Human resources have been developed over the years. Training institutions have been upgraded using quality criteria, and new curricula have been implemented for nurses and doctors. However, the ratio of doctors and nurses is still unfavourable for shifting tasks and responsibilities and exercising new models of care. The continuing education activities for health professionals and quality management mechanisms have not yet been implemented fully. The new challenges have emerged after EU membership and motivating the workforce to remain in Estonia.

OPPORTUNITIES	CHALLENGES
• A comprehensive set of strategic documents in the health sector • Well-developed family medicine centred primary health care already accepted by the stakeholders • Rationalized hospital system • Transparent public health and health care service purchasing • Strong technological and information technology development • Societal change and strong economic growth until 2008	• The leadership role of the Ministry of Social Affairs needs to be improved • Difficulty with continuity of care and chronic disease management and poor intersectoral links between health care, public health and social care • Increasing out-of-pocket payments as an expression of inability to cope with cost increases • Narrow revenue base of the health insurance system to ensure financial sustainability in terms of demographic changes and other cost drivers in health care • Unfavourable ratio of different competencies, lack of continuing education for health personnel • Ecological and public health threats • Increasing population expectations and increasing need for citizens' engagement

PARTNERS

United Nations agency representation has been scaled down since the late 1990s, and the trend is similar for development cooperation. Health collaboration is active, with few United Nations agencies present at the country level (such as the United Nations Children's Fund national commission) or with programmes in Estonia without a country presence (such as UNAIDS, UNODC, ILO). Currently WHO is the only specialized United Nations agency at the country level. The World Bank was actively supporting the health sector in the late 1990s and since 2008 Estonia became a donor country. Estonia is currently in the process to become a member of OECD. Over the years, European Commission and other EU institutions and funding sources have organized several collaboration activities as multi-country projects. Financial support for development (including health with other sectors) has been increasingly transformed through EU schemes and Norwegian and European Economic Area financial mechanisms. In recent years, bilateral partners have scaled down their initiatives, but several countries are still active in health or other sectors. Collaboration with the European Observatory on Health Systems and Policies has developed policy dialogue in the region and shared knowledge on health system reforms.

OPPORTUNITIES	CHALLENGES
• Integration with the EU and other international organizations with their respective structures • EU support for fostering development in Estonia • Several active multi-country projects and programmes	• Moderate stewardship role for coordination • Limited sharing of information and best practices among national institutions • Estonia is not eligible for many international support activities

WHO STRATEGIC AGENDA (2008–2013)

WHO has supported health systems development since 1993, when Estonia joined WHO after regaining its independence. During the 1990s, WHO supported health care reforms in close collaboration with other international partners such as the World Bank and national authorities. WHO is one of the few international agencies with permanent representation. The main cooperation topics are technical support in key reform areas, evaluating the changes during the past decade and sharing knowledge to learn from other countries' experiences. These have been selected because the complex health system needs further fine-tuning to perform better. For this, WHO applies a strategic focus and health systems approach concentrating on health system outcomes and long-term sustainability.

Development of health policy and implementing strategies. This includes several supportive activities such as promoting stewardship and policy development; increasing awareness and developing capacity on policy development and implementation; providing analytical support for strategically important topics; analysing and developing the organizational model of public health services; and measuring the performance of the health system.

Health system financing and sustainability. WHO provides analytical and policy support, such as analysing the financial protection, financial sustainability and broadening the revenue base to ensure sufficient funding, moving towards universal coverage and improving purchasing and developing recommendations for reforms in health care funding to improve equity and financial protection. Further, to improve the performance of the health system, WHO supports analysis of financial flow and cost-effectiveness in health care and public health.

Health services. WHO provides analytical support in measuring the performance of primary health care and in improving further the primary health care system with the aim of broadening the scope of and access to services; in developing models for integrated care and improving quality; in restructuring the hospital system; and in developing long-term care and nursing services linked to social support networks.

Human resources for health and generating resources. This includes support for developing and implementing policy through capacity-building to improve the quality of human resources for health system management and public health services. In addition, WHO provides support for further developing the pharmaceutical policy by analyzing the medicines sector, training local experts and sharing experience on policies related to pricing and other features related to medicines.

Prevention. treatment and preparedness to respond to communicable diseases, HIV and tuberculosis. WHO provides support for developing strategy; external monitoring and evaluation of the current situation to provide suggestions for improvement; improving local monitoring capacity; strategic support to increase access to prevention and treatment (pricing, comparison and legal instruments); implementation of therapeutic consensus and sharing best practices; joint HIV and tuberculosis planning exercises and preparation of guidelines; preparing a modern monitoring and surveillance system for communicable diseases; and assessing the preparedness of the current system; supporting implementation of the International Health Regulations (2005).

Reducing environmental and life cycle related risk factors for population health. WHO provides support in several areas to share best practices and update national plans according to international agreements and the national situation in environment and health; addressing noncommunicable diseases, mental health and lifestyles, including promoting health among children and adolescents, nutrition, alcohol, tobacco and improving chronic disease management. WHO provides external evaluation with suggestions to support the implementation of national strategies.

ADDITIONAL INFORMATION:

WHO headquarters country page: **http://www.who.int/countries/est/en**
WHO Regional Office for Europe country page: **http://www.euro.who.int/estonia** **and** **http://ee.euro.who.int**

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