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EUROPEAN SOCIAL CHARTER

10th National Report on the implementation of
the Revised European Social Charter

submitted by

THE GOVERNMENT OF ESTONIA

(Articles 3, 11, 12, 13 and 14
for the period of

01/01/2008 – 31/12/2011)

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CYCLE 2013

EUROPEAN SOCIAL CHARTER (REVISED)

10th Report of

the Republic of Estonia

On the accepted provisions

For the reference period 2008 – 2011

Articles 3, 11, 12, 13, 14

For the period 2008–2011 made by the Government of Estonia in accordance with Article C of the Revised European Social Charter, on the measures taken to give effect to the accepted provisions of the Revised European Social Charter, the instrument of ratification or approval of which was deposited on 11 September 2000.

In accordance with Article C of the Revised European Social Charter and Article 23 of the European Social Charter, copies of this report have been communicated to the Estonian Central Federation of Trade Unions (EAKL), the Estonian Employees Unions Confederation (TALO) and the Estonian Confederation of Employers (ETK).

All Estonian legal acts that have been translated to English are available on the Internet at http://www.legaltext.ee/indexen.htm. The English version of the new Employment Contracts Act can be accessed at: http://www.sm.ee/eng/activity/working-and-managing/employment-contracts-act.html.

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Article 3 – The right to safe and healthy working conditions

Article 3 § 1 - Health and safety and the working environment

1) Please describe the national policy on occupational health and safety and the consultation with employers' and workers' organisations in formulating this policy. Please specify the nature of, reasons for and extent of any reforms.

In 2009, the National Health Plan (hereinafter NHP) up to 2020 was completed by the Ministry of Social Affairs and approved by the Government, which addresses living, working and learning environment to support health next to other fields. The aim is to decrease health risks deriving from living, learning and working environment. The strategy sets tasks to government authorities, but next to that, it gives advisory measures to local governments and companies.

NHP is related to the Strategy on Health and Safety at Work and the activity plan of the strategy elaborated by the Ministry of Social Affairs. This strategy document defines the development targets of Estonian working environment for 20010-2013. Several relevant documents have been considered while composing this strategy, including the European Commission's community strategy 2007-2012 on health and safety at work, Action Plan for Development of Estonian National Health Plan 2009-2020 and Action Plan for Growth and Jobs 2008-2011 (for implementation of Lisbon Strategy).

Areas of development, goals and actions described in the strategy for 2010-2013 and action plan:

- Legislative framework of occupational health and safety
- Raising awareness of the value of health-preserving work environment
- Occupational health and safety training
- Development of occupational health services
- Identifying and reducing the impact of emerging risks
- Raising knowledge-based approach and administrative capacity in policy making and implementation.

- Scientific knowledge generation in occupational health and safety
- National and international co-operation

National institutions of this field (the Labour Inspectorate, the Health Board), educational institutions (Tallinn University of Technology) and social partners are involved in implementing the strategy.

2) Please indicate the measures taken (administrative arrangements, programmes, action plans, projects, etc.) to implement the national policy in consultation with employers' and workers' organisations.

Activities of the Labour Inspectorate during 2008-2010

1) Surveillance campaigns:

National target checks conducted in 2008 were:

- Manual heavy lifting in construction and trade sectors
- Target check for biological hazard
- Ascertainment for quality of the risk assessment

National target checks conducted in 2009 were:

- Target check for the quality of occupational health service
- Target check for falls caused by slipping and tripping

National target checks conducted in 2010 were:

- Target check for metalworking
- Target check for the usage of dangerous chemicals

2) Information campaigns:

- In November and December of 2009, the information campaign "Instruction of employees and in-service training" during which 7 information days both in Estonian and Russian took place.

- During a campaign "Slipping and tripping - how to avoid accidents" in 2009, a target check was carried out in 200 companies, information materials were distributed, advice was given and thematic information days were arranged.
- In 2010, a chemicals safety campaign "Risk assessment of using hazardous substances", where the fields covered were bakeries, timber industries, body shops, and dry-cleanings chosen by the European Union Senior Labour Inspectors Committee (SLIC).

3) Social campaigns:

- In 2010 an Estonian-wide work stress thematic social campaign was conducted where psychosocial risks were pointed out.
- Each December, youth information fair TEEVIIT takes place. The aim of the fair is to provide young people with as much information as possible about studying, leisure time activities, employment and other aspects concerning planning their future life. At the information fair, the Estonian Coordination Centre of Occupational Safety and Health Administration (OSHA) distribute information materials about the European Week for Safety and Health at Work. The Labour Inspectorate participates as well and distributs information materials about work safety, for example, in 2009, an information booklet "Reference book of work safety for young people" was distributed to young people.

4) New initiative: e-LabourInspectorate (http://www.ti.ee/index.php?page=3&):

Internet-based e-LabourInspectorate enables quick, handy and paper-free communication between an employer and the Labour Inspectorate. The website enables to check the Labour Inspectorate’s database the information about companies (for example, results of inspections, accidents at work, labour disputes).

In addition to checking information, the e-LabourInspectorate's website enables:

- to inform about removal of infringements identified during inspections;
- to forward notices of accidents at work and reports of accidents at work or contractions of occupational diseases;
- to submit and update the information about employers;
- to announce about the appointment of the working environment specialist, election of working environment representative or formation of working environment council;

- to submit petitions to resolve labour disputes and other documents related to the labour dispute;
- to submit notices (for example, of commencement of activities, commencement of construction work, of working with asbestos, of working with carcinogens, of commencement of work with biological risk factors).

Activities of the Ministry of Social Affairs in 2008-2011

In 2008-2009, the electronic work equipment SWLS (Safety Working Life Software) was composed and made available. It helps employers to conduct risk assessment of working environment. In 2010, the expansion of this work equipment began. The development of a new version of the work equipment is conducted in 2012. The work equipment enables entrepreneurs to administer the data related to their working environment, conduct risk assessment, maintain necessary databases and use reminders to have all the necessary activities done timely.

The composition of a working life webpage has been started. The working life webpage assembles the data of working environment from various webpages of the public departments to have all the necessary data on one webpage for the users. In addition to the information, the new webpage offers many possibilities for users, for example, the possibility to find necessary service providers, trainings, audio-visual study materials, etc. The webpage enables users to communicate to each other in a forum.

To raise the awareness of employers and employees, several instruction manuals were composed and made available electronically and on paper (in Estonian and in Russian):

- Taxation of expenses related to occupational health and safety (2011);
- Methods of low-risk working with asbestos in dismantling, renovation, and repair and maintenance works (2011);
- Measuring characteristics of physical risk factors in working environments (2010).

The Ministry of Social Affairs translated the collection "Euroopa Liidu tasandi sotsiaalpartnerite raamkokkulepped" ("Framework Agreements of Social Partners on European Union Level") (2009) and conducted presentation seminar of the collection. Based on the framework agreement of using crystalline silicon dioxide submitted in the collection, the instructional material "Appropriate Processing of Crystalline Silicon Dioxide and its Products" was composed for employers / employees. The instruction manual was translated to Russian.

The following instructions of the European Commission are made available to the public on the internet (homepages of the Ministry of Social Affairs and the Labour Inspectorate):

- Guide to the implementation of the vibration directive 2002/44/EC (in Estonian)
- Guide to the implementation of the noise directive 2003/10/EC (in Estonian)
- Guide to the implementation of the construction directive 92/57/EEC (in Estonian)
- Guide to the implementation of the artificial optical radiation directive 2006/25/EC (in Estonian).

3) Please provide pertinent figures, statistics or any other relevant information, if appropriate.

Research of occupational health and safety

1) In 2007, a regularly conducted survey was developed in the Ministry of Social Affairs to describe working fields. The main idea of the survey was to cover important topics and problematic aspects of Estonian working life, employment relationships and working conditions. The data collected by the working life survey is used for scientific analysis of working life and political analysis of legislation regarding working life. Analysing collected data enables to describe the interconnections and dynamics of the development of Estonian society and working life, and the situation of work as a central social activity and work-related social relations in a changing society. The collected statistical data is needed and used by universities and other scientific research institutions for scientific analysis of working life, and by ministries and think-tanks for political analysis and other similar applied analysis.

The Estonian Working Life survey was conducted the first time in 2009. The aim of it was to collect statistical data of employment relationships and working conditions. The topics of working life survey were:

- occupational health;
- organization of work;
- employment relationships;
- inclusion of employees;
- collective employment relationship.

The data was collected on two levels - from the representatives of organizations and from the employees of those organizations. The conclusions of the occupational health research are:

- 2.4% of the employees have had accident at work;
- 11% of the employees have had health issues caused by work;
- 15% of the employees have experiences stress related to work;
- 48% of the organizatios have a working environment representative;
- 90% of the organizations have persons who deal with working environment;
- risk assessment has been conducted in 75% of the organizations;
- employees' health surveillance has been conducted in 65% of the organizations;
- health promotion is carried out in 69% of the organizations.

2) In 2009, a survey was conducted to assess the expenses of employers deriving from the Occupational Health and Safety Act. The survey analysed employers' expenses:

- on notification and instruction of employees;
- on arrangement of risk assessments;
- on prevention activities;
- on training persons related to organization of occupational health;
- on the research of accidents at work and occupational diseases.

The results of the survey showed that the total expenditure of all the companies was ca 2 billion EEK a year (15.6 EEK = 1 EUR) and the total amount of time spent of all the companies is ca 6.5 million hours a year. The expenditure of an employer per one employee in a year is 1.7 times higher in the private sector than it is in the public sector and it is 1.6 times higher in small enterprises than in large ones. The expenditure of an enterprise deriving from the Occupational Health and Safety Act is on the average of 0.2% of the total expenditure.

Article 3 § 2 - Issue of safety and health regulations

1) Please describe the general legal framework. Please specify the nature of, reasons for and extent of any reforms.

The main legal acts protecting employees' health and safety are:

- The Occupational Health and Safety Act (amended accordingly in 2009):

Obligations of employer: An employer is required to grant a pregnant employee time off, to be included in the working time, at the time indicated in a decision made by a doctor for prenatal examination. An employer is required to notify a minor and a legal representative of a minor under 15 years of age of risks related to the work of the minor and of the measures implemented for the protection of his or her safety and health. An employer shall pay to an employee, from the fourth until the eighth calendar day of sickness or injury, sick leave benefit of 80 per cent of the employee's average wages calculated pursuant to subsection 29 (8) of the Employment Contracts Act. The aim of the amendments is to enforce employers to contribute more to the improvement of working environment to lessen work-related illnesses of employees.

- The Employment Contracts Act (2009):

Regulation of teleworking: If an employer and employee agree that the employee does work, which is usually done in the employer's enterprise, outside the place of performance of the work, including at the employee's place of residence (teleworking), the employer shall, in addition to what has been specified in section 5 of this Act, notify the employee that the duties are performed by way of teleworking.

Regulation of temporary agency work: If an employer and employee agree that the employee does work, on a temporary basis, in compliance with a third party's (user undertaking) instructions and supervision (temporary agency work), the employer shall notify the employee that the duties are performed by way of temporary agency work in the user undertaking.

Regulation of minors' employment: An employer shall not enter into an employment contract with a minor under 15 years of age or a minor subject to the obligation to attend school, or

allow such a minor to work, except in the cases provided for in subsection (4) of this section. An employer shall not enter into an employment contract with a minor or allow a minor to work if the work:

1) is beyond the minor's physical or psychological capacity;
2) is likely to harm the moral development of the minor;
3) involves risks which the minor cannot recognise or avoid owing to lack of experience or training;
4) is likely to hinder the minor's social development or the acquisition of his or her education;
5) is likely to harm the minor's health due to the nature of the work or the working environment.

An employer may enter into an employment contract with a minor of 13–14 years of age or a minor of 15–16 years of age subject to the obligation to attend school and allow him or her to work if the duties are simple and do not require any major physical or mental effort (light work). Minors of 7–12 years of age are allowed to do light work in the field of culture, art, sports or advertising.

Other:

1) The Regulation of the Government of the Republic of 2008 on the Procedure of Registration, Notification and Investigation of Accidents at Work and Contraction of an Occupational Disease – considers accidents at work of self-employed persons as well. As a new feature in the regulation, such cases are considered accidents at work, where the employee comes into intracutaneous contact with an infectious or an infection carrying object, person or animal and he or she is prescribed preventive treatment.
2) The Regulation of the Government of the Republic of 2009 - Occupational health and safety requirements for work of pregnant and breastfeeding women;
3) The Regulation of the Government of the Republic of 2009 - List of working environment risk factors and work forbidden for minor;
4) The Regulation of the Government of the Republic of 2009 - Light work permitted for minor;

5) Regulation No. 293 of the Government of the Republic of 18 September 2001 - Limit values for chemical hazards in the working environment was amended (2011).According to the directive 2009/161/EU, new substance or amended limit values were given in annex 19 of the regulation, regarding which the Scientific Committee Group on Occupational Exposure Limits has recommended to establish new limit value after the consideration of the latest scientific data.

2) Please indicate the measures taken (administrative arrangements, programmes, action plans, projects, etc.) to implement the legal framework in consultation with employers' and workers' organisations.

In 2010 and 2011, NOASR (Netherlands Organisation for Applied Scientific Research) http://www.tno.nl/) in cooperation with CentAR (Estonian Center for Applied Research) conducted the Occupational Health and Safety Act's research project ordered by the Ministry of Social Affairs (available online http://www.sm.ee/meie/uuringud-ja-analuusid/toovaldkond.html). As a result of the research, analysis and proposals were drawn up for the Government of the Republic, which covered legal acts and practice of the Estonian occupational health and safety field, and their consistency with the international law, EU directives, practice and good practices of other member states. Attention was paid to the creation of the infrastructure of occupational health and safety in Estonia; the specifics of Estonia were taken into consideration.

The Committee asks for confirmation that Directive 2003/18/EC of the European Parliament and the Council of 27 March 2003 and Commission Directive 1999/77/EC3 of 26 July 1999, which bans the placing on the market and use of products containing asbestos as from 2005, have been transposed into domestic law and that they are observed in practice.

The directive 2003/18/EC has been transposed by the regulation no. 224 of the Government of the Republic of 11.10.2007: Requirements of occupational health and safety for working with asbestos.

As a result of applying the regulation, both employers and employees have to be aware of the hazardousness of asbestos and have to know how to apply safe working methods to protect the health of employees who are in contact with asbestos. The Labour Inspectorate,

which is conducting state supervision of working environment, receives an overview of working with asbestos. Important activities that employers and employees have to be able to do are:

- to assess the hazard of the asbestos before commencing work;
- to implement the most effective safety measures in case the asbestos is present;
- to use safe working methods while performing work;
- to use and maintain personal protective equipment;
- to handle asbestos waste;
- to be aware of the asbestos concentration in the air and the established maximum levels of exposure.

According to the regulation, an employer is obliged to conduct the verification of asbestos and keep record of the results before each dismantling, reconstruction, maintenance or reparation of a construction. The verification is facilitated by the brochure about asbestos concentration in construction materials composed by the National Institute for Health Development published since 2007.

The directive 1999/77/EC is transposed by the regulation no. 36 of the Minister of Social Affairs of 28th of February 2005: Limitations of the handling of chemicals dangerous to population and nature.

More particularly: it is prohibited to place and occupy the following asbestos fibres:

1) crocidolite (blue asbestos), CAS no. 12001-28-4;amosite, CAS no. 12172-73-5;
2) anthophyllite, CAS no. 77536-67-5;
3) actinolite, CAS no. 77536-66-4;
4) tremolite, CAS no. 77536-68-6;
5) chrysotile, CAS no. 12001-29-5.

It is prohibited to place and occupy products where the asbestos fibres listed in subsection 1 have been added purposely.

The Commitee asks whether the authorities have drawn up an inventory of all contaminated buildings and materials. Bearing in mind the importance of this question in the light of the right to health of the population (Article 11), the Committee asks for the next report to provide specific information on steps taken to this effect.

According to Occupational Health and Safety Requirements for Work with Asbestos, asbestos works shall mean demolition, reconstruction, repair and maintenance of buildings containing asbestos, including removal of asbestos from building, machinery, equipment or ship and collection of asbestos wastes and preparation of removal from the place of work, transportation and landfill. Employer shall ascertain before the start of asbestos works whether it contains or does not contain asbestos. If the presence of asbestos is confirmed, the work will be performed following the requirements for asbestos works provided for in the Regulation.

According to the regulation Requirements of occupational health and safety for working with asbestos, employers are obliged to inform a regional office of the Labour Inspectorate for at least 7 days in advance about commencing working with asbestos by submitting a notification in writing or in a format which can be reproduced in writing according to the form indicated in the annex of the regulation. In case of dismantling works or removal of asbestos the notification shall be accompanied by detailed work plan.

The Labour Inspectorate assesses work plans and if necessary, inspects the implementation on the spot. According to the data of the Estonian Labour Inspectorate, there are now up to 8 companies engaged in working with asbestos whose employees have mostly had their in-service training in Finland.

In practice, not all the smaller dismantling works have been notified to the Labour Inspectorate. In these cases, the Labour Inspectorate cannot inspect the implementation of work schedules.

The Committee asks that the next report confirm explicitly that non-permanent employees are provided with adequate information and training to carry out their work in a safe manner (especially upon recruitment, or in the event of the introduction of new equipment or technology). The Committee reiterate its request for information on how medical surveillance is made available to this category of workers.

The situation is regulated in § 12 of the Occupational Health and Safety Act:

An employer shall ensure the conformity with occupational health and safety requirements in every work-related situation. If duties are performed by way of temporary agency work, the user undertaking shall guarantee the conformity with occupational health and safety requirements in the user undertaking. An employer shall not allow an employee to work if he or she lacks the necessary professional knowledge and skills, and knowledge about occupational health and safety.

An employer shall inform another employer whose employees perform duties in the enterprise of the employer of the hazards related to the operation of such enterprise and of the measures for avoiding such hazards, and who shall in turn inform its employees of the hazards present at the workplace and instruct them in ways to avoid such hazards before they commence performance of their duties. Also, the measures relating to rescue operations and provision of first aid and employees responsible therefor must be made public.

It means that the user undertaking shall inform the employee before commencing work about the work, working conditions, health risks, and dangers that might accompany the work. Applied safety measures and, if necessary, occupational safety cooperation and notification procedure in the company, and other arrangements related to occupational health shall be notified as well. The user undertaking is responsible for meeting the occupational health and safety requirement in the company during work.

The same system applies if a self-employed person works for an employer. If a sole proprietor works at a workplace concurrently with one or several employees of an employer, he or she shall notify the employer who organises the work or, in the absence of such employer, the other employers of the hazards relating to his or her activities and shall ensure that his or her activities do not endanger other employees. The employer who organises the work or, in the absence of such employer, the other employers shall inform the sole proprietor of the hazards related to the operation of such enterprise and of the measures for avoiding such hazards.

How is the provision of occupational health services to temporary workers organized?

The Occupational Health and Safety Act applies to temporary workers as well. According to this, the employer is required to organize for employees whose health may be affected, in the course of the work process, by a working environment hazard or the nature of the work, the provision of initial medical examination in the course of one month after the commencement of employment, and then periodically after every three years, if the occupational physician has not set a shorter deadline. The medical examination of minors takes place every two years. The Occupational Health and Safety Act applies to persons employed under the contract of employment and to the work of public servants.

The Committee asks that the next report indicates whether the Government Regulation No. 75 on the procedure of registration, reporting and investigations of occupational accidents and cases of occupational disease, adopted in 2008, also protects domestic workers.

The regulation mentioned above is implemented if an employer and en employee have employment relationship. If a domestic worker and his or her employer have concluded employment contract, then the domestic worker is protected by law in the event of damage to health related to work.

Article 3 § 3 - Provision for the enforcement of safety and health regulations by measures of supervision

1) Please describe the enforcement of safety and health regulations. Please specify the nature of, reasons for and extent of any reforms.

Inspection of meeting the requirements of occupational health and safety is based on the Occupational Health and Safety Act (chapter 6). The Labour Inspectorate has composed an instruction manual of conducting working environment supervision for the inspectors. The main types of supervision are:

- inspection;
- specific inspection (during a project or campaign);
- follow-up inspection (to inspect compliance with the precept);
- inspection of a new or reconstructed construction;
- market monitoring of personal protective equipment.

The Labour Inspectorate inspects occupational health and safety in all areas of activity. In case of a violation of the requirements of legal acts, a labour inspector has the right to issue a precept which is mandatory for an employer. In case of a failure to comply with a precept, a labour inspector may impose a penalty payment.

According to the data of the Statistical Office, persons with 15-74 years of aged were active in the labour market:

- in 2008 – 656 500;
- in 2009 – 595 800;
- in 2010 – 570 900;
- in 2011 – 609 100.

According to the data of the Estonian Tax and Customs Board, there were enterprises with more than one employee:

- in 2009 – 48 934;
- in 2010 – 43 282;
- in 2011 – 46 568.

2) Please provide pertinent figures, statistics (for example Eurostat data) or any other relevant information:

on the number of accidents at work, including fatal accidents, in absolute figures as well as in terms of standardised accident rates per 100,000 workers;

on the number of health and safety inspection visits by the labour inspectorate and the proportion of workers and companies covered by the inspections;

on the number of breaches to health and safety regulations and the nature and type of sanctions imposed.

In 2011, the Labour Inspectorate was notified of 3,741 accidents at work; in comparison with 2010, registered accidents at work have been increased by 16.4% i.e. by 526 accidents.

By the severity of a personal injury, in 2011 there were 796 accidents at work resulting in serious bodily injury, 2,926 accidents at work resulting in minor bodily injury, and 19 accidents at work resulting in death.

Per 100,000 employees there were 614 registered accidents at work in 2011, whereas 480 minor accidents at work, 131 serious accident at work and 3 accidents at work resulting in death (in 2010 it was 563 accidents at work, 435 minor, 125 serious, and 3 accidents at work resulting in death respectively).

Per 100,000 employees, the most accidents at work in processing industry fields happened in timber industry (2,006), food industry (1,471), and paper industry (1,189). Of other sectors, the largest amount of accidents at work happened in administrative and support service activities (1,631), public administration and national defence sector (1,054), and accommodation and catering field (760).

Number of accidents at work, including fatal accidents, in absolute figures as well as in terms of standardised accident rates per 100,000 workers

Table 1: Number of registered accidents at work by the severity, 2008–2011

	2008	2009	2010	2011
Total number of accidents at work, including	4,075	2,939	3,215	3,741
minor	3,106	2,323	2,481	2,926
serious	948	597	717	796
resulting in death	21	19	17	19

Source: the Labour Inspectorate

Taking into consideration of the smallness of Estonia there are not much deaths and thus the statistics is more dependent on a single accident at work. The number of serious accidents at work has been relatively stable in recent years. The total amount of accidents at work increases by minor accidents at work, which indicates the improvement of registering accidents at work, the awareness of employers, and increase in law compliance.

Table 2: Number of accidents at work by areas of activity, 2008 – 2011

Accidents at work by principal activity	2008	2009	2010	2011
TOTAL				
Employees	656,500	595,800	570,900	609,100
Accidents at work	4,075	2,939	3,215	3,741
resulting in death	21	19	17	19
Accidents at work per 100,000 employees	620.7	493.3	563.1	614.2
Agriculture, hunting, fishery, and forest management				
Employees	25,300	24,000	24,100	26,900
Accidents at work	189	144	150	164
resulting in death	1	1	1	3
Accidents at work per 100,000 employees	747.0	600.0	622.4	609.7
Mining industry				
Employees	6,000	6,400	6,900	6,100
Accidents at work	43	40	31	37
resulting in death	4	0	0	0
Accidents at work per 100,000 employees	716.7	625.0	449.3	606.6
Processing industry				
Employees	135,000	113,800	108,400	121,000
Accidents at work	1,470	926	1,037	1,205
resulting in death	4	2	0	3
Accidents at work per 100,000 employees	1,088.9	813.7	956.6	995.9
Electricity, gas and water supply				
Employees	10,500	10,100	11,000	12,100
Accidents at work	66	47	55	43
resulting in death	0	0	0	0
Accidents at work per 100,000 employees	628.6	465.3	500.0	355.4
Construction				
Employees	81,000	58,300	47,900	59,000
Accidents at work	479	262	272	293
resulting in death	6	5	4	4
Accidents at work per 100,000 employees	591.4	449.4	567.8	496.6
Wholesale and retail, repair of motor vehicle, motorcycles, personal utility articles, and household appliances				

Employees	92,500	83,200	80,000	81,300
Accidents at work	404	279	313	360
resulting in death	0	0	1	3
Accidents at work per 100,000 employees	436.8	335.3	391.3	442.8
Hotels and restaurants				
Employees	23,600	20,100	19,400	19,200
Accidents at work	131	116	113	146
resulting in death	0	0	0	0
Accidents at work per 100,000 employees	555.1	577.1	582.5	760.4
Transportation, warehousing, communications				
Employees	49,900	49,700	43,600	48,300
Accidents at work	294	237	252	319
resulting in death	3	3	6	2
Accidents at work per 100,000 employees	589.2	476.9	578.0	660.5
Information and communications				
Employees	15,300	14,300	12,400	16,700
Accidents at work	17	15	11	19
resulting in death	0	1	0	0
Accidents at work per 100,000 employees	111.1	104.9	88.7	113.8
Financial intermediation, real estate				
Employees	20,600	20,600	19,500	20,600
Accidents at work	56	27	37	45
resulting in death	1	0	1	0
Accidents at work per 100,000 employees	271.8	131.1	189.7	218.4
Professional, scientific and technical activities				
Employees	20,500	20,500	21,200	23,300
Accidents at work	127	27	32	30
resulting in death	0	0	1	0
Accidents at work per 100,000 employees	619.5	131.7	150.9	128.8
Administrative and support service activities; compulsory social insurance				
Employees	17,300	16,800	18,900	17,100
Accidents at work	97	181	209	279
resulting in death	1	1	1	1
Accidents at work per 100,000 employees	560.7	1077.4	1105.8	1631.6
Public administration and national defence; compulsory social insurance				

Employees	38,400	36,700	40,400	40,300
Accidents at work	373	334	368	425
resulting in death	1	5	2	3
Accidents at work per 100,000 employees	971.4	910.1	910.9	1,054.6
Education, health and social welfare				
Employees	91,000	95,500	90,700	92,700
Accidents at work	234	216	231	273
resulting in death	0	1	0	0
Accidents at work per 100,000 employees	257.1	226.2	254.7	294.5
Arts, entertainment				
Employees	14,800	14,200	14,700	14,300
Accidents at work	65	73	76	73
resulting in death	0	0	0	0
Accidents at work per 100,000 employees	439.2	514.1	517.0	510.5
Other public, social and personal services				
Employees	14,800	11,500	11,900	10,300
Accidents at work	30	15	28	30
resulting in death	0	0	0	0
Accidents at work per 100,000 employees	202.7	130.4	235.3	291.3

Source: the Labour Inspectorate

Table 3: Accidents at work resulting in death by areas of activity, 2008-2011

	Number of accidents at work				Accidents at work per 100,000 employees			
	2008	2009	2010	2011	2008	2009	2010	2011
Agriculture, hunting	1	1	1	3	5.8	5.7	5.8	15.5
Forest management	0	0	0	0	0.0	0.0	0.0	0.0
Fishery	0	0	0	0	0.0	0.0	0.0	0.0
Mining industry	4	0	0	0	66.7	0.0	0.0	0.0
Processing industry	4	2	0	3	3.0	1.8	0.0	2.5
Electricity, gas, steam, and conditioned air supply	0	0	0	0	0.0	0.0	0.0	0.0
Water supply; sewerage, waste and pollution handling	0	0	0	0	0.0	0.0	0.0	0.0
Construction	6	5	4	4	7.4	8.6	8.4	6.8
Wholesale and retail; motor vehicles and morotcycles repair	0	0	1	3	0.0	0.0	1.3	3.7
Transportation and warehousing	3	3	6	2	6.0	6.0	13.8	4.1
Accommodation and catering	0	0	0	0	0.0	0.0	0.0	0.0
Information and communications	0	1	0	0	0.0	7.0	0.0	0.0
Financial and insurance activities	0	0	0	0	0.0	0.0	0.0	0.0
Real estate activities	1	0	1	0	9.8	0.0	9.9	0.0
Professional, scientific and technical activities	0	0	1	0	0.0	0.0	4.7	0.0
Administrative and support service activities	1	1	1	1	5.8	6.0	5.3	5.8
Public administration and national defence	1	5	2	3	2.6	13.6	5.0	7.4
Education	0	1	0	0	0.0	1.6	0.0	0.0
Healt and social welfare	0	0	0	0	0.0	0.0	0.0	0.0
Arts, entertainment	0	0	0	0	0.0	0.0	0.0	0.0
Other service activities	0	0	0	0	0.0	0.0	0.0	0.0

Total	**21**	**19**	**17**	**19**	**3.2**	**3.2**	**3.0**	**3.1**

Source: the Labour Inspectorate

Table 4: Serious accidents at work by areas of activity, 2008-2011

	Number of accidents at work				Accidents at work per 100,000 employees			
	2008	**2009**	**2010**	**2011**	**2008**	**2009**	**2010**	**2011**
Agriculture, hunting	37	35	42	38	215.1	201.1	244.2	195.9
Forest management	9	3	2	8	126.8	56.6	33.9	131.1
Fishery	2	0	0	4	181.8	0.0	0.0	285.7
Mining industry	16	14	11	14	266.7	218.8	159.4	229.5
Processing industry	329	195	244	260	243.7	171.4	225.1	214.9
Electricity, gas, steam and conditioned air supply	3	5	7	6	36.6	64.9	80.5	73.2
Water supply; sewerage, waste and pollution handling	21	1	4	10	913.0	41.7	173.9	256.4
Construction	127	61	84	81	156.8	104.6	175.4	137.3
Wholesale and retail; motor vehicles and morotcycles repair	86	38	60	62	93.0	45.7	75.0	76.3
Transportation and warehousing	85	59	64	93	170.3	118.7	146.8	192.5
Accommodation and catering	17	17	16	15	72.0	84.6	82.5	78.1
Information and communications	4	3	1	4	26.1	21.0	8.1	24.0
Financial and insurance activities	2	1	2	4	19.2	8.8	21.3	39.2
Real estate activities	12	7	4	13	117.6	76.1	39.6	125.0
Professional, scientific and technical activities	19	6	6	9	92.7	29.3	28.3	38.6
Administrative and support service activities	22	34	42	42	127.2	202.4	222.2	245.6
Public administration and national defence	64	42	44	52	166.7	114.4	108.9	129.0
Education	37	40	33	26	61.8	64.0	58.8	45.5
Health and social welfare	33	23	27	29	106.1	69.7	78.0	81.7
Arts, entertainment	16	9	15	19	108.1	63.4	102.0	132.9
Other service activities	7	4	9	7	47.3	34.8	75.6	68.0
Total	**948**	**597**	**717**	**796**	**144.4**	**100.2**	**125.6**	**130.7**

Source: the Labour Inspectorate

Health disorders caused by work

The Occupational Health and Safety Act classifies the health disorders caused by work as occupational diseases, illnesses caused by work, and work-related illnesses. In 2011, the Labour Inspectorate received a notification of occupational disease about 87 employees. By the areas of activity of the enterprises, a little more than one third of the contraction of an occupational disease happened with employees in processing industry, more often in textile industry, metallurgical industry, and food industry. Agriculture, hunting and forest management sector, and professions related to construction, trade and transportation could be pointed out from other activities.

