

State of Health in the EU

Estonia

Country Health Profile 2023

The Country Health Profile Series

The *State of Health in the EU's Country Health Profiles* provide a concise and policy-relevant overview of health and health systems in the EU/European Economic Area. They emphasise the particular characteristics and challenges in each country against a backdrop of cross-country comparisons. The aim is to support policy makers and influencers with a means for mutual learning and voluntary exchange. For the first time since the series began, the 2023 edition of the Country Health Profiles introduces a special section dedicated to mental health.

The profiles are the joint work of the OECD and the European Observatory on Health Systems and Policies, in co-operation with the European Commission. The team is grateful for the valuable comments and suggestions provided by the Health Systems and Policy Monitor network, the OECD Health Committee and the EU Expert Group on Health Systems Performance Assessment (HSPA).

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Data and information sources

The data and information in the *Country Health Profiles* are based mainly on national official statistics provided to Eurostat and the OECD, which were validated to ensure the highest standards of data comparability. The sources and methods underlying these data are available in the Eurostat Database and the OECD health database. Some additional data also come from the Institute for Health Metrics and Evaluation (IHME), the European Centre for Disease Prevention and Control (ECDC), the Health Behaviour in School-Aged Children (HBSC) surveys

and the World Health Organization (WHO), as well as other national sources.

The calculated EU averages are weighted averages of the 27 Member States unless otherwise noted. These EU averages do not include Iceland and Norway.

This profile was finalised in September 2023, based on data that were accessible as of the first half of September 2023.

Demographic and socioeconomic context in Estonia, 2022

Demographic factors	Estonia	EU
Population size	1 331 796	446 735 291
Share of population over age 65 (%)	20.4	21.1
Fertility rate ¹ (2021)	1.6	1.5
Socioeconomic factors		
GDP per capita (EUR PPP ²)	30 671	35 219
Relative poverty rate ³ (%)	22.8	16.5
Unemployment rate (%)	5.6	6.2

1. Number of children born per woman aged 15-49. 2. Purchasing power parity (PPP) is defined as the rate of currency conversion that equalises the purchasing power of different currencies by eliminating the differences in price levels between countries. 3. Percentage of persons living with less than 60 % of median equalised disposable income. Source: Eurostat Database.

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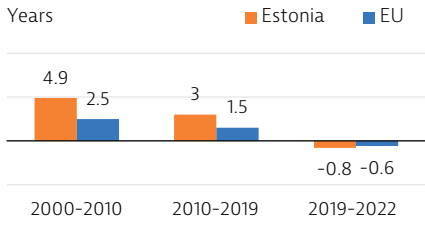
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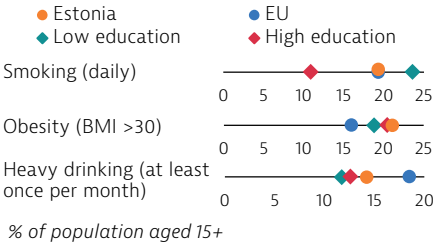
1 Highlights



Changes in life expectancy at birth

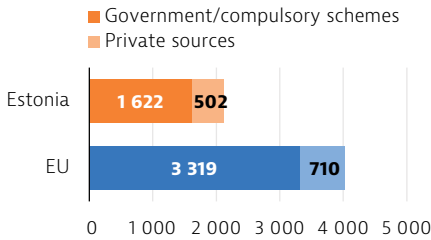
Health Status

The significant gains in life expectancy achieved in Estonia between 2000 and 2019 were reversed during the early years of the COVID-19 pandemic, with an overall decline of 0.8 years between 2019 and 2022. Excess mortality was driven by COVID-19 and alcohol-related deaths in these years. Inequalities in life expectancy are substantial between genders and across income and education levels.



Risk Factors

Tobacco consumption rates in Estonia are similar to the EU average, but those with low education levels are twice as likely to smoke. Use of vaping products is growing among young people. The increasing prevalence of obesity is a current policy focus. Overall, behavioural risk factors were responsible for nearly 39 % of all deaths in Estonia in 2019.



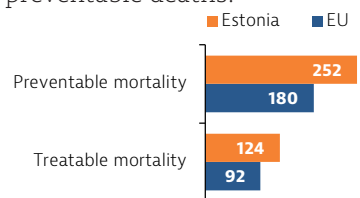
EUR PPP per capita, 2021

Health System

Public financing accounts for more than 76 % of current health expenditure, which was equivalent to EUR 1 622 per capita in 2021. The share of transfers from the state budget to the Estonian Health Insurance Fund has increased. At EUR 2 124 per capita in 2021, Estonia spent around half of the average total health expenditure across the EU.

Effectiveness

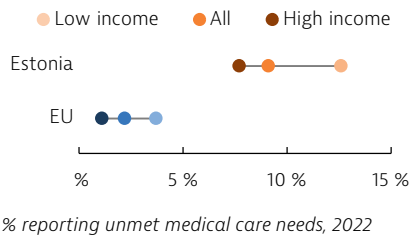
Deaths from preventable and treatable causes have steadily decreased, but rates are still higher than EU averages. As in most other EU countries, preventable mortality increased in 2020 because COVID-19 deaths were classified as preventable. Cardiovascular disease is the leading treatable cause of death, while alcohol consumption accounts for a fifth of all preventable deaths.



Age-standardised mortality rate per 100 000 population, 2020

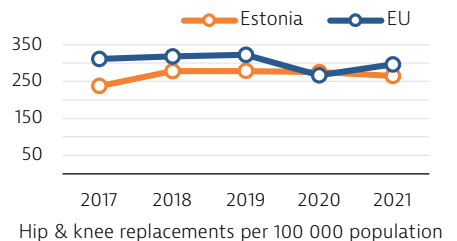
Accessibility

Between 2019 and 2022 the total number of adults experiencing unmet medical needs reduced from 15.5 % to 9.1 %. The largest improvements were in high-income groups, increasing inequalities further. Nevertheless, Estonians are more likely to report unmet medical care needs than other Europeans. This is most commonly due to waiting times for elective care.



Resilience

The disruption to health services in Estonia during the COVID-19 pandemic was less severe than elsewhere in Europe. Elective surgery, such as hip replacements, continued, while the volume of some other procedures declined. Health workforce shortages are being addressed but remain an urgent policy issue, and are likely to test the resilience of the health system.



Mental Health

Before the COVID-19 pandemic, more men (11.7 %) than women (9.7 %) in the lowest income quintile reported depression. However, Estonian national data indicate that there was a sharp increase in mental health problems in 2020-22. The pandemic has prompted strong action to improve mental health service delivery. Estonia adopted the Action Plan on Mental Health 2023-26 in 2022, and is developing a suicide prevention plan, expected by the end of 2024.

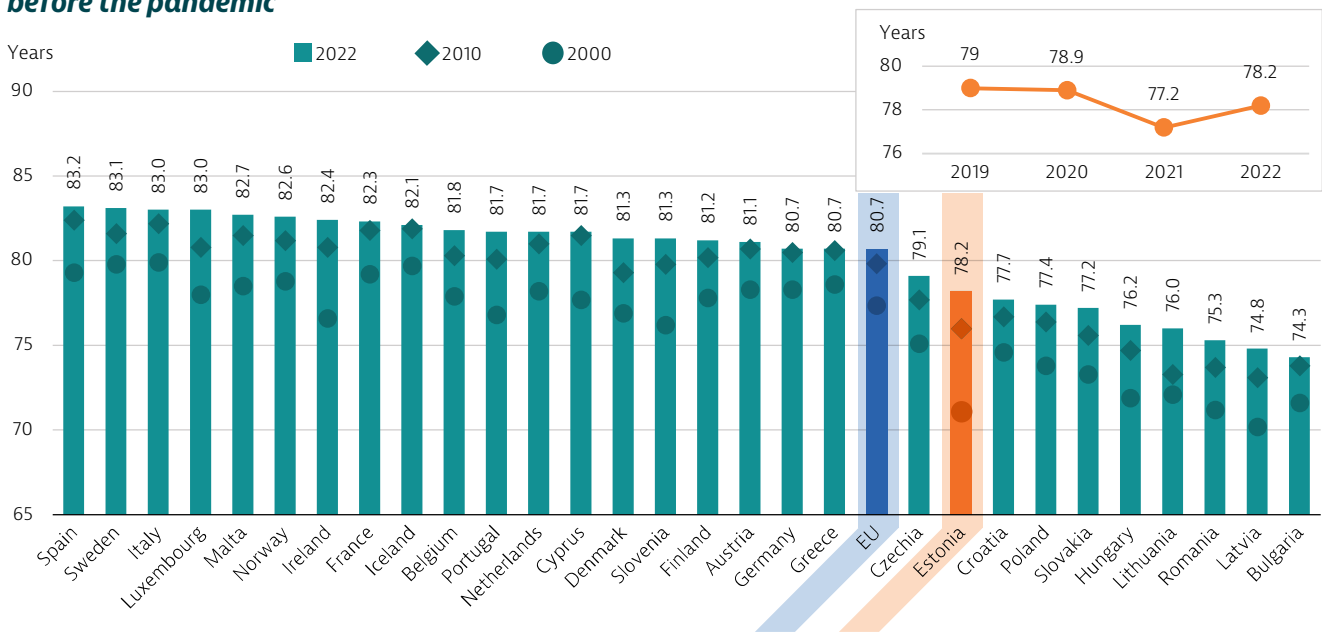
2 Health in Estonia

Life expectancy increased more than in any other EU country before the pandemic, but fell in 2020 and 2021

Life expectancy at birth in Estonia rose by nearly eight years between 2000 and 2019, from 71.1 years to 79.0 years, but it fell slightly in 2020 and even more in 2021 during the COVID-19 pandemic. Between 2019 and 2021 life expectancy at birth decreased by 1.8 years, but in 2022 it recovered by a whole year, reaching 78.2 years (Figure 1).

In 2022, women in Estonia could expect to live an average of 8.7 years longer than men. This is the third largest gender gap in life expectancy in the EU after Lithuania and Latvia, and much greater than the EU average of 5.4 years. Inequalities in life expectancy by socioeconomic status are very marked. In 2021, life expectancy among 30-year-old men with no secondary education was 9.3 years shorter than among those with a university degree, while the gap for 30-year-old women was 8.1 years.

Figure 1. Life expectancy in Estonia is still lower than the EU average, but was improving rapidly before the pandemic



Notes: The EU average is weighted. The 2022 data are provisional estimates from Eurostat that may be different from national data and may be subject to revision. Data for Ireland refer to 2021.

Source: Eurostat Database.

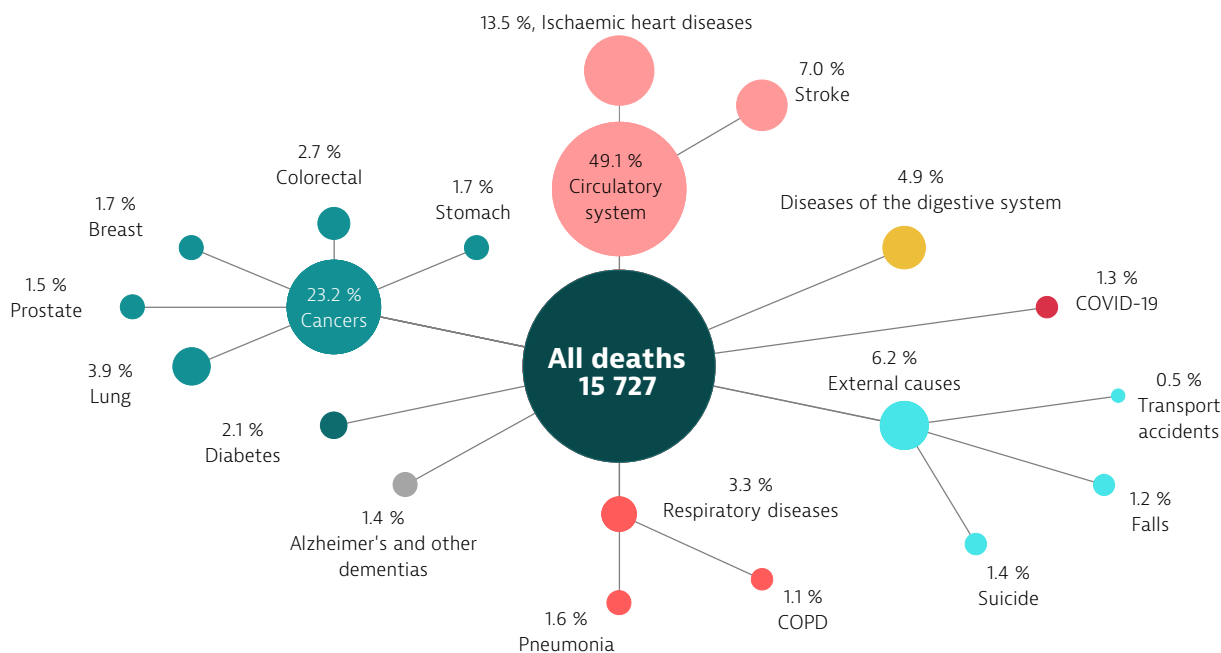
Cardiovascular diseases are the main cause of death

Diseases of the circulatory system account for just under one half of all deaths in Estonia (Figure 2). Despite a sustained decrease of almost 60 % since 2011, in 2020 the mortality rate from ischaemic heart disease was still 40 % higher than the EU average, and it was the leading cause of death in Estonia, responsible for almost one in six of all deaths. The large reduction can in part be attributed to decreases in the prevalence of important risk factors such as smoking – particularly among Estonian men – and significant improvements in the quality of healthcare (see Sections 3 and 5.1). In 2020, cancer was the second most common cause of death, with lung cancer the most frequent cause of cancer death. COVID-19

accounted for 203 deaths in Estonia in 2020, which is 1.3 % of total deaths, but the number increased in 2021, reaching 1 765 COVID-19 deaths.

The broader indicator of all-cause excess mortality, defined as the number of deaths from all causes above what would normally be expected based on the baseline from the previous five years, was among the lowest in the EU in 2020, but rose above the EU averages in both 2021 and 2022. Mortality from COVID-19 was lower than all-cause excess mortality in all three years of the pandemic (Figure 3), suggesting that the indirect death toll related to COVID-19 was higher than the toll reported as directly related to the virus. In parallel, a sharp increase in alcohol-related deaths was identified during the three years of the pandemic, contributing to the increasing excess mortality

Figure 2. Ischaemic heart disease was the main cause of death in Estonia in 2020

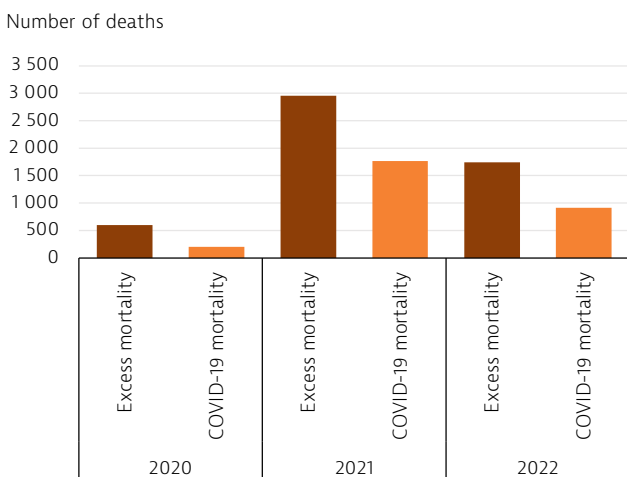


Note: COPD refers to chronic obstructive pulmonary disease.

Source: Eurostat Database (data refer to 2020).

rate. Heat-related deaths among elderly people also spiked in 2021 (National Institute for Health Development, 2023).

Figure 3. Excess mortality in Estonia was higher than the COVID-19 mortality recorded between 2020 and 2022



Note: Excess mortality is defined as the number of deaths from all causes exceeding the average annual number of deaths in the five years preceding the pandemic (2015-19).

Sources: National Institute for Health Development (for COVID-19 mortality) and OECD Health Statistics based on Eurostat data (for excess mortality).

Self-reported health status varies widely across income groups

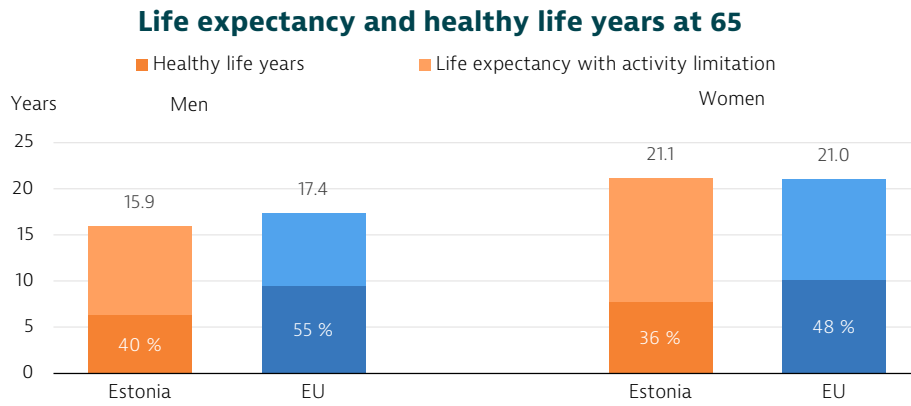
In 2022, nearly 58 % of the adult Estonian population reported being in good health,

compared to 68 % of people across the EU. However, more than 78 % in the highest income quintile considered themselves to be in good health compared to 34 % in the lowest quintile. The gap across income groups is one of the largest among all EU countries.

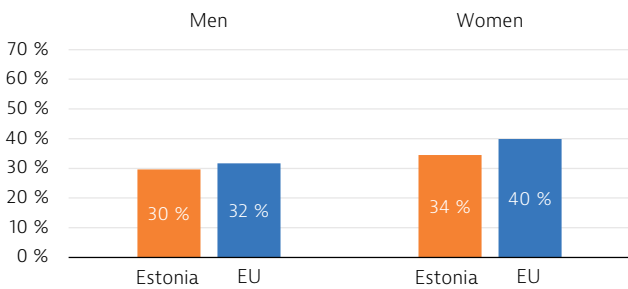
Older Estonians can expect to spend a significant proportion of their lives with activity limitations

The proportion of people aged 65 and over in Estonia increased from 15 % in 2000 to 20 % in 2020 – an increase mainly attributable to the steep rise in life expectancy. This share is projected to reach 28 % by 2050. Despite the gains in life expectancy, however, the number of healthy life years that Estonians can expect at age 65 remain below the EU average, as both men and women spend a larger share of their remaining lives with activity limitations. The proportion of older women in Estonia reporting multiple chronic conditions and limitations in daily activities is higher than the proportion of men (Figure 4).

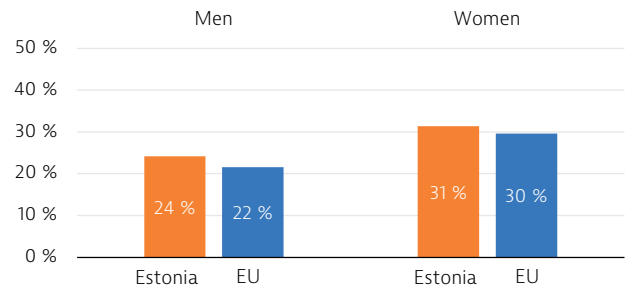
Figure 4. The number of healthy life years of Estonians at age 65 was below the EU average in 2020



Proportion of people aged 65 and over with multiple chronic conditions



Limitations in daily activities among people aged 65 and over



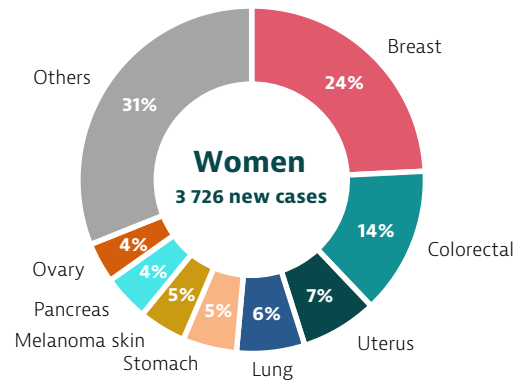
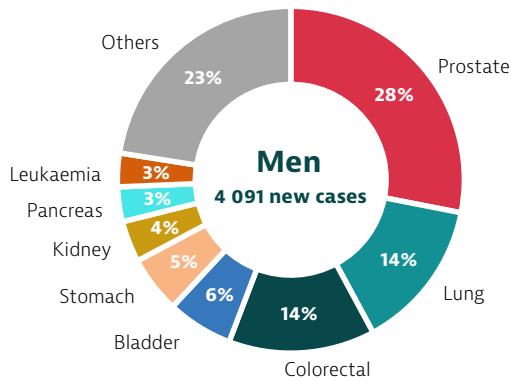
Sources: Eurostat Database (for life expectancy and healthy life years) and SHARE survey wave 8 (for multiple chronic conditions and limitations in daily activities). All the data refer to 2020.

The estimated incidence of cancer for men in Estonia is above the EU average

According to estimates from the Joint Research Centre based on incidence trends in previous years, over 7500 new cancer cases were expected to be diagnosed in Estonia in 2022. Estonia had above-average total estimated cancer incidence

among men, with prostate cancer making up approximately 28 % of all cancer diagnoses, followed by lung and colorectal cancer (Figure 5). In contrast, total estimated cancer incidence among Estonian women was lower than the EU average, with breast cancer by far the most commonly diagnosed (24 %).

Figure 5. More than 7 500 cancer cases in Estonia were expected to be diagnosed in 2022



Age-standardised rate (all cancer): 780 per 100 000 population
EU average: 684 per 100 000 population

Age-standardised rate (all cancer): 452 per 100 000 population
EU average: 488 per 100 000 population

Notes: Non-melanoma skin cancer is excluded. Uterus cancer does not include cancer of the cervix.
 Source: ECIS – European Cancer Information System.

3 Risk factors

Behavioural risk factors account for a substantial share of all deaths

Behavioural risk factors, including tobacco smoking, dietary risks, alcohol consumption and low levels of physical activity, were associated with 39 % of all deaths in Estonia in 2019. Nearly a fifth of all deaths could be attributed to dietary risks – a proportion close to the EU average. Tobacco use (including second-hand smoke) is the second most important behavioural risk factor contributing to

mortality, accounting for 15 % of deaths. Alcohol consumption accounted for 8 % of all deaths in 2019, but alcohol-related mortality increased during the COVID-19 pandemic (National Institute for Health Development, 2023). Physical inactivity accounted for 2 % of all deaths, in line with the EU average. Air pollution in the form of fine particulate matter (PM_{2.5}) and ozone accounted for about 1 % of all deaths – a lower share than the EU average of 4 % (Figure 6).

Figure 6. Nearly 40 % of deaths in Estonia can be attributed to modifiable lifestyle risk factors



Notes: The overall number of deaths related to these risk factors is lower than the sum of each one taken individually, because the same death can be attributed to more than one risk factor. Dietary risks include 14 components, such as low fruit and vegetable intake, and high sugar-sweetened beverages consumption. Air pollution refers to exposure to PM_{2.5} and ozone.

Sources: IHME (2020), Global Health Data Exchange (estimates refer to 2019).

Policy action on nutrition and obesity is regaining momentum

According to the European Health Interview Survey (EHIS), more than one in five adults in Estonia were obese in 2019. More recent data from a national health survey show that more than half of people aged 16-64 were either overweight or obese in 2020. The share of overweight or obese men in particular has increased from 53 % in 2010 to 61 % in 2020 (National Institute for Health Development, 2023). Overweight and obesity rates are also a growing issue among adolescents: the rates have increased substantially over the last two decades, reaching 21.3 % of 15-year-olds in 2022, up from only 7 % in 2002.