Table 5: Registered occupational diseases and illnesses caused by work in Estonia, 2008-2011

	Number of occasions				**Per 100,000 employees**			
	2008	**2009**	**2010**	**2011**	**2008**	**2009**	**2010**	**2011**
Contraction of occupational desease	75	73	104	87	11.4	12.3	18.2	14.3
Illnesses caused by work	266	139	154	167	40.5	23.3	27.0	27.4

Source: The Labour Inspectorate

Number of visitors / number of enterprises / number of employees covered by inspection:

- **in 2008** – 5,294 / 4,201 / 143,049;
- **in 2009** – 5,096 / 4,042 / 134,556;
- **in 2010** – 4,748 / 3,718 / 107,465;
- **in 2011** – 4,339 / 3,359 / 125,962.

On-compliance with the requirements of occupational health and safety

According to the Penal Code:

§ 197. Violation of occupational health and safety requirements if through negligence significant damage is thereby caused to the health of a person or the death of the person is caused.

§ 198. Violation of occupational health and safety requirements if through negligence significant damage is thereby caused to the health of a person or the death of the person is caused.

Statistics on the number and amount of fines in 2010-2011:

	2010	2011
For legal persons	5 fines/amount EUR 166	0 / 0
For natural persons	4 fines/amount EUR 383	2 fines/amount EUR 165
Total	9 fines/amount EUR 549	2 fines/amount EUR 165

According to the Occupational Health and Safety Act:

The Labour Inspectorate may, in case of non-compliance with requirements of occupational health and safety and in case of hiding an accident at work or occupational disease, punish by pecuniary punishment of 2,000-2,600 EUR in course of a misdemeanour procedure.

Table 6: Infringements proceeded by the Labour Inspectorate, 2008-2011

	Number of infringements	Worned with penalty payment	Enforced penalty payment / sum
2008	10,530	381	9 / 4,026.43 EUR
2009	13,780	643	20 / 4,301.25 EUR
2010	15,959	944	55 / 16,041.82 EUR
2011	12,855	725	31/ 9,867 EUR

Source: the Labour Inspectorate

In 2011 the Labour Inspectorate proceeded misdemeanour matters of non-compliance with the requirements of occupational health and safety for 157 times. Fines were imposed on 144 times with the total sum of 24,680 euros, including for legal persons on 99 times with the total sum of 21,010 euros and for natural persons on 45 times with the total sum of 3,670 euros. Including the results of inspections of accidents at work and occupational diseases, legal persons were imposed fines on 83 times with the total sum of 15,995 euros and natural persons on 20 times with the total sum of 1,536 euros.

Number of misdemeanours proceeded		Number / sum of fines imposed
• **in 2008** -	117	107 / 20,616.60 EUR;
• **in 2009** -	151	119 / 25,286.64 EUR:
• **in 2010** -	173	151 / 21,012.23 EUR.

The Committee asks that the next report indicates the updated number of enterprises inspected by the Labour Inspectorate as well as the number of employees concerned by these inspections.

Please see the answer to the previous question.

Article 11 – The right to protection of health

Article 11 § 1 - Removal of the causes of ill-health

1) Please describe the general public health policy and legal framework. Please specify the nature of, reasons for and extent of any reforms.

The National Health Plan for 2009-2010 (NHP) raises strategic goals for the continuing improvement of the public health. The Government of the Republic has set the elongation of lifetime and raising the quality of life as a priority and this is what the plan is based on. NHP assembles and targets several development plans and strategies in the field of health and incorporates variety of strategies which are already operating, or strategic documents of other fields which are being created.

The Public Health Act is in force.

- Amendments to the Health Insurance Act in 2008-2011

The economic turndown influenced health care system as well. Of the total income of the health insurance fund, 98% is health insurance, which is mostly coved from wages. During previous years that were economically better, the receipt of social tax increased thanks to raise in wages. The decrease of employment and average salary in 2009 influenced the receipt of social tax in a negative direction. Compared to 2008, the amount of the incomes of Estonian Health Insurance Fund was 11.4% smaller, but the expenditures decreased only by 2.2%. Hence, the supervision and reduction of expenditure was very difficult. The health insurance benefits expenditures could be divided in two: open obligations and expenditures related to contractual obligations. Open obligations such as reimbursement of pharmaceuticals, benefits for incapacity for work, other monetary benefits and EU medical costs must be compensated by the health insurance fund even if the sum planned in the budget is not enough for that. The only chance to decrease those expenditures was to lessen the obligations provided by the law and this is what was done in 2009. In the beginning of the year, paying dental treatment benefit for working age persons was stopped, and from the 1st of July, the calculation of the benefit for incapacity for work was changed and the replacement rate of it was reduced.

The amount of the benefit for temporary incapacity for work is:

- 70% in the event of provision of stationary or out-patient health care services and of temporal incapacity to work due to a state of health, of temporary release of performance of employment duties and of quarantine. The health insurance fund pays the insured person the benefit for temporary incapacity for work from the 9th day of incapacity for work (since 01.07.2009).
- 80% in the event of caring for a sick child under 3 years of age or for a disabled child under 16 years of age when the person caring for the child is himself or herself ill or is receiving obstetrical care, caring a family member who is ill at home and caring a child under 12 years of age at home or in a hospital (since 01.07.2009);
- 100% in the event of pregnancy or maternity leave;
- 100% in the event of an adoptive parents leave;
- 100% in the event of an illness or injury caused as a result of an occupational disease or an accident at work;
- 100% in the event of preventing a criminal offence, protecting national or public interests or saving a human life.

Concluding contracts for financing medical treatment:

- The health insurance fund enters into a contract for financing medical treatment with a health care provider of the hospital network for a term of five years.
- The health insurance fund enters into a contract for financing medical treatment with a health care provider outside of the hospital network for a term of at least three years.
- If the health insurance fund enters into a contract for financing medical treatment with a health care provider for the first time, the contract shall be entered into for a term of at least three years.

There have been changes in paying dental care benefit - the health insurance fund shall not assume the obligation of an adult insured person to pay for dental care services, except in the cases provided by the law:

- an insured person under 19 years of age;
- if the treatment of an insured person within one year after the person attains 19 years of age is based on therapeutic indications and if such indications were or should have been evident at the time of the insured person’s last visit to the provider of the dental care service before the person attained 19 years of age;

- compensate for insured persons receiving a pension for incapacity for work or an old-age pension pursuant to the State Pension Insurance Act, insured persons of at least 63 years of age, pregnant women, mothers of children under one year of age and persons who have an increased need for dental care services as a result of health services provided to them. The health insurance fund shall, to the extent, under the conditions and pursuant to the procedure established by a regulation of the Minister of Social Affairs, compensate the certain amounts paid for dental care services during one calendar year;
- compensate for a person receiving a pension for incapacity for work or an old-age pension pursuant to the State Pension Insurance Act and an insured person of at least 63 years of age for certain amounts paid for dentures once every three years to the extent, under the conditions and pursuant to the procedure established by a regulation of the Minister of Social Affairs.

The changing economic situation affected the length of waiting lists as well. The maximum length of waiting lists is established by the decision of the council of the health insurance fund. By the decision number 4 of the council of the health insurance fund of the 6th of March 2009, the maximum length of a waiting list was lengthened to 6 weeks in out-patient specialised medical care (it used to be 4 weeks), except in one-day surgery (one-day treatment) and infertility treatment. The maximum length of an in-patient treatment waiting list was not amended.

2) Please indicate the measures taken (administrative arrangements, programmes, action plans, projects, etc.) to implement the public health policy and the legal framework.

The National Health Plan up to 2020

In addition to the National Health Plan for 2009-2020, there are several other programmes and strategies such as the National Cancer Strategy for 2007-2015, the National Strategy for the Prevention of Heart and Vascular Diseases for 2005-2020, the National Strategy for Fighting Tuberculosis for 2008-2012, the Updated Immunization Plan, the Strategy for HIV and AIDS for 2006-2015, the National Strategy for the Prevention of Drug Addiction up to 2012, the Development Plan of Physical Activities for 2011-2014, the programme "Measures Supporting Healthy Choices 2008-2009" (ESF), programme "Measures Supporting Healthy Choices 2010-2011" (ESF).

3) lease supply any relevant statistics or other information on the main health indicators and on health services and professions (for example WHO and/or Eurostat data).

Table 7: Life expectancy and healthy life expectancy at birth by sex, 2008–2011

	2008	2009	2010	2011
Life expectancy, total	74.06	75.04	75.84	76.28
Males	68.59	69.84	70.62	71.16
Females	79.23	80.07	80.52	81.09
Healthy life expectancy, total	55.0	56.9	56.1	56.0
Males	52.7	54.8	54.1	53.9
Females	57.2	59.0	58.1	57.7

Source: Statistics Estonia

Life expectancy has increased during 2008-2011 in both sexes, starting 2010 the difference in females and males life expectancy has decreased below 10 years. The healthy life expectancy increased quickly until 2009, there is some decrease during last few years, which is implact of financial crisis.

Hospitals and bed fund

By 31.12.2011, there were 59 hospitals with 7,167 beds in Estonia, including 4,685 active treatment beds.

- 3 regional hospitals – 2,353 beds;
- 4 central hospitals – 1,624 beds;
- 11 general hospitals – 1,737 beds;
- 3 rehabilitation hospitals – 161 beds;
- 23 nursing hospitals – 1 558 beds;
- 9 special hospitals – 220 beds;
- 5 local hospitals – 400 beds.

In 2011, there were:

- Treatment beds of tuberculosis – 187 (in 2007 – 270);

- Psychiatric treatment beds – 735 (in 2007 – 754);
- Adults– 690 (in 2007 – 709):
    - Psychiatry – 571 (in 2007 – 628);
    - Acute psychiatry – 119 (in 2007 – 81);
- Psychiatry of children – 45 (in 2007 – 45);
- Treatment beds of oncology – 122 (in 2007 – 72);
- Treatment beds of nursing – 1,558 (in 2007 – 1,348).

During the period of 2008-2011, the number of treatment beds of acute psychiatry, oncology and nursing has increased.

Table 8: Number of hospitals and active treatment beds in a county in 2011

County	Hospitals	Beds
Estonia	59	4,687
Harju county	15	1,999
..Tallinn	8	1,898
Hiiu county	1	32
Ida-Viru county	10	434
Jõgeva county	3	80
Järva county	2	75
Lääne county	3	166
Lääne-Viru county	2	148
Põlva county	2	96
Pärnu county	3	297
Rapla county	2	90
Saare county	1	104
Tartu county	8	831
..Tartu	4	776
Valga county	3	97
Viljandi county	3	142
Võru county	1	96

Source: the National Institute for Health Development, Health Statistics and Health Research Database

Table: 9 Number of employed health care personnel, 2008–2011

	2008	2009	2010	2011
Physicians	4,469	4,378	4,319	4,372
..incl family doctors	833	834	857	869
Nurses and midwives	8,979	8,605	8,524	8,664

Source: National Institute for Health Development, Health Statistics and Health Research Database

Number of employed health care personnel shows a slight decreasing trend, but at the same time number of family doctors is increasing.

Table 10: Death rate of infants, 2008-2011

	2008	2009	2010	2011
Infant mortality per 1,000 live births	5.0	3.6	3.3	2.5
Total of perinatal deaths	99	100	91	77
Early neonatal deaths	36	21	24	16
Dead-born	63	79	67	61
Coefficent of perinatal deaths per 1,000 births	6.2	6.3	5.7	5.2
Early neonatal per 1,000 live births	2.2	1.3	1.5	1.1
Coefficent of dead-born per 1,000 births	3.9	5	4.2	4.1

Source: the National Institute for Health Development, Estonian Causes of Death Registry

Infant mortality is decreased two times, other perinatal indicators show also decreasing trend.

Table 11: Number of morbidity cases (incident cases except cancer cases) during 2008-2011

Year	Number of incident morbidity cases
2008	2,478,447
2009	2,451,365
2010	2,335,184
2011	2,424,067

Source: the National Institute for Health Development

There were 2,424,067 incidental cases (excl. cancers) registered in 2011 (in 2008 – 2,478,447cases). Compared to 2008, the number of registered incidental cases has decreased by 2%. The most frequent registrations:

- Respiratory illnesses – 626,163cases (in 2008 – 688,710), of which the most common incident cases were:
    - Acute bronchitis and bronchitis – 78,584 (in 2008 – 81,148);
- Injuries, intoxications and other certain consequences of the impact of external causes – 254,922 (in 2008 – 287,608);
- Musculoskeletal and connective tissue illnesses – 229,236 (in 2008 –220,697);
- Skin and skin appendages illnesses – 158.064 (in 2008 – 159,185).

Number of first-registered cancer diagnosis and cancer deaths has been stable during the years, constituting 24% of all deaths in 2011.

Table 12: Deaths caused by malignant neoplasm, 2008-2011

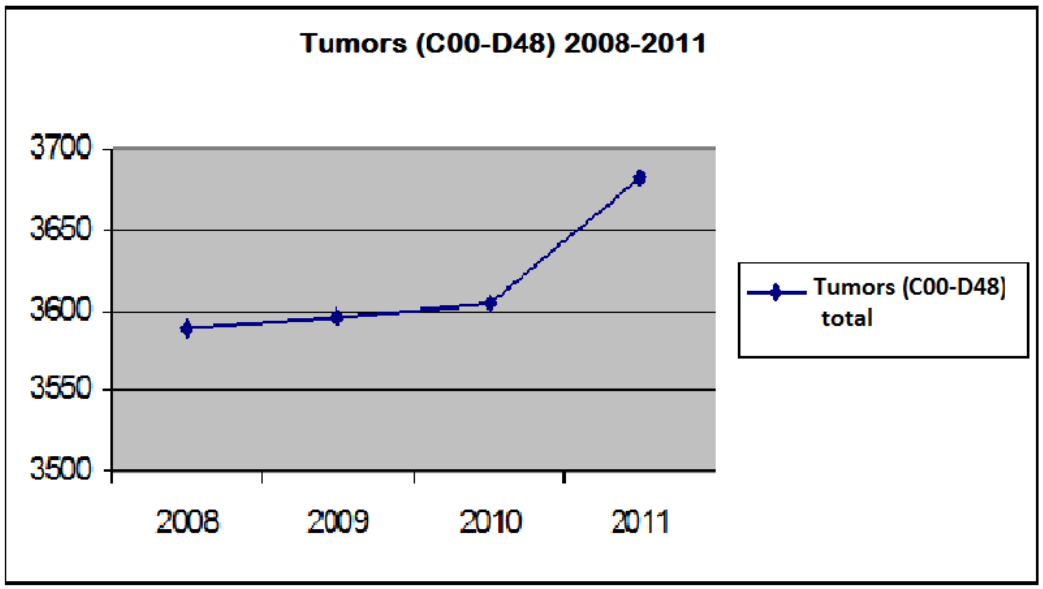
Location		2008	2009	2010	2011
Neoplasm (C00-D48)	TOTAL	3,589	3,595	3,605	3,682
	Men	1,932	1,929	1,968	1,946
	Women	1,657	1,666	1,637	1,736
...malignant neoplasm (C00-C97)	Total	3,547	3,529	3,549	3,624
	Men	1,911	1,897	1,945	1,922
	Women	1,636	1,632	1,604	1,702
...malignant neoplasms of lip, oral cavity and pharynx (C00-C14)	Total	97	85	133	86
	Men	67	65	107	65
	Women	30	20	26	21
...malignant neoplasms oesophagus (C15)	Total	56	63	62	58
	Men	48	54	48	48
	Women	8	9	14	10
...malignant neoplasm of stomach (C16)	Total	289	303	289	288
	Men	150	153	161	169
	Women	139	150	128	119
...malignant neoplasms of colon and rectosigmoid junction (C18, C19)	Total	286	286	268	300
	Men	130	141	125	123
	Women	156	145	143	177
...malignant neoplasm of colon (C18)	Total	260	258	237	267
	Men	112	129	111	109
	Women	148	129	126	158
...malignant neoplasms of rectosigmoid junction (C19)	Total	26	28	31	33

	Men	18	12	14	14
	Women	8	16	17	19
...malignant neoplasms of rectum and anus and anal canal (C20, C21)	Total	115	131	141	132
	Men	58	63	75	80
	Women	57	68	66	52
...malignant neoplasm of liver and intrahepatic bile ducts (C22)	Total	88	97	104	85
	Men	51	51	62	45
	Women	37	46	42	40
....malignant neoplasms of pancreas (C25)	Total	229	242	215	258
	Men	101	106	108	121
	Women	128	136	107	137
...malignant neoplasms of respiratory and intrathoracic organs (C30-C39)	Men and women	758	660	686	690
	Men	608	522	545	528
	Women	150	138	141	162
...malignant neoplasm of larynx, trachea, bronchus and lung (C32-C34)	Total	741	646	674	681
	Men	596	510	535	522
	Women	145	136	139	159
...malignant melanoma of skin (C43)	Total	57	65	60	59
	Men	29	25	27	31
	Women	28	40	33	28
...malignant neoplasm of breast (C50)	Total	233	236	227	256
	Men	1	0	0	3
	Women	232	236	227	253
... malignant neoplasm of cervix uteri (C53)	Total	71	59	71	77

	Men	.	.	.	0
	Women	71	59	71	77
... malignant neoplasm of other parts of uterus (C54, C55)	Total	72	50	52	49
	Men	.	.	.	0
	Women	72	50	52	49
...Malignant neoplasm of ovari (C56)	Total	93	118	93	104
	Men	.	.	.	0
	Women	93	118	93	104
...malignant neoplasm of prostate (C61)	Total	250	243	256	223
	Men	250	243	256	223
	Women	.	.	.	0
...malignant neoplasm of kidney, except renal pelvis (C64)	Total	114	116	105	123
	Men	67	73	56	75
	Women	47	43	49	48
...malignant neoplasm of bladder (C67)	Total	95	109	106	121
	Men	67	84	70	91
	Women	28	25	36	30
...malignant neoplasms of lymphoid, haematopoietic and related tissue (C81-C96)	Total	240	0	268	275
	Men	107	129	128	124
	Women	133	116	140	151
...leukemias (C91-C95)	Total	135	115	116	126
	Men	60	67	62	53
	Women	75	48	54	73

Source: the National Institute for Health Development, Estonian Causes of Death Registry

Diagram 1:



The Committee notes that deaths due to ischemic heart failure are much more frequent in Estonia than in the other European countries, and likewise accidental deaths, deaths due to alcohol abuse, AIDS related deaths and deaths by homicide. The Committee asks which measures are taken to combat these causes of mortality.

Number of cardiovascular deaths is decreased by 10% and constitutes 54% of all registered deaths in 2011. Deaths due to ischaemic heart diseases have been decreased by15%.

Table 13: Number of cardiovascular deaths, 2008-2011

		2008	2009	2010	2011
Diseases of the circulatory system (I00-I99)	TOTAL	9,093	8,796	8,750	8,163
	Men	3,970	3,743	3,687	3,394
	Women	5,123	5,053	5,063	4,769
...chronic rheumatic heart diseases (I05-I09)	Total	27	41	36	28
	Men	11	11	6	11
	Women	16	30	30	17
...hypertensive diseases (I10-I15)	Total	1,544	1,829	1,848	1,935
	Men	613	696	662	654
	Women	931	1,133	1,186	1,281
...ischaemic heart diseases (I20-I25)	Total	4,594	4,332	4,323	3,887
	Men	2,043	1,881	1,900	1,697
	Women	2,551	2,451	2,423	2,190
...acute myocardial infarction subsequent (I21-I22)	Total	656	598	642	546
	Men	345	323	339	276
	Women	311	275	303	270
...other coronary diseases, except rheumatic and valvular disorders (I30-I33, I39-I52)	Total	835	760	700	641
	Men	466	409	398	345
	Women	369	351	302	296

Source: the National Institute for Health Developmentthe Ministry of Social Affairs, Estonian Causes of Death Registry

Table 14: Deaths due to some selected diseases, 2008–2011.

		2008	2009	2010	2011
HIV-disease (B20-B24)	Total	42	52	42	60
	Men	30	42	32	48
	Women	12	10	10	12
Alcoholic liver disease (K70)	Total	251	169	201	165
	Men	170	119	140	116
	Women	81	50	61	49
Injury and poisoning (V01–Y89)	Total	1 369	1 283	1 135	1 130
	Men	1 067	1 002	873	884
	Women	302	281	262	246
... accidents (V01-X59)	Total	928	822	752	766
	Men	718	640	572	594
	Women	210	182	180	172
... accidental poisoning by alcohol (X45)	Total	131	113	98	126
	Men	104	85	66	99
	Women	27	28	32	27
... homicide (X85-Y09)	Total	92	81	63	65
	Men	72	56	48	51
	Women	20	25	15	14

Source: the National Institute for Health Development, Estonian Causes of Death Registry

Deaths due to HIV disease have been increased by 43%. Deaths due to injuries and poisonings have been decreased by 17%, two third of deaths caused by injuries and accidents happen due to accidents. Deaths due to homicides have been decreased even more – by 29%. Deaths due to alcoholic liver disease have been decreased by 34% and deaths due to alcohol poisonings only by 4%.

Estonia implemented activities according to the National Health Plan for 2009-2010, the National Strategy for the Prevention of Heart and Vascular Diseases for 2005-2020, the Strategy for HIV and AIDS for 2006-2015, the National Strategy for the Prevention of Drug Addiction up to 2012, the programme "Measures Supporting Healthy Choices 2008-2009" (ESF) and the programme "Measures Supporting Healthy Choices 2010-2011" (ESF) to combat those health problems.

The Committee asks what the main causes of infant mortality are.

According to the database of the Statistics Estonia Office, number infant deaths decreased from 80 to 536 deaths between 2008 and children of 0-14 years of age died in 2011. Main causes of infant deaths are perinatal conditions (44%), congential malformations (28%) and accidents and injuries (17%).

Table 15: Causes of infant mortality (death of children until 1 years of age), 2008-2011

	2008	2009	2010	2011
Total number of deaths	80	57	53	36
Certain infectious and parasitic diseases (A00-B99)	1	2	2	0
Neoplasms (C00-D48)	1	1	0	0
Endocrine, nutritional and metabolic diseases (E00-E90)	2	2	0	1
Diseases of the blood and blood-forming organs and certain disorders involving the immune mechanisms (D50-D89)	1	0	0	0
Mental and behavioural disorders (F00-F99)	0	0	0	0
Nervous system and sense organ disorders (G00-H95)	6	0	2	1
Diseases of the circulatory system (I00-I99)	2	3	2	0
Diseases of the respiratory system (J00-J99)	2	2	2	1
Diseases of the digestive system (K00-K93)	0	0	0	0
Diseases of the skin and subcutaneous tissue (L00-L99)	0	0	0	0
Diseases of the musculoskeletal system and connective tissue (M00-M99)	1	0	0	0
Diseases of the genitourinary system (N00-N99)	0	0	0	0
Certain conditions originating in the perinatal period (P00-P96)	32	30	24	16
Congenital malformations, deformations and chromosomal abnormalities (Q00-Q99)	23	10	13	10
Symptoms, signs and ill-defined causes (R00-R99)	4	2	2	1
Accidents, intoxications and traumas (V01-Y89)	6	5	6	6

Source: the Statistics Estonia

The Committee asks what are the principal causes of maternal mortality.

The annual number of maternal deaths is 0 or 1.

Table 16: Number of maternal deaths, 2008-2011

Cause	2008	2009	2010	2011
Complications of pregnancy, childbirth and puerperium	0	0	1	1
... pregnancy with abortive outcome (O00-O08)	0	0	0	0

Source: the National Institute for Health Development

The Committee invites the Government to provide all the information on the policy to combat infant and maternal mortality.

The National Health Plan (NHP) approved by the Government of the Republic sets strategic goals of preservation and continuous improvement of health. Reaching positive birth rate and lengthening of the expected and actual lifetime are on an important place amongst the priorities of the Government of the Republic and these directions are the basis for all the aims and activities mentioned in the National Health Plan.

The main measure concerning the field "Safe and healthy development of children and young people" of the NHP is developing promotion work to reduce risk behaviour of children, pregnant women and mothers:

- Promotion of the reproductive and sexual health awareness of people; prevention of undesired pregnancy and illness of STDs; reduction of health disorders and social problems caused by infertility.
- Promotion of the health and health behaviour of pregnant women, and breastfeeding.
- Increasing the availability of free health care, advisory and support services for pregnant women and families raising an infant.
- Ensuring the availability of high-quality perinatal diagnostics, congenital disease screening programmes, and advisory service for pregnant women and new-born children.
- Promotion of perinatal and postnatal medical aid by developing perinatal indicators and by regular screening.
- Creation of the system of post active treatment medical monitoring and development treatment for improvement of the quality of life of the newborn children with high risk.
- Enhancing regular preventive health checks for children to discover the development and health disorders of children under 1 year of age early, to advise parents, and to ensure immunization coverage.

- Regular monitoring and assessment of the populations' sexual-reproductive health, and infant health indicators and influence by arranging investigations, developing medical registries and health information system, and by specifying the composition of the collected data.

The Committee asks whether access to health care is guaranteed equally to Estonian nationals and foreign nationals residing or working lawfully in Estonia.

Citizens of foreign countries are not treated differently from Estonian citizens when providing health care; they are treated equally despite their citizenship.