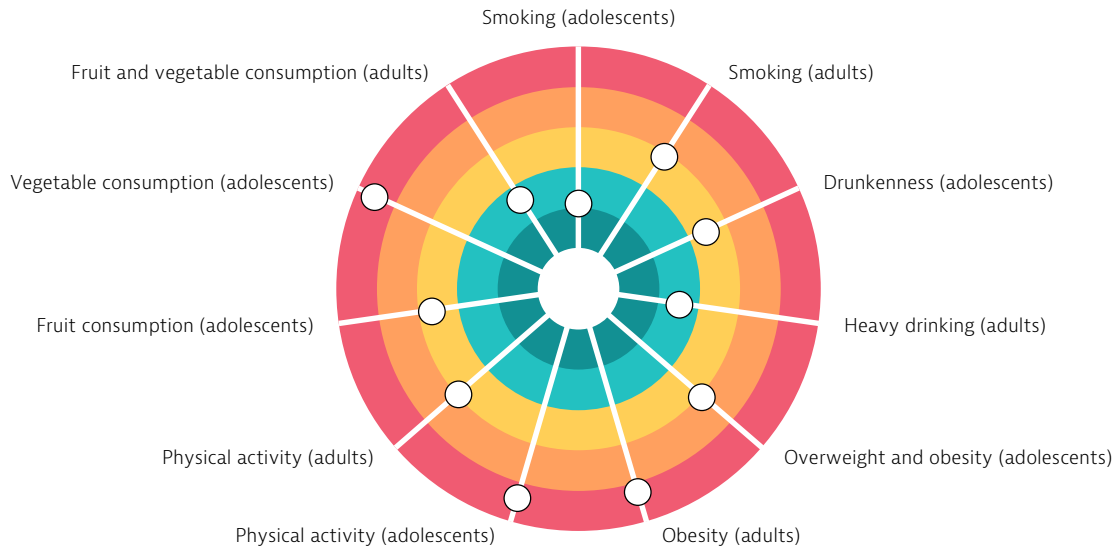
While the Estonian population reports greater fruit and vegetable intake than the populations of most EU countries, fewer than one in seven adults (13 %) consumed at least five portions of

fruit and vegetables per day in 2019 (Figure 7). A Green Paper on physical activity and nutrition was developed in 2014; it has not yet been approved by the government, but it was included in the Government's Action Plan 2023-2027, and the plan is to adopt it in November 2024. Despite this delay, other policies to address obesity have been advanced – for example, a food reformulation plan has been drafted and will be negotiated with the food industry starting September 2023. In 2022, a code of conduct on responsible advertising of food and drink during children's television programmes was also prepared.

More than one fifth of adults smoke daily

Tobacco consumption remains a major public health problem in Estonia, especially among men, although smoking rates have fallen significantly since 2000. One in five men still smoke daily, and almost twice as many men as women were daily

Figure 7. Obesity, particularly among adults, is an important public health concern in Estonia



Notes: The closer the dot is to the centre, the better the country performs compared to other EU countries. No country is in the white "target area" as there is room for progress in all countries in all areas.

Sources: OECD calculations based on HBSC survey 2022 for adolescents indicators; and EHIS 2019 for adults indicators.

smokers in 2019. Smoking rates among 15-year-olds have fallen below the EU average, and 12 % reported having smoked in the past month in 2022. However, regular use of vaping products among young adults (aged 15-24) has increased sharply, to nearly 30 % in 2022. In 2019, amendments to the Tobacco Act came into effect, banning the display of tobacco products and related items at points of sale. The Act also prohibits flavours and fragrances other than tobacco in e-cigarette liquids, and bans remote sales of tobacco products.

Heavy alcohol consumption remains a concern

In 2022, 21 % of 15-year-olds reported having been drunk more than once – a share above the EU average (18 %) but down from 50 % in the early 2000s. Since 2014, systematic implementation of the Green Paper on alcohol policy has led to a decline in overall adult alcohol consumption, which reached its lowest point in 2018. However, this positive trend was reversed during the pandemic, following a reduction in alcohol excise duty in 2019. As a result, alcohol is now the main preventable cause of mortality (see Section 5.1). The gender gap in excessive alcohol consumption is wide: 23 % of males reported regular heavy drinking in 2019 compared to only 6 % of women.¹

People in Estonia are less physically active than people in most other EU countries

Regular physical activity is slightly less common in Estonia than in most other EU countries. Three quarters of Estonians reported doing fewer than

150 minutes of exercise per week – a higher share than the EU average. Only one in eight 15-year-olds reported doing at least some moderate physical activity in 2022, which is also below the EU average. Results from the 2020 National Health Behaviour Data Survey also show an increasingly sedentary lifestyle: more than 22 % of respondents reported that they had more than four hours of screen time per day – up from 16 % in 2018 (National Institute for Health Development, 2023).

Socioeconomic inequality has a large impact on health risks

Lower levels of education among the Estonian population are associated with higher rates of smoking, contributing to lower life expectancy among this group. In 2019, 24 % of adults with lower education levels smoked daily; this is one of the highest rates in the EU, and 13 percentage points higher than the EU average. In contrast, the smoking rate among Estonians with higher education levels was only 11 %.

In addition, Estonians with lower education levels were less likely to meet the recommended levels of physical activity and fruit and vegetable consumption in 2020 than those with higher levels. They also had higher rates of overweight and obesity (63 %) than those with tertiary education (46 %), based on a national survey conducted in 2020 (National Institute for Health Development, 2023).

¹ Heavy drinking is defined as consuming six or more alcoholic drinks on a single occasion for adults.

4 The health system

Estonia has a single health insurance fund, which covers the majority of the population

The Estonian health system is based on a social health insurance model and is largely funded through payroll tax, although state budget transfers to this scheme play an increasingly important role (making up 7.4 % of current health expenditure in 2021, excluding COVID-19-related transfers). Currently, 96 % of the population are covered by social health insurance (Statistics Estonia, 2023). Most uninsured people are in informal or temporary employment. The Estonian Health Insurance Fund (EHIF) is a semi-autonomous public organisation. It pools most of the public funding for health and is responsible for purchasing health services. The health system is centralised and overseen by the Ministry of Social Affairs. All major hospitals in Estonia are publicly owned; they provide inpatient care and the majority of outpatient specialist care. Most primary care and dental care providers are privately owned, as are some providers of specialist outpatient and long-term nursing care.

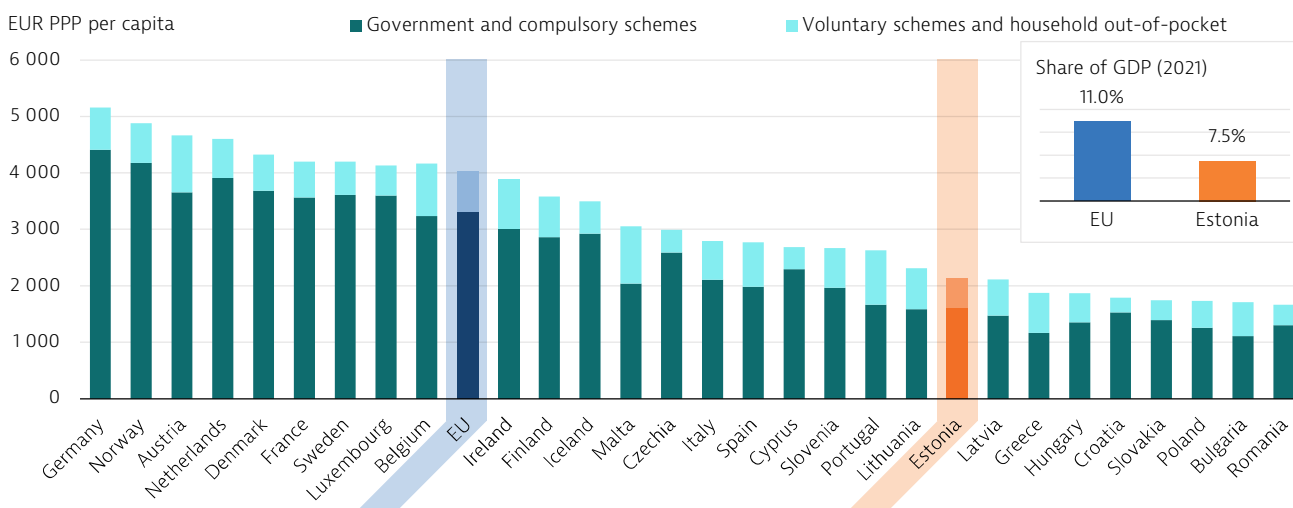
Health spending increased substantially during the COVID-19 pandemic

Per capita health expenditure has grown steadily, increasing almost five-fold over the last 20 years. In 2021, Estonia spent EUR 2 124 per capita (adjusted

for differences in purchasing power) on health, which is about half the EU average of EUR 4 028 but close to the amounts spent by Latvia and Lithuania (Figure 8). Current health expenditure grew by 10.3 % in 2019-20 and again by 8.7 % in 2021 as part of the country's response to the COVID-19 pandemic. As a percentage of GDP, Estonia's health spending reached 7.5 % in 2021.

There are concerns that the Estonian health financing system is not sustainable due to a shrinking working-age population and increased flexible employment. Currently, social health insurance contributions come from an earmarked payroll tax of 13 %, paid by the employer. From 2022, the state also transfers 13 % of pensions on behalf of non-working pensioners to the EHIF. The COVID-19 pandemic required extraordinary government transfers of EUR 193 million in both 2020 and 2021 (Eesti Haigekassa, 2021). In 2021, 76.4 % of health spending in Estonia was financed through government schemes, while 21.9 % was paid out of pocket, including copayments for dental care, outpatient medicines, long-term care and specialist outpatient care (see Section 5.2). The remaining 1.7 % of health spending is from voluntary health insurance payments. Informal payments are rare. The EHIF benefits package is considered to be comprehensive, and is defined by a positive list of health services and products.

Figure 8. Estonia spends about half the EU average on health per capita



Note: The EU average is weighted.

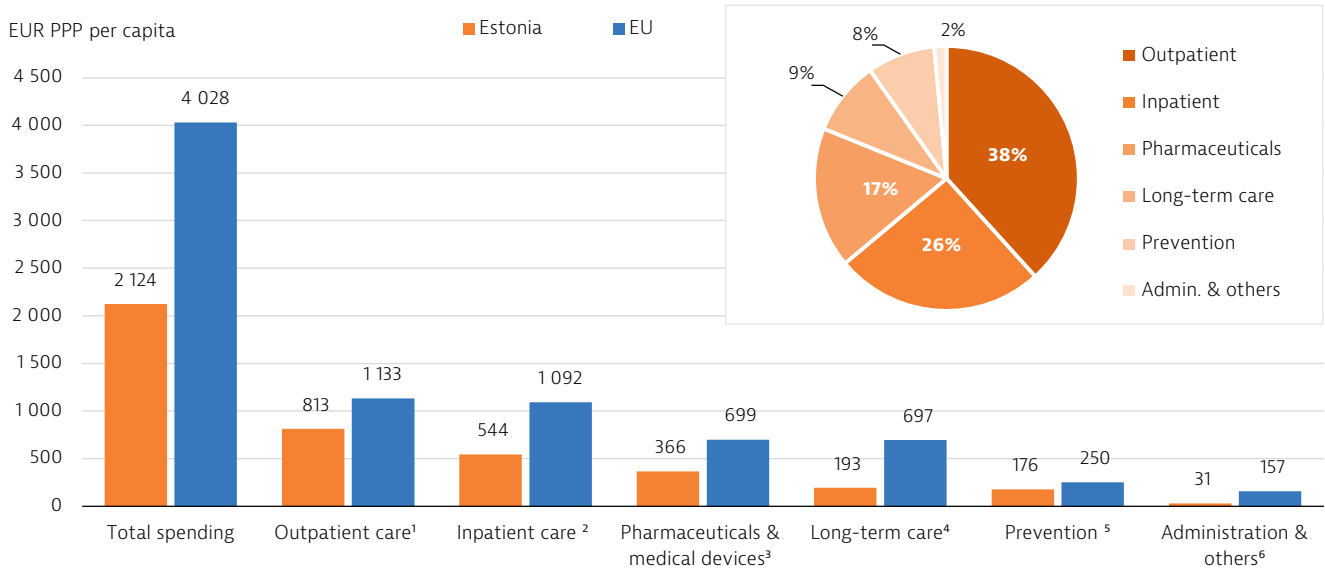
Source: OECD Health Statistics 2023 (data refer to 2021, except Malta (2020)).

The Estonian health system spends more on outpatient than inpatient care

Outpatient care (including dental care) accounts for the largest share of health expenditure in Estonia, followed by inpatient care and pharmaceuticals. The country spends significantly less than the EU average on long-term care. Reflecting additional

expenses related to COVID-19 vaccinations and other preventive measures, around 8 % of health expenditure went on public health and prevention in 2021, which is above the EU average of 6 % (Figure 9). The high share of expenditure on outpatient care is partly explained by the high cost of dental care in Estonia (see Section 5.2).

Figure 9. Estonia directed significant resources towards prevention in 2021



Notes: 1. Includes dental care, home care and ancillary services (e.g. patient transportation); 2. Includes curative-rehabilitative care in hospital and other settings; 3. Includes only the outpatient market; 4. Includes only the health component; 5. Includes only spending for organised prevention programmes; 6. Includes health system governance and administration and other spending. The EU average is weighted.

Sources: OECD Health Statistics 2023 (data refer to 2021, except Malta (2020)).

Estonia had enough hospital beds during the COVID-19 pandemic

The number of hospital beds in Estonia was 4.4 per 1 000 population in 2021, which is lower than the EU average of 4.8 per 1 000. Bed numbers have decreased markedly over time as service provision has shifted to outpatient settings. Nonetheless, Estonia did not experience a shortage of beds during the COVID-19 pandemic (see Section 5.3). Similarly, the number of hospitals has more than halved in the last three decades. The remaining hospitals are well distributed, and 94 % of the population live within a 30-minute drive of a hospital (Statistics Estonia, 2023). While some hospitals have outdated infrastructure, one third of the total hospital floor area is either newly built or substantially renovated (European Commission TSI, 2022).

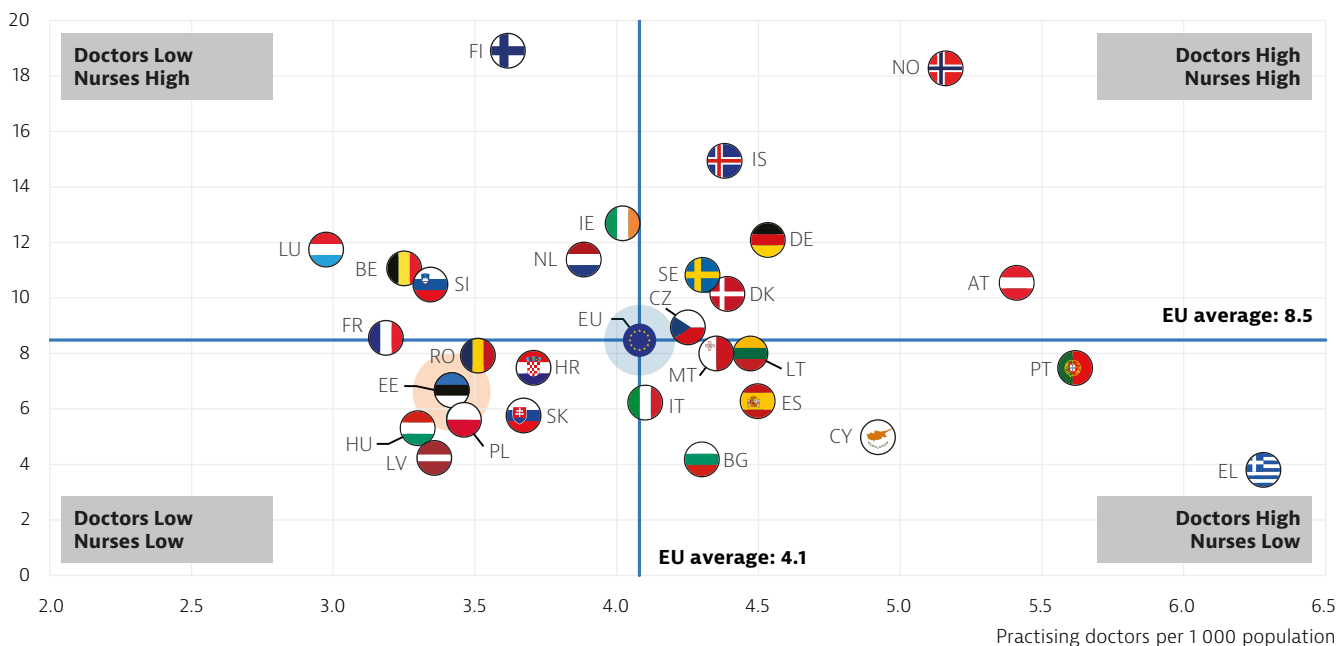
Some regions in Estonia face acute shortages of health workers

In 2021, Estonia had fewer physicians (3.4 per 1 000 population) and nurses (6.5 per 1 000 population) than the EU averages (Figure 10). The physician workforce is ageing, and there are acute workforce

shortages in family medicine – especially outside the biggest cities (Tallinn and Tartu) – and in psychiatry. There is also an acute shortage of nurses throughout the system. There are more dentists in Estonia than the EU average, but most allied health professionals are in short supply. This reduces the potential for using skill-mix solutions, such as task shifting, to overcome health workforce shortages, which is likely to challenge the resilience of the health system (see Section 5.3).

Figure 10. Estonia has low numbers of doctors and nurses compared to the EU averages

Practising nurses per 1 000 population



Notes: The EU average is unweighted. The data on nurses include all categories of nurses (not only those meeting the EU Directive on the Recognition of Professional Qualifications). In Portugal and Greece, data refer to all doctors licensed to practise, resulting in a large overestimation of the number of practising doctors (e.g. of around 30 % in Portugal). In Greece, the number of nurses is underestimated as it only includes those working in hospitals. Source: OECD Health Statistics 2023 (data refer to 2021 or the nearest available year).

5 Performance of the health system

5.1 Effectiveness

Mortality rates from preventable and treatable causes decreased rapidly before the pandemic

Between 2015 and 2019, preventable mortality rates in Estonia decreased by 13.5 %. However, in 2020, the trend changed as COVID-19 deaths were classified as preventable. In 2020, Estonia reported 252 preventable deaths per 100 000 population. Alcohol-related causes of death accounted for over 20 % of preventable deaths, lung cancer for 12 %, and ischaemic heart disease and accidents for 10 % each (Figure 11). Since 2014, Estonia has implemented comprehensive national strategies to reduce alcohol and tobacco use, which are the key risk factors behind the country's preventable mortality rates (see Section 3).

Rates of mortality from treatable causes (deaths deemed avoidable through more effective healthcare) have decreased in Estonia – from 148 deaths per 100 000 population in 2015 to 124 deaths per 100 000 in 2020. However, this is still relatively high compared to the EU average of 92 treatable deaths per 100 000 population in 2020 (Figure 11). The most frequent causes of treatable death are

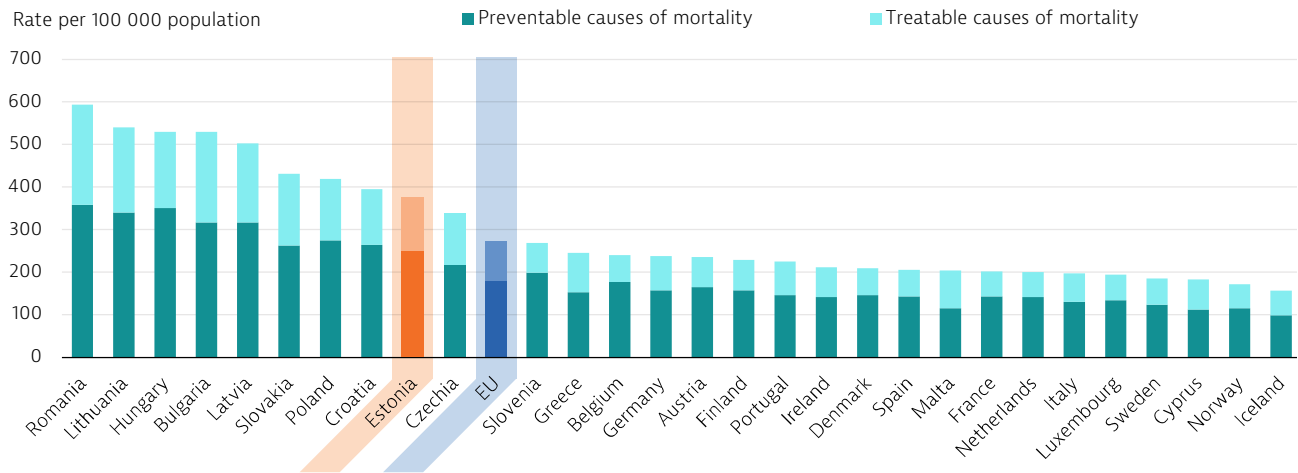
attributable to cardiovascular conditions – most commonly ischaemic heart disease, hypertension and stroke.

Immunisation rates are persistently lower than the EU averages

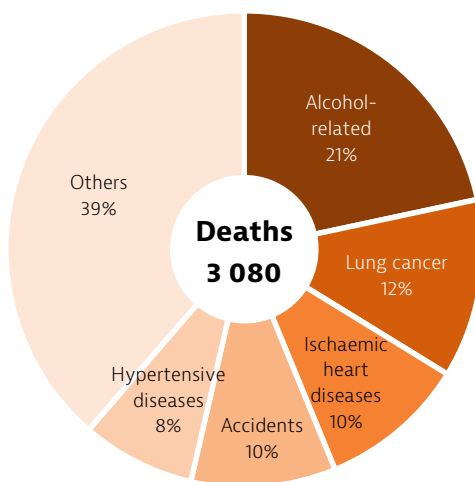
Routine immunisation rates in Estonia have been falling. In 2017, 93 % of children were fully vaccinated against diphtheria, tetanus and pertussis, but this fell to 90 % in 2021 – below the EU average of 95 % and the level required to assure herd immunity. The human papilloma virus (HPV) vaccination rate for girls aged 15 improved from 48 % in 2019 to 60 % in 2022, following the 2018 inclusion of the vaccine in the national vaccination schedule for girls aged 12-14.

The influenza vaccination rate for people aged 65 and over increased from 15 % in 2019 to 21 % in 2021; however, this remains significantly lower than the EU average of 51 %. By 2022, the national immunisation schedule included influenza vaccination for pregnant women, people aged 65 and over, children aged 6 months to 7 years, and people aged under 18 who are considered at risk.

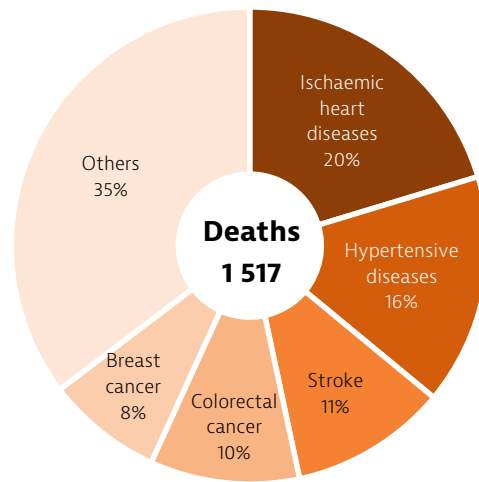
Figure 11. Preventable and treatable mortality rates remain higher than in many EU countries



Preventable causes of mortality



Treatable causes of mortality



Estonia

Notes: Preventable mortality is defined as death that can be mainly avoided through public health and primary prevention interventions. Treatable (or amenable) mortality is defined as death that can be mainly avoided through healthcare interventions, including screening and treatment. Both indicators refer to premature mortality (under age 75). The lists attribute half of all deaths from some diseases (e.g. ischaemic heart disease, stroke, diabetes and hypertension) to the preventable mortality list and the other half to treatable causes, so there is no double-counting of the same death.

Source: Eurostat Database (data refer to 2020).

Improvements in cancer screening coverage were delayed by the COVID-19 pandemic

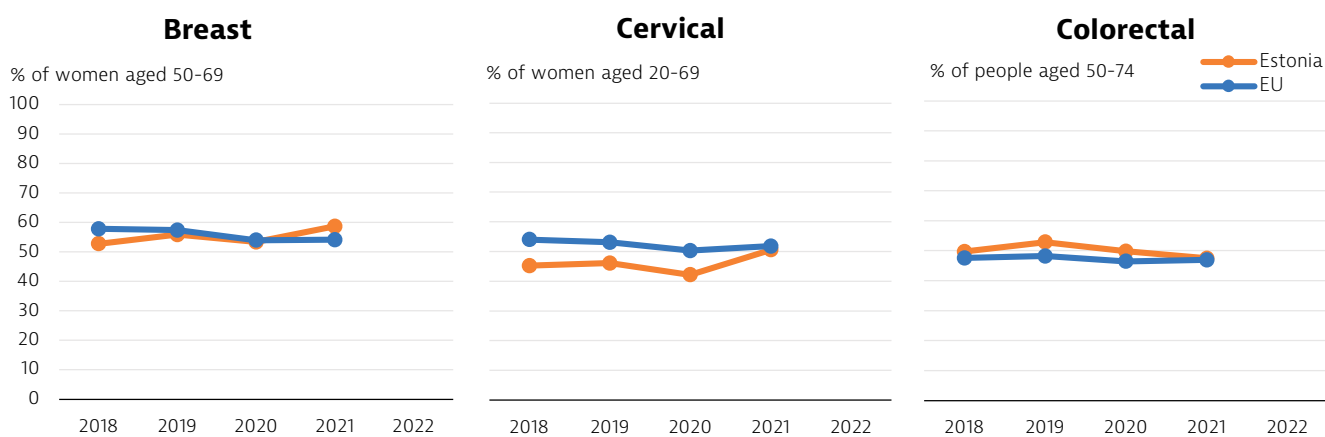
One of the objectives of the Cancer Control Plan 2021-30 is to improve cancer detection. To achieve this, the EHIF extended cancer screening coverage for breast, colorectal and cervical cancers to the uninsured population in 2021. Estonia's screening rates for some cancers either surpassed or neared the EU average. In 2021, 58.7 % of women in the target group had been screened for breast cancer within the last two years, compared to the EU average of 54.0 %, and 50.6 % of women had been screened for cervical cancer, compared to the EU average of 51.8 %. The colorectal cancer screening rate for 2021 and 2020 in Estonia (47.5 %) is similar to the EU average of 47 %, but it had been higher in 2019 (Figure 12). Despite the overall increase in cancer screening rates in 2021, the EHIF reported an underspend in the cancer prevention budget

due to the COVID-19 pandemic and the associated delays in scheduled screening appointments (Eesti Haigekassa, 2021).