The health insurance in regulated by the Health Insurance Act and it is based on solidarity. According to this act, the health insurance is a system for covering health care expenses incurred to finance disease prevention and treatment and purchase of medicinal products and medical devices for insured persons, and to pay benefits for temporary incapacity for work and other benefits. Health insurance is based on the solidarity of and limited cost-sharing by insured persons and on the principle that services are provided according to the needs of insured persons, that treatment is equally available in all regions and that health insurance funds are used for their intended purpose. An insured person is a permanent resident of Estonia or a person living in Estonia on the basis of a temporary residence permit or right of residence, for whom a payer of social tax is required to pay social tax or who pays social tax for himself or herself pursuant to the procedure, in the amounts and within the terms provided for in the Social Tax Act, or a person considered equal to such persons.

The organization and requirements for health care services and the management, financing and supervision of health care is regulated by the Health Care Services Organisation Act, which is also applied in the area of government of the Ministry of Defence regarding the exceptions deriving from the Defence Forces Service Act, in prisons regarding exceptions deriving from the Imprisonment Act and at schools regarding the exceptions deriving from the Basic Schools and Upper Secondary Schools Act. By this act, the health care service is the health care professional's activity of prevention, diagnosing and treatment of illness, injury or intoxication to relieve the impairment of the person, to prevent the worsening or intensification of his or her condition and to restore the health of the person. Emergency care in this law is referred to as a health care service provided by the health care professional in a situation when postponement of the treatment or withholding the treatment may cause the

death or constant personal injury of the person in need of treatment. Each person who is in the territory of the Republic of Estonia has the right to receive emergency care.

Emergency care provided for persons having compulsory health insurance and for the person considered equal to such person is covered from the state budget from the available funds of the health insurance. Emergency care provided for a person not covered by the health insurance is covered from the available funds of the state budget and in accordance with the contract concluded between the Ministry of Social Affairs and the health insurance fund.

Number of recipients of Estonian health insurance according to the annual report of the Health Insurance Fund:

- **in 2008** 1,281,718 (95,5% of the population;
- **in 2009** 1,276,366 (95.2% of the population);
- **in 2010** 1,256,240 (93.7% of the population);
- **in 2011** 1,245,469 (92.9% of the population).

The priority concern of the government programme of action for 2007-2011 is to offer the services of a doctor to persons without health insurance. The Committee asks that the next report provide more particulars of the situation of disadvantaged people and of the measures taken to give them access to care, particularly to bring them under the public health insurance system, and make an appraisal of the aforementioned government action programme.

The most vulnerable groups are covered by the health insurance – they are equal to an insured person. According to the Health Insurance Act, the persons equal to an insured person are:

- pregnant women whose pregnancy is established by a doctor or a midwife;
- persons under 19 years of age;
- persons who receive a state pension granted in Estonia;
- persons with up to five years left until attaining pensionable age who are maintained by their spouses who are insured persons;

- students of up to 21 years of age acquiring basic education, students of up to 24 years of age acquiring general secondary education, persons in vocational training without the requirement of basic education, pupils and students acquiring vocational education on the basis of basic education or secondary education in educational institutions of Estonia or equivalent educational institutions of foreign states founded and operating on the basis of legislation, and higher education students who are permanent Estonian residents.

According to the Health Care Services Organisation Act, health care service is provided for the uninsured person as an emergency care and it is funded from the state budget. Emergency care is a health care service provided by the health care professional in a situation when postponement of the treatment or withholding the treatment may cause the death or constant personal injury of the person in need of treatment. A health care professional is a doctor, a dentist, a nurse and a midwife, if they are registered in the Health Board. A health professional is obliged to provide emergency care in his or her capacity and within the possibilities available for him or her. A family physician is obliged to provide emergency care to a non-resident or to a person living in his or her service area, even if the person is not in his or her practice list.

Available funds of the state budget for medical care of uninsured persons:

- **in 2008** 100,894,000 EEK;
- **in 2009** 111,084,294 EEK;
- **in 2010** 116,400,000 EEK;
- **in 2011** 7,071,696 EUR (110,64,000 EEK).

Provision of emergency medical care is financed from the state budget as well.

Medical care is provided on the local government level as well, although the set practice of reimbursement of medical care expenses of uninsured persons differs in local governments.

In smaller local governments the local government often provides premises for a family physician or supports him or her by other means. In such local governments the family physician often provides free medical care for uninsured persons. So called authorized doctors system operates in larger local governments such as Tallinn. This means that there is a particular health care unit for such medical care. In Tallinn, the unit is in AS Ida-Tallinna Keskhaigla (East-Tallinn Central Hospital). The unit provides out-patient and in-patient health care service for uninsured persons. The unit of Ida-Tallinna Keskhaigla has 25 beds and

persons are sent there by an attending physician in an out-patients' clinic or after acute treatment in an inpatient clinic.

The report acknowledges that the question of the long waiting periods in some specialist medical branches is emphasised by patients in the satisfaction surveys. The Committee enquires which actions are envisaged to shorten the waiting periods.

The council of the Health Board approves the maximum lengths of waiting lists, which are the basis for purposes of availability of treatment in the health insurance fund. Treatment is considered to be received timely if due to financial reasons and insufficient capacity of a medical institution (i.e. there are not enough doctors, working space including ORs) the waiting list is no longer than the maximum length established by the council.

The health insurance board has analysed the availability of medical treatment on the basis of waiting lists' data submitted by the contract partners. In case of excessing the maximum length of waiting lists, the regional department of the health insurance fund inspects the availability of problematic areas of health care in the whole region and specifies the reasons for excess length of the waiting lists. If it is necessary, the waiting lists' data is controlled at the medical institution and if the increase in a contract volume would improve the availability of medical care, the contract is amended accordingly.

Compared to the previous year and despite of additional financing, the availability of the service has not improved during the reference period. The number of persons in the waiting lists for out-patient, one-day and in-patient treatment has increased. Compared to the beginning of the year, the average waiting period increased by a few days. The waiting period for out-patient services is 25 days, for one-day treatment it is 43 days and for in-patient treatment it is 50 days. Of out-patient professions, the most people are in line for gynaecology and ophthalmology visits. Longer waiting periods are in specific surgical out-patient professions such as neurosurgery, and face and chinbone surgery; in internal medicine such professions are gastroenterology and endocrinology. Of in-patient professions, the most persons wait for general surgery and otorhinolaryngology. The shortest waiting periods for an insured person are in out-patient cardio surgery and in occupational medicine visits. Of in-patient services, the shortest waiting periods are in nephrology and internal medicine. The availability of the services is the priority of the health insurance fund. However, it shall be admitted that the shortening of waiting lists does not depend on money

as much as it does depend on the number and organization of labour of doctors and nurses. (Source: the report of the Health Insurance Fund 2011)

The budget allocated to health care represented 5% of GDP in 2006. The Committee considers that public spending on health is low compared with other European countries and asks for updated information on this point.

Table 17: Indicators of total health expenditure, 2008-2011

	2008	2009	2010	2011
The share of total health expenditure in GDP, %	6.1	7.0	6.3	5.9
The share of public health expenditure in public health expenditure, %	11.9	11.6	12.3	12.3
The share of public health expenditure in total health expenditure, %	77.8	75.3	78.9	79.3
...The share of health expenditure of central government in total health expenditure, %	11.5	8.6	9.5	9.3
...The share of health expenditure of local government in total health expenditure, %	1.5	1.5	1.2	1.4
...The share of health expenditure of Health Insurance Fund in total health expenditure, %	64.8	65.2	68.2	68.6
The share of health expenditure of private sector in total health expenditure, %	20.6	20.9	20.3	19.2
...The share of households' out-of-pocket expenditure in total health expenditure, %	19.7	20.3	18.6	17.6

Source: the National Institute for Health Development

The total spending on health as percentage of GDP started to increase in 2007 reaching its maximum in 2009, after that decline is observed. The quick increase in 2009 was caused by financial crisis when health spending were cut less than general state budget, ie health was considered as a priority in the state budget. Approximately 80% of total health spending comes from public money, majority via social health insurance. The Ministry of Social Affairs and Estonian Health Insurance Fund have been aimed not to let out-of-pocket expenditure to grow. The out-of-pocket expenditures have been stable or even decreasing. A real successful effort was reducing out-of-pocket payments of pharmaceuticals, numerous

generic drugs promotion campaigns were launched for that together with some supportive legal amendments towards substance based prescriptions.

Article 11 § 2 - Advisory and educational facilities

1) For States that have not accepted paragraph 1, please describe the general public health policy and legal framework. Please specify the nature of, reasons for and extent of any reforms.

Please see the answer for Article 11 § 1

2) Please indicate the measures taken (administrative arrangements, programmes, action plans, projects, etc.) to implement the public health policy and the legal framework.

In the National Health Plan for 2009-2020 (NHP), strategic goals are set for continuous improvement of the public health. The Government of the Republic has set the elongation of lifetime and raising the quality of life as a priority and this is what the plan is based on. NHP for 2009 – 2020 assembles and targets vertical development plans and strategies in the field of health and incorporates a wide variety of strategies which are already operating or strategic documents of other fields that are being created.

The aim of the National Health Plan for 2009-2020 is to reach life expectancy of 75 years for men and of 84 years for women by the year of 2020. In the time of composing the plan, the latest data about the life expectancy was from the year of 2006 and thus the basis for it in the plan is 67.4 years of age for men and 78.5 years of age for women.

During the years after 2006, the predictable lifetime of the Estonian population improved in a moderately together with the economic growth.

Since the end of 2008, the influences of the global economic downturn reached Estonia and this affected the planned activities of the NHP. Although there were some limitations to the activities, they were rearranged promptly and some of the activities had to be even added and financed more in the new situation. Similarly, unexpected changes in the results of the indicators revealed themselves due to changed conditions.

One of the most important and even unexpected changes involved life expectancy, which increased to a great extent from the beginning of 2008 (the data was available by the end of 2009). So the expectancy increased by an average of 1.1 years in comparison with the years

2007 and 2008 and by 1 year in comparison with the years 2008 and 2007, while by the year 2007, the increase of life expectance had been stagnant and even decreased by 0.23 years compared to 2006. Thereby it is important to note that even if the life expectancy of women increased again starting from 2008, then in 2008-2009 the life expectancy of men increased twice as much and the difference between the life expectancy of men and women decreased.

It is not possible to distinguish the impact of the NHP and economic downturn on the acceleration of increase of life expectancy. The impact of economic downturn on the public health may occur with a shift during the following years.

1st subject field. Social cohesion and equal opportunities

According to the performance report of the first period (2009-2010) of the National Health Plan for 2009-2020, the social cohesion has increased and inequality in health has decreased.

The results of the indicators showing economic well-being have worsened significantly in 2009-2010 – for example, compared to the base level of 2006, the percentage of long-term unemployed persons of the workforce has increased many times (in 2006 and 2009 it was respectively on the average of 2.3% and 7.7%) and the number of persons insured with health insurance decreased to 94%. The worsening of those indicators would have probably been even greater, if several labour marked measures would have not been implied extensively to improve the situation of people.

Concurrently the indicators showing social differentiation improved significantly – relative poverty limit decreased by 2.5 percentage points and reached 15.8% by 2009, whereas the poverty risk of children decreased even more and reached 16.3% by 2009. Therefore, if the general economic well-being of the population decreased, then the inequality between communities decreased as well, and social cohesion which was the goal of the first subject field of the NHP increased.

During the next period of the NHP it is important to contribute to the prevention of long-term unemployment, improvement of the availability of various support systems and benefits, expansion of the coverage by health insurance, and other similar activities.

The general goal in the field of social cohesion is to avoid another socio-economic growth of inequality as the economy grows and to ensure the availability of health services to all who need these services.

2nd subject field. Safe and healthy development of children and young people

According to the performance report of the first period (2009-2010) of the National Health Plan for 2009-2020, the mortality, and mental and behavioural disorders of children and young people have decreased prima facie and young people give their health more positive score.As mentioned before, the poverty risk of children decreased and the goal set to this indicator of the NHP for 2020 was reached in 2009. All the other indicators of the second subject field of the NHP showed great positive changes as well. For example, by the end of 2009 the goal for new cases of mental disorders of children and young people set for 2020 was reached in 2009. The increase in social cohesion influenced the improvement of children's health positively, as events of mental disorders on children are considerably related to the occurrence and perception of socio-economical differences.

In addition to the decrease of mental disorders, it is noteworthy that deaths of children caused by accidents have decreased more than twice. Therewith it is important that the decrease of mortality was faster in case of boys as it was the same with life expectancy. To maintain and improve the reached results it is necessary to apply and develop the already started activities more extensively and systematically.

3rd subject field. Health preserving living, working and learning environment

According to the performance report of the first period (2009-2010) of the National Health Plan for 2009-2020, there are no extremely positive or negative changes in the indicators of environmental health field, but they are different in each field. On the one hand, all the indicators describing working environment have improved as well as the indicators of the quality of ambient air, and the increase of the percentage of the population provided with appropriate drinking water exactly follows the prognosis. But on the other hand, the occurrence of contagious diseases caused by food has decreased less than predicted and the trend of new asthma cases is opposite to what it was expected to be. If the economic downturn affected considerably the situation of the labour market’s general level, then the impact of it on relative indicators such as occupational diseases resulting in death per 100,000 employees (in 2010 - 3.0), the number of lost working days due to accidents at work per 100,000 employees (in 2010 - 15.9) and on the percentage of persons rating their working environment as healthy (56%) should be minimal or non-existent. The main reasons

for improvement of the indicators mentioned above are probably the active measures of occupational health and safety, which have been significantly improved and developed together with intensifying general labour market measures. Another reason is that the construction sector has not been that active. On the other hand, due to the economic downturn, food safety surveillance of 2010 was conducted in a smaller volume than during previous years and this might be related to the smaller decrease of the number of contagious diseases caused by food than expected.

Other indicators of environmental health and safety show expected results in case of drinking water and the annual average concentration of particulate matters in ambient air of Estonian towns has improved faster than expected. The goal of the last indicator set to 2012 was reached in 2010, when the ambient air in Estonian towns contained averagely 18 micrograms of particles with diameter of 10 micrometres (so called PM10 particles) per cubic meter. As the PM10 particles mostly come from the soil, covering, and environmental dust, then in addition to the activities increasing environmental safety, the improvement of the conditions might have also been influenced to some extent by the economic downturn, which lessened the traffic flows and breaking the coverings. The economic downturn probably affected more the significant lessening of dying due to respiratory diseases as the exhaust of vehicles is the main source of PM2.5 particles (particles in ambient air with the diameter of 2.5 micrometres), which in turn is the cause for respiratory deaths.

4th subject field. Healthy lifestyle

According to the performance report of the first period (2009-2010) of the National Health Plan for 2009-2020, the physical activity of the population has increased, nutrition has become more balanced and risk behaviour has lessened. All the NHP indicators measuring health behaviour have improved, except for the overweight indicator. In 2006, 30.5% of the adults were overweight and while the goal of the NHP set to 2012 was to reach the level of 28%, it instead increased and reached 31.7% in 2010. Concurrently, the percentage of obese people raised from the base level of 15.2% in 2006 to 16.9% in 2010 and the percentage of overweight students raised a little as well (in 2010 – 9.8%). The results of earlier years show that overweight started increasing mostly among young people and during years expanded to older age groups.

In addition, scientific literary works indicate that eating habits of people become less healthy during economic downturn as people start to save money by not consuming fruits and vegetables and prefer high calorie food. Lot of effort have to be made to change eating

habits more healthy in wealthy societies where people obtain energy from food more easily but at the same time, the consumption of energy is lower. In Estonia, it has not been managed to slow down the increase of overweight by now and it is even harder as eating habits have gone through a relapse in the circumstances of the economic downturn and people have gone back to their former eating habits.

Since 2008, the alcohol excise duty has been significantly raised twice – by then, the purchasing power of people raised faster than alcohol prices, so the relative price of alcohol dropped and the attainability of alcohol improved despite all other applied measures. While the alcohol excise duty raised, the general purchasing power of people decreased due to the economic downturn and the impact of those two factors lessened the attainability of alcohol significantly. As a result, in 2008, the consumption of alcohol started to decrease after a very long and fast increase.

In addition to the aforementioned, the health behaviour indicators show positive trends in the field of HIV prevention as well – in 2010, new cases of HIV infection reached 27.8 cases per 100,000 persons and the percentage of pregnant women infected by HIV is less than 1% of all pregnant women. As a result it could be stated that the activities of combating HIV spread have been efficient and the spread of HIV infection from injecting drug users to general population has been slower than expected.

5th subject field. Development of the health care system

The revenue base of health care system has been reduced considerably in recent years and the coverage with health insurance of the population has lessened. Despite that, the indicators of the first period (2009-2010) of the National Health Plan for 2009-2020 show that the general satisfaction of people towards the quality of medical aid has not lessened and in 2010 it was rated good or very good by 74% of people.

The quality of the health care services did not worsened, but there was a relapse in the availability of the services - it was rated good or very good by only 55% of people, which is a significant change for the worse compared to t–e base level of 2007 and the goal for 2012 (60% and 62% respectively). In the circumstances of economic downturn in Estonia, some lessening of health insurance coverage and lengthening of waiting lists had to be put up with to avoid the increase in patient's co-payment and to maintain the quality of health care.

One way to improve the cost efficiency is the structural change of healthcare personnel. By changing the proportion of doctors and nurses in and by expanding independent work

opportunities for nurses it is possible to relieve the general pressure of resource needs in health care. That is why the importance of family nurses has been raised, midwives been have given the possibility to have appointments on their own, and other similar initiatives have been conducted during the first period of the NHP. However, the number of doctors per 100,000 people was 329 in 2009 (320 in 2006) and the number of nurses per 100,000 people has fallen from 680 in 2006 to 666 by now.

3) Please supply any relevant statistics or other information, including on consultation and screening services in schools and for the rest of the population.

Children are screened by family physicians (by being on family physician's practice list) and health care professionals at school.

Bases for organisation of studies of basic school and upper secondary school, the rights and obligations of students and their parents or guardians, and other activities related to school are regulated by the Basic Schools and Upper Secondary Schools Act. Pursuant to this law, the regulation Activities to be carried out by nurses providing health services at school and the requirements for the time, scope, availability and location of the activities of the nurses is enacted. The regulation enacts activities of school health care services' for nurses working in basic school, upper secondary school and vocational educational institution provided for full-time study students receiving basic and general secondary education (hereinafter students), and requirements for the time, volume, availability and place of the activities. The regulation provides a list of individual activities of school health care aimed at students (for example assessment of health and coping of new students, frequency of health checks in stages of study, immunization, etc.).

Health care is schools in one of the projects of disease prevention financed by the health insurance boars. According to the accounts of 2011 of the health insurance fund, health care in schools was financed by 3,198,000 euros.

The Committee asked in its previous conclusion (Conclusions 2005) what measures had been taken to provide information to the general public on sexual and reproductive health as well as on a healthy environment. In the absence of specific information on these questions in the report, the Committee reiterates its question.

The Ministry of Social Affairs takes the National health plan as bases to implement evidence-based measures in monitoring and surveillance of forming health policy, raising awareness of people, and providing services to considerably improve the public health. There are three measures to reach the goal:

(1) promotion of healthy choices and lifestyle,

(2) ensuring health preserving living, working, and learning environment and

(3) providing the availability of high-quality health care services to all persons in need.

Promotion of healthy choices and lifestyle

It is considered that the attitude, belief, values, awareness, abilities, and motivation of people influence health behaviour. In addition to the commitment of a person, non-governmental organizations and local governments whose initiatives are supported by the Ministry of Social Affairs by financing the initiatives from public funds have an important function.

The Public Health Department of the Ministry of Social Affairs has leading function in increasing healthy choices of people and decreasing risk behaviour. The most important policy instruments of the measure are the influence on consideration of health in all fields of life, raising awareness, forming a society that promotes healthy choices, and continuous development and providing of services. The implementation is carried out by the National Institute for Health Development, the health insurance fund and the Health Board. Cooperation with the Ministry of Culture is conducted to promote physical activities. The Ministry of Agriculture is the cooperation partner for conducting the activities of healthy eating. The Ministry of Internal Affairs and the Ministry of Economic Affairs and Communication are the main partners in prevention of injuries.

Promotion is conducted in the media, the activities of health promoting networks are supported, and food business operators are trained to promote healthy eating choices and physical activity of the population. Promotion and training activities are developed to advance nutrition counselling. It is planned to arrange nutrition research to get better overview of eating habits of the population and to elaborate recommendations to canalize the marketing

of products with high sugar, salt, or fat content in cooperation with the Ministry of Agriculture and involving manufacturers as partners.

Measures are implemented to reduce the availability and consumption of alcohol in order to lessen the damage of it. The system of early discovery of alcohol overuse and counselling is elaborated to prevent chronic alcohol addiction.

Cross-sector policy paper is prepared to decrease the number of deaths by injuries.

Promotion of the harmfulness of tobacco products and counselling service for quitting smoking are conducted to reduce smoking. It is agreed in the framework instrument of tobacco policy to modernize the Tobacco Act in order to implement the agreed measures.

The priority of combating HIV infection is to decrease the number of new cases by paying special attention to preventive measures aimed at young people and by actively continuing with providing and developing the service of reducing damages. One of the important activities is to get HIV positive persons to the scope of the health care system to ensure their timely ARV treatment.

In the field of preventing drug addiction, effort is being made to limit the availability and use of phentanyl as among drug addicts, amphetamine is the most used substance next to opiates. According to the plan of the Ministry of Social Affairs, availability of addiction treatment and rehabilitation is extended and information about these possibilities is spread.

To reduce the new cases of tuberculosis, measures are implemented to prevent, discover early, and to combat tuberculosis with the focus on HIV positive people, injecting drug addicts and alcohol addicts. In case of these patients, treatment of entailed infection, addiction treatment or social needs have to be handled in addition to tuberculosis treatment. The plan is to expand the volume of other integrated services provided with directly controlled treatment of tuberculosis on the principle that the person with tuberculosis can presumably get all the necessary services from one place.

Ensuring health preserving living, working and learning environment

It is necessary to systematically assess and manage health risks caused by the environment to reduce such risks. It is very important to raise the awareness of people about the risks affecting them and to guarantee the readiness of the state to deal with potential emergencies. The Public Health Department of the Ministry of Social Affairs has an important

role here. Great part of the implementation activities including information activities are carried out by the Health Board.

To reduce the health risks of living, working and learning environment, it is important for the whole population – employees, employers and children – to be aware of risks and risk reducing measures, and that informed choices would be made to form living, working and learning environment and reducing risks. In connection with reaching the aims of Parma Declaration, activities aimed at preventing diseases and injuries are developed to create healthy living environment.

The Ministry of Social Affairs, together with the Ministry of the Environment, the Ministry of Agriculture and the Ministry of Economic Affairs and Communication, plans to develop necessary legal framework (in the field of chemical safety and environmental health) to achieve living, working and learning environment which enables the preservation and improvement of health.

Cooperation is conducted between institutions to prevent and combat communicable diseases. To increase the percentage of population covered by immunization, attention is paid to information and awareness-raising about the spread, risk factors and prevention of communicable disease.

Ensuring the availability of high-quality health care services

Health Care Department and Medicine Department of the Ministry of Social Affairs have the leading role here. Health care services provided by health care providers are the most important policy instruments financed through the health insurance fund. The implementing agencies on the state level are the Health Board, the Estonian e-Health Foundation and the State Agency of Medicines in the field of medicine policy.

The information about health care services is widely available including the availability on the internet.

The Committee asks whether the school curricula covers prevention of smoking and alcohol abuse, sexual and reproductive education, in particular with regard to prevention of sexually transmitted diseases and Aids, road safety and promotion of healthy eating habits, for the whole duration of schooling.

Health education is covered by the national curricula of basic and upper secondary school. General values of health education are integrated with other subjects, but topics such as smoking, over-consumption of alcohol, sexual health, traffic safety, and healthy eating are covered in the field of social subjects, in the subject syllabus of personal education. The volume of the personal education in the curricula is 2 academic hours a week down the line with 1st to 3rd stage of study. In the upper secondary school, personal education focuses on the aspects of sexual health.

As regards pregnant women, the only testing mentioned in the report is the possibility of testing for genetic diseases. The Committee requests more information on the consultations and screening for pregnant women.

All pregnant women are covered by health insurance. According to § 5 (4) of the Health Insurance Act, not working pregnant women are covered by health insurance, if the pregnancy is identified by a doctor or midwife. The insurance is valid until 3 months after childbirth. The insurance continues, if a parent raises a child under 3 years of age. According to the Estonian health care administration, gynaecologist, midwife or family physician may provide prenatal care. The preferences of a pregnant woman about service provider are taken into account when providing the service.

Instructions for observation of pregnancy are developed to unify the standards of observation of pregnancy. The instructions cover epidemiology, general requirements for providing prenatal care service (including documentation of pregnancy observation), counselling of pregnant women, working and nutrition, use of medicaments and food supplements, vaccination, use of drugs, physical stress, sexual life, travelling, hygiene procedures, often occurring complaints during pregnancy, assessment of pregnancy risks, etc. (the instructions are available online www.ens.ee/webfm_send/95). The instructions cover analysis during pregnancy. All pregnant women are screened for genetic diseases.

The Committee asks that the next report specify the staff resources available in the field of school healthcare.

According to the Basic Schools and Upper Secondary Schools Act, the school keeper makes health care service available at school, cooperates with school health care provider, and ensures the availability of premises and non-medical devices at school to ensure consistency. The regulation of the Minister of Social Affairs Activities to be carried out by nurses providing health services at school and the requirements for the time, scope, availability and location of the activities of the nurses enacts requirements for providing health care service at school.

Health care professional entered in the Health Board' health care professionals' registry may provide health care service at school. Health care service at school may be provided on the basis of an activity licence of school health care service.

According to the Health Board's activity licences registry, activity licences have been issued for 34 nursing service providers and for 10 doctors providing school health care service.

Article 11 § 3 - Prevention of diseases

1) For States that have accepted neither paragraph 1 nor paragraph 2, please describe the general public health policy and legal framework. Please specify the nature of, reasons for and extent of any reforms.

Answer: Please see the answer for Article 11 § 1

2) Please indicate the measures taken (administrative arrangements, programmes, action plans, projects, etc.) to implement the public health policy and the legal framework.

Answer: Please see the answer for Article 11 § 1.

3) Please supply any relevant statistics or other information on the percentage of smokers in the general population, trends in alcohol consumption and the rates of vaccination cover for infectious and epidemic diseases.

34.2% of adult population are smokers, 26.2% are regular smokers. (Health Behaviour among Estonian Adult Population, 2010)

Alcohol consumption in 2008-2011 (litres of alcohol at 100% vol. per person in a year):

- **in 2008** 12.06;
- **in 2009** 10.09;
- **in 2010** 9.68;
- **in 2011** 10.20.

Table 18: Childhood immunization - coverage among 2 years old (%)

	Diphtheria and tetanus	**Pertussis**	**Poliomyelitis**	**Measles, mumps and rubella**	**Hepatitis B**	***Haemophilus influenzae* type B**
2008	96,1	96,1	96,2	95,4	96,2	96,0
2009	96,0	96,0	96,0	95,2	96,1	96,1
2010	96,1	96,1	96,1	95,1	96,4	96,1
2011	94,9	94,8	94,9	93,9	95,0	95,3

Source: Ministry of Social Affairs

The Committee asks to be kept informed of all developments on the prevention of avoidable environmental risks.

The 3rd subject field of the National Health Plan for 2009-2020 is about reducing the risks deriving from the environment: health preserving living, working, and learning environment, with the strategic goal to reduce health risks deriving from living, working and learning environment. Priorities of the subject field:

- To intensify the system of assessment, management and notification of health risks deriving from living, working, and learning environment.
- To increase state preparedness for combating the spread of communicable diseases and for epidemics and pandemics.
- To intensify surveillance over living, working and learning environment
- To improve the arrangement of health at work, to considerably increase the quality of health care services at work and to ensure the availability of the services for all
- To increase and maintain the coverage with immunization of the population.

Please see the answer for Article 11 § 2.

The Committee asks whether smoking in all public places is prohibited and whether it is prohibited to sell tobacco products to persons under 16 years of age.

It is prohibited to sell tobacco products to persons under 18 years of age (§ 28 of the Tobacco Act).