Primary care has an important role in reducing avoidable hospital admissions

Low hospitalisation rates for conditions that can be managed effectively in outpatient settings – such as asthma, chronic obstructive pulmonary disease (COPD) and diabetes – indicate strong primary care in Estonia. Pre-pandemic hospitalisation rates for asthma and COPD were declining steadily and stood among the lowest in the EU, at 116.6 hospitalisations per 100 000 population in 2019. The trend for diabetes admissions also declined, remaining below the EU average. Nevertheless, the 2020 and 2021 decreases in avoidable admissions for these conditions should be interpreted in the context of the COVID-19 pandemic, which reduced hospital

Figure 12. The screening rate for breast cancer in Estonia exceeds the EU average



Note: Rates refer to the share of individuals within the target groups who have undergone screening in the last two years. Source: OECD Health Statistics 2023 (based on national programme data).

capacity for acute care and patient utilisation of healthcare services (see Section 5.3). To strengthen primary care further, Estonia is expanding the role of family nurses to manage patients with chronic conditions by increasing their prescribing powers.

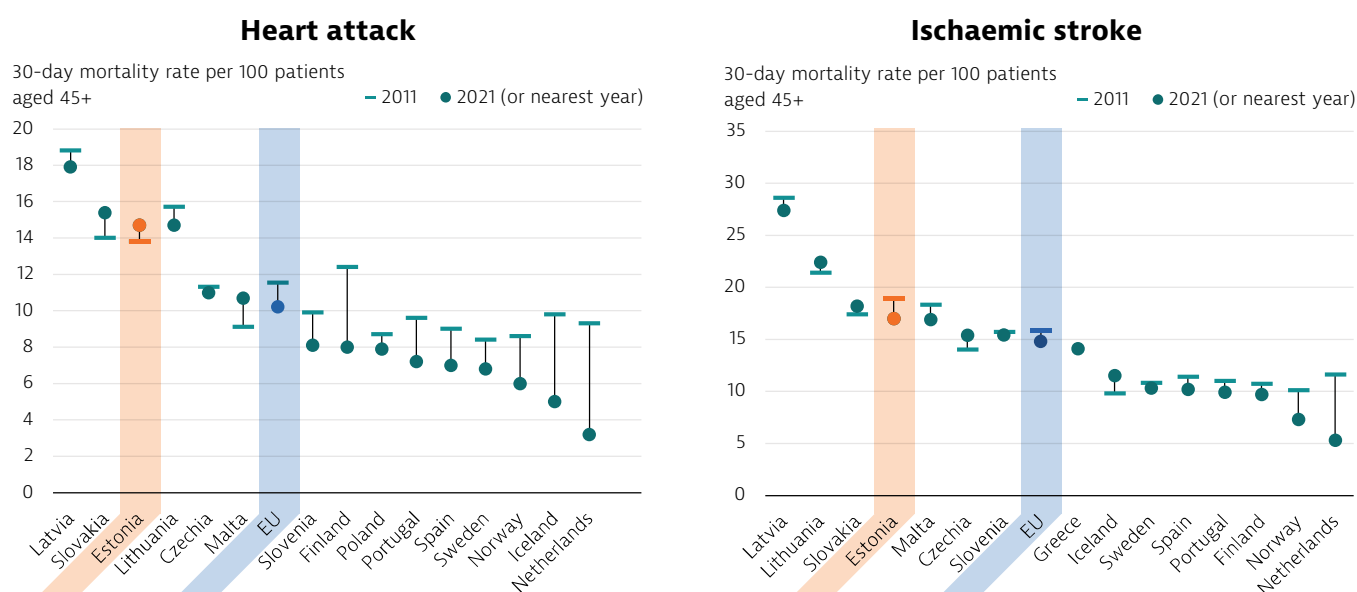
Advances in the stroke patient pathway have led to better patient outcomes

The 30-day mortality rate for ischaemic and haemorrhagic stroke in Estonia improved from 19 deaths per 100 patients in 2015 to around 17 in 2021, based on linked patient data. However, the rate is still higher than the EU average (Figure 13). Estonia implemented a pilot project to improve ischaemic stroke treatment in 2021. This aims to introduce a comprehensive treatment pathway,

linked to a bundled payment, across different care settings (excluding primary care) to enhance coordination of care. The impact of the project has been positive, with significant improvements in patient outcomes (Tervisekassa, 2023).

The mortality rate associated with heart attacks within 30 days of admission to hospital has been measured since 2011 (when it was 13.8 deaths per 100 patients discharged after the heart attack), and by 2019 it had fallen to 12.7 deaths per 100. However, progress was reversed during the pandemic, and this indicator increased to a rate of 14.7 per 100 in 2021 – its highest recorded level (Figure 13).

Figure 13. Hospital-level mortality due to heart attack increased slightly over the last decade



Note: Figures are based on patient data and have been age- and sex-standardised to the 2013 patient population aged 45+ admitted to hospital for heart attack and ischaemic stroke. Source: OECD Health Statistics 2023.

5.2 Accessibility

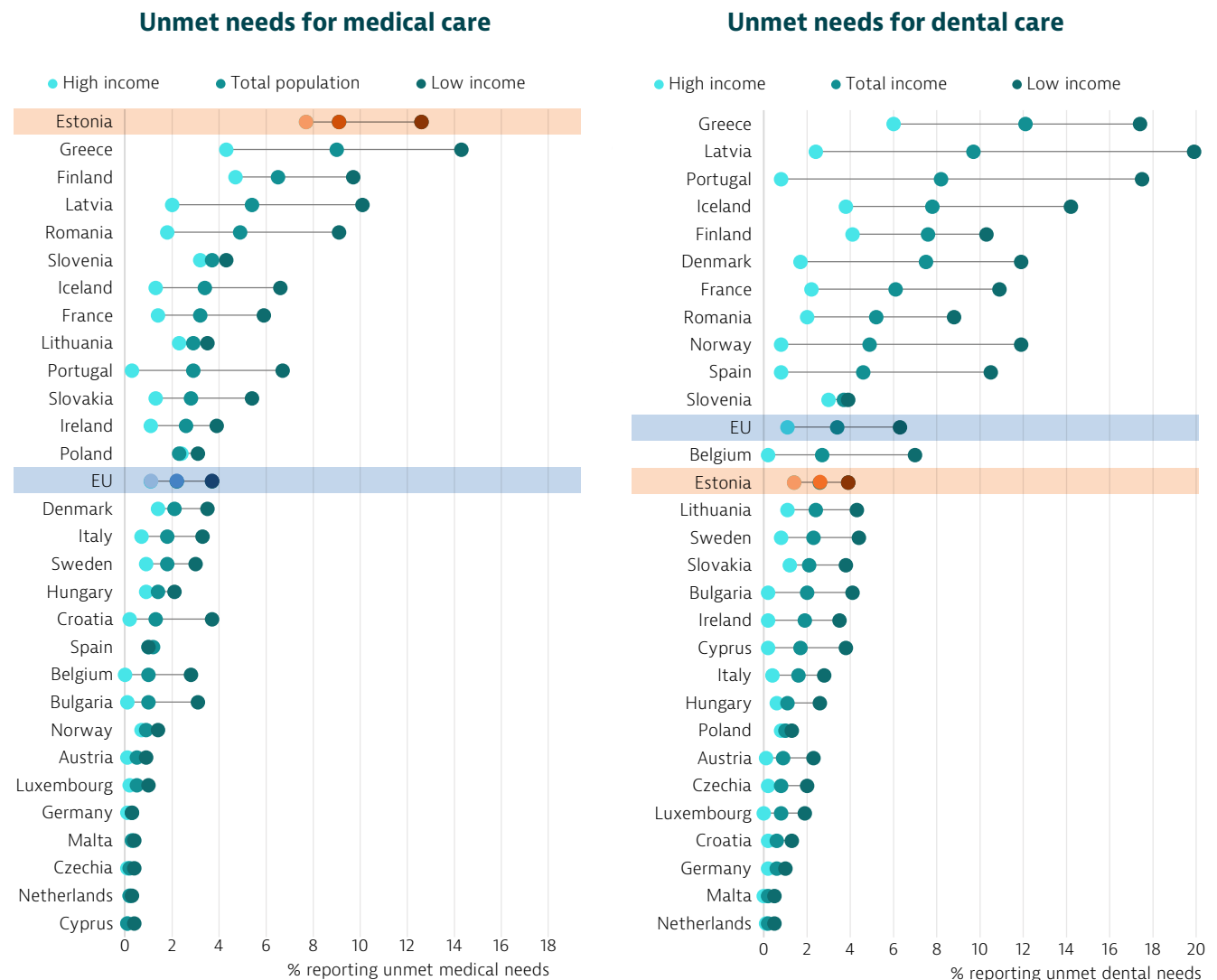
The proportion of Estonians reporting unmet health needs has almost halved in the last few years

According to the annual EU-SILC survey, the proportion of adults experiencing unmet medical needs decreased from 15.5 % in 2019 to 9.1 % in 2022, but this remains the highest rate in the EU (Figure 14). The reduction in unmet medical needs was driven by improvements for the high-income population group, where unmet medical needs decreased from 16.5 % in 2019 to 7.7 % in 2022, widening inequalities further.

The data from two waves of Eurofound² surveys show that unmet needs remained relatively high

in both 2021 and 2022, at 24-25 % (Eurofound, 2021; 2022). The higher levels reported for Estonia with this survey may indicate that some patients delayed seeking care earlier in the pandemic; unmet care needs in the first year of the pandemic were at 19 %, and the system may yet need to cope with a delayed backlog of unmet needs (see Section 5.3). According to the National Audit Office (NAO, 2022), unmet needs for specialist care increased rapidly from 2009 to 2020 but declined in 2021-22. People living in urban areas systematically reported higher unmet needs for specialist care than those in rural areas. While cost and travel distance play a minor role, waiting times are the main reason for the high level of unmet needs in Estonia.

Figure 14. Improvements in dental care coverage helped to reduce unmet needs



Notes: Data refer to unmet needs for a medical or dental examination or treatment due to costs, distance to travel or waiting times. Caution is required in comparing the data across countries as there are some variations in the survey instrument used.

Source: Eurostat Database, based on EU-SILC (data refer to 2022, except Norway (2020) and Iceland (2018), and Slovakia (2020) for dental needs).

² The data from the Eurofound survey are not comparable to those from the EU-SILC survey because of differences in methodologies.

EU-SILC survey data show that the percentage of people with unmet dental care needs across all income groups decreased from 6.7 % to 2.6 % between 2017 and 2022 (Figure 14). In addition, urban–rural differences in access to dental care have disappeared in recent years. A nationwide National Audit Office study found that the number of first-time dentist visits and more frequent visits increased after the reintroduction of the dental care benefits in 2017. However, the study also found that people on higher incomes used the benefits of the EHIF more frequently than those on lower incomes (NAO, 2021).

Working-age people in informal employment are those most likely to be uninsured in Estonia

In 2022, the EHIF covered almost 96 % of the Estonian population – around 1.3 million people. Population coverage increased slightly from 94 % in 2012 to 96 % in 2022 due to higher employment rates and expansion of government coverage for the non-working population. Eligibility is determined by regulation, and for the majority of the population is linked to employment, pensioner or child status, or belonging to socially vulnerable groups. Those with insecure or informal jobs are more likely to be uninsured. People without insurance only have access to emergency medical care; cancer screening; HIV, tuberculosis, drug cessation (and substitution) services; and COVID-19

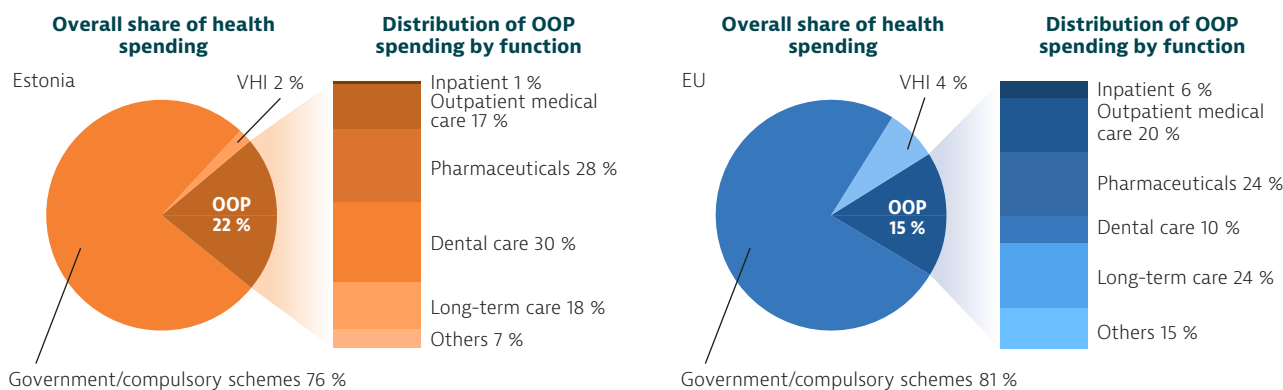
diagnostic tests and related treatment. Notably, uninsured people do not have access to most primary care services or the benefits package for essential medicines.

By the end of 2022, almost 5 % of Estonia's population consisted of war refugees from Ukraine – the highest proportion in the EU. Estonia offers Ukrainian refugees access to the same health services as uninsured people, but once they receive their residence permits, they have similar insurance eligibility criteria to Estonian residents (Mauer et al., 2022).

High out-of-pocket spending causes financial hardship

Out-of-pocket (OOP) payments for healthcare accounted for 22 % of current health expenditure in 2021 – well above the EU average of 15 % (see Section 4). Dental care is the largest driver of OOP expenditure, accounting for 30 % of total OOP spending. This is closely followed by pharmaceuticals (28 % of OOP expenditure) and long-term care (18 %) (Figure 15). Incidence of catastrophic spending on health³ decreased from 7.4 % in 2015 to 7.2 % in 2020. Half of the households affected by catastrophic spending on health belonged to the lowest income quintile (3.8 % of all households).

Figure 15. Outpatient pharmaceuticals and dental care drive private spending



Notes: VHI refers to voluntary health insurance, which also includes other voluntary prepayment schemes. The EU average is weighted.

Sources: OECD Health Statistics 2023; Eurostat Database (data refer to 2021).

Adult dental and pharmaceutical benefits intend to improve coverage

The EHIF covers a wide range of health services, including preventive and curative services, as well as prescription medicines and medical devices. Some of these may require cost sharing. Services

not on the positive list include cosmetic surgery, alternative therapies and optician services.

In 2017, Estonia reintroduced dental care benefits for adults, and increased the benefits for unemployed people and those receiving basic subsistence income to improve dental coverage.

³ Catastrophic expenditure is defined as household out-of-pocket spending exceeding 40 % of total household spending net of subsistence needs (i.e. food, housing and utilities).

In a similar move for pharmaceuticals, from 2018, the EHIF changed the additional reimbursement of prescription medicine costs: if an individual's total expenditure on prescription medicines in a year exceeds EUR 100, the EHIF compensates 50 % of the OOP costs; if the annual spend exceeds EUR 300, it compensates 90 %. A copayment of EUR 2.50 per prescribed item is also included in the individual annual cap. Calculation and administration of these copayments are automatic, using the health system's extensive digital infrastructure, and happen at the time of purchase.

Long waiting times for specialist care create access challenges but have reduced significantly

Despite significant improvements, more adults in Estonia reported that they had gone without medical care because of waiting times than in any other EU country. Long waiting times for specialised care encourage some to pay out of pocket to use private services, leading to inequalities in access. Waiting lists are legally regulated, with appointment targets of 6 weeks for outpatient specialist care, 8 months for elective inpatient care, and up to 1.5 years for elective surgery. Waiting times for cataract surgery have decreased significantly – from 349 days in 2017 to 200 days in 2020 (see Section 5.3) – following a long-term increase in funding for the procedure and the emergence of more service providers.

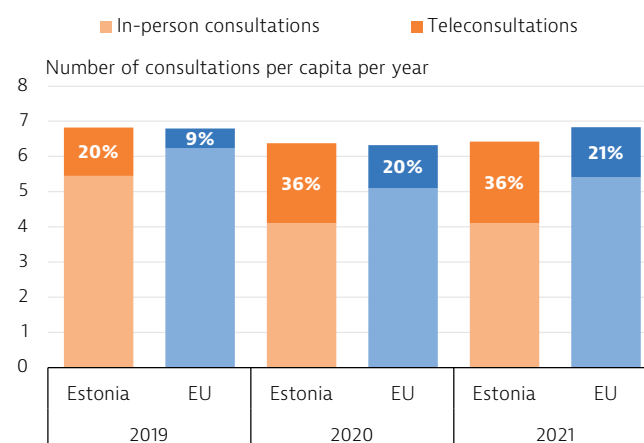
Furthermore, the EHIF increased transparency in waiting times in 2021 by publishing median waiting lists for contract partners. To address the issue of long waiting times, the national booking system includes a time-finding function. With this, patients can select a treatment service and the system automatically searches for an appointment time that matches their preferences on the day a referral is issued. This system, introduced in March 2022, has resulted in a significant reduction in waiting times for all elective procedures. For example, the mean waiting time for cataract surgery fell to 48 days further in 2022. Patients needing hip or knee replacement surgery spent less than 6 months waiting for an endoprosthesis in 2022, compared to at least 1.5-2 years before the pandemic.

Digital tools to improve access to care are widely used in Estonia

During the first two years of the COVID-19 pandemic, over one third of medical consultations in Estonia occurred remotely (Figure 16). Teleconsultations were added to the benefits package in July 2020, and digital consultations with multiple specialists were included on the

list of health services on 1 January 2021, to improve continuity of care and access to services. The new teleconsultation service simplifies the patient's clinical pathway, and eliminates the need to travel to see multiple doctors in different locations. The European Commission's Technical Support Instrument (TSI) has played a key role in development and implementation of the digital health governance framework to ensure better-quality, efficient and accessible person-centred care through better-managed digital developments within the sector. In addition, an ongoing project, initiated through TSI funding, aims to design a strategy for better teaching of digital competences to the health workforce across the country.

Figure 16. Even prior to the COVID-19 pandemic, Estonia used teleconsultations more frequently than the majority of EU countries



Sources: OECD Health Statistics 2023.

5.3 Resilience

The COVID-19 pandemic has proved to be the most significant disruption to health systems in recent decades. It has shed light on the vulnerabilities and challenges within countries' emergency preparedness strategies and on their ability to provide healthcare services to their populations. In response to the enduring effects of the pandemic – as well as other recent crises, such as cost-of-living pressures and the impact of conflicts like the war against Ukraine – countries are implementing policies to mitigate the ongoing impacts on service delivery, invest in health system recovery and resilience, improve critical areas of the health sector, and fortify their preparedness for future shocks.

Hospital occupancy rates in Estonia dropped during the pandemic due to postponed care

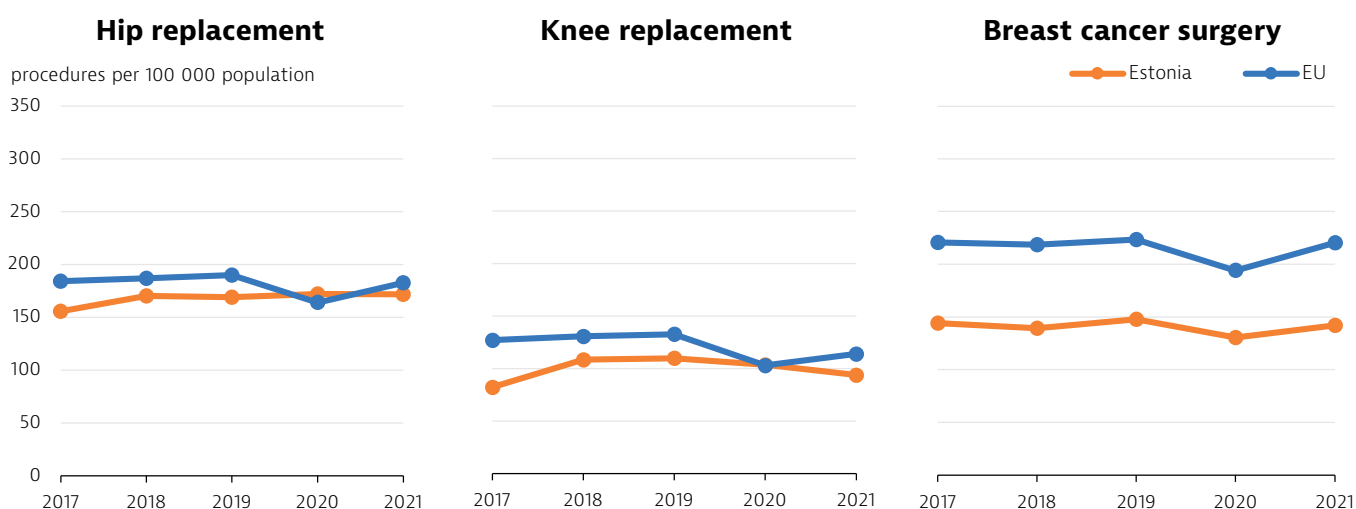
Estonia's hospital capacity has been decreasing for the last few decades and steadied in recent years to 4.4 beds per 1 000 population, which is slightly below the EU average. Hospital occupancy rates dropped from 73.8 % in 2019 (before COVID-19) to 66.0 % in 2021. Estonia has one of the highest intensive care unit (ICU) bed densities in the EU, with 4.1 ICU beds per 1 000 population in 2021. Overall, Estonia did not experience a shortage of beds during the COVID-19 pandemic, although during the peak of October-November 2021 and February 2022, bed capacity was at its maximum (Health Board, 2023).

Some elective surgical activity was maintained during the COVID-19 pandemic

Following the intermittent suspension of elective care during the peak phases of COVID-19, the

volume of non-urgent surgery performed in most EU countries decreased in 2020 but picked up again in 2021. In Estonia, some elective procedures continued throughout the pandemic, while the volume of other procedures decreased. For example, there were slightly more hip replacements in Estonia in 2021 than in 2019 and 2020, but fewer knee replacements over the three years (Figure 17). There were some fluctuations in the volume of breast cancer surgery in Estonia before the COVID-19 pandemic, but after a temporary reduction in 2020, the activity returned to pre-pandemic levels in 2021. Some waiting lists in Estonia may have increased because the pandemic slowed elective surgical activity, but the impact of the pandemic on surgical activity and waiting lists was less pronounced than in other EU countries (see Section 5.2).

Figure 17. The pandemic had a relatively limited impact on the volume of elective procedures performed in Estonia



Source: OECD Health Statistics 2023.

Only a small proportion of older adults received two COVID-19 booster vaccines

Estonia had a similar COVID-19 vaccination rate to the EU average until mid-May 2021. The rates diverged over the summer of 2021, and by the end of 2022, only 17 % of adults aged 60 and over had received a primary vaccination and two booster doses: well below the EU average of 36 %.