Smoking is not prohibited in all public places. Smoking is prohibited in the following places:

- in the premises and on the bounded territory of social welfare institutions for children;
- in the premises and on the bounded territory of pre-school child care institution, basic school, upper secondary school, vocational educational institution, hobby school, open youth centre or permanent youth camp and youth project camp;
- in the premises of pharmacies;
- in the production room and warehouse of an enterprise;
- in a salesroom of shops and mobile shops;
- in a catering establishment, except in the room established for smoking or on a seasonal extension outside the interior space of and near the catering establishment;
- in enterprises where work is performed on the request of a client;
- in premises for sport;
- in dressing-rooms or restrooms if not in private use;
- in public transport shelters, departure lounge and passenger terminal;
- in a vehicle used for passenger transport service;
- at close quarters of tanker, fuel container or gas pump;
- near flammable or explosive chemicals, at sites with flammable or explosive spaces, at places of loading hazardous loads, near parcels waiting to be loaded, near a stagnant traction unit and in it;
- in a territory of explosive substance warehouse, up to 20 meters from storage place of explosive substance on a ship, in warehouses of pyrotechnic product or near ammunition containing explosive substance;
- in working of mines, in lamp rooms and loading tables' rooms, and closer than 20 meters from shaft orifice;
- near the barrel while loading the weapon, in weapons storage rooms, in armouries or in weapon rooms;
- during fire-risk time in forest or on territory covered with other flora;
- in pedestrian tunnel;
- in passageways, stairway or other public space of apartment buildings.

The Committee asks to be kept informed of all trends in tobacco consumption.

The number of consumers of tobacco products has been constant since 2006; there was a little decrease among regular smokers – in 2006 it was 27.8% and in 2010 it was 26.2% of of adult population.

The Committee notes the measures taken in order to reduce alcohol consumption, it asks the next report to provide information on the rules regarding the sale and distribution of alcohol as well as updated information on trends in alcohol consumption.

Since 2008, the prohibition of alcohol retail sale in shops from 10 pm. to 10 am. is effective.

A new Excise Act took effect in the beginning of 2008; alcohol excise increased twice in 2008 – 20% and 10% and increased by 10% in 2010.

The following limitations and requirements are established for alcohol advertisements provided by the Advertisement Act entered into force in November, 2008:

Alcohol advertisement is prohibited:

- in educational and child care institutions, and in hobby schools;
- sports institutions;
- health care and social welfare institutions;
- constructions of the Defence Forces and the National Defence League institutions and boarder surveillance authorities;
- on a construction and in a territory;
- in, on and on the territory of custodial institutions;
- in recreational establishment;
- on the front and back page of periodical publications and in publications mainly for children;
- in the events mainly for children and on the ticket of such event;
- on broadcast from 7 am. to 9 pm;
- on audio-visual data medium and on the package of it;
- outdoor advertising of alcoholic beverage with the ethanol content of over 6% by volume.

Alcohol advertisement may not:

- include direct calling to buy or consume alcohol or describe positive qualities of alcohol;
- picture moderate alcohol consumption or abstinence in a negative light;
- use famous people (actors and actresses, athletes, etc.) or picture famous characters from works for children;
- associate alcohol consumption with driving a vehicle;
- emphasize large ethanol content as a positive characteristic of alcohol;
- contain information that buying alcohol enables to get product or services for free or for cheaper fee.

Prohibited advertisement is:

- distributing an object or publication related to alcohol to children for free;
- exposing alcohol outside of a place of sale, except for introducing products on an exhibition, fair or other similar event;
- handing out free alcohol on selling or offering goods or services, except for consuming in catering establishments; possibility to receive an alcoholic beverage as a promotional campaign or as a price, gift or other benefit of other activities, the goal of which is to increase the sales of goods and services.

Alcohol advertisement must contain the following warning notice: "Attention! This product contains alcohol. Alcohol may damage your health“.

The Committee notes the information on measures taken to reduce drug abuse and to assist drug addicts. It also noted the information on trends in drug use and asks to be kept informed of these trends.

The National Strategy for the Prevention of Drug Addiction up to 2012 has set the following goals:

- effective treatment and rehabilitation system;
- functioning reduction of damages caused by drug using
- directed social network;

- complex prevention system;
- cooperation between force structures and decrease in drug offering;
- efficient and overall drug information surveillance system.

Comparing the data of 2003 and 2008 of the population survey, it could be stated that unfortunately, the percentage of people having used drugs during their lifetime has increased. The survey showed that if in 2003, the percentage of people between 15-64 years of age having tried drugs during their lifetime was 15%, then the survey conducted in 2008 showed that 21% of people of this age group had tried drugs. Drug use during lifetime, that is also trying drugs just once in a lifetime, has increased in younger and older age groups, but it has significantly increased in younger age groups. The increase has happened in the age group of 25-35 where 36% of people have tried any drugs even if just for once (in 2003 - 16.7%). Cannabis is the most used drug during last 30 days or during last 12 months among people, followed by ecstasy and amphetamine.

The estimated number of injecting drug addicts in Estonia is 13,886, which is 2.4% of the population of 15-44 years of age. Injecting drug addicts in Estonia are young people, mostly men, injecting phentanyl, amphetamine and / or poppy seed liquid as the main drugs, most of then start to inject before the age of 18.

On the basis of a survey ESPAD about drug use conducted in 2011, it could be stated that the usage of drugs among students has slowed down. If the number of students who had tried some kind of narcotics was 7% in 1995, 15% in 1999, 24% in 2003 and 30% in 2007, then the results of the survey of 2011 showed that the percentage has increased by 2%.

Drug addiction treatment is methadone replacement based treatment. Seven centres in Estonia provide opiate replacement treatment on state level. In 2008, 1008 drug addict received replacement treatment and in 2009 the number was 1012, then 2010 the number of clients was 1064. By the end of the year, the number of clients having methadone replacement treatment was 662 (600 drug addicts were receiving treatment by the end of 2009). However, the data of the drug addiction treatment database show that 65 patients received aversion therapy in 2010. The problem is still the large percentage of quitters of the treatment programme.

Significant investments have been made to increase the volume of treatment, rehabilitation and damage reducing services, and increasing the quality of services. The possibilities to treat drug addiction in Estonia have improved in years, but further development is necessary

to ensure the effectiveness of replacement and weaning treatment of opiates, and treatment of stimulant addicts.

The number of people receiving replacement treatment in Estonia has increased fast during the previous years and such treatment is available in houses of detention and in prisons. However, 5% of injecting drug addicts receive this treatment which is a bit over 1,000 persons a year (in 2008 – 1008; in 2009 - 1012; in 2010 – 1064).

The Committee asks the next report to provide information on measures taken to attempt to reduce the number of accidents.

Since 2009, campaigns for the prevention of overuse of alcohol have been conducted every year; introduction of the system for early discovery and counselling of alcohol overuse, and the development of alcohol policy conception have been commenced.

The Estonian Road Administration yearly conducts traffic safety campaign „Sõida kaine peaga“ (Drive Sober).

According to the development plan for reducing violence for 2010-2013, instructions were composed for practitioners who come across with violence cases in close relationships and resolving those cases.

With the support of the Ministry of Social Affairs, The Estonian Women’s Associations Roundtable and the Young Women Support Centre conducted trainings for girls’ self-enforcement.

The Ministry of Justice supports third sector prevention projects in course of the development plan of reducing violence and has conducted an information campaign „Sekkumata jätmine tuleb ringiga tagasi“ (Not Intervening Comes Around).

The Ministry of Internal Affairs arranged water safety campaign „Kui jood, ära uju“ (Don’t Swim When Drinking) in 2011 and conducted continuous awareness raising of fire safety including campaign and making smoke detectors obligatory for everyone in 2008-2011.

Article 12 – The right to social security

Article 12 § 1 - Existence of a social security system

1) Please describe the general legal framework. Please specify the nature of, reasons for and extent of any reforms.

Estonian social insurance system covers social insurance fields which cover all usual social risks: illness, unemployment, old-age, accident at work, family, maternity, incapacity for work, and loss of a provider.

During the reference period, the following acts are amended in Estonia:

- the Health Insurance Act;
- the Labour Market Services and Benefits Act;
- the Unemployment Insurance Act;
- the State Pension Insurance Act;
- the State Family Benefits Act;
- the Parental Benefit Act
- the Social Tax Act.

The Maintenance Allowance Act entered into force on the 1st of January, 2008.

The amendments are indicated under article 12 § 3.

During the reference period, the pension reform was proceeded with the aim to lose special pensions and due to demographic changes to raise retirement age.- In 2010, the amendment of the State Pension Insurance Act was passed which raises the general retirement age from 63 years of age now to 65 years of age since 2017.

A reform with the aim to pay pension supplement for raising children was commenced during the reference period.

2) Please indicate the measures taken (administrative arrangements, programmes, action plans, projects, etc.) to implement the legal framework.

All the measures are regulated by legal acts (see the answer to previous question).

3) Please provide pertinent figures, statistics or any other relevant information, if appropriate.

Table 19: Number of persons covered with social security scheme, 2011

	Number of insured persons	Population	Percentage, %	Notes
...of the population is covered by health insurance[1]	1,245,469	1,339,662	93.0	
...of active population is covered by sickness insurance	568,434[2]	1,339,662	42.4	
...of active population is covered by unemployment insurance	581,600	1,339,662 (the whole population) 853,400 (16 years of age to retirement age)	68.2 (of the population of 16 years of age to retirement age)	Insured from 16 yers of age to retirement age
...of old-age pensioners are covered by pension system				About 99% (more particularly 99.8 %) of old-age pension age people (men 63+ and women 61.5+) are insured with

[1] Report of the Code of Social Security.

[2] Persons covered by health insurance (incl. self-employed persons that are not separately brought out).

				pension system[3]
...of people covered by pension system	407,014[3]	1,339,662	30.4	30.4% of the population is entitled to some kind of pension.
....of people from 0-19 years of age are covered by family benefit scheme	257,006[1]	1,339,662[2] (the whole population) 277,237 (0-19 years of age)	92.7	92,7% of children from 0-19-years of age receive child allowance

[1] Number of children receiving child allowance, as of the end of 2011. Data of the Estonian National Social Insurance Board.

[2] The data of population of the Statistical Office as of the 1st of January.

[3] The total amount of pension recipients (including family members receiving survivor's pension) as of the end of 2011 (recipients of old-age pension, superannuated pension, pension for incapacity for work, survivor's pension, national pension), data of the Estonian National Social Insurance Board.

[4] The number of old-age pensioners (as of the end of 2011), data of the Estonian National Social Insurance Board.

Source: the Ministry of Social Affairs, the Estonian National Social Insurance Boars, the Statistical Office data of population

[3] Old-age pensioners are men of 63 and more years of age and women of 61.5 and more years of age. Total number of old-age pensioners of that age is 274,084 and residents of that age is 274,730. The quotient is 99.8%.

Health insurance

Number of recipients of Estonian health insurance:

- **in 2008** 1,281,718 (95.5% of population);
- **in 2009** 1,276,366 (95.2% of population);
- **in 2010** 1,256,240 (93.7% of population);
- **in 2011** 1,245,469 (92.,9% of population).

Source: the report of the Health Insurance Fund

Unemployment allowance

In 2011 30,449 registered unemployed persons received unemployment allowance. It is 33% less than in 2010 and 33% more than in 2008. In 2011 27% of new registered unemployed persons received unemployment allowance (2010 – 31%).

Table 20: Unemployment allowance recipients, 2008-2011

	2008	**2009**	**2010**	**2011**
Unemployment allowance recipients	22,878	46,376	45,401	30,449
New unemployment allowance recipients	18,600	38,179	29,010	21,480
New unemployment allowance recipients as a share of new registered unemployed persons	39%	32%	31%	27%
Daily unemployment allowance rate (EEK, since 2011 EUR)	32.90 EEK	32.90 EEK	32.90 EEK	2.11 EUR

Source: the Estonian Unemployment Insurance Fund

Unemployment insurance benefit

The number of unemployment insurance benefit recipients increased almost four times during the period of 2008-2010. The increase was caused by the rapid growth of unemployment. In 2011, the number of unemployment insurance benefit recipients decreased 47%. In 2011, 25% of newly registered unemployed persons recieved unemployment insurance benefit (2010 – 34%). Since 2009, the number of unemployment insurance benefit recipients exceed the number of unemployment allowance recipients.

Table 21: Table. Unemployment insurance benefit recipients, 2008-2011

	2008	2009	2010	2011
Unemployment insurance benefit recipients	15,402	57,617	61,012	32,104
New unemployment insurance benefit recipients	15,743	54,970	32,363	19,830
New unemployment insurance benefit recipients as a share of new registered unemployed persons	33%	45%	34%	25%
Average unemployment insurance benefit payment (in euros)	231	287	265	257

Source: the Estonian Unemployment Insurance Fund

Pensions

Pension is increased by indexation

Table 22: Value of national pension index

Since the 1st of April, 2008 it is 1.216
Since the 1st of April, 2009 it is 1.050
Since the 1st of April, 2010 it is 1.000
Since the 1st of April, 2011 it is 1.000
Since the 1st of April, 2012 it is 1.044

Source: the Estonian National Social Insurance Board

Table 23: Changes in the base value of pension, value of a year and limit of national pension (in 2008-2010 EEK and from 01.01.11 EUR)

Date	Value of a year	Base value of pension	Limit of national pension
01.04.2008	65.01	1,699.94	1,913.14
01.04.2009	67.94	1,793.44	2,008.80
01.04.2010	67.94	1,793.44	2,008.80
01.01.2011	4.343	114.6575	128.45
01.04.2012	4.515	120.2069	134.10

Source: the Estonian National Social Insurance Board

Table 24: Amounts of old-age pension, pension for incapacity for work and national pension (EEK per month, since 2011 EUR per month)

	1.04.2008	1.04.2009	1.04.2010	1.04.2011	1.04.2012
Average old-age pension (in case of 44-years service period)	4,560	4,783	4,783	305.75	318.87
Old-age pension in case of 30-years service period	3,650	3,832	3,832	244.95	255.66
Old-age pension in case of 15-years service period	2,675	2,813	2,813	179.80	187.93
National pension	1,913	2,009	2,009	128.45	134.10
Minimum pension for incapacity for work in case of 100% 40% loss of capacity for work:					
... of 100% loss	3,650	3,832	3,832	244.95	255.66
... of 40% loss	1,460	1,533	1,533	97.98	102.26

Source: the Ministry of Social Affairs

Table 25: The number of pension recipients by types of pension (as of the 1st of January)

Pension type	2008	2009	2010	2011	2012
Total number of pension recipients[1]	381,121	382,316	389,402	398,540	407,014
men, %	36.6	36.8	37.4	37.7	38.4
women, %	63.4	63.2	62.6	62.3	61.6
Share of pensioners in population, %	28.5	28.5	29.1	29.7	30.4
Total number of old-age pension recipients	290,903	290,967	292,343	296,199	297,985
old-age pensioners	289,628	290	290,922	294,724	296,462
early-retirement pension	13,409	14,639	16,893	19,327	20,602
deferred old-age pension	487	559	636	740	881
national special pension recipients	1,275	1,343	1,421	1,475	1,523
Superannuated pension recipients	2,772	2,683	2,,632	2,568	2,555
Recipients of pension for incapacity for work	67,459	70,024	76,662	82,590	90,093
100% loss of incapacity for work	8,853	9,001	9,655	9,661	9,941
90% loss of incapacity for work	3,280	3,314	3,699	3,967	4,057
80% loss of incapacity for work	22,152	22,342	23,736	24,458	25,547
70% loss of incapacity for work	6,022	6,430	7,086	7,788	8,372
60% loss of incapacity for work	12,257	12,719	13,581	14,309	15,428
50% loss of incapacity for work	6,484	7,046	8,344	10,025	11,781
40% loss of incapacity for work	8,411	9,172	10,561	12,382	14,967
Survivor's pension recipients					
families	9,126	9	9	8,272	7,642
family members	12,247	11,554	11,309	10,828	9,953
Total number of national pension recipients	7,740	7,088	6,456	6,355	6,428

[1] The basis for all pensions is the person receiving pension (not families).

Source: The Estonian National Social Insurance Board

Table 26: Average fixed pension by types of pension (as of the 1st of January)

Type of pension	EEK			EUR	
	2008	**2009**	**2010**	**2011**	**2012**
Recipients of old-age pension	3,763	4,554	4,768	304.91	303.86
...including early retirement pension	2,991	3,616	3,795	243.44	242.15
Superannuated pension	3,510	4,424	4,624	316.90	319.06
Pension for incapacity for work	2,241	2,703	2,820	179.06	176.03
including percentage of loff of incapacity for work:					
...100%	3,084	3,735	3,915	251.69	249.78
...90%	2,785	3,381	3,554	226.44	226.84
...80%	2,470	2,994	3,138	201.94	200.56
...70%	2,197	2,666	2,799	179.10	178.33
...60%	1,880	2,279	2,391	153.65	152.87
50%	1,614	1,959	2,056	131.93	131.69
40%	1,579	1,920	2,016	129.51	128.92
Families having lost a provider	1,814	2,187	2,293	150.91	146.64
including with one family menber	1,543	1,870	1,962	130.91	126.44
two family menbers	2,440	2,969	3,116	203.81	201.08
three and more family menbers	3,086	3,747	3,900	251.11	248.07
Recipients of national pension	1,285	1,539	1,613	106.09	101.90
...of whome: due age	1,574	1,916	2,010	130.00	129.88
...incapacitated for work	1,187	1,443	1,508	100.03	93.22
...families faving lost a provider	997	1,113	1,140	76.57	73.87
AVERAGE	**3,395**	**4,103**	**4,275**	**272.43**	**269.40**

Source: the Estonian National Social Insurance Board

Table 27: Expenses on state pension insurance

Type of pension	Million EEK			Thousand EUR
	2008	2009	2010	2011
Old-age pension	15,256.7	16,593.8	16,887.8	1,082,403.9
Pension for incapacity for work	2,220.1	2,544.3	2,750.4	188,289
Survivor's pension	230.4	239.0	236.8	14,082.3
Superannuated pansion	126.9	134.4	138.5	9,039.3
National pension	124.4	121.2	120.2	7,702.3
Parliament pension, occupational pension for the President of the Republic[1]	54.8	62.2	61.7	3,995.5
Total pension expenses	18,013.2	19,695.0	20,195.5	1,305,512.3
pensions financed from social tax income	17,356.1	19,007.6	19,499.7	1,260,320.8
pensions and pension supplements financed from the state budget[2]	657.1	687.4	695.8	45,191.5

[1] Paid from the budgets of Riigikogu (the parliament) and the Office of the President.

[2] Types of pensions and pension supplements financed from the state budget: state pension, pensions of certain officials (judges, prosecutors, officials of the State Audit Office, Chancellor of Justice, member of the Defence Forces, police officers, members of the parliament, the President of the Republic), pensions paid on the bases of the length of service and other pension supplements (including for officials).

Source: the Estonian National Social Insurance Board

Family benefits

The total number of family benefits recipients is based on statistics concerning child allowance recipients. As of the end of 2011, state family benefits were paid to 163,309 families and 255,522 children.

Table 28: Amounts of state family benefits, 2006–2012 (in EEK, since 2011 in EUR)

Type of benefit	in EEK					in EUR	
	2006	2007	2008	2009	2010	2011	2012
Birth allowance, single allowance							
1st child (incl. multiple births, from 2000)	5,000	5,000	5,000	5,000	5,000	320	320
2nd and subsequent child	5,000	5,000	5,000	5,000	5,000	320	320
Adoption allowance, single allowance	5,000	5,000	5,000	5,000	5,000	320	320
Child allowance, per month							
1st child	300	300	300	300	300	19.18	19.18
2nd child	300	300	300	300	300	19.18	19.18
3rd and subsequent child[1]	300	900	900	900	900	57.54	57.54
Childcare allowance, per month[2]							
for child up to 3 years of age	600	600	600	600	600	38.35	38.35
for children aged 3–8 years in families with a child under 3 years	300	300	300	300	300	19.18	19.18
for children aged 3–8 years in families with 3 or more children	300	300	300	300	300	19.18	19.18
supplementary childcare allowance for a child up to 1 year of age	100	100	100	100	100	6.40	6.40
Parental allowance of a family with 7 and more children, for one parent per month[3]	2,520	2,640	2,640	2,640	2,640	168.74	168.74
Child's school allowance, at the beginning of the school year[4]	450	450	450	–	–	–	–
Single parent's child allowance, per month[5]	300	300	300	300	300	19.18	19.18
Allowance for a child in guardianship or in foster care, per month	900	1,500	3,000	3,000	3,000	191.8	191.8
Conscript's child allowance, per month[6]	750	750	750	750	750	47.95	47.95
Start in independent life	6,000	6,000	6,000	6,000	6,000	383.47	383.47

allowance, single allowance[7]							
Allowance for families with three or more children, per child in a quarter[8]							
per child for families with 3 children	300	–	–	–	–	–	–
per child for families with 4–5 children	450	–	–	–	–	–	–
per child for families with 6 and more children	450	–	–	–	–	–	–
Allowance for families with triplets, per family in a quarter[9]	1,350	–	–	–	–	–	–

[1] From 1 July 2007, an increased rate of child allowance is used from the third child and the allowance for families with three or more children and allowance for families with triplets is no longer paid.

[2] From 1 January 2009, childcare allowance is not paid for any child in the family during the period of the parental benefit.

[3] Children entitled to child allowance.

[4] From 1 January 2009, the child's school allowance is no longer paid.

[5] A child is entitled for the single parent's child allowance if the child's birth certificate or the Population Registry contains no details about the child's father or if the entry has been made on the basis of the mother's statement or if the other parent has been declared to be a fugitive pursuant to the procedure established by law.

[6] From 1 January 2009, the conscript’s child allowance is paid from the budget of the Ministry of Defence.

[7] Paid to children without parental care raised in child welfare institutions or at schools for the children with special needs, when starting independent life.

[8] From 1 January 2004, allowance for families with three or more children is paid instead of former allowance for families with four or more children.

[9] If the family raises only triplets.

Source: the Social Insurance Board

Table 29: Receivers of state family benefits, 2005–2011 (number of people receiving the allowance at the end of the year, in case of single benefits total during the year)

Benefit type	2006	2007	2008	2009	2010	2011
Birth allowance	14,917	15,624	16,070	15,930	15,724	15,361
1st child	7,363	7,599	7,820	7,461	6,765	6,226
2nd child	7,187	7,621	7,760	7,908	8,497	8,669
multiple births	367	404	490	561	462	466
Adoption allowance, children	42	28	20	32	20	23
Child allowance[1]	274,985	270,087	265,418	261,443	258,795	255,522
1st child	180,096	176,512	172,958	169,405	166,542	163,309
2nd child	72,476	71,571	70,814	70,461	70,557	70,607
3rd and subsequent child	22,413	22,004	21,646	21,577	21,696	21,606
Childcare allowance[2]	48,355	50,331	46,989	40,928	40,629	41,034
for child up to 3 years of age[3]	27,722	28,742	24,823	24,108	23,678	23,090
for children aged 3–8 years in families with a child under 3 years	12,076	12,927	13,474	8,122	8,139	8,899
for children aged 3–8 years in families with 3 or more children	8,557	8,662	8,692	8,698	8,812	9,045
Parental allowance of a family with 7 and more children, families	198	185	176	173	156	152
Child's school allowance[4]	180,594	172624	165,452	398	27	6
Single parent's child allowance, children[5]	27,258	26,287	25,188	24,310	23,260	22,223
Single parent's child allowance, families	23,040	22,145	21,160	20,311	19,390	18,510
Allowance for a child in guardianship or in foster care, children	2,262	2,087	2,038	2,015	1,956	1,880
Allowance for a child in guardianship or in foster care, families	1,859	1,722	1,668	1,622	1,580	1,524
Conscript's child allowance, children[6]	30	25	27	14	28	33
Start in independent life	110	155	167	161	133	152

allowance[7]						
Allowance to a family raising three or more children and raising triplets, children[8]	67,836	60,039	–	–	–	–

[1] The number of children for whom the allowance is paid. The number of people receiving the allowance for the first child also shows the general number of families to whom child allowances are paid.

[2] From 1 January 2009, childcare allowance is not paid for any child in the family during the period of the parental benefit.

[3] Incl. supplementary childcare allowance for a child up to 1 year of age.

[4] From 2009, the child's school allowance is no longer paid, however in individual cases payments were made retroactively for the previous years.

[5] A child is entitled for the single parent's child allowance if the child's birth certificate or the Population Registry contains no details about the child's father or if the entry has been made on the basis of the mother's statement or if the other parent has been declared to be a fugitive pursuant to the procedure established by law.

[6] From 1 January 2009, the conscript’s child allowance is paid from the budget of the Ministry of Defence.

[7] Paid to children without parental care raised in child welfare institutions or at schools for the children with special needs, when starting independent life.

[8] From 1 July 2007, an increased rate of child allowance is used from the third child and the allowance for families with three or more children and allowance for families with triplets is no longer paid.

Source: the Social Insurance Board

Table 30: Expenditure on state family benefits and parental benefit, 2006–2011(million EEK, since 2011 thousand euros)

Type of benefit	in million EEK					in thousand EUR
	2006	2007	2008	2009	2010	2011
Family benefits and parental benefit TOTAL	2,541.6	2,790.6	3,577.2	3,975.5	4,293.3	272,105.3
Family benefits, total	1,643.6	1,677.4	1,710.3	1,586.2	1,570.6	98,812.0
Birth allowance, total, single allowance	72.6	78.1	80.4	79.7	78.6	4,911.8
1st child	36.1	38.0	39.1	37.3	33.8	1,992.0
2nd and subsequent child	34.8	38.1	38.8	39.5	42.5	2,773.5
multiple births	1.8	2.0	2.5	2.8	2.3	146.3
Adoption allowance	0.2	0.1	0.1	0.2	0.1	10.6
Child allowance, total	1,006.7	1,059.8	1,125.3	1,108.2	1,095.5	68,920.0
1st child	658.2	642.6	631.3	618.8	606.6	38,069.6
2nd child	265.6	259.6	257.2	255.3	254.6	16,227.5
3rd and subsequent child[1]	82.9	157.6	236.8	234.0	234.3	14,622.9
Childcare allowance, total[2]	268.9	278.4	254.4	228.6	231.5	14,805.8
for child up to 3 years of age	192.6	199.3	172.1	166.4	168.6	10,602.8
for children aged 3–8 years in families with a child under 3 years	43.8	46.6	49.4	29.5	29.9	2,055.9
for children aged 3–8 years in families with 3 or more children	32.5	32.4	32.9	32.6	33.0	2,147.1
Parental allowance of a family with 7 and more children	6.0	6.2	5.8	5.6	5.3	306.6
Child's school allowance, once a year[3]	81.3	77.7	74.5	0.2	0.0	0.6
Single parent's child allowance[4]	100.2	96.6	93.2	89.3	86.0	5,308.7
Allowance for a child in guardianship or in foster care	26.0	391	75.4	73.5	72.5	4,473.6
Conscript's child allowance[5]	0.2	0.2	0.2	0.1	0.2	15.8
Start in independent life	0.6	0.9	1.0	1.0	0.8	58.5

allowance, single allowance						
Allowance to a family raising three or more children and raising triplets[6]	80.8	40.3	–	–	–	–
Parental benefit	898.0	1,113.1	1,866.9	2,389.3	2,722.6	173,293.3

[1] From 1 July 2007, an increased rate of child allowance is used from the third child and the allowance for families with three or more children and allowance for families with triplets is no longer paid.

[2] From 1 January 2009, childcare allowance is not paid for any child in the family during the period of the parental benefit.

[3] From 2009, the child's school allowance is no longer paid, however in individual cases payments were made retroactively for the previous years.

[4] A child is entitled for the single parent's child allowance if the child's birth certificate or the Population Registry contains no details about the child's father or if the entry has been made on the basis of the mother's statement or if the other parent has been declared to be a fugitive pursuant to the procedure established by law.

[5] From 1 January 2009, the conscript's child allowance is paid from the budget of the Ministry of Defence.

[6] From 1 January 2004, allowance for families with three or more children is paid instead of former allowance for families with four or more children.

Source: Social Insurance Board

Parental benefit

The largest part of parental benefit recipients are persons whose parental benefit equals 100% of their average monthly income earned during the previous calendar year – their share in benefit recipients in 2011 was 62.9%. Persons who received the two lowest benefit types comprised 34% of all parental benefit recipients in 2011. This means that in comparison to previous years, the number of persons to whom the benefit was granted at the benefit rate had increased in 2011, and the number of persons whose parental benefit equalled 100% of their monthly income and at the minimum wage rate had decreased. The

share of persons to whom parental benefit had been granted in the maximum amount of the benefit decreased also from the highest level 5.6% in 2008 to 3.1% in 2011.