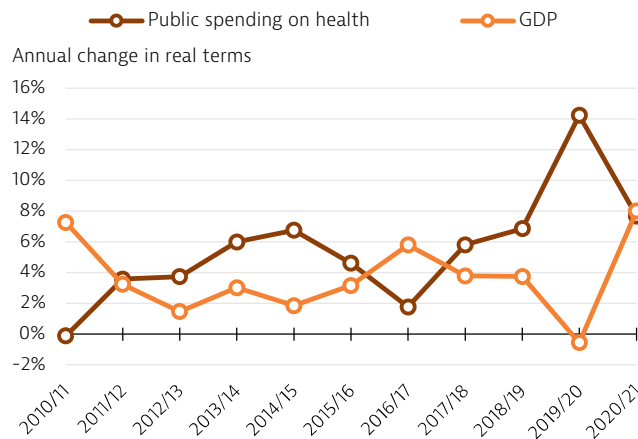
Public spending on health has been growing every year, supported by investment from the EU

Public spending on health in Estonia has grown since 2010. It continued to increase in 2019-20, even

as the country's economy contracted during the first year of the COVID-19 pandemic (Figure 18). Capital investments in the Estonian healthcare system have relied on EU structural funds. These have established long-term, primary, secondary and tertiary care facilities and supported primary care digitalisation. Recovery Assistance for Cohesion and the Territories of Europe (REACT-EU) funds have supported COVID-19 vaccinations and recovery, and the European Social Fund has supported disease prevention programmes. The European Commission's TSI has also steered development of an integrated Hospital Master Plan to improve geographical distribution of infrastructure (European Commission TSI, 2022).

Furthermore, under the EU Cohesion Policy 2021-27 programme, Estonia is set to invest EUR 1.4 million to improve the accessibility, effectiveness and resilience of the health system, with 61 % co-financed from the EU's Just Transition Fund.⁴ Estonia's Recovery and Resilience Plan includes construction of a county hospital and health centre in Vijandi.

Figure 18. Public spending on health increased considerably during the COVID-19 pandemic



Source: OECD Health Statistics 2023.

Recent reforms seek to enhance health system efficiency

Some recent health system reforms have focused on efficient use of resources. The EHIF introduced financial incentives for multidisciplinary primary healthcare centres and for primary care networks that provide better access to services. As of 2021, the EHIF has enabled primary healthcare centres to hire additional staff according to local need, and to pay salaries based on staff working hours. A 2023 health system performance assessment encouraged development of a sustainable governance plan that makes use of abundant available healthcare data for purposes such as service integration, clinical decision making and outcome measurement (OECD, 2023). Additionally, the proposed new hospital network outlined in the Hospital Master Plan includes transformation of multiple hospitals into community hospitals that will be integrated into the primary care network (European Commission TSI, 2022). The government has set a deadline of summer 2024 for completion of the updated Hospital Master Plan and the overall Health System Development Strategy, which will incorporate plans for primary care, emergency services and hospital development.

⁴ These EU Cohesion Policy figures reflect the status as of September 2023.

Estonia makes good use of health technology assessment processes and digital technologies

Estonia has made use of health technology assessment (HTA) processes since 2012. HTA findings are considered a crucial part of the decision-making process to add new services to the benefits package and when designing clinical guidelines. New treatments can be included in the EHIF benefits package if medical efficacy, cost-effectiveness, alternative treatments, consistency with national health policy and availability of financial resources are demonstrated. Similarly, Estonia utilises digital technologies throughout the health system (see Section 5.2). The current challenges include standardisation, interoperability and timely exchange of data. These are addressed in part by the Recovery and Resilience Plan reforms, as governance of digital activity across government will be streamlined.

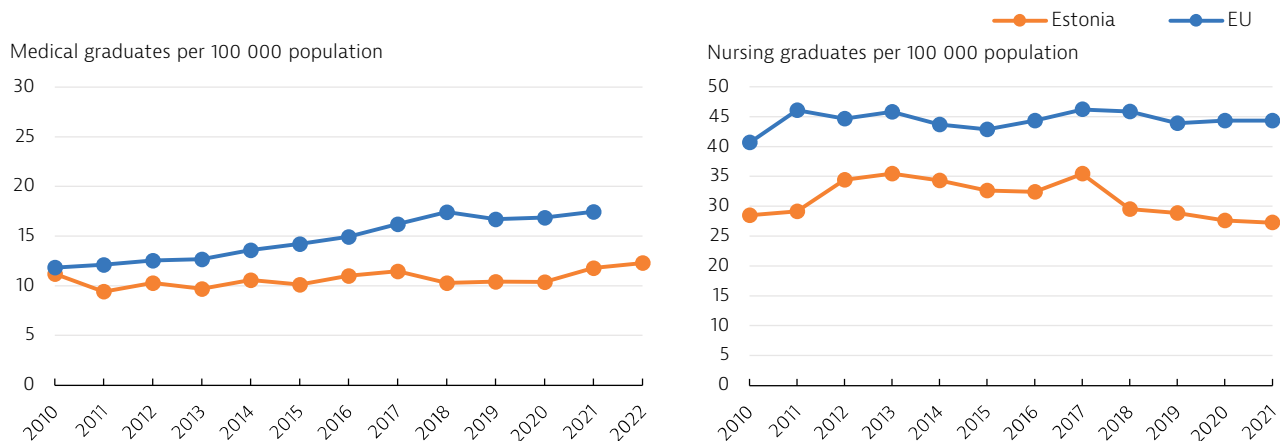
Not enough family doctors and nurses are being trained in Estonia

In Estonia, the Ministry of Social Affairs, in close co-operation with the Ministry of Education and Research, is responsible for planning human resources for the health system. Through stakeholder discussions and joint agreements, it sets admissions quotas for public medical and nursing university courses and for state-funded medical specialty training programmes. The number of new medical and nursing graduates in Estonia remained near static between 2010 and 2022, and below the EU average (Figure 19). As there is a shortage of health workers, admissions quotas for these programmes are set to rise, but the revised quotas remain below projected need (see Section 4). The quality of health workforce education is deemed good, and meets EU, international peer review and accreditation requirements. To support the education and training system further, recent REACT-EU funds have financed clinical instructors at healthcare institutions.

Health workforce shortages are being tackled but remain an important policy issue

Other recent policy changes aim to make a career in health more attractive. At the national level, medical specialty training was reformed in 2020 to allow for greater flexibility and part-time options. There has also been recent debate on attracting more health workers from abroad, as well as retaining Estonian health workers in the system. Estonia has implemented EU standards of mutual

Figure 19. There has been almost no growth in the numbers of medical or nursing graduates in Estonia in the last 10 years



Note: The EU average is unweighted.

Sources: OECD Health Statistics 2023; Eurostat Database.

recognition of professional qualifications, although health professionals from third countries are required to pass strict national requirements that include work experience, licensing and language exams. The application process for registration has been simplified for qualified Ukrainian refugees, but strict language and work experience requirements remain. Health workforce shortages remain an urgent issue in the Estonian health system, and they are the key capacity constraint behind long waiting times.

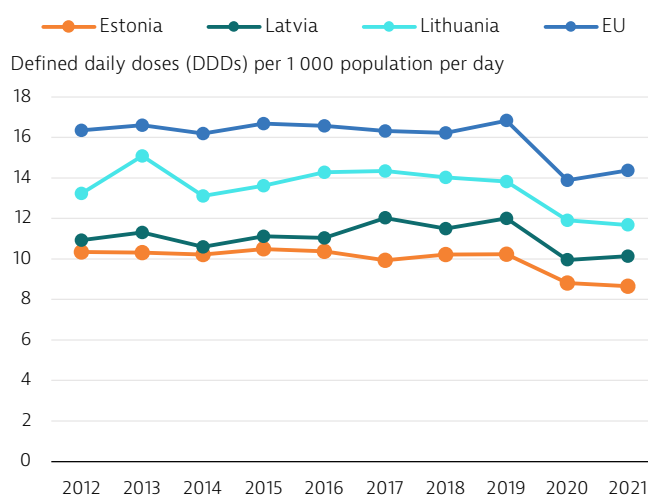
Estonia is making some progress on tackling challenges such as antimicrobial resistance and climate change

The Emergency Act in Estonia, as amended in 2022, is compliant with Art. 6 of the EU Regulation on Serious Cross-border Health Threats. Progress is also being made on crises that are unfolding at a slower pace, such as antimicrobial resistance (AMR) and climate change. Antibiotic consumption in the community is low in Estonia compared to other European countries (Figure 20). However, consumption of broad-spectrum antibiotics is high and rising, indicating a need to review prescribing patterns (WHO Regional Office for Europe, 2022). While the rate of AMR is low in Estonia compared to other European countries, multisectoral collaboration between the health, veterinary and agricultural sectors is also weaker (WHO Regional Office for Europe/ECDC, 2022). To date, Estonia is not enrolled in the WHO Global AMR Surveillance System.

The climate change adaptation plan has been merged with the environmental strategy to form the Environmental Development Plan 2030

(Ministry of the Environment, 2023). Health goals of this strategy focus on monitoring, risk management and rescue capacity.

Figure 20. Estonian antibiotic use in the community is comparatively low



Notes: The EU average is unweighted. The data only cover consumption in the community (outpatient).

Source: ECDC ESAC-Net.

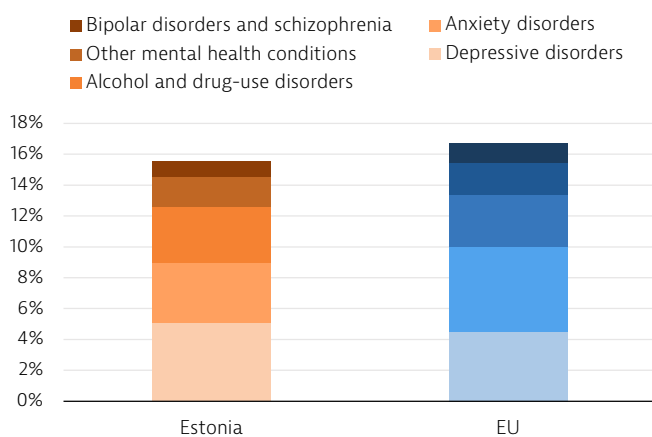
6 Spotlight on mental health

Prevalence of mental ill health grew during the COVID-19 pandemic, prompting additional funding for mental health services

The proportion of the population with a diagnosed mental illness in Estonia is 16 %, which is similar to the prevalence in neighbouring Latvia (16 %) and Lithuania (17 %) and the EU average (17 %) (Figure 21). According to estimates from the first Estonian National Mental Health Study 2022, one in four adults were at risk of depression, and one in five were at greater risk of generalised anxiety disorders after the COVID-19 crisis (National Institute for Health Development, 2022).

The economic cost of mental disorders in Estonia amounted to 2.8 % of GDP or almost EUR 572 million in 2015, compared to 4.1 % of GDP on average across the EU (OECD/EU, 2018). Unfortunately, more recent calculations that could assess the economic burden of mental illness during and after the COVID-19 pandemic are not yet available. The government recognises the value of improved mental healthcare, and allocated an additional EUR 4.7 million in extra funding from the state budget, bringing the total public funding for mental health services to EUR 7 million (Ministry of Finance, 2022).

Figure 21. Prevalence of mental ill health in Estonia was below average before the pandemic



Source: IHME (data refer to 2019).

Depression is more common among people in the lowest income group, with the pandemic increasing risks

Data from the EHIS 2019 show that 7 % of adults (10.4 % in the lowest income quintile and 4.2 % in

the highest quintile) in Estonia reported symptoms of depression before the pandemic. The results of the Estonian National Mental Health Study 2022 reported worsening mental health after the beginning of the pandemic. According to registry-based calculations, depression and anxiety disorders were the most common diagnoses, and the risk of these conditions increased considerably during the pandemic (National Institute for Health Development, 2022).