The share of men in parental benefit recipients has been very small. In 2004, men comprised only 2% of the persons to whom the benefit was granted during the year, but it increased to 3.9% in 2007 and to 8.5% in 2009. The increase in the share of men was the result of the legislation amendment that entered into force in autumn 2007, when fathers become entitled to parental benefit when their children turn 70 days old instead of the former six months. In 2010, the share of men started to decrease and comprised 6.9% of the persons to whom the parental benefit was granted during the year. In 2011, the share of men decreased to 5.2%. The change in parental benefit recipients is affected by the changes in labour market (higher unemployment rate) and by the changes in wages and salaries during the economic crisis.

Table 31: Parental benefit duration and rates, 2008–2011

	2008	**2009**	**2010**	**2011**
Parental benefit duration together with the maternity and pregnancy leave period (in days)	575	575	575	575
... for not working parent (in months)	18	18	18	18
Parental benefit rate (EEK, since 2011 in euro)	3,600	4,350	4,350	278.02 EUR *(4,350 EEK)*
Parental benefit in the amount of minimum monthly wage (EEK, since 2011 in euro)	4,350	4,350	4,350	278.02 EUR *(4,350 EEK*)
Parental benefit maximum amount (EEK, since 2011 in euro)	25,209	30,729	35,316	2157.03 EUR *(33,750 EEK)*

Source: the Ministry of Social Affairs

Table 32: Parental benefits granted[1] by benefit type and gender, and average amount of granted benefit, 2004–2011 (during the year)

	2008	2009	2010	2011
TOTAL persons who have been granted parental benefit	**15,868**	**17,147**	**16,514**	**18,905**
male, %	6.5	8.5	6.9	5.2
female, %	93.5	91.5	93.1	94.8
Parental benefit in amount of 100% of the income of one calendar month	9,260	11,327	11,125	11,885
male, %	8.1	10.1	8.7	7.0
female, %	91.9	85.6	91.3	93.0
Parental benefit in maximum amount	883	847	448	586
male, %	18.9	26.7	24.3	18.1
female, %	81.1	73.3	75.7	81.9
Parental benefit in the amount of minimum monthly wage rate	3,770	3,008	2,318	2,810
male, %	1.6	1.7	1.3	1.0
female, %	98.4	98.3	98.7	99.0
Parental benefit at the parental benefit rate	1,955	1,965	2,623	3,624
male, %	2.4	1.9	1.2	0.6
female, %	97.6	98.1	98.8	99.4
Amount of average annual parental benefit granted, in EEK and since 2011 in EUR	9,421	11,614	11,546	712.40
male, %	14,284	18,007	18,272	1,206,56
female, %	9,084	7,235	11,046	685,12

Source: the Social Insurance Board

The Committee requests that the next report continue to provide the relevant up-to-date figures on risks covered, financing of benefits and personal coverage.

Up-to-date statistics and proportion of risks covered, showing personal coverage of each branch of the social security, are mentioned above under the answer for article 12. For health insurance see article 11 § 1.

The system is based on collective financing as before, because it is funded from payments (employers, employees) and from the state budget.

There are certain insured people that the state is paying social tax for:

- one non-working parent residing in Estonia who is raising three or more children below 19 years of age residing in Estonia, at least one of whom is below 8 years of age;
- persons registered as unemployed pursuant to the Labour Market Services and Benefits Act (01.05.2009);
- persons participating in labour market training, work practice provided or coaching for working life;
- persons who are granted the allowance of a rescue worker waiting for old-age pension on the basis of § 19 of the Rescue Service Act (since 01.03.2008);

Rural municipalities or cities shall pay social tax for persons who:

- care for a disable person and to whom a rural municipality or city government pays allowance for taking care of a disabled person and who neither work nor receive state pension (14.02.2011), or who care for a disable child and to whom a rural municipality or city government pays allowance for taking care of a disabled child and who neither work nor receive state pension (entered into force 01.03.2009).

Pension insurance and health insurance are financed by specific purposes social tax in Estonia, which is paid by employers, self-employed persons, the state and local governments. Unemployment insurance (involving the part 4 of the code) is financed by payments of employers and employees (the limits of unemployment insurance premium in 2012 is 1.4% and 2.8% of wages).

According to the Social Tax Act, the monthly rate providing the basis for the payment of social tax shall be established in the state budget for a budgetary year since 01.07.2010. The monthly rate established in the state budget shall not be less than the minimum wages

established by the Government of the Republic that was in force on 1 July of the year preceding a budgetary year.

1. The amendment of the State Family Benefits Act entered into force on the 1st of January, 2009, according to which the family benefits are financed from the state budget through the budget of the Ministry of Social Affairs and the conscript's child allowance is financed from the state budget through the budget of the Ministry of Defence. If was previously provided that the family benefits are financed from the state budget.

The Committee concludes that the situation in Estonia is in not in conformity with Article 12§1 of the Revised Charter on the ground that the unemployment benefit, the minimum unemployment insurance benefit, the national pension and the minimum old age and invalidity pensions are manifestly inadequate.

The daily rate of unemployment allowance has been the same since 2007. From the 1st of January, 2007, the daily rate of unemployment allowance is 32.90 EEK (about 1,000 EEK per month), from the 1st of January, 2011 the daily rate is 2.11 EUR (about 65 EUR per month). From the 1st of January, 2013 the daily rate of unemployment allowance is 3.27 EUR.

The unemployment insurance benefit depends on the previous wages of a person. The amount of the unemployment insurance benefit is: 1) 50% for the period of 1 to 100 calendar days and 2) 40% for the period of 101 to 360 calendar days (the maximum duration for receiving unemployment insurance benefit is 360 days). The maximum limit of the unemployment insurance benefit is 50% and 40% respectively of the three times Estonian average wages per calendar day of the previous calendar year. The minimum unemployment insurance benefit rate is 50% respectively of the minimum wage rate per calendar day of the previous calendar year. Thus, the minimum unemployment insurance benefit rate increases respectively with the minimum wage rate. According to the agreement of social partners, the minimum wage rate is 320 EUR per month from 2013.

The statistics indicated below show that in 2008-2010, the unemployment increased multiple times, but despite that the daily rate of unemployment allowance and the minimum unemployment insurance benefit rate have not decreased.

The Republic of Estonia has continuously increased the base amount of pension and the

limit of national pension. Benefits and allowances have not been decreased during the years of crisis. Corresponding statistics is mentioned above in this article.

Table 33: Net income of household member, average gross wages and average old-age pension

Indicator	2008	2009	2010	2011
Net income of household member, EUR per month	6,389	6,006	...	...
Average gross wages, EUR per month	825	784	792	839
Average old-age pension, EUR per month	278	301	304	305
Average old-age pension of average calculated actual wages, %	41.5	47.3	47.8	45.4
Change in actual income compared to previous year, %				
Net income of household member[1]	…	–5.9	…	...
Average gross wages	3.2	–4.9	–1.9	0.9
Average old-age pension	11.4	8.3	–1.9	-4.6

The change in income compared to 2007 is not reported as the methodology changed in 2008.

Sources: the Estonian National Social Insurance Boars, the Statistical Office

The statistics indicated above show that the minimum pension for incapacity for work rate has been raised continuously as well.

Please have a look at the reports submitted to the Council of Europe regarding the Social Security Code.

Reports for reference:

- European Social Security Code's third report submitted by the Government of Estonia on Article 74, for the reporting period of 01.07.2007 – 30.06.2008;
- European Social Security Code's fourth report submitted by the Government of Estonia on Article 74, for the reporting period of 01.07.2008 – 30.06.2009;
- European Social Security Code's fifth report submitted by the Government of Estonia on Article 74, for the reporting period of 01.07.2009 – 30.06.2010;
- European Social Security Code's sixth report submitted by the Government of Estonia on Article 74, for the reporting period of 01.07.2010 – 30.06.2011;
  European Social Security Code's seventh report submitted by the Government of Estonia on Article 74, for the reporting period of 01.07.2011 – 30.06.2012;

Please see:

- European Social Security Code's second report submitted by the Government of Estonia on Article 76, for the reporting period of 01.07.2006 – 30.06.2008;
- European Social Security Code's third report submitted by the Government of Estonia on Article 76, for the reporting period of 01.07.2008 – 30.06.2010;
- European Social Security Code's fourth report submitted by the Government of Estonia on Article 76, for the reporting period of 01.07.2010 – 30.06.2012.

Article 12 § 2 - Maintenance of a social security system at a satisfactory level at least equal to that required for ratification of the European Code of Social Security

The parts 2-5 (health care, sickness, unemployment and old-age benefits) and 7-10 (family, maternity, incapacity for work and survivor's benefits) of the European Code of Social Security are binding for Estonia.

Conclusions of 2011 of the Committee of Experts on the Application of Conventions and Recommendations of the International Labour Organisation GC(2012)04 involving the implementation of the social security code in Estonia (covers period 01.07.10 – 30.06.11) was as follows: "[...] based on the explanations responding to its previous conclusions, the committee finds, that all the approved parts of the code are implemented in national laws and activities (part 2-5 and 7-10); the committee expects the information inquired".

Estonia submitted the inquired information to the Council of Europe on the 30th of July, 2012 with the 7th general annual report of the European Code of Social Security.

Please see also the other reports submitted to the Council of Europe about the European Code of Social Security.

Article 12 § 3 - Development of the social security system

1) Please describe the general legal framework. Please specify the nature of, reasons for and extent of any reforms.

Amendments regarding health insurance

According to § 5 (2) of the Health Insurance Act the circle of insured people is specified as follows:

- persons working in public service, persons employed in contractual service as regular members of the Defence Forces, members of the Riigikogu, the President of the Republic and members of the Government of the Republic, for whom the state or a local government (since the 2nd of January, 2009);
- persons receiving remuneration or service fees on the basis of a contract for services, an authorisation agreement or a contract under the law of obligations for the provision of any other services which is entered into for a term exceeding three months or for an unspecified term, who are not entered in the commercial register as sole proprietors and for whom the other party to the contract is required to pay social tax each month in the amount calculated on the basis of at least the monthly rate established in the state budget for the given budgetary year (since the 1st of January, 2009).

According to § 5 (3) of the Health Insurance Act, an insured person is also the person who pays social tax for himself or herself, who is a person who is entered in the commercial register, and a notary, sworn translator or bailiff registered with the regional tax centre of the Tax and Customs Board of his or her residence as a sole proprietor and who pays social tax on his or her business income pursuant to the Social Tax Act (since the 1st of January, 2009).

All pregnant women living in Estonia, who formerly did not have health insurance on any other grounds, are provided health care from the medical confirmation of pregnancy (from the 1st of July, 2009). From the 1st of April, 2010 the medical confirmation of pregnancy by midwives is accepted as well.

Amendments concerning sickness benefit

From the 1st of January, 2009 employers to employees until the 4th or 8th day in case of illness, quarantine, domestic injury, traffic injury and in case of complication or illness caused by traffic injuries and the health insurance fund shall pay benefits from the 9th day. In other cases (such as occupational disease, accident at work (including accident at work in traffic and complication or illness caused by accident at work), injury got by protecting the interests of the state or the public, or combating crime) the health insurance fund pays benefit starting from the second day of leave.

The health insurance fund pays benefits from the second day if the basis for it is an employee's temporary refusal to perform work or temporary release from the performance of duties of a public servant; sickness benefits from the second day are paid in case of pregnancy as well. If the basis for paying sickness benefit is that the employee is provided with work suitable to him or her, considering the employee's state of health, or temporary transfer for of a public servant or temporary easement of conditions of service, then the benefit is calculated from the first day that an employee or public servant is starting to perform work or duties on a new or eased post. The health insurance fund pays care allowance, maternity benefit and adoption benefit from the first day of leave.

Amendments concerning unemployment benefit

In 2008, the amendment of the Labour Market Services and Benefits Act entered into force, according to which the amount of the unemployment allowance is 31-fold daily unemployment allowance rate. The condition for receiving unemployment allowance was amended and now, a person whose income is less than the 31-fold daily unemployment allowance rate has the right to receive unemployment allowance. The earlier condition was that a person had to miss income by the extent of the unemployment allowance.

As the Estonian Unemployment Insurance Fund and the Labour Market Board were incorporated from the 1st of May, 2009, then a provision of the Labour Market Services and Benefits Act entered into force, according to which a person may apply for an unemployment allowance from the Estonian Unemployment Insurance Fund.

The following amendments have been made in relation to the incorporation of institutions.

According to § 7 (1) of the Labour Market Services and Benefits Act, the Estonian Unemployment Insurance Fund shall make a decision on termination of a person's registration as unemployed if:

1. the unemployed person fails, at least on one occasion within a period of thirty days, to appear at the Estonian Unemployment Insurance Fund for a visit, except in the case where the unemployed person was unable to appear for a visit for a good reason or the unemployed person was participating in labour market training or work practice and there was a notification made in his or her individual work plan beforehand, that he or she will contact the Estonian Unemployment Insurance Fund by phone;

2. the unemployed person fails, without a good reason, to appear at the Estonian Unemployment Insurance Fund for a visit at the prescribed time for the third time;

3. cases listed in § 6 (5) 2)–11) of the Labour Market Services and Benefits Act occur:

2) a person has reached the pensionable age or an early-retirement pension has been granted to him or her;

3) a person is working based on a contract of employment, contract for services, authorisation agreement or contract under the law of obligations for provision of other services, or is in public service;

4) a person is a member of the management or supervisory body of a legal entity and receives remuneration for such work, unless the person is a member of the management or supervisory body of a foundation, non-profit association or non-profit cooperative and receives remuneration for such work in the amount forming less than half of the minimum wage established under § 29 (5) of the Employment Contracts Act;

5) a person is registered as a sole proprietor;

6) a person is a student enrolled in daytime study or full-time study unless the person enrolled in full-time study has performed work in Estonia or as an employee sent from Estonia on assignment abroad on the basis of an employment contract or in public service, or performed work in Estonia based on a contract of employment, contract for services, authorisation agreement or contract under the law of obligations for the provision of other services least 180 days during the last twelve months or is on academic leave;

7) a person is performing conscript service obligation;

8) a person cares for a disabled person and a rural municipality or city government pays him or her allowance for such care;

9) a person does not conform to one of the following terms and conditions: permanent residents of Estonia; alien residing in Estonia on the basis of temporary residence permits or temporary right of residence; citizen of the European Union, European Economic Area or the Swiss Confederation staying in Estonia; persons enjoying international protection staying in Estonia or asylum seekers staying in Estonia, under the conditions provided for in the Act on Granting International Protection to Aliens;

10) is the non-working spouse accompanying an official working in a foreign mission of the Republic of Estonia for whom the spousal allowance is paid on the basis of § 67 (1) of the Foreign Service Act;

11) receives the allowance of a rescue worker waiting for old-age pension on the basis of § 19 of the Rescue Service Act.

4. the unemployed person refuses to approve the Individual Action Plan;

5. the unemployed person refuses, without a good reason, to comply with the Individual Action Plan for the third time;

6. the unemployed person refuses, without a good reason, to accept suitable work for the

7. business start-up subsidy has been transferred to the bank account of the unemployed person;
8. at the request of the unemployed person;

9. upon the death of the unemployed person.

The circle of persons who are not registered as unemployed is specified in § 6 (5) of the Labour Market Services and Benefits Act (LMSBA).

A person shall not be registered as unemployed if the person:

1) is a member of the management or supervisory body of a legal entity and receives remuneration for such work, unless the person is a member of the management or supervisory body of a foundation, non-profit association or non-profit cooperative and

receives remuneration for such work in the amount forming less than half of the minimum wage established under the Wages Act (from 23.11.2008);

2) is a student enrolled in daytime study or full-time study unless the person enrolled in full-time study has been engaged with work for at least 180 days during the last twelve months or is on academic leave (from 01.05.2009);

3) cares for a disabled person and a rural municipality or city government pays him or her allowance for such care (from 01.03.2009);

Amendments concerning unemployment insurance benefits

In addition to what was mentioned under article 12 § 1, the following amendments were made to the Unemployment Insurance Act:

The following amendments have been made in relation to the incorporation of institutions.

According to § 13 (1) of the Unemployment Insurance Act, the payment of an unemployment insurance benefit shall be terminated:

1) as of the date following the date of termination of the registration as unemployed if the registration as unemployed of the unemployed person is terminated on the basis of § 7 (1) 1), 3), 4) or 7)–9) of the Labour Market Services and Benefits Act;

2) as of the date following the date on which the circumstances which affect the person's right to receive the benefit arise if the insured person refuses, without good reason, to comply with the Individual Action Plan provided in § 10 of the Labour Market Services and Benefits Act or the suitable employment provided in subsections 12 (3) and (4) of the same Act;

3) as of the date following the date of the person's failure to appear for the visit if the insured person fails to appear for a visit at the unemployment insurance fund at the time appointed to him or her without good reason;

4) as of the final date of the end of the period for search for work indicated in § 12^1 (1) in another EEA country or the Swiss Confederation if the insured person does not return to Estonia before the end of the period permitted for search for work;

5) as of the date of submission of the application if the insured person submits a written application to this effect.

In 2009, an amendment of the Unemployment Insurance Act entered into force, providing the waiting periods for paying unemployment insurance benefit for an unemployed person, whose last employment or service relationship was cancelled due to a lay-off or who cancelled his or her contract of employment, if an employer, due to unforeseen economic circumstances beyond its control, fails to provide an employee with work to the agreed extent. The unemployment insurance benefit is paid after the period when an employee receives lay-off benefit (according to law, 1 or 2 months from the termination of an employment relationship).

For an insured person who used a pregnancy leave, maternity leave, adoptive parents leave or parental leave during the 36 months, the 36 months period shall be extended by the time spent on leave if there is no information in the unemployment insurance database concerning the person's unemployment insurance period. (From 1st of July, 2009.)

On 01.05.2011, the 7-day waiting period for receiving unemployment insurance benefit was abrogated for cases when a person becomes unemployed again during 12 months and he or she has the right to continuation of unemployment insurance benefit (§ 11 (5)).

Amendments concerning pension insurance

In 2010, an amendment of the State Pension Insurance Act was passed, according to which from 2017, the retirement age is raised gradually to 65 years of age.

Table 34: Retirement age corresponding to the year of birth

Year of birth	Age
1953	63 years
1954	63 years and 3 months
1955	63 years and 6 months
1956	63 years and 9 months
1957	64 years
1958	64 years and 3 months
1959	64 years and 6 months
1960	64 years and 9 months

In 2008, the procedure of examination for establishing permanent incapacity for work of was specified in the State Pension Insurance Act. State pension is granted to a person on the basis of the assessment of examination for establishing permanent incapacity for work.

2008. An amendment entered into force in 2008, according to which the survivor's pension is until the whereabouts of the provider are established, but not longer than for a period of five years or if the survivors' pension is granted if the provider is missing and the police authorities have initiated proceedings for establishing the whereabouts of a missing person concerning him or her and the police authorities have failed to establish the whereabouts of the person within 12 months. After five years, a person may be declared dead and in that case the survivor's pension is paid on that basis.

In 2008, an amendment entered into force, according to which the pension qualifying period in the territory of the former Union of Soviet Socialist Republics is included in the years of pensionable service if no other state is paying pension for such pension qualifying period (no double payment for qualifying period).

In 2008, an amendment entered into force according to which the time during which a person is in compulsory military service or compulsory alternative service is included in the years of pensionable service if the person was referred to service from Estonia or the person lived in Estonia before and after being referred to service from outside of Estonia and the pension

qualifying period of the person earned in Estonia is at least fifteen years and no other state is paying pension for such pension qualifying period.

In 2008, an amendment entered into force, according to which the rules of calculation for pensions of European Communities' servants were specified.

An amendment entered into force of the 1st of January, 2009, according to which the pension qualifying period required for granting pension for incapacity for work was decreased. The following requirements for pension qualifying period took effect:

Table 35: Pension qualifying period for granting pension for incapacity for work

	Required pension qualifying period in years
16–24	No requirements for pension qualifying period
25–26	1
27–28	2
29–30	3
31–32	4
33–35	5
36–38	6
39–41	7
42–44	8
45–47	9
48–50	10
51–53	11
54–56	12
57–59	13
60–62	14

Amendments concerning state family benefits

In 2008, an amendment of the State Family Benefits Act entered into force, which increased the foster care allowance. It is paid at twenty times the child allowance rate instead of the earlier ten times rate.

In 2008, an amendment entered into force, by which the cases were specified when the single parent's child allowance is terminated.

In 2008, an amendment entered into force, which the payment of family benefits is suspended for the time a person is held in custody. The family benefits shall be paid to the person retroactively after a court judgment enters into force if the person is acquitted or is not subject to punishment by imprisonment.

In 2008, an amendment of the Parental Benefit Act entered into force, according to which paying the parental benefit for a working parent was prolonged to 575 days from the beginning of pregnancy and maternity leave, and for a non-working parent until the child is 18 months old (01.01.2008).

From the 1st of January, 2009, the school allowance paid once a year was declared invalid by the amendments of the State Family Benefits Act. This was one of the few cuts during the economic crisis that was made concerning benefits paid for people.

From the 1st of January, 2009, the child care allowance is not paid for a child or children whose adoption gives basis to pay adoption benefit, which means that double payment is ruled out.

From the 1st of January, 2009, the child care allowance is not paid for any children in a family if a parent is a recipient of a parental benefit pursuant to the Parental Benefit Act, which means that double payment is ruled out.

From the 1st of January, 2009, the child care allowance is not paid for a child or children whose birth gives basis to pay maternity benefit, which means that double payment is ruled out.

In 2009, an amendment entered into force, according to which child allowance and single parent's child allowance is paid to a child without parental care who does not stay in a social welfare institution due to studying.

On the 1st of January, 2008 the Maintenance Allowance Act entered into force. According to this act, a child is paid maintenance allowance in the case his or her parent does not comply with the maintenance obligation. Maintenance allowance is paid during the judicial

proceedings of a maintenance claim. Maintenance allowance is paid for ninety days. Maintenance allowance is paid for a parent who has filed in a maintenance claim to court. Maintenance allowance is paid for permanent residents of Estonia or for aliens residing in Estonia who hold a temporary residence permit issued for a specified term or who has the right of residence.

The number of maintenance allowance recipients has increased considerably during the three years the allowance has been available. The highest number of recipients was in 2010, when maintenance allowance was paid for 588 children in 416 families. In 2011, the number of maintenance allowance recipients decreased and maintenance allowance was paid to 402 children in 270 families.

There are no other amendments made during the reference period.

2) Please indicate the measures taken (administrative arrangements, programmes, action plans, projects, etc.) to implement the legal framework.

From 01.05.2009, the Unemployment Insurance Fund and Labour Market Board were incorporated to one legal person governed by public law called the Estonian Unemployment Insurance Fund. The Estonian Unemployment Insurance Fund deals with the state unemployment allowance scheme and the unemployment insurance benefits scheme, accepts and proceeds applications of unemployment allowance and unemployment insurance benefits, and grants and pays unemployment allowance and unemployment insurance benefits, and provides employment services to persons seeking work and unemployed people.

From the 1st of February, 2010 there are two regional departments of the Pension Boards instead of four – North Department of the Pension Board and South Department of the Pension Board. Bureaus and customer services which are the staff units of the bureaus are the subdivisions of the both departments. The sums of benefits and allowances were converted to euros after starting using euro on the 1st of January, 2011.

3) Please provide pertinent figures, statistics or any other relevant information on the improvement of the social security system as well as on any measures taken to restrict the system.

The statistic is indicated under article 12 §1.

The Committee asks the next report to indicate who still is not covered by health insurance.

An insured person is a permanent resident of Estonia or a person living in Estonia on the basis of a temporary residence permit or right of residence, for whom a payer of social tax is required to pay social tax or who pays social tax for himself or herself pursuant to the procedure, in the amounts and within the terms provided for in the Social Tax Act, or a person considered equal to such persons. Persons considered equal to an insured person are: persons under 19 years of age; persons who receive a state pension granted in Estonia; persons with up to five years left until attaining pensionable age who are maintained by their spouses who are insured persons; students.

According to the amendment of the Social Tax Act entered into force on 01.05.2009., a person is covered by health insurance if the person is registered as unemployed pursuant to the Labour Market Services and Benefits Act, in addition the recipients of unemployment insurance benefit and unemployment allowance.

Thus, persons not covered by health insurance are the persons not registered as unemployed pursuant to the Labour Market Services and Benefits Act, which means that they have not turned to the unemployment insurance fund. The Labour Market Services and Benefits Act provides a circle of persons who are not to be registered as unemployed, but they can be covered by health insurance on other basis, i.e. if they are equal to an insured person.

Certain persons not covered by health insurance, such as pensioners who are not granted pension in Estonia, but who are granted pension in another foreign state, have the possibility to enter into a written contract with the health insurance fund according to the Health Insurance Act, unless otherwise provided by an international agreement. Such persons are not covered by health insurance only if they do not enter into a contract with the health insurance fund.

Please see additionally the report of article 11 § and article 13 § 3.

The report indicates that the rules for terminating the payment of unemployment insurance benefits were clarified by the adoption of amendments to the Labour Market Service and Benefits Act. However, no details in this regard are provided. The Committee asks the next report to provide them.

The cases when the payment of the unemployment insurance benefit is terminated are specified under the first question of the article § 1.

A new obligation of the Government to regularly (every 5 years) prepare an impact assessment of the bases for calculating state pensions on the financial and social sustainability of the pensions system. The Committee asks the next report to provide information about the result of the first of such assessments, bearing in mind its conclusion on the manifestly inadequate level of the national pension and the minimum old age and invalidity pensions under Article 12 § 1.

In 2011, analysis The Possibilities for Sustainable Financing of the Estonian Social Insurance System was conducted by Praxis, the Centre for Policy Studies requested by the Ministry of Finance.

The analysis indicate that the financial sustainability of the national pension insurance and the sufficiency of pensions is influenced by the number of persons receiving pension, the sum of pension, the number of persons paying the pension insurance part of the social tax, and the volume of tax base. The number of persons receiving pension influences mainly the retirement age, which, according to laws, increase gradually from 2017 to 2026 to 65 years of age for men and women.

The result of the analysis show that the percentage of pensioners in the population increases. According to the base scenario, the percentage of pensioners in the population will be 31% in 2030, 33% in 2040 and 38% in 2060 as it was 29% in the beginning of 2010. This in turn puts pressure on the national pension system as the number of pensioners per one working person raises.

The predicted results of expenses of pension insurance stabilize on the level of *ca* 6.5–6.6% and the income on the level of 5.5% of the GDP. As a result of that, the national pension insurance yearly deficit is *ca* 1% of the GDP. The deficit is the highest in the following years, when the payments to the 2nd pillar are restored and the compensation for suspension of payments to the 2nd pillar is conducted in 2014-2017. The deficit then decreases in 2017-2026 as the retirement age is raised, and later the level of expenses stabilizes, because the rights for the national pension insurance start to lessen as more and more pensioners are part of the funded pension scheme.

Article 12 § 4 - Social security of persons moving between states

1) Please describe the general legal framework, in particular the complete list of bilateral and multilateral agreements or any other means such as unilateral, legislation proposed or adopted, or administrative measures and indicate how they allow for the various social benefits the implementation of the principles provided in sub-paragraphs a) and b).

Estonia has effective social insurance agreements with the following states:

- Ukraine: The Social Insurance Agreement of the Republic of Estonia and Ukraine
- The Russian Federation The Cooperation Agreement of Pension Insurance of the Republic Estonia and the Russian Federation, The Agreement of the Republic of Estonia and the Russian Federation on the Social Guarantees of the Pensioners of the Armed Forces of the Russian Federation on the Territory of the Republic of Estonia;
- The Republic of Moldova: the Social Insurance Agreement of the Republic of Estonia and the Republic of Moldova;
- The Republic of Lithuania: the Agreement of the Government of the Republic of Estonia and the Government of the Republic of Lithuania on the Recognition of Insurance Periods of the Soviet Union;
- The Republic of Latvia: the Agreement of the Government of the Republic of Estonia and the Government of the Republic of Latvia on the Recognition of Insurance Periods Formed on the Territory of the Former Soviet Union;
- Canada: the Social Insurance Agreement of the Republic of Estonia and Canada.

The European Union social insurance coordination regulations apply on Latvia and Lithuania, but bilateral agreements are entered into as well, which regulate pension payment for the so called length of service of the Soviet Union. Basically it is the coordination for resigning the length of service of the Soviet Union.

Table 36: Agreements concluded during the reference period

Country	Date of signing	Date of entry into force
Ukraine (new agreement)	05.10.2010	01.02.2012
Russian Federation (new agreement)	14.07.2011	21.10.2011
Republic of Moldova	19.10.2011	01.08.2012

Source: the Ministry of Social Affairs

The agreements with the Russian Federation and Ukraine are new agreements which replace the old agreements.

The rights for pension of a person are ensured by the social insurance agreements (old-age, incapacity for work, survivor's and national pension), i.e. if necessary, the aggregation of acquired insurance periods and export of pensions is conducted under the legal acts of the parties. The agreement with Ukraine covers benefits for accidents at work and occupational diseases, family allowances and parental benefits, and unemployment allowance and unemployment insurance benefits in addition to pensions.

Estonia is now negotiating with the United States of America, Australia, Republic of Azerbaijan, and Georgia. Written procedure has been commenced with the Republic of Belarus.

The Social Insurance Agreement of the Republic of Estonia and the Republic of Finland has become invalid according to the agreement as of the entry into force of the European Union regulation no. 884/2004 on the 1st of May, 2010 and due to the implementation of the regulation by the parties to the agreement.

There are no other amendments made during the reference period.

2) Please indicate the measures taken (administrative arrangements, programmes, action plans, projects, etc.) to implement the legal framework.

Corresponding implementing agreements are concluded to implement all the existent social insurance agreements.

3) Please provide pertinent figures or any other relevant information, Please, indicate also the length of residence requirements when applicable.

The number of persons covered by the effective international agreements as of the first half year of 2012:

- Russia 5978;
- Latvia 2950;
- Ukraine 1271;
- Lithuania 849;
- Canada 22.

Table 37: The number of European health insurance cards issued and total cost thereof (printing, packaging and posting) (in Euros)

	2008	**2009**	**2010**	**2011**	**Kokku**
Number of cards	100,005	52,118	55,790	69,693	613,866
Sum	48,296	30,363	17,396	33,448	258,411

Source: the Health Insurance Fund

Table 38: Total amount of reimbursement to insured persons, included in the EU, 2008-2011

	2008	**2009**	**2010**	**2011**
Total amount of repayments to insured persons EUR	32,067	54,274	25,092	56,832

Source: the Health Insurance Fund

Table 39**:** Country-specific number of reimbursement applications submitted by the persons insured by the health insurance fund, 2008-2011

Country	2008	2009	2010	2011	TOTAL
Austria	1	1			2
Belgium	15	12	14	12	53
Bulgaria		1			1
Spain		3	4	1	8
Netherlands				2	2
Ireland	1		2		3
Iceland		1		2	3
Italy		1	1		2
Greece				1	1
Lithuania	2	3	5	5	15
Luxembourg	2	6	2	12	22
Latvia	6	5	5	8	24
Norway	4	5	1	4	14
Poland	2	3	1	2	8
Sweden	30	30	26	22	108
Germany		2	2		4
Slovakia				1	1
Slovenia		2	2		4
Finland	75	87	45	9	216
United Kingdom	2	1	1	2	6
Denmark	1		1		2
Czeck Republic		1		1	2
TOTAL	**141**	**164**	**112**	**84**	**501**

Source: the Health Insurance Fund

Table 40: Persons sent abroad for specific treatment by countries, 2008-2011

Countries, where persons have been to scheduled treatment / examinations	2008	2009	2010	2011	TOTAL
Finland	18	18	26	35	97
Netherlands	20	19	13	31	83
Germany	17	16	16	24	73
Belgium	18	15	23	20	76
Sweden	14	7	17	8	46
Russia	8	5	7	2	22
Denmark	2	3	0	0	5
Austria	6	2	1	2	11
Lithuania	4	7	1	6	18
United Kingdom	1	0	6	6	13
Latvia	2	1	1	1	5
Norway	2	1	0	0	3
Spain	1	2	0	0	3
USA	0	0	1	0	1
Italy	1	0	0	0	1
France	0	0	1	0	1
Thailand	0	0	1	0	1
Ukraine	0	0	0	1	1
Switzerland	0	3	1	0	4

Source: the Health Insurance Fund

Table 41: Form E121 for Estonian pensioners residing in another Member State, 2008-2011

Country	2008	2009	2010	2011	TOTAL
Austria		1		3	4
Belgium			1		1
Bulgaria		2			2
Spain			4		4
Ireland					0
Italy			1		1
Lithuania		4	6	2	12
Latvia			3		3
Luxembourg				1	1
Greece		1			1
France			2		2
Sweden		2	1	1	4
Germany	1	8	23	9	41
Finland	22	48	121	71	262
Czeck Republic			1		1
Hungary	1		3		4
United Kingdom			1		1
Unspecified country*	61	10	12	32	115
TOTAL	**85**	**76**	**179**	**119**	**459**

Source: the Estonian National Social Insurance Board

Table 42: Form E121 for pensioners of other Member States residing in Estonia, 2008-2011

Country	2008	2009	2010	2011	TOTAL
Belgium			2		2
Spain				1	
Netherlands		1	3	1	5
Italiy	1	1	3	2	7
Lithuania	6	2	8	6	22
Luxembourg			2		2
Latvia	5	3	19	2	29
Norway		1	8	2	11
France	1				1
Poland			1	1	2
Sweden	1	14	52	10	77
Germany	3	3	22	10	38
Finland	10	31	115	33	189
United Kingdom	2	1	23	2	28
Switzerland	1				1
Denmark		2	8	1	11
Unspecified country*	11			3	14
TOTAL	**41**	**59**	**266**	**74**	**439**

Source: the Estonian National Social Insurance Board

Table 143: Form E106 for employees posted from Estonia to another Member State, 2008-2011

Country	2008	2009	2010	2011	TOTAL
Austria	1	5	4	4	14
Belgium	37	32	55	52	176
Bulgaria			11	27	38
Spain		2		3	5
Netherlands	6	10	5	8	29
Ireland					0
Italy	1		1		2
Greece				2	2
Lithuania		2	10	2	14
Luxembourg		1			1
Latvia		2	4	3	9
Norra	1	1	1		3
Poland	2	1	1	5	9
Portugal					0
France		3	3	3	9
Sweden	2	1	2	3	8
Germany	9	3	10	16	38
Finland	13	5	11	72	101
United Kingdom					0
Switzerland	2		3	5	10
Denmark	2		3	2	7
Czeck Republic			3		3
Hungary	1	1	2		4
Unspecified country	138	161	877	1,883	3,059
TOTAL	**215**	**230**	**1,006**	**2,090**	**3,541**

Source: the Estonian National Social Insurance Board

Table 44: E106 for employees posted to Estonia from another Member State, 2008-2011

Country	2008	2009	2010	2011	TOTAL
Belgia		2	2	6	10
Bulgaria		2			2
Spain			1		1
Netherlands		42	24	70	136
Ireland	2				2
Italy	1	3	5	3	12
Greece		5		3	8
Lithuania		2		4	6
Latvia		2	6	4	12
Norway	13	14	44	82	153
Poland	1	8	8	6	23
France		2	3		5
Sweden	2	3	8	2	15
Germany		35	3	76	114
Slovakia		2			2
Finland	2	11	3	23	39
United Kingdom		2	8	12	22
Denmark	2	6	3	7	18
Czeck Republic	2		4		6
Unspecified country*	97		1	19	117
TOTAL	**122**	**141**	**123**	**317**	**703**

Tabel 45: Grant of family benefit to EU persons, 2008-2011

	2008	2009	2010	2011
EU persons who have been granted family benefit	964	1367	2261	5197

Source: Social Insurance Board

Table 46: The number of instances of EU coordinated unemployment insurance by years, 2008-2011

	2008	2009	2010	2011
Proof of insurance periods completed in Estonia for claiming benefits in a foreign state	213	517	428	380
Including insurance periods completed in a foreign country into determination of Estonian unemployment insurance benefits	447	1484	1509	1849
People with foreign state unemployment benefits seeking employment in Estonia	14	44	35	37
People who applied for the export of Estonian unemployment benefits into a foreign state	8	75	69	50
Total number of unemployment benefits coordination cases	**682**	**2120**	**2041**	**2316**

Source: Unemployment Insurance Fund

Other statistics and accompanying texts according to the previous report.

The Committee notes that negotiations have been started with Moldova and are in progress with Ukraine, and that the fundamental principles of an agreement with Georgia have been laid down. A draft agreement has also been submitted to Azerbaijan. It asks that the next report provide information on the outcome of these negotiations.

The Republic of Estonia has finished negotiations with Ukraine and the new agreement of social insurance of the Republic of Estonia and Ukraine entered into force on the 1st of February, 2012.

The Republic of Estonia has finished negotiations with the Republic of Moldova and the new agreement of social insurance of the Republic of Estonia and the Republic of Moldova entered into force on the 1st of August, 2012.

Estonia has had three rounds of negotiations with Georgia. The negotiations have been suspended due to the national legislation of Georgia.

Estonia has had two rounds of negotiations with the Republic of Azerbaijan, the last of which was in 2012. The next meeting will be in Tallinn, in 2013, but the exact date has not been agreed on yet.

The Committee asks that the next report provide information on the agreements envisaged with Albania, Armenia and Turkey and the timeframes involved. In the case of Georgia, it asks whether the draft agreement in preparation will cover family benefits. It also asks whether the conclusion of such agreements is foreseen with States which have ratified the Charter outside the reference period, i.e. Serbia and the Russian Federation.

During the reference period, in 2009, Albania submitted an official application to become the member of the European Union. Due to Albania's possible joining, Estonia does not see the necessity to conclude bilateral agreement.

Estonia does not see the necessity to conclude bilateral agreement with Turkey which is an official candidate state to the European Union.

Estonia does not see the necessity to conclude bilateral agreement with Serbia which is an official candidate state to the European Union.

In 2010, the Republic of Estonia sent a proposal to Armenia for concluding the contract, but Armenia was not interested due to unfinished national reforms.

The draft agreement with Georgia does not cover family allowances. The Estonian family allowance system is residence-based and irrespective of the nationality, all Estonian residents have the possibility to receive family allowances, if they meet other requirements for receiving the allowance.

The new agreement with the Russian Federation has entered into force.

Given that no bilateral agreements have been concluded with the States Parties which are not EU members and do not form part of the European Economic Area (Albania, Andorra, Armenia, Azerbaijan, Bosnia and Herzegovina, Croatia, Georgia, "the former Yugoslav Republic of Macedonia", Moldova, Turkey and Ukraine), the retention of accrued benefits is not guaranteed for nationals of those states. As there has been no change in the situation, the Committee reiterates its conclusion of non-conformity on this point.

Albania, and Bosnia and Herzegovina are potential candidate countries to the European Union and Estonia does not see the necessity to conclude bilateral agreements with them.

There has been no practical nee to conclude the agreement with Andorra.

Explanations about the possible agreement with Armenia may be found under the previous question. Explanations about the possible agreement with Azerbaijan may be found under the previous question.

Our position still is that there is no necessity to conclude bilateral agreement with Croatia, as according to the data of the European Commission, Croatia joins the European Union already on the 1st of July, 2013. The entry into force of a bilateral agreement takes at least a year from the beginning of negotiations.

Negotiations have been commenced with Georgia.

The Former Yugoslav Republic of Macedonia is a candidate country to the European Union and Estonia does not see the necessity to conclude bilateral agreement.

Updated agreement have been concluded with Ukraine and a new agreement with the Republic of Moldova.

Explanations about Turkey may be found under the previous question.

We are still ready to conclude bilateral agreements, but that requires reciprocal interest of both countries.

Right to maintenance of accruing rights (Article 12§4b). The Committee previously found that the situation was not in conformity because nationals of States Parties which are not covered by Community regulations or not bound by an agreement with Estonia cannot aggregate periods of insurance or employment completed in other countries. The report contains no information on this subject. The Committee therefore reiterates its conclusion of non-conformity on this point.

All effective bilateral agreements allow to aggregate periods of insurance (i.e. pension qualifying period) if they are not already aggregated by the regulations of the European Union. The same could be said about pensions export.

The Republic of Estonia does not see the possibility to aggregate insurance periods without regulations of the European Union or bilateral agreement, but we work to have agreements with as many countries as possible.

The Committee concludes that the situation in Estonia is not in conformity with Article 12§4 of the revised Charter, for the following reasons:

- *the retention of accrued benefits for persons moving to a State Party which is not covered by Community regulations or not bound by an agreement with Estonia is not guaranteed;*
- *nationals of States Parties which are not covered by Community regulations or not bound by an agreement with Estonia cannot accumulate periods of insurance or employment completed in other countries.*

Explanations may be found under the previous question.

Article 13 – The right to social and medical assistance

Article 13 § 1 - Adequate assistance for every person in need

1) Please describe the general legal framework. Please specify the nature of, reasons for and extent of any reforms.

Social assistance

Social assistance is regulated by the Social Welfare Act,. The main principles and amendments made during this reference period are indicated under this question.

The arrangement of the provision of social services, emergency social assistance and other assistance, as well as granting and payment of social benefits is in the capacity of local governments in Estonia.

The main social benefit for the persons who need assistance is the subsistence benefit, which is paid by the local governments from the funds of the state budget. Supplementary allowance, paid from the funds of the state budget, is paid for the subsistence benefit recipients whose members of the family are all minors. Additionally, local governments may pay supplementary social benefits from the local government budget under the conditions and pursuant to the procedure established by the local government council.

A person has the right to receive a subsistence benefit, if he or she living alone, or a family whose monthly net income, after the deduction of the fixed expenses connected with dwelling calculated under the conditions provided for in the Social Welfare Act, is below the subsistence level. Subsistence level is established based on minimum expenses made on consumption of foodstuffs, clothing, footwear and other goods and services which satisfy the primary needs.

The Riigikogu (the Parliament) establishes the subsistence level by the state budget, whereby the new subsistence level may not be less than the level in force. It is calculated for a person living alone and to the first member of a family for each budgetary year. The

subsistence level of the second and each subsequent member of a family is 80% of the subsistence level of the first member of the family. 2007. The subsistent level was 900 EEK i.e. 57.52 EUR in 2007, in 2008-2010 it was 1000 EEK i.e. 63.91 EUR. From 2011, the subsistence level is 76.70 EUR. Thus, the subsistence level now is 33% higher than in 2007. The subsistence level of the second and each subsequent member of a family is 80% of the subsistence level of the first member of the family. In 2011, the subsistence level of the second and each subsequent member of a family is 61.36 EUR.

The supplementary social allowance, which is paid for a person whose all family members are minors, increased by 17%. If the sum of the benefit used to be 200 EEK i.e. 12.78 EUR, then from 2011 it is 15 EUR.

There have not been many amendments to laws during the reference period, but there have been made few amendments to the Social Welfare Act.

For example, provisions regarding legal bases for a use of a dwelling on granting of subsistence benefit. If one of the legal bases for using dwelling used to be a lease contract, then since 31st of October, 2009 it may be any kind of a contract that allows a person to use a dwelling. Thus, the contract does not have to be a lease contract concluded under the Law of Obligations Ac. The amendment was motivated by a case where a local government gave a person a dwelling to use without expecting any payment for it.

A provision concerning incomes not included in the income of a person living alone or a family upon calculating a subsistence benefit has been amended twice. Until the 30th of April, 2009, the law provided that upon calculating a subsistence benefit, the stipends and transport and accommodation benefits payable for participation in vocational training and the transport and accommodation benefits payable for participation in work practice based on the Labour Market Services and Support Act may not be included in the income of a person living alone or a family. From the 1st of May, 2009, transport and accommodation benefits payable for participation in coaching for working life are not included in the income upon calculating a subsistence benefit. The aim of paying the benefits was to compensate the expenses of an unemployed person on transport to go to the coaching for working life. In January, 2012, an amendment entered into force, according to which the list of incomes not included in the in the income of a person living alone or a family upon calculating a subsistence benefit elongated even more. The effective law provides that upon calculating a subsistence benefit, grants and transport and accommodation benefits paid on the basis of the Labour Market Services and Benefits Act may not be included in the income. So there is

no difference any more, whether the grant is paid for an unemployed person for participation in labour market training, in work practice or coaching for working life.

From the 8th of July, 2010 an amendment entered into force, according to which enables the rural municipality or city government to pay the subsistence benefit on the bank account of another person. It used to be possible to pay the subsistence benefit to the applicant's bank account, by post or in cash only. The corresponding wish of the applicant as expressed beforehand have to be taken into consideration upon the payment of the subsistence benefit. In essence, the amendment helps to ensure that the funds for covering fixed expenses connected with dwelling would reach the account of a person providing public services by taking into consideration the corresponding wish of the applicant as expressed beforehand.

From the 1st of April, 2010, a new information system "Sotsiaalteenuste ja -toetuste andmeregister" (the register for the data of social services and benefits) was taken into use instead of the national social registry. If the national social registry was originally developed for only one measure – for granting and processing the applications of subsistence benefit – and it was a compound of independently acting social data information systems of local governments, then the register for the data of social services and benefits (RDSS) as a central national database is established to arrange social work, social services and benefits and other assistance conducted by the management system principle, and to administer activities and to record by an electronic file. The new data registry enables to get better overview of all the assistance provided for a person and to provide better management system.

Paragraph 5 of the Health Services Organisation Act provides the definition of emergency care. Emergency care in this case is health services which are provided by health care professionals in situations where postponement of care or failure to provide care may cause the death or permanent damage to the health of the person requiring care. According to § 6 of the act, each person who is in the territory of the Republic of Estonia has the right to receive emergency care. A health professional is obliged to provide emergency care in his or her capacity and within the possibilities available for him or her. Emergency medical care is provided by all institutions providing health care services and doctors working as self-employed persons (for example some family physicians).

Emergency care provided for a person having compulsory health insurance and for the person considered equal to such person is covered from the state budget from the available funds of the health insurance. Emergency care provided for a person not covered by health

insurance is covered from the available funds of the state budget and in accordance with the contract concluded between the Ministry of Social Affairs and the health insurance fund according to the Health Insurance Act. Emergency medical care is financed from the state budget.

Medical assistance

The most vulnerable groups are covered by the health insurance – they are equal to an insured person. According to the Health Insurance Act, the persons equal to an insured person are:

- pregnant women whose pregnancy is established by a doctor or a midwife;
- persons under 19 years of age;
- persons who receive a state pension granted in Estonia;
- persons with up to five years left until attaining pensionable age who are maintained by their spouses who are insured persons;
- students of up to 21 years of age acquiring basic education, students of up to 24 years of age acquiring general secondary education, persons in vocational training without the requirement of basic education, pupils and students acquiring vocational education on the basis of basic education or secondary education in educational institutions of Estonia or equivalent educational institutions of foreign states founded and operating on the basis of legislation, and higher education students who are permanent Estonian residents.

Number of recipients of Estonian health insurance:

- **in 2008** 1,281,718 (95.5% of the population);
- **in 2009** 1,276,366 (95.2% of the population);
- **in 2010** 1,256,240 (93.7% of the population);
- **in 2011** 1,245,469 (92.9% of the population).

Source: the report of the health insurance fund

According to the Health Care Services Organisation Act, health care service is provided for the uninsured person as an emergency care and it is funded from the state budget. Emergency care is a health care service provided by the health care professional in a situation when postponement of the treatment or withholding the treatment may cause the death or constant personal injury of the person in need of treatment. A health care

professional is a doctor, a dentist, a nurse and a midwife, if they are registered in the Health Board. A health professional is obliged to provide emergency care in his or her capacity and within the possibilities available for him or her. A family physician is obliged to provide emergency care to a non-resident or a person living in his or her service area, even if the person is not in his or her practice list.

Emergency care provided for a person having compulsory health insurance and for the person considered equal to such person is covered from the state budget from the available funds of the health insurance. Emergency care provided for a person not covered by the health insurance is covered from the available funds of the state budget and in accordance with the contract concluded between the Ministry of Social Affairs and the health insurance fund.

Available funds of the state budget for medical care of uninsured persons:

- **in 2008** 100,894,000 EEK;
- **in 2009** 111,084,294 EEK;
- **in 2010** 116,400,000 EEK;
- **in 2011** 7,071,696 EUR (110,648,000 EEK).

Provision of emergency medical care is financed from the state budget as well.

Medical care is provided on the local government level as well, although the set practice of reimbursement of medical care expenses of uninsured persons differs in local governments. In smaller local governments the local government often provides premises for a family physician or supports him or her by other means. In such local governments the family physician often provides free medical care for uninsured persons. In larger local governments such as Tallinn the so called authorized doctors' system operates, which means that there is a special health care unit for such service, for example AS Ida-Tallinna Keskhaigla (East-Tallinn Central Hospital) in Tallinn has one unit like that. There is a unit established that provides out-patient and in-patient health care service for uninsured persons. The unit of Ida-Tallinna Keskhaigla has 25 beds and persons are sent there by an attending physician in an out-patients' clinic or after acute treatment in an inpatient clinic.

2) Please indicate the measures taken (administrative arrangements, programmes, action plans, projects, etc.) to implement the legal framework.

The principle of subsidiarity is the basis for providing welfare services, which means that public obligations are carried out preferably by authorities closest to a person and firstly, the resources of the closest level (first contact resources) to the person who needs assistance are applied. This is why the main providers of welfare services and benefits are local governments. Welfare services provided by local governments are for example the services of personal assistant, support person, transportation for the disabled, customisation of residence, safe house, shelter, social housing, foster care, social counselling and care assistance.

The state organizes those welfare services that are complex and thus unreasonable to provide on the local level. The following welfare services are provided on the state level: special care services for persons with grave and long-time special psychological needs; service of technical aid allocated at a discount; medical rehabilitation service for the disabled people; substitute home service for children. The state finances provision of childcare service for children with severe and profound disability as well.

Local governments pay subsistence benefit for persons in need from the budgetary support. Additionally, the local governments have the right to pay supplementary social benefits from a local government budget under the conditions and pursuant to the procedure established by the local government council. Most of the local governments pay benefits related to the income of a family and not related to the income. Benefits related to the income of a family are for example medicament allowance, firewood allowance, education allowance, alimentation allowance for students and kinder-garden children. Single allowance in case a necessity of a person occurs is paid as well. Benefits not related to the income of a family are for example childbirth allowance, death grant, allowance for the start of school year, Christmas allowance, allowance for entering first grade.

On the 26th of April, 2012, the Government of the Republic endorsed an updated Competitiveness Plan „Eesti 2020“ (Estonia 2020). Under the subject field Education and Cohesive Society of this document, the policy of the government focuses on the topics of labour market activity, including active involvement of all groups of the society and providing high-quality workforce. One of the main goals of Eesti 2020 is to reduce the rate of relative poverty after social transferences. The base level for composing this document was the year of 2010, when the rate of relative poverty was 17.5%. The document sets the aim to reduce the rate of relative poverty after social transferences to 16.5% in 2015 and to 15% in 2020.

Unemployed people and persons of 65 and more years of age living alone have been in the highest poverty risk during the years. In 2009, 42,000 persons of retirement age came out of relative poverty on background of raise of pensions and general decrease of incomes. Pensions were increased in 2012 as well.

Assistance of persons in need of assistance has been addressed in the yearly development plans of the Ministry of Social Affairs. The following is pointed out in the Development Plan of the Ministry of Social Affairs for 2012-2015: "We will continue to provide need-based welfare services for persons who need assistance." […] "We will develop and provide welfare services with the aim to increase the ability to cope, decrease the need for assistance and relieve shortage of person with problems and his or her family, and support working in case of a working age person. We will help to improve the cooperation of local governments and the Estonian Unemployment Insurance Fund on resolving client cases. We value the maintenance of social networks of people and the development of community network". [...] “To ensure people minimal subsistence, we will pay subsistence benefit with local governments. We contribute to restore socio-economic subsistence by providing social services. We will aim to achieve the consistent increase of the level subsistence benefit. By providing social services restoring subsistence (including counselling, self-help groups, psycho-social rehabilitation, support person service, conjunction with labour market measures) we try to reduce the increase of persons receiving subsistence benefit and the long-time dependence on the payment of subsistence benefit, and we will support entering and remaining in the labour market. We will provide the organization of paying subsistence benefit in a way which avoids the formation of poverty trap." […]

One of the strategic goals of the Development Plan of Children and Families for 2012-2020 endorsed on the 21st of October, 2011 by the Government of the Republic is the following: Estonia has a combined system of benefits and services supporting the adequate economic subsistence, which provides constant security to a family. The principle of universality is the basis to favour the welfare of children and their families by covering all children and families with children. The state provides supplement aid for children and their families that are greater need of assistance. According to the document, the rate of relative poverty of children, i.e. persons of 0-17 years of age, may not be more than 17% in 2015 and the respective reference level for 2020 is 16.5%. In addition to monetary allowances and benefits, the importance of provided services is valued for coming out of poverty. As the best preventive measure for avoiding the poverty of a family is the possibility of a parent to participate in the labour market, then it is necessary to provide services that would support participating in employment. In the Estonian education strategy for 2012-2020, attention is

paid on the relations of poverty and unemployment and the level of education and that is why the importance of the increase of the availability of education for everyone and the participation in the learning process is emphasized.

Concerning the implemented programmes, it could be pointed out that in 2007-2013, welfare measures supporting employment are conducted with the support of the European Social Fund. The aim of the activities is to prevent unemployment and non-activity through individual approach and to support people moving to labour market based on a necessity. During the programme, welfare services are provided, which prevent and help to resolve social problems and support the participation in employment and maintaining a job of working age people. In 2012-2013, the emphasis is directed on social or economic problems, and persons with special needs and increasing the employment of their family members. The activities of the programme include the provision and development of supporting welfare services and the development and implementation of welfare measures corresponding to the needs of risk groups of labour market.

3) Please provide pertinent figures, statistics or any other relevant information, in particular: evidence that the level of social assistance is adequate, i.e. the assistance should enable any person to meet his/her basic needs and the level of the benefits should not fall below the poverty threshold. Information must therefore be provided on basic benefits, additional benefits and on the poverty threshold in the country, defined as 50% of the median equivalised income and calculated on the basis of the poverty risk threshold value published by Eurostat.

The general data of the subsistence benefit in 2007-2011 and the first half year of 2012 is indicated in the following table. The table shows that during the period of 2007-2012, the number of subsistence benefit recipients has been the lowest in 2008. The most applications for subsistence benefit have been acceded to in 2010. The average sum of subsistence benefit has increased year by year.

Table 47: General data about the subsistence benefit in 2007-2011 and the first half-year of 2012

	2007	2008	2009	2010[4]	2011	2012 1st h-y
The number of households that received subsistence benefit	12,972	11,391	20,149	…	24,114	18,496
The number of persons (number of household members) that received subsistence benefit	22,091	19,825	38,122	...	44,146	33,181
Number of acceded applications	72,541	59,587	106,819	165,119	161,638	77,555
The funds used for subsistence benefit and supplement ary allowances (in euros)	6,264 722	5,840 109	11,576 572	20,447 958	23,756 374	12,037 484
The average amount of benefit per one application	86.36	98.01	108.38	123.84	146.97	155.21

Source: the Ministry of Social Affairs

The following table gives an overview of budgetary funds for social benefits. The main benefit paid from the state budget is subsistence benefit. Additionally, supplementary allowance is paid to all the recipients of subsistence benefit if all members of the family are minors.

Local governments may pay other social benefits to persons in need to support their subsistence and provide social services under the conditions and pursuant to the procedure established by the local government from the excess, if the funds immobilized for subsistence benefit by the state are sufficient. From the 6th of July, 2009, the local governments may use the excess of subsistence benefit payment only if the excess derives

[4] In relation to transition to the new register of social benefits and services on the 1st of April, 2010, much data about the recipients of subsistence benefit is not available about the year 2010.

from the same budgetary year and if social benefits are provided during the respective budgetary year.