Suicide rates in Estonia have fallen, but remain well above the EU average

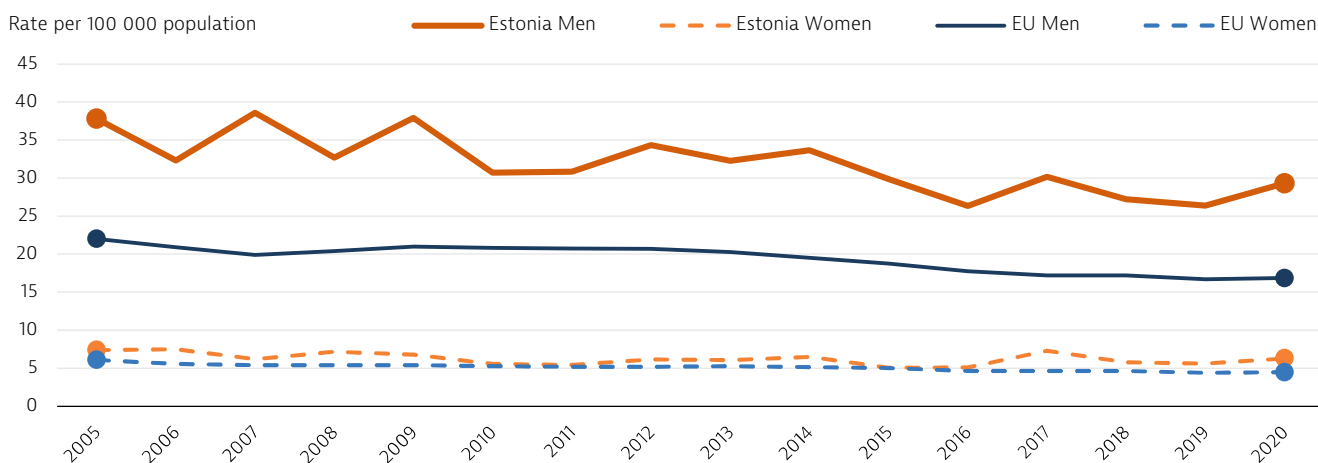
Estonia has made progress in reducing the suicide rate for both genders, although a notable inequality persists. For men, the overall downward trend has fluctuated over the last two decades, with an overall decline of 24 % since 2015, but the suicide rate remains 1.5 times higher than for women. There was a slight increase in death by suicide among men (29.3 per 100 000) and women (6.3 per 100 000) in the first year of the COVID-19 pandemic compared to 2019 figures (26.4 per 100 000 for men and 5.6 per 100 000 for women) (Figure 22). To address the issue, Estonia is developing its first suicide prevention action plan, based on the recently adopted Mental Health Action Plan 2023-26.

The pandemic prompted strong action to improve mental health services delivery

Mental healthcare in Estonia is provided by family doctors, nurses, psychiatrists, psychiatric nurses and clinical psychologists. Services are provided in both outpatient and inpatient settings, with a shift towards outpatient treatment and primary care. In addition, mental health services are increasingly being provided remotely, using teleconsultations or videoconferencing. Child mental health services are provided through four regional child mental health centres and satellites, which were developed in 2016 with funding from the Norwegian and European Economic Area programmes. Psychiatric beds are integrated into larger hospitals, and there are two private specialised psychiatric hospitals.

The role of the mental health nurse in hospitals or primary care was strengthened in 2021, and primary care group practices are set to become the first point of contact for people seeking mental health help. A mental health nurse can carry out the initial assessment and refer patients to a

Figure 22. Suicide rates have fluctuated widely but improved overall in the last 15 years



Source: Eurostat Database.

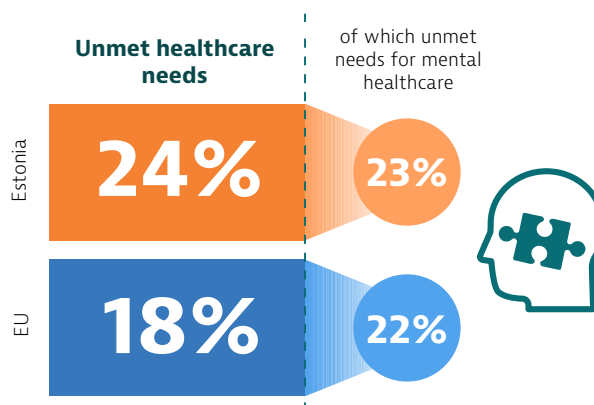
psychiatrist if needed. Psychiatric help for people under 18 has become available without requiring consent from a legal representative.

Strengthening provision of mental health services in primary care aims to address the high level of unmet needs for mental healthcare during and after the COVID-19 pandemic. According to the Eurofound surveys conducted in spring 2021 and spring 2022, 24 % of Estonians reported unmet healthcare needs during the pandemic, of which nearly one quarter were for mental healthcare (Figure 23).

Estonia is actively developing comprehensive policies to strengthen mental health

In 2021, Estonia implemented a Green Paper on mental health, which uses a pyramid approach to provide a comprehensive, intersectoral and multi-level mental health system. The approach starts with self-care and self-help, followed by community-based support services and primary healthcare, outpatient psychiatric care and counselling, and hospital psychiatric services. In early 2022, a Mental Health Department was established within the Ministry of Social Affairs to centralise efforts to improve mental health outcomes. By the end of 2022, a Mental Health Action Plan 2023-26 had been drawn up, defining concrete actions for the coming years. The focus of its activities is to ease the pressure on specialised mental healthcare services by strengthening the role of primary care, applying a stepped care model and low-intensity interventions, and ensuring sufficient prevention and promotion in mental healthcare.

Figure 23. Nearly one in four unmet healthcare needs during the pandemic related to mental healthcare



Note: Survey respondents were asked whether they had any current unmet healthcare needs and, if so, for what type of care, including mental healthcare.

Sources: Eurofound (2021; 2022).

7 Key findings

- Life expectancy at birth in Estonia fell by 0.8 years between 2019 and 2022 during the COVID-19 pandemic, compared to an EU average fall of 0.6 years. Before this, it had risen by nearly 8 years since the start of the millennium, to a pre-COVID-19 peak of 79 years. However, the gender gap is wide: in 2022, women in Estonia could expect to live an average of 8.7 years longer than men, compared to the EU average gender gap of 5.4 years.
- Estonia also has marked health inequalities by socioeconomic status. At age 30, life expectancy for men with lower education levels is 9.3 years shorter than for those with higher levels. Estonia also has one of the widest gaps in self-reported health status across income groups in the EU. These socioeconomic disparities are shaped by risk factors that are more prevalent among Estonians with lower education levels, who are more likely to smoke and to be obese.
- Since 2014, Estonia has implemented comprehensive national strategies to reduce alcohol and tobacco use, as the key risk factors behind the country's preventable mortality rates. Before 2020, preventable mortality rates had been falling, but from 2021, COVID-19 deaths have been classed as preventable and the number of COVID-19 deaths in Estonia was high. By the end of 2021, only 17 % of adults aged 60 and over had received a primary COVID-19 vaccination and two booster doses.
- Progress in health system efficacy in Estonia is reflected in falling rates of treatable mortality – more Estonians are surviving strokes and accessing cancer screening. However, COVID-19 has led to delays in preventive cancer care, and the Estonian Health Insurance Fund continues to report underutilisation of its cancer prevention budget, despite increasing coverage of breast, cervical and colorectal cancer screening.
- Public expenditure on health in Estonia increased between 2019 and 2021, reflecting the growing role of government transfers in financing healthcare as the system moves away from reliance on employer contributions through social health insurance. However, the share of out-of-pocket expenditure remains high, causing financial hardship for more than 7 % of all Estonian households.
- Estonia has seen significant reductions in unmet needs for medical care: the rate declined significantly between 2019 and 2022, from 15.5 % to 9.1 %. Thanks to improvements in dental care coverage, only 2.5 % of Estonians reported not seeking dental services due to cost, distance or waiting times in 2021. Access to services has also improved thanks to the increased use of telemedicine and significant reductions in waiting times for some elective procedures, such as hip or knee replacements and cataract surgery. These were high and exceeded legally defined standards before the renewal of the waiting lists system in 2022.
- Estonia is not training enough family doctors to meet future needs projections. Admissions quotas to medical and nursing courses have increased recently, but the size of the new intake is still below projected requirements to meet future demand. While recent changes have made medical specialty training more flexible, health workforce shortages remain an urgent issue.
- The burden of common mental health problems and unmet needs for mental health services was high during the COVID-19 pandemic, and there was a sharp rise in the number of alcohol-related deaths between 2020 and 2022. To address this, Estonia established a Mental Health Department for central coordination of mental health policy in 2022, and set priorities for action in the Mental Health Action Plan 2023-26 to strengthen provision of mental health services, as well as prevention and mental health promotion efforts.

Key sources

Kasekamp K et al. (2023). Estonia: health system review. *Health Systems in Transition*, 25(5): i-204.

OECD/EU (2022), *Health at a Glance: Europe 2022 – State of Health in the EU Cycle*. Paris.

References

Eesti Haigekassa (2021), *Eesti Haigekassa 2021. aasta majandusaasta aruanne [Estonian Health Insurance Fund 2021: Annual report]*. Tallinn.

Eurofound (2021), *Living, working and COVID-19 survey, rounds one, two and three (spring 2020, summer 2020 and spring 2021)*. Dublin.

Eurofound (2022), *Living, working and COVID-19 survey, rounds four and five (November 2021 and May 2022)*. Dublin.

European Commission TSI (2022), *Person-centred integrated hospital master plan in Estonia. Deliverable D: Hospital Master Plan 2040*. Tallinn.

Health Behaviour in School-aged Children study (2023), *Data browser (findings from the 2021/22 international HBSC survey)*: <https://data-browser.hbsc.org>.

Health Board (2023), *Coronavirus dataset*. Tallinn, <https://www.terviseamet.ee/en/coronavirus-dataset>.

Mauer N et al. (2022), *Report on access to health care in EU Member States Implementation of Temporary Protection Directive (2001/55/EC) and Council Implementing Decision (EU) 2022/382*. Brussels, European Observatory on Health Systems and Policies/European Commission.

Ministry of Finance (2022), *Riigieelarve Seletuskiri [Explanatory note to 2023 state budget]*. Tallinn.

Ministry of the Environment (2023), *Climate change adaptation development plan*. Tallinn.

NAO (2022), *Eesti tervishoiu suundumused [Estonian healthcare trends]*. Tallinn, National Audit Office of Estonia.

NAO (2021), *Adult dental care benefit*. Tallinn, National Audit Office of Estonia.

National Institute for Health Development (2022), *Estonian National Mental Health Survey: final report of the population health survey*. Tallinn,.

National Institute for Health Development (2023). *Health Statistics and Health Research Database*, https://statistika.tai.ee/index_en.html.

OECD (2023), *Health system performance assessment framework for Estonia*, OECD Publishing, Paris.

OECD/EU (2018), *Health at a Glance: Europe 2018 – State of Health in the EU Cycle*. Paris.

Statistics Estonia (2023). *Statistics Database*, <http://www.stat.ee>.

Tervisekassa (2023), *Insuldi juhtprojekti looparuanne 2023 [Stroke Management Project. Report 2023]*. Tallinn.

WHO Regional Office for Europe/ECDC (2022), *Antimicrobial resistance surveillance in Europe 2022–2020 data*. Copenhagen.

WHO Regional Office for Europe (2022), *Tackling antimicrobial resistance in primary health care in Estonia*. Copenhagen.

Country abbreviations

Austria	AT	Denmark	DK	Hungary	HU	Luxembourg	LU	Romania	RO
Belgium	BE	Estonia	EE	Iceland	IS	Malta	MT	Slovakia	SK
Bulgaria	BG	Finland	FI	Ireland	IE	Netherlands	NL	Slovenia	SI
Croatia	HR	France	FR	Italy	IT	Norway	NO	Spain	ES
Cyprus	CY	Germany	DE	Latvia	LV	Poland	PL	Sweden	SE
Czechia	CZ	Greece	EL	Lithuania	LT	Portugal	PT		

State of Health in the EU

Country Health Profile 2023

The *Country Health Profiles* are a key element of the European Commission's *State of Health in the EU* cycle, a knowledge brokering project developed with financial support from the European Union.

These Profiles are the result of a collaborative partnership between the Organisation for Economic Co-operation and Development (OECD) and the European Observatory on Health Systems and Policies, working in tandem with the European Commission. Based on a consistent methodology using both quantitative and qualitative data, the analysis covers the latest health policy challenges and developments in each EU/EEA country.

The 2023 edition of the Country Health Profiles provides a synthesis of various critical aspects, including:

- the current state of health within the country;
- health determinants, with a specific focus on behavioural risk factors;
- the structure and organisation of the health system;
- the effectiveness, accessibility and resilience of the health system;
- For the first time in the series, an account of the state of mental health and related services within the country.

Complementing the key findings of the Country Health Profiles is the Synthesis Report by the European Commission.

For more information, please refer to: ec.europa.eu/health/state

Please cite this publication as:

OECD/European Observatory on Health Systems and Policies (2023),
Estonia: Country Health Profile 2023, State of Health in the EU,
OECD Publishing, Paris/European Observatory on Health Systems and Policies, Brussels.

ISBN 9789264603479 (PDF)

Series: State of Health in the EU

SSN 25227041 (online)