Table 48: Expenses on the payment of subsistence benefit in 2007-2011 and in the first half-year of 2012 (in euros)

	Sum payd for subsistence benefit (including supplementary allowance for families with one parent)	**Sum spent on housing expences from the subsistence benefit**	**Other social benefits from the budgetary funds for subsistence benefit**	**Total of the benefits from the budgetary funds for subsistence benefit**
2007	6,264,722	1,110,371	2,482,526	8,747,248
2008	5,840,109	1,175,517	1,893,500	7,733,609
2009	11,576,572	2,647,896	419,255	11,995,827
2010	20,447,958	5,843,935	156,351	20,604,309
2011	23,756,374	6,626,088	143,477	23,899,851
2012 1st h-y	12,037,484	3,872,147	18,319	12,055,803

Source: the Ministry of Social Affairs

In addition to the benefits allocated from the state budget, local governments pay supplementary social benefits from the local government budget as well, but the Ministry of Social Affairs does not collect the respective data.

The data of 2007-2010 about relative poverty are indicated in the following table. The table indicated that the rate of relative poverty has decreased since 2008. The reason for this is the general income decrease of people.

Table 49: Relative poverty rate in 2007-2010

	2007	2008	2009	2010
Relative poverty rate 50% of median equivalent net income (euros per month)	231	259	239	233

Source: the Statistical Office

The following table indicates the estimated minimum means of subsistence for 30 days of a household with one member in 2007-2011. The increase of the minimum means of subsistence and the increase of a cost of a minimal basket of food in 2011 may be related to joining the Eurozone on the 1st of January, 2011.

Table 50: Estimated minimum means of subsistence for 30 days of a household with one member and the cost of a minimal basket of food in 2007-2011 (in euros)

	2007	2008	2009	2010	2011
Estimated minimum means of subsistence	149.6	169.1	170.0	174.8	186.3
Cost of minimal basket of food	65.9	75.5	75.3	77.6	85.1

Source: the Statistical Office

The Committee asks for statistics regarding the number of cases where a person without resources has been refused assistance benefit.

The subsistence benefit is paid to persons and families that meet the requirements set in the Social Welfare Act, i.e. whose monthly net income, after the deduction of the fixed expenses connected with dwelling, within the limits of the socially justified standards for dwellings and within the limits established, is below the subsistence level. A rural municipality or city government has the discretion to refuse to grant a subsistence benefit on following occasions:

- to a person between the age of 18 and the pensionable age with capacity for work who is not working or studying, and who has, more than once and without good reason, turned down suitable work offered to him or her, or has refused to participate

in employment services or in social services or study organised by a rural municipality or city government directed towards independent ability to cope;

- a person who, or whose ward, has the right to receive support but who refuses to submit a document certifying the right to receive the support or refuses to claim the support;
- if the corresponding committee of a rural municipality or city government finds that the movables and immovables used or owned by an applicant for subsistence benefit or his or her family ensure sufficient funds for coping for the person or his or her family.

The data is collected about the applications filed in for receiving subsistence benefit and about satisfaction of applications. The following table shows the data of the applications filed in to receive the subsistence benefit and the place of satisfaction of applications by local governments, whereas in 2010, the data is indicated only regarding the II-IV quarters. The table shows that the number of rejected applications is very small.

Table 51: The statistics of submitted, satisfied and rejected applications of subsistence benefit in 2007-2011 and the first half year of 2012

	2007	2008	2009	2010 2nd to 4th quarter[5]	2011	2012 1st to 2nd quarter
Number of submitted applications	74,001	60,661	108,982	124,952	167,112	80,105
Number of satisfied applications	72,541	59,587	106,819	120,023	161,638	77,555
Number of rejected applications	1,460	1,074	2,163	4,929	5,474	2,550
The percentage of rejected applications of all applications (%)	2.0%	1.8%	2.0%	3.9%	3.3%	3.2%

Source: the Ministry of Social Affairs

Person whose application has been rejected by the rural municipality or city government has the right to turn to a county governor with a challenge. The county governor exercise supervision over local governments as regards the granting of subsistence benefit. The Ministry of Social Affairs does not collect data about submitted challenges to county governors and the results of those.

The Committee notes from MISSOC that for determining the entitlement to and amount of subsistence benefit, housing expenses are taken into account within established limits. The Committee asks what these limits are.

According to the Social Welfare Act, local government councils establish the limits for the types of housing expenses, the limits for housing expenses have not been established on a state level.

Housing expenses considered upon calculating the subsistence benefit are:

[5] In relation to transition to the new register of social benefits and services on the 1st of April, 2010, much data about the recipients of subsistence benefit is not available about the year 2010.

- the actual rent or maintenance fee of the apartment;
- the value of thermal energy or fuel consumed for heating or supply of hot water;
- the value of consumed water and sewerage services;
- the value of consumed electricity;
- the value of consumed household gas;
- the expenses made on land tax, which is calculated based on the size of land that equals three times the area under the dwelling;
- the expenses made on building insurance, calculated for dwelling in use;
- the actual municipal waste transport fee.

The law fixes the socially justified standards for dwellings, which is 18m^2 per each family member and additional 15 m^2 for family. If the number of rooms equals to the number of persons constantly living there, but the total area of the apartment is larger than the standard area, then the total area serves as a basis. If the actual total area of the apartment is smaller than the standard area, then the actual area serves as a basis. Upon granting the subsistence benefit for pensioners living alone, the standard area may be calculated as up to 51 m². Limits for fixed expenses connected with dwelling are left for local governments to decide, because the amount of expenses varies in different areas and local governments know local conditions better. So there are no general national limits for expenses established. The Social Welfare Act provides that local government councils shall establish limits for the expenses, which ensure decent subsistence for persons.

The Committee notes from MISSOC that social assistance benefits are granted to permanent residents. The Committee asks that the next report to provide more information on this issue. In the meantime it reserves its position on this point.

According to the Social Welfare Act, in addition to permanent residents of Estonia, aliens residing in Estonia on the basis of residence permits or right of residence or persons enjoying international protection staying in Estonia have the right to receive social services, social benefits and other assistance. Every person staying in Estonia has the right to receive emergency social assistance.

Which regards the social assistance provided for citizens of foreign countries, it is possible to indicate subsistence benefit statistics only about those foreign countries, which have ratified the European Social Charter and which the head of a household was from, and only up to the first quarter of 2010, when the data was collected through the national social registry.

Respective statistics is indicated in the following table. The table shows that in 2008, no applications were submitted by citizens of countries that have ratified the European Social Charter if the head of a family was from such country. In 2007, 3 applications were submitted by Swedish citizens. A bit more applications were submitted in 2009 and in the first quarter of 2010 by citizens of countries that have ratifies the European Social Charter.

Table 52: Subsistence benefit statistics of countries that have ratified the European Social Charter if the head of a family was from such country during the period of 2007-2009 and the 1st quarter of 2010

	2007	2008	2009	2010 1st Q
Number of satisfied applications, where a head of a family is a citizen of a country that has ratified the European Social Charter	Sweden - 3 **TOTAL: 3**	**TOTAL: 0**	Bulgaria – 7 Finland – 5 Germany – 1 Ireland – 6 **TOTAL: 19**	Bulgaria – 4 Finland – 6 Germany – 2 Hungary – 3 Ireland – 3 **TOTAL: 18**
Number of household that received subsistence benefit and which head of a family is a citizen of a country that has ratified the European Social Charter	Sweden – 2 **TOTAL: 2**	**TOTAL: 0**	Bulgaria – 2 Finland – 2 Germany – 1 Ireland – 1 **TOTAL: 6**	Bulgaria – 2 Finland – 2 Germany – 1 Hungary – 1 Ireland – 1 **TOTAL: 7**
Number of recipients od subsistence benefit (number of members of a household) which head of a family is a citizen of a country that has ratified the European Social Charter	Sweden - 2 **TOTAL: 2**	 **TOTAL: 0**	Bulgaria – 8 Finland – 2 Germany – 1 Ireland – 1 **TOTAL: 12**	Bulgaria – 7 Finland – 2 Germany – 1 Hungary – 1 Ireland – 1 **TOTAL: 12**

Source: the Ministry of Social Affairs

In the next table, data for the period of 2007-2009 and the 1st quarter of 2010 is indicated, which show the number of satisfied applications for subsistence benefit submitted by persons living in Estonia on the basis of a temporary residence permit. The most applications submitted by persons living in Estonia on the basis of a temporary residence permit were satisfied in 2009.

Table 53: Number of satisfied applications for subsistence benefit submitted by persons living in Estonia on the basis of a temporary residence permit during the period of 2007-2009 and the 1st quarter of 2010

	2007	2008	2009	2010 1stQ
Number of satisfied applications	72,541	59,587	106,819	44,404
Number of satisfied applications submitted by persons living in Estonia on the basis of a temporary residence permit	4,836	3,914	5,752	2,114

Source: the Ministry of Social Affairs

The statistics of subsistence benefit granted for the citizens of foreign countries during the period of the 2nd quarter of 2010 to the 1st quarter of 2012 is indicated in the following table. The data shows that the most applicants and recipients of the subsistence benefit are the citizens of the Republic of Estonia followed by persons with undefined citizenship and the citizens of the Russian Federation. Somewhat smaller number of subsistence benefit recipients is the citizens of Ukraine, Latvia and Lithuania. The percentage of subsistence benefit recipients among citizens of other countries is even smaller.

Table 54: Number of satisfied subsistence benefit applications, households and members of a household by citizenship during the period of the 2nd quarter of 2010 to 2011

2010 2nd to 4th quarter				2011			
Country	Number of satisfied applications	Number of households that	Number of family members who	Country	Number of satisfied applications	Number of households that	Number of family members who
TOTAL	**120,023**	**22,790**	**41,643**	**TOTAL**	**161,638**	**24,114**	**44,146**
Estonia	83,405	16,375	30,606	Estonia	110,741	17,330	32,608
Undefined citizenship	24,913	4,446	7,789	Undefined citizenship	34,265	4,647	8,060
Russia	10,323	1,878	3,264	Russia	14,530	1,992	3,384
Ukraine	443	94	207	Latvia	734	101	222
Latvia	424	76	168	Ukraine	718	100	202
Lithuania	178	36	68	Lithuania	244	38	64
Belarus	87	18	32	Belarus	102	19	34
Kazakhstan	40	7	13	Kazakhstan	50	7	11
Armenia	38	6	17	Armenia	45	7	17
Afghanistan	29	8	8	Finland	29	4	5
Other countries	143	27	53	Other countries	180	33	63

Source: the Ministry of Social Affairs

The Committee asks what measures exist to ensure that persons who do not fall within the compulsory health insurance scheme and are without resources have effective access in practice to medical care in case of need.

Please see the answer for Article 13 § 1 question 1).

Article 13 § 2 - Non-discrimination in the exercise of social and political rights

1) Please describe the general legal framework. Please specify the nature of, reasons for and extent of any reforms.

There are no changed compared to the previous period. The political and social rights of persons are not restricted in relation to receiving social and medical assistance.

Paragraph 12 of the Constitution of the Republic of Estonia provides that everyone is equal before the law and that no one shall be discriminated against on the basis of nationality, race, colour, sex, language, origin, religion, political or other opinion, property or social status, or on other grounds.

Paragraph 36 of the Social Welfare Act provides that a welfare worker may disclose information concerning a person or family receiving social welfare only if failure to disclose such information endangers the life or health of others or if the information is related to the commission of a criminal offence.

Paragraph 4 (2) of the Personal Data Protection Act lists the sensitive personal data:

1) data revealing political opinions or religious or philosophical beliefs, except data relating to being a member of a legal person in private law registered pursuant to the procedure provided by law;
2) data revealing ethnic or racial origin;
3) data on the state of health or disability;
4) data on genetic information;
5) biometric data (above all fingerprints, palm prints, eye iris images and genetic data);
6) information on sex life;
7) information on trade union membership;
8) information concerning commission of an offence or falling victim to an offence before a public court hearing, or making of a decision in the matter of the offence or termination of the court proceeding in the matter;

According to the Personal Data Protection Act, processing of personal data is permitted without the consent of a data subject if the personal data are to be processed:

1) on the bases of law;
2) for performance of a task prescribed by an international agreement or directly applicable legislation of the Council of the European Union or the European Commission;
3) in individual cases for the protection of the life, health or freedom of the data subject or other person if obtaining the consent of the data subject is impossible;
4) for performance of a contract entered into with the data subject or for ensuring the performance of such contract unless the data to be processed are sensitive personal data.

2) Please indicate the measures taken (administrative arrangements, programmes, action plans, projects, etc.) to implement the legal framework.

In area of government of the Ministry of Justice, the Data Protection Inspectorate operates, which activities are aimed at the protection of fundamental rights and freedoms by independent data protection surveillance. The aim of protecting personal data is to ensure the legality of data processing.

Next to self-initiative surveillance, the inspection is also obliged to process applications, complaints and petitions submitted by persons, with the aim to react operationally on all infringements and suspicion of infringements regarding processing personal data.

If the processed data include sensitive personal data, then the processor, when processing the data, is obliged to follow more strict requirements provided by law and register the processing of sensitive personal data to in the surveillance institution of data protection.

3) Please provide pertinent figures, statistics or any other relevant information, if appropriate.

The Ministry of Social Affairs does not have any information about the political and social rights of persons to have been restricted by providing social ad medical assistance.

Article 13 § 3 - Prevention, abolition or alleviation of need

1) Please describe the general legal framework. Please specify the nature of, reasons for and extent of any reforms.

There have not been made large legislative amendments during the reference period regarding providing assistance to the recipients of social assistance.

The organization of providing social services, emergency social assistance and other assistance as well as granting and paying social benefits is still the obligation of local governments. According to the Social Welfare Act, local governments provide social counselling services to the subsistence benefit applicants and their family members in need of assistance upon grant of subsistence benefit. Social counselling is the provision to a person of necessary information about social rights and opportunities for protecting lawful interests, and assistance in solving specific social problems in order to contribute towards future coping. Counsellors are welfare workers who have received special training for counselling work.

From the 1st of January, 2009, the list of social services regulated by the Social Welfare Act has supplemented. In addition to social services regulated before, (social counselling, rehabilitation, provision of prosthetic, orthopaedic and other appliances, child care service, home service, housing services, foster care, substitute home service, care in social welfare institutions, other services necessary for coping such as personal assistant service, support person service, care for a disabled adult at home) there are five special welfare services indicated. Those are

- everyday life support service;
- employment support service;
- supported living service;
- community living service;
- 24-hour special care service.

2) Please indicate the measures taken (administrative arrangements, programmes, action plans, projects, etc.) to implement the legal framework.

The aim of the social counselling service is the prevention of social problems and assistance in solving social problems that have already started. Social counselling service is aimed at person or a family, whose independent coping in everyday life is disturbed or about to be disturbed due to social, economic, health or psychological factors. A person who has problems or persons living with such person have the right to receive such service as often all the people living together are affected by that problem (for example, illness or unemployment of a family member). This is why the service shall be provided for those persons as well, whose ability to cope is disturbed. A person or a family is notified about social rights, possible social services and benefits during the provision of the service and solutions are sought in cooperation with the person to improve his or her socio-economic functioning and ability to cope independently. Social counselling may be provided individually or for couples and / or families. Motivation of a person or family, teaching coping skills, giving alternatives to resolve problems and arranging the availability of other assistance is part of social counselling as well.

Counsellors are welfare workers who have received higher education in social work. Counsellors are expected to have the willingness to serve and communicate to persons, empathy, tension tolerance and tolerance. In case of social counselling, the specialized education ensures that the counsellor has the abilities of counselling, knowledge of social welfare and counselling techniques, and that he or she is capable of providing the best advice on how to improve independent coping to persons who need assistance.

During the programme of the European Social Fund, Welfare Measures Supporting Employment 2012-2013, a pilot project Provision of Need-Based Services to Persons with Multiple Problems by Case-by-Case Networking has started. The target group is persons with multiple problems and their families, i.e. working age people, who have more than one obstacle due to which they do not cope with everyday life and working. To help such people, single services of local governments are often no enough. It is necessary to develop case-by-case networking between local governments, various service providers and other institutions. The aim of the project is to provide high-quality and available need-based combined welfare services by case-by-case networking of local governments. This will increase persons' in difficulties and their families' ability to cope, relieve various problems including poverty and support adult persons to use active labour market services, maintain

their jobs or start work. During the project, customers are offered debt counselling, psychological counselling (including family counselling) and support person service.

3) Please provide pertinent figures, statistics or any other relevant information, if appropriate.

There are 226 local governments in Estonia. Thus, the provision of assistance in ensured to persons near their homes. The Ministry of Social Affairs does not collect data about the number of persons that local governments have provided with social counselling. Nevertheless, according to the Social Welfare Act, social counselling shall be provided to the recipients of subsistence benefit. During the period of 2007-2011 and the 1st quarter of 2912, 598,163 applications for subsistence benefit were satisfied. Local governments may provide social counselling service to persons who do not receive subsistence benefit as well.

Which regards to the projects conducted under the programme Welfare Measures Supporting Employment of the European Social Fund, then during the project conducted in 2010-2011, family counselling, psychological counselling and debt counselling was provided for 2,503 persons. In addition, during the project conducted in 2011-2012, debt counselling was provided for 380 persons. 2012. In 2012, a new welfare programme Welfare Measures Supporting Employment 2012-2013 started and during the pilot project of that programme, Provision of Need-Based Services to Persons with Multiple Problems by Case-by-Case Networking, 412 persons were provided debt counselling, support person service and psychological counselling (incl. family counselling) during the first four months of the project (from April 2012 to July 2012) During the first four months, 82 local governments i.e. 36.3% of all Estonian local governments were already involved in the programme.

The Committee notes that as of 2008 the case management principle has been applied in order to improve the ability of a person to cope independently. The Committee wishes to be informed about the implementation of this principle.

The principle of management system is used more and more to resolve the problems of persons. At the same time, the implementation of management system is different in various local governments. There are many local governments in Estonia, where the management system has found a place next to other social work interruptions on supporting of clients with multiple problems. In some local governments, the application of management system is

hampered by different reasons, for example the lack of sufficient know-how or cooperation problems between the specialists of different fields. The application of management system as a method is supported by the register for the data of social services and benefits (RDSS), where an electronic case plan has been integrated to the data base.

The number of specialists who have gained their basic knowledge about management system from an in-service training or during their main studies is increasing as well. In-service training of management system is provided by various institutions of higher education, such as the College of Pärnu of University of Tartu and Tallinn University. During 2009-2012, 155 participants have passed the respective in-service training in the College of Pärnu of UT. The study module of management system is integrated in the social work management curricula of both full-time study and open university of the College of Pärnu of UT. In 2009-2013, 121 students passed the respective curricula. To support effective resolving of cases and to create bases for good practice in networking, the Ministry of Social Affairs requested for instructions for application of management system networking in 2012. These instructions are designed for social workers of local governments, child protection specialists, specialists of rehabilitation and health care and for other partners of social network. Instructions for implementation of networking help to conduct procedural acts in the registry of social benefits and services (RSBS) as well. To promote using the instructions, the Ministry of Social Affairs plans to introduce the instructions on a seminar aimed at local governments' social field professionals.

The Committee asks whether social services concerned with Article 13 § 3 are provided with sufficient means to give appropriate assistance as necessary.

As the organization of social services is the obligation of local governments in Estonia, then the provision of many social services are financed from the budgets of local governments. However, the state organizes those social services that are complex and thus unreasonable to provide on the local level. And those services are mostly funded by the state budget. With certain services, person's co-payment is partially used as well.

The following table indicates the amount of expenses on social welfare from the state budget. As the table shows, there are more and more expenses made year by year and this is why the percentage of welfare expenses has increased in GDP and state budget.

Table 55: Expenses on the welfare from the state budget in 2007-2011, thousand euros

	2007	2008	2009	2010	2011
Social welfare	44,393.0	52,382.0	51,615.0	63,227.4	71,325.4
social benefits	11,286.8	10,123.6	13,683.5	22,272.1	25,653.7
social services	27,648.2	35,867.2	35,419.8	35,735.2	38,238.1
other expenses related to welfare	5,458.1	6,391.2	2,511.7	5,220.1	7,433.6
Percentage of welfare expenses, %					
In GDP[1]	0.28	0.32	0.38	0.44	0.45
In state budget[2]	0.91	0.92	0.92	1.13	1.16

[1] The updated data of the Statistical Office is used as of 07.09.2012.

[2] Execution of the state budget by expenses

Sources: the Estonian National Social Insurance Board, the Ministry of Finance, the Ministry of Social Affairs

Article 14 – The right to benefit from social welfare services

Article 14 § 1 - Provision or promotion of social welfare services

1) Please describe the general legal framework. Please specify the nature of, reasons for and extent of any reforms.

The activity programme of the Government of the republic for 2011-2015 foresaw the development of social services instructions as one of the activities in 2011. In 2011, the Ministry of Social Affairs composed recommended instructions about the social services in the area of government of local governments. The introductions and discussion about the instructions took place in a seminar Introduction of Social Researches and Open Discussion on the Instructions of Social Services, where the representatives of local governments, service providers and client organizations were involved. The form of the instructions is developed with the aim to compose back-up materials instructing by unified form to which the local governments could base on to provide services or to delegate services to private sector or third sectors. At the same time, the instructions are useful for the consumers of services or their families to understand the essence of a service, to form and assess expectations about a service and to know their right and possibilities when using a service.

Recommended instructions were composed about the following services:

- Care service;
- Personal assistant service;
- Domestic service;
- Child care service;
- Social counselling service;
- Social transport service;
- Support person service for a child;
- Support person service for an adult;
- Shelter house service for a child;
- Shelter house service for victims of violence;
- Shelter home service;

- Debt counselling service;
- Family conciliation service;

2) Please indicate the measures taken (administrative arrangements, programmes, action plans, projects, etc.) to implement the legal framework.

Institutions providing social services and their geographic location

By the end of 2011, 345 institutions provided social services (including institutions providing substitute home service, special welfare services, care for adults in social welfare institutions, day centre services, shelter home service and homeless shelter service), of which 62 provided two or more services.

There were 198 institutions providing 24-hour welfare and care services (i.e. 57% of the service providers), of whom 20 institutions provided service for more than one target group (foremost, the elderly and persons with special psychological needs). Two thirds, i.e. 131 institutions provided 24-hour service of care for adults (excl. special care services). 24-hour special care service was provided by 33 institutions out of 100 institutions providing such service and there were 33 institutions providing substitute home service as well.

By the of 2011, 109 institutions provided day centre services, 33 institutions provided shelter home service and 11 institutions provided homeless shelter service. During a year, there were 91 providers of rehabilitation service per three target groups.

Table 56: Number of institutions providing social services in 2008-2011 (end of the year)

Type of service	2008	2009	2010	2011
Substitute home service	35	36	37	33
Care of adults in social welfare institutions (excl. special care service)	121	122	129	131
Special care services[1]	91	94	93	100
24-hour care service	28	31	33	33
Rehabilitation service of the disabled persons[2],	70	75	89	101
Rehabilitation service of adults with special psychological needs[2],	37	48	56	61
Rehabilitation service of minors with special behavioural needs[2]	6	6	9	10
Day centers services	101	102	106	109
Shelter home services	32	39	38	33
Service of homeless shelters	10	10	11	11

[1] Until 2008, it was called the welfare services for adults with special psychological needs.

[2] The number of institutions providing rehabilitation service reflects data during a year.

Source: the Ministry of Social Affairs, the Estonian National Social Insurance Board of the data about institutions providing rehabilitation service.

The geographic location of institutions providing social services varies a lot. For example, if there are 32 service providing institutions in Tallinn with the population of 400,000, then there are 36 service providers in Lääne-Viru county with the population of 66,800. To keep in mind the smallness of Estonia, it not always possible to consider the territorial principle on the occasion of the need for service and the most suitable service providers are searched for from Estonia for a person in need of assistance. It mostly concerns 24-hour service providers (care for adults in social welfare institutions, substitute home service and special welfare services). For example, in recent years there have been about 500 free beds in institutions providing care for the elderly (it is related to the new service providers entering the market). On the other hand, there may be waiting lists for services in regional level. The person can then decide whether to wait or to have their service outside the county of his or her home.

Table 57: Institutions providing social services by location, by the end of 2011

County / town	Care of adults in welfare institutions	Substitute home service	Shelter service	Homeless shelter service	Special welfare service	incl. providing 24-hour service	Day center services	**TOTAL number of service providers[1]**	incl. providing more than one service
TOTAL	**131**	**33**	**34**	**11**	**100**	**33**	**109**	**345**	**62**
Tallinn (town)	5	1	5	2	6	1	17	**32**	5
Harju	9	3	1	2	12	4	9	**28**	7
Hiiu	1	-	1	-	2	-	6	**8**	2
Ida-Viru	15	8	4	2	9	3	6	**35**	7
Jõgeva	5	1	-	1	6	1	-	**10**	3
Järva	3	3	1	-	5	1	3	**10**	4
Lääne	3	2	2	-	5	3	2	**9**	4
Lääne-Viru	13	3	1	1	6	3	15	**36**	3
Põlva	13	1	-	-	5	3	5	**20**	3
Pärnu	9	1	3	-	13	2	11	**30**	7
Rapla	9	1	1	-	5	3	4	**18**	2
Saare	7	1	1	1	4	1	3	**13**	3
Tartu	7	5	5	1	7	1	12	**33**	3
Valga	12	2	3	-	5	3	10	**24**	6
Viljandi	14	1	3	-	7	3	5	**28**	1
Võru	6	-	2	1	3	1	1	**11**	2

[1] Number of institutions, irrespective of the number of services provided. Thus, the number of institutions indicated in the column is larger than the actual number of institutions

Source: the Ministry of Social Affairs

Table 58: Number of spots in institutions providing social services, by the end of 2011

County / town	Care for adults in welfare institutions	Substitution home service	Shelter service	Homeless shelter service	Special welfare services	incl. 24-hour services
Total	**6,213**	**1,407**	**1,055**	**366**	**3,158**	**2,509**
Tallinn (town)	527	246	636	124	70	12
Harju	330	144	2	25	549	473
Hiiu	50	-	14	-	3	-
Ida-Viru	1 096	248	73	75	123	77
Jõgeva	279	35	-	12	403	347
Järva	154	53	8	-	108	86
Lääne	112	65	65	-	252	206
Lääne-Viru	484	110	-	24	246	193
Põlva	387	65	-	-	257	181
Pärnu	408	48	114	-	114	91
Rapla	337	40	6	-	111	70
Saare	176	40	7	8	387	377
Tartu	501	186	75	82	96	35
Valga	628	67	20	-	124	103
Viljandi	558	60	24	-	219	187
Võru	186	-	11	16	96	71

Source: the Ministry of Social Affairs

In addition to the institutions providing social services, local governments organize the provision of many social services themselves (they either provide it themselves or by in necessary service). In most cases it is the so called open care service, which enables the person in need of assistance to continue living in homely conditions. Such services are: housing service, domestic service, care for disabled person at home, foster care, personal assistants service, support person service and child care service.

If the three first services mentioned in the table above are provided in most of the local governments (housing service and domestic service are provided by around 78% of local

governments and care for disabled persons is provided by 95% of local governments), then the percentage of providing support person service, personal assistant service or child care service is around 22-38%. On the other hand, the services are still in the stage of development and the table indicates the increase of local governments providing the service.

Table 59: Number of local governments providing social services, by type of service, in 2008-2011 (during a year)

	2008	2009	2010	2011
Housing service[1]	159	166	176	175
Domestic service	169	173	176	177
Care for disabled persons[2]	225	225	216	216
Foster care	114	105	95	98
Support person service	58	62	66	79
Personal assistant service	42	41	41	50
Childcare service[3]	45	63	82	85

[1] According to § 14 of the Social Welfare Act, the local government bodies are required to provide dwellings for persons or families who are unable or incapable of securing housing for themselves or their families and to create. Persons who have difficulties moving about, caring for themselves or communicating in a dwelling shall be assisted by the rural municipality or city government in adapting their dwelling or in obtaining a more suitable dwelling. The statistics of housing services are collected about the service users of social housing and municipal dwellings, which are leased as social service pursuant to the Social Welfare Act.

[2] Adult person under curatorship – according to § 28^2 of the Social Welfare Act is an adult who due to mental or physical disability needs assistance in the exercise of his or her rights and the performance of his or her obligations and over whom curatorship is exercised by a curator appointed by a rural municipality or city government according to the procedure of establishing and appointing curatorship established by a local government council. Minor person under curatorship – a minor (up to 18 years of age) child, whose parent, step-parent, guardian or caregiver provided by § 25^2 (1) of the Social Welfare Act is paid for curatorship of a disabled child under the procedure established by local government council.

[3] Child care service is provided by a provider of child care service who ensures the care,

development and security of a child to support working, studying or coping of a parent. The provision of a child care service does not have to be provision of primary education. State-financed child care service is aimed at children with severe or profound disability. In 2011, the limit of state-financed child care for a child with severe or profound disability is 731 euros in a calendar year. In most cases, parents pay for child care service for a healthy child. Some local governments support parents with paying for child care service by establishing a procedure for support by decision of council. For example, child care allowance is paid or a contract in entered into with a parent that specifies the payment for the service. The procedures and conditions of financing child care are different in local governments.

The Social Welfare Act establishes professional requirements for childcares, the number of children per child carer is limited and if the childcare service is provided outside the dwelling of the child receiving the childcare service, the premises where the childcare service is provided shall comply with the health protection requirements for the childcare service established on the basis of the Public Health Act.

Source: The Ministry of Social Affairs

3) Please provide pertinent figures, statistics or any other relevant information to demonstrate the effective access to social services (beneficiaries in total and per category of social welfare services, number and geographical distribution of services, staff number and qualifications).

Users of social services

24-hour welfare services (substitute home service, special welfare services and care for adults in welfare institutions) were provided to 12,539 persons during 2011 (excl. special welfare services), two thirds (66%) of them used adult care service followed by special welfare service users (22%) and substitute home service users (12%). Compared to 2008, the number of service users has increased by 6% (by 707 persons). There were more users of adult care service and 24-hour special welfare service (the increase compared to 2008 was 11.6% and 7.7% respectively).

The largest changes could be seen among adult care service users. The average growth among service users per year has been 250-300 persons (excl. 2009, when the number of

service users decreased by 56 persons compared to 2008). This might have been influenced by the economic crisis, when the unemployment rate was higher and there was a person in the household of a person who needed assistance that could are for the person himself or herself. Compared to 2003, the number of persons using adult care service has increased 1.5 times. The percentage of elderly service users have increased significantly. If in 2003 there were 34% (1321 persons) of service users of 80 and more years of age then in 2011 it was 45% (3,480 persons).

The 2% increase in service users of special welfare services has been influenced by the increase of 24-hour service users by 200 persons.

The number of children in substitute homes has decreased compared to 2008 by 20% by 2011. This is foremost influenced by the changes in the orientation of child protection worker: child protection work is more and more focused on solving problems in families.

Although there were 500 more children registered in 2011 than in 2010, the percentage of children separated from their family of all the registered children is only 17.6% (in 2008 it was 38.8%).

The number of children registered as in need of assistance in local governments describes the need for assistance of children and the work load of social workers to some degree, but it should be considered that the annual statistics is to some extent influenced by the different nature of work of the social workers: the habit to register data and the understand of who is a child in need of assistance (the visions and experience in this field differs in local governments). Thus, the increase in the number of children registered as in need of assistance in 2011 compared to 2010 might be explained by the above mentioned (i.e. registration of cases). And so it is much more relevant to compare year-on the separation from family of children. It actually means that the work of child protection workers is more effective and that they deal more with children and problematic families than before. This has become possible due to the increase in the number of child protection workers in last 3 years. The number of child protection workers (incl. child protection workers of county governments) has increased by 15 persons compared to 2008 (from 162 to 177) and the number of children from 0-17 years of age per one child protection worker has decreased by 144 children during the same period.

Of other services provided by institutions, day centre services have the most service users. Despite the increase of the number of day centres, the number of service users has

decreased and it ranges during years. It has to be considered that the number of regular customers (persons who visit day centre at least once a week) has not decreased and has been around 17,500 persons during the whole reference period. Thus, the number of users has decreased who have visited a day centre for only a few times during a year (this mainly involves people who have participated in some events).

The increase in the number of homeless shelter users was influenced by persons who used the service due to other reasons (for example, one person missed a bus and used the service during one night). If the number of homeless people increased by 18% during the reference period, then the number of other users of the service increased 2.3 times. As a result of that, the percentage of other service users increased to 17% of all the service users in 2011 compared to 10% in 2008.

Table 60: Number of service users in institutions providing services by types of services, in 2008-2011 (during a year)

Type of service	2008	2009	2010	2011
Substitute home service	1,791	1,592	1,496	1,435
Special welfare services	5,201	5,347	5,231	5,304
incl. 24-hours care service	2,583	2,739	2,760	2,782
Care for adults in welfare institutions	7,458	7,704	7,903	8,322
Day center services	58,447	55,753	54,091	51,361
incl. the number of regular customers[1]	17,415	17,412	17,181	17,594
Shelter service	3,280	2,986	3,229	3,079
Homeless shelter service	1,055	1,092	1,202	1,355
Rehabilitation service of the disabled persons	14,033	10,911	11,381	11,584
Rehabilitation service of adults with special psychological needs	2,086	1,766	1,726	1,842
Rehabilitation service of minors with special behavioural needs	71	93	81	92

[1] Service users who visit day centre at least one time a week.

Source: the Ministry of Social Affairs

Table 61: First registering children without parental care and children in need of assistance and separating children from their families, in 2008–2011 (during a year)

Indicator	2008	2009	2010	2011
TOTAL number of children registered	1,732	2,184	2,054	2,574
boys, %	53.2	54.7	54.2	56.6
girls, %	46.8	45.3	45.8	43.4
Registered 0-17 years of age children per children 10,000	69	88	83	105
TOTAL number of children separated from their families[1]	585	664	460	454
Number of children separated from their families of the number of registered children, %	33.8	30.4	22.4	17.6
Children from 0-17 years of age separated from their families per 10,000 children	23	27	19	18

[1] The number of children separated from their families during a year shows all children who have been separated from their family for a short or long time during the reference year (incl. children who have been sent back to their families and children who have been sent to substitution care).

Source: the Ministry of Social Affairs

Table 62: Child protection workers in county governments and local governments and the number of children per one child care worker, in 2008–2011 (during one year)

	2008	2009	2010	2011
TOTAL number of child protection workers	162	176	178	177
with professional training	129	140	139	145
children from 0-17 years of age per one child protection worker	1,535	1,403	1,382	1,391

Source: the Ministry of Social Affairs

The most important social services provided by local governments are domestic services and housing services. Those are services that local government may provide for an elderly

and / or disabled person in need of assistance to let the person live in his or her home as long as possible. At the same time, it shall be considered that only less than one fourth of the users of housing service are in retirement age and all the others are families in difficulties or persons who need housing for a period of life for different reasons. According to the statistics submitted by local governments a bit less than a half of housing service users have come from private dwellings. Young people who have left from substitute homes form a small part as they have to be guaranteed a dwelling by local governments of their former residence. The same goes to people who have been released from custodial institution and who have to be guaranteed a dwelling by local government of their former residence if necessary. The number of housing service users have increased by 1473 persons, i.e. 15% compared to 2008. The increase in the number of service users has been enabled by the increase of provision of social dwellings.

Although the number of local governments providing domestic service has been increased by 8 local governments compared to 2008, then the number of service users has decreased a little. At the same time, the number of persons using 24-hour care service is increasing. It is a situation when a social worker and a person in need of assistance and his or her family make the best choice for the person in need together, taking into account the health condition and necessities occur with the condition of the person, which could mean 24-hour care in a welfare institution.

In 2011, caregivers have been appointed to a disabled adult in 216 local governments (in 95% of all local governments). The number of persons receiving care has decreased compared to 2008. The main reason for this is the changes in collecting data (changeover to registry-based collecting), according to which records is kept only about those people receiving care for whose caregiver is paid benefit (earlier, the number of those persons under curatorship were shown in reports as well of whose caregivers did not receive any benefit).

Care for disabled children was passed on to local governments in 2009. The number of service users has not changed during those years and is still less than 1,100.

The number of persons using care service in a family is decreasing. If during 2008 there were 612 (605 of them were children) persons using the service in 144 local governments, then in 2011, 471 persons (462 of them were children) used the service in 98 local governments. Thus, 98-99% of the users of care service in a family are children. Looking at the children who have left the service by destination, positive changes have been made to

increase more secure living environment to a child. When in 2008, 92 children (i.e. 45%) of the 204 children that have left the service returned to their biological families, were sent to live with a guardian or were adopted and 26 children (12.7%) were sent to substitute home service, then in 2011, of 133 children who had left the service, 70 children (52.6%) returned to their biological families or were adopted and 35 children of those 70 children were adopted. Only 8 (6%) children were sent to a substitute home in 2011.

The number of adopted children has been varying in years by reaching 181 in 2008 and 124 in 2011.

The number of children adopted by a citizen of a foreign country has been 12-21% of all adopted children. If during 2008-2010 the number of children took under guardianship was quite stable by staying between 240-250, then in 2011 it fell to 177.

The services of support person and personal assistant are still in the development stage. In the middle of 2000's those services were starting to receive significantly more attention. The number of support person service users have been on the level of 800-900 persons during last three years, and the number personal assistant service users has been around 350-400. The number of local governments providing those services has increased in recent years forming 35% of local governments providing support person service and 22% of local governments providing personal assistant service in 2011.

Table 63: Number of persons using services provided by local governments by types of services, in 2008-2011 (during a year)

	2008	**2009**	**2010**	**2011**
Housing service	9,822	10,698	10,814	11,295
Domestic services	6,530	6,140	6,225	6,116
Care for disabled adult	21,079	18,324	14,611	13,518
Care for disabled children	...	1,023	1,025	1,087
Personal assistant service	401	356	344	387
Support person service	**458**[1]	916	798	831
Care in a family	612	534	520	471
Child care service[2]	655	926	1,218	1,405

[1] Families with children using support person not included.

[2] Number of children with severe or profound disability and without disability or with moderate disability that have received the service financed only by the state, only by local

government or both the state and a local government.

Source: The Ministry of Social Affairs

Table 64: Number of persons who have been cared by a family and number of families giving care, in 2008–2011 (by the end of a year)

	2008	2009	2010	2011
Total number of persons receiving care	408	385	356	334
children (0–17 years of age)[1]	401	377	352	329
adults (18 and more years of age)	7	8	4	5
Number of children receiving the service per 10,000 children from 0–17 years of age[1]	16	15	14	13
Total number of foster families	327	308	288	268
families giving care to children	322	301	284	263
families giving care to adults	5	7	4	5

[1] In the age group of service users from 0–17 years of age, children of 19 years of age who study in basic school, upper secondary school or vocational educational institution until the end of a school year are included.

Source: the Ministry of Social Affairs

Table 65: Adopted children and children taken under guardianship, in 2008–2011 (during a year)

	2008	2009	2010	2011
Total number of adopted children	181	126	131	124
number of children adopted by a citizen of a foreign country	28	24	28	15
Among adopted children				
boys, %	48.6	54.0	48.9	47.6
girls, %	51.4	46.0	51.1	52.4
Number of children taken under guardianship	250	251	242	177
boys, %	44.0	52.6	47.1	49.7
girls, %	56.0	47.4	52.9	50.3

Source: the Ministry of Social Affairs

Personnel providing social services and their qualification

By the end of 2011, a bit less than 5,900 persons worked in institutions providing social services. More than one third (34.7%) of the personnel were employees dealing with educational and development work and one fourth (23.5%) were caregivers and caretakers. 65% of the personnel including nurses and social workers was directly working with service users. Most of the personnel is women (a little less than 90%). A bit over one third (11.1%) of the employees are men and most of them are working among other personnel where the percentage of men is around 25% (do not work directly with service users).

In 2011, two thirds of all the employees (excl. economic, catering and cleaning personnel) had higher, secondary specialized or vocational education. Of such profession groups as psychologists, physiotherapists, occupational therapists, speech therapists, special education teachers and doctors, 93% of the employees had higher education. 75% of social workers and 67% of the administration had higher education. 62% of specialists conducting educational and development work had higher or secondary specialized and vocational education, and 29% had secondary education. Persons with secondary education are assistant educators of substitute home service or activity supervisors of special welfare service and most of them have passed in-service trainings on the bases of secondary education.

84% of the administration, 93% of psychologists, physiotherapists, occupational therapists, speech therapists, special education teachers and doctors, and 97% of nurses had education corresponding to their work. 66% of professionals conducting educational and development work and 36% of caregivers had education corresponding to their work.

According to § 11^{34} of the Social Welfare Act, special care services may be provided directly by a natural person (hereinafter activity supervisor), if the person has acquired state-recognised secondary specialized or higher education in social work, higher education in special needs or social education, higher education in occupational therapy, vocational secondary education in activity supervision or secondary specialized or higher education in mental health nursing or who has acquired at least secondary education and shall have undergone a 260-hour training in accordance with the plan established by the Minister of Social Affairs. According to the administrative provisions of the Social Welfare Act, the transitional period for meeting the requirements of training ends on the 31st of December, 2014, and until that time, service may be provided by any person who has registered for in-service training. A person working as an activity supervisor is not indicated as person having the corresponding education as long as he or she has not passed in-service training.

The following table gives an overview of institutions providing social services and the number of service users. The number service providers has increased in recent years regarding most services, only the number of substitute home service providers is smaller in 2011 than it was in 2008. The number of service users has increased in case of some services (for example housing service and homeless shelter service), but in some cases it decreased (for example substitute home service, day care service and shelter home service).

Table 66: Number institutions providing social services and number of service users, in 2008-2011

Type of service	Number of institutions (by the end of the year)				Number of service users (during the year)			
	2008	2009	2010	2011	2008	2009	2010	2011
Substitute home service[1]								
	35	36	37	33	1,698	1,509	1,419	1,435
Care for adults in social welfare institutions (excl special welfare services)								
	121	122	129	131	7,458	7,704	7,903	8,322
Special welfare services[2]								
	91	94	93	100	5,201	5,347	5,231	5,304
24-hour care service								
	28	31	33	34	2,583	2,739	2,760	2,782
Rehabilitation of persons with disability[3]								
	70	75	89	101	14,033	10,911	11,381	11,584
Rehabilitation service of adults with special psychological needs[3]								
	37	48	56	61	2,086	1,766	1,726	1,842
Rehabilitation service for children with special behavioural needs[3]								
	6	6	9	10	71	93	81	92
Day center service[4]								
	101	102	106	109	58,447	55,753	54,091	51,361
Housing service[5]								
	159	166	176	175	9,822	10,698	10,814	11,295
Shelter home service								
	32	39	38	33	3,280	2,986	3,229	3,079
Homeless shelter service								
	10	10	11	11	1,055	1,092	1,202	1,355

[1] Children who receive state welfare service and children with severe or profound disability who receive substitute home service on the basis of an application of a parent.

[2] Until 2008, it was called the welfare services for adults with special psychological needs.

[3] The basis for the data is the decisions of medical expert assessment departments of the Estonian National Social Insurance Board of providing a person a service, made based on the applications submitted by persons from 2006, and paying for the service within the limits of the respective year. A person might submit more than one application during the period. This is why the person might be reflected more than once.

[4] The number of persons using the service has been reflected once, irrespective of how many times and how many different services they used in this day centre.

[5] Number of local governments where housing service was provided in municipal or social dwellings pursuant to § 14 of the Social Welfare Act (i.e. in social apartments or dwellings).

Sources: the Ministry of Social Affairs, the Estonian National Social Insurance Board

The following table provides an overview of the number of employees of institutions providing social services and their profession. Hereby it should be noted that only employees of those institutions are indicated whose main activity is providing social welfare service. For example the personnel of hospitals is not reflected.

Table 27: Employees of institutions providing social services by profession, in 2008-2011 (by the end of a year)

Profession	2008	2009	2010	2011
TOTAL number of employees	5,711	5,806	5,804	5,863
Administration, managing and middle level specialists	664	696	665	669
Persons conducting educational and development work[1]	1,835	1,926	1,964	2,035
Social workers	172	178	165	174
Medical nurses	201	204	200	198
Caregivers, caretakers	1,375	1,369	1,388	1,380
Psychologists, physiotherapist, speech therapists, doctors, teachers	98	113	120	111
Other personnel (economc, catering, cleaning and other personnel)	1,366	1,329	1,302	1,296

[1] Educator, assistant educator, activity supervisor.

Source: the Ministry of Social Affairs

The Ministry of Social Affairs does not keep records of social work specialists working in local governments. However, the Ministry of Social Affairs conducted a survey during the second half of 2011, to get an overview of social work specialists working in local governments. Data was collected only about specialists conducting direct social work in local governments and thus the employees of institutions administered by local governments and home care workers. The main results of survey are indicated below.

The survey gave data about 720 specialists of social work. The scale of the name for a profession is very large in local governments, but the following group may be generally distinguished: child protection specialists, social work specialists (excl. child protection, heads of departments (divisions) and deputies. According to the survey research, the social workers could be divided according to such division as follows: 23% of the total number of social workers was child protection specialists, 66% of the total number of social workers were social work specialists and 10% of the total number of social workers were heads of departments (divisions) and deputies. The following table gives more specific overview.

Table 68: Specialists conducting social work of local governments by profession*, in 2011*

Name of profession	Number of employees	Percentage, %
Child protection specialists[1]	163	22.6
Specialists of social work	472	65.6
Heads of social departments (divisions) and deputies	73	10.1
Other[1]	12	1.7
TOTAL	720	100

[1] Secretary of juvenile committee, information secretary, assistant adviser, regstrar.

Source: the Ministry of Social Affairs

The data indicated by local governments show that social workers have quite long lengths of service in working in their field. More than two thirds of social workers have worked in the field at least 6 years. 23% of workers have 16 and more years of experience in working in social field. Average estimated time of working in social field is 10 years.

To look the social workers working in local governments by the year of receiving their education, then 37% of the social workers have graduated during 6 recent years. 64% of the social workers have graduated from school during 11 recent years.

Of 720 persons conducting social work, 426 i.e. 58% of them have participated in long in-service trainings i.e. at least 40 hours long trainings. The indicated data shows that persons that have not participated in such in-service training have education in social work and it has been received in recent years. There variety of themes of in-service training is very large and most of them are related to social work in general, for example social work in rural municipality and in town, legal order of social work and practical social work, case-by-case social work. Other themes of popular in-service trainings have been trainings for assessment of need for care, debt counselling trainings and child protection trainings.

Table 69: Employees of institutions[1] providing social services by profession and sex (by the end of a year)

	2008	2009	2010	2011
Total of employees	5,711	5,806	5,804	5,863
men, %	11.3	11.5	11.5	11.1
women, %	88.7	88.5	88.5	88.9
Administration, managing and middle level specialists	664	696	665	669
men, %	16.7	15.7	15.3	15.4
women, %	83.3	84.3	84.7	84.6
Persons conducting educational and development work[2]	1,835	1,926	1,964	2,035
men, %	8.2	8.6	12.6	7.8
women, %	91.8	91.4	87.4	92.2
Social workers	172	178	165	174
men, %	4.7	5.1	4.8	2.3
women, %	95.3	94.9	95.1	97.7
Medical nurses	201	204	200	198
men, %	2.0	1.5	1.5	2.0
women, %	98.0	98.5	98.5	98.0
Caregivers, caretakers	1,375	1,369	1,388	1,380
men, %	3.3	3.9	4.5	4.4
women, %	96.7	96.1	95.5	95.6
Psychologists, physiotherapist, speech therapists, doctors, teachers	98	113	120	111
men, %	12.2	12.4	12.5	11.7
women, %	87.8	87.6	87.5	88.3
Other personnel (economc, catering, cleaning and other personnel)	1,366	1,329	1,302	1,296
men, %	23.2	23.8	24.6	23.6
women, %	76.8	76.2	75.4	76.4

[1] The table shows the number of employees of institutions whose main activity is providing welfare service. If the main activity of an institution is not providing social services (for example hospitals), then there is no data of such institutions.

[2] Educator, assistant educator, activity supervisor, hobby coordinator.

Source: The Ministry of Social Affairs

Table 70: Employees by the level of education (in per cents of respective category of employees) (by the end of 2011)

	TOTAL	Level of education				
		Higher education	Secondary specialized and vocational education	Secondary education (education of upper secondary school)	Basic education	Without basic education
Administration	100	67.4	26.5	5.8	0.3	0.0
Managing and middle level specialists	100	46.5	40.6	12.3	0.6	0.0
Persons conducting educational and development work (senior educator, educator, junior educator, assistant educator; activity supervisor, hobby coordinator)	100	26.7	35.6	28.8	8.5	0.3
Nurse	100	12.6	87.4	0.0	0.0	0.0
Social worker	100	74.7	20.7	4.6	0.0	0.0
Caregiver, caretaker / care nurse	100	7.0	43.7	35.7	12.7	0.9
Psychologist, vocational expert, physiotherapist, occupational therapist, speech therapist, special education teacher,	100	92.8	5.4	1.8	0.0	0.0

teacher, doctor						
TOTAL	100	28.0	38.7	25.2	7.7	0.4

Source: the Ministry of Social Affairs

Table 71: Number of employees with education corresponding to their profession, in 2011 (by the end of the reference year)

	2011
Administration	84.3
Managing and middle level specialists	68.6
Persons conducting educational and development work (senior educator, educator, junior educator, assistant educator; activity supervisor, hobby coordinator)	66.1
Nurse[1]	97.0
Social worker	86.2
Caregiver, caretaker / care nurse	35.7
Psychologist, vocational expert, physiotherapist, occupational therapist, speech therapist, special education teacher, teacher, doctor	92.8
TOTAL	61.2

[1] Employees of a medical assistant profession that have passed in-service training and that rather perform the tasks of care nurse.

Source: the Ministry of Social Affairs

In addition to the data indicated above, the following table shows the data of the providers of open care service organized by local governments.

According to the statistics, more than 1,500 persons or families (care in family) provide open care service. The most services are provided by home service providers. As the number of persons receiving the service has decreased, then the number of social caregivers providing the service has decreased as well. The number of care families has decreased as well. 80% of the home service providers and care family service providers have passed relevant training.

Table 72: Number of non-institutional service providers and their qualification, in 2008-2011 (by the end of a year)

Type of service	2008	2009	2010	2011
Home services (by the end of the year)	705	684	670	663
with respective education (social caregivers) or having passed respective training	524	519	521	536
of the number of service providers, %	74,3	75.9	77.8	80.8
Personal assistant service (during the year)	357	345	354	388
having passed personal assistant training	19	8	55	53
of the number of service providers, %	5.3	2.3	15.5	13.8
Support person service (during the year)	249	274	276	291
having passed support person training	100	183	177	158
of the number of service providers, %	40.2	66.8	64.1	54.3
Care in family (number of care families)[1]	327	308	289	268
number of care families, which have passed PRIDE training or training supporting care	208	241	231	193
of the number of service providers, %	63.6	78.2	79.9	72.0
Child care service (number of childcarers)[1],[2]	376	476	566	...

[1] By the end of the year.

[2] Childcarers have all passed training and they have respective activity licence.

Source: the Ministry of Social Affairs

in 2011, there were 720 social work specialists in local governments.

The results of the level of education of social workers are positive in every way. 78% of the total number of social workers have higher education and a bit less than half of them (48%) have academic higher education, 27% have professional higher education and 3% have vocational education. 433 employees i.e. 60% of all employees had education in social work. 64% of the employees with academic education and 89% of the employees with professional higher education had education in social work.

Table 73: Social workers by level of education[2] and education in social work, in 2011

	TOTAL number of social workers	of the total number of social workers, %	TOTAL number of social workers with the education in social work[1]	Number of social workers with the education in social work of the total number of social workers, %
Higher education	564	78.3	419	74.3
academic higher education (received from a university)	344	47.8	221	64.2
professional higher education	197	27.4	175	88.8
higher vocational education	23	3.2	23	100
Vocational secondary education	8	1	4[1]	50.0
Vocational education (incl. on the basis of secondary education)	5	0.8	2[1]	40.0
Secondary specialized education	82	11.4	8	0
Secondary education (general secondary education)	59	8.2	0	0
No data	2	0.3	0	0
TOTAL	720	100	433	60.1

[1] Incl. education in social care.

[2] The provided division does not totally comply with the division of education levels provided by the Education Act.

Source: the Ministry of Social Affairs

Work on reforming the 1995 Social Welfare Act began during the reference period with a view to improving the provision and quality of social services. The Committee asks to be informed of all reforms.

Expenses on providing social services and sources of financing, 2008-2011

In 2011, around 116 million euros were spent on provision of social services, of which the state covered 41%, i.e. a bit more than 47 million euros. Local governments paid 31% and service users covered 27% of expenses on provision of social services.

Compared to 2008, the percentages of financing have changed – the percentage of local governments has decreased by 6.5 percentage points and the percentage of service users and the state has increased by 4.6 and 1.5 percentage points respectively. The highest growth in the expenses by the state could be observed with appliances provided at a discount and rehabilitation service for disabled children. Compared to 2008, the state allocated 2.9 million euros (79%) more money on appliances provided at a discount and 3.2. million euros (2.2 times) more money on the rehabilitation of disables persons. The increase of the percentage of co-payment by service users is mostly influenced by the constant increase of 24-hour care service users and the increase of the percentage of them in financing. The co-payment of persons have increased 1.7 times in 2011 compared to 2008 reaching 22.4 million euros. The expenses made on that service are the highest, constituting 29.5% of the expenses on provision of social services of the year in question.

The following table provides an overview of social services and donors of the services.

Table 74*:* Expenses on social services and financing in 2008-2011

Type of service / year	Number of service users (during the year)	Total amount of expenses (thousand euros)	Donor of expenses, %			
			persons	local government	state	other sources
TOTAL						
2008	..	110,808.3	22.5	37.6	39.2	0.7
2009	..	113,419.9	24.7	36.4	38.2	0.8
2010	..	112,029.6	26.1	32.5	40.3	1.1
2011		115,871.8	27.1	31.1	40.7	1.1
Care for orphans and children without parental care in welfare institutions (substitute home service)						
2008	1,698	13,432.2	0.1	8.6	88.7	2.5
2009	1,509	12,619.9	0.3	7.5	89.3	2.9
2010	1,419	13,566.6	0.1	5.0	91.7	3.1
2011	1,367	12,341.8	0.1	6.2	90.1	3.6
Welfare services of children with severe or profound disability receiving substitute home service on the basis of an application of a parent (substitute home service)						
2008	93	658.0	10.3	28.3	609	0.5
2009	83	524.8	10.3	28.3	60.9	0.5
2010	77	691.0	5.9	15.5	78.6	0.0
2011	68	419.8	6.8	31.0	62.2	0.0
Care for adults on welfare institutions (excl. special welfare services)						
2008	7,458	28,880.2	60.7	38.2	0.8	0.3
2009	7,704	31,610.5	63.4	35.5	0.7	0.4
2010	7,903	32,678.6	64.9	34.0	0.6	0.5
2011	8,322	34,211.9	65.6	33.4	0.6	0.4
Special welfare services[2]						
2008	5,921	21,320.7	22.0	8.9	68.8	0.3
2009	6,255	22,084.6	22.9	8.4	68.4	0.3
2010	6,027	22,246.3	23.0	7.9	68.7	0.4
2011	6,043	22,998.6	23.4	8.3	67.7	0.5
Rehabilitation service of disabled persons						
2008	14,033	4,626.6	...	...	100.0	...

2009	10,911	4,226.2	..	...	100.0	..
2010	11,381	4,391.6	...	...	100.0	..
2011	11,584	5,823.9	...	...	100.0	..
Rehabilitation service of adults with special psychological needs						
2008[3]	2,086	1,105.5	...	...	100.0	...
2009[3]	1,766	873.1	...	...	100.0	...
2010	1,726	789.6	...	...	100.0	...
2011	1,842	1,137.8	...	...	100.0	...
Rehabilitation service of children with special behavioural needs						
2008	71	38.6	...	...	100.0	...
2009	93	73.6	...	...	100.0	...
2010	81	63.5	...	...	100.0	...
2011	92	83.0	...	...	100	...
Prosthetic, orthopaedic and other appliances						
2008	0,820	7,153.0	28.3	–	71.7	–
2009	48,952	7,395.6	28.3	–	71.7	–
2010	50,796	7,433.1	28.4	–	71.6	–
2011	57,760	9,256.6	28.8	–	71.2	0
Shelter home service						
2008	3,280	3,685.8	2.1	91.5	4.3	2.0
2009	2,986	3,946.9	2.6	90.8	3.3	3.3
2010	3,229	3,992.9	3.9	88.6	2.8	4.6
2011	3,079	4,427.4	4.2	86.7	5.0	4.1
Household service						
2008	9,822	2,836.0	…	97.1	2.9	…

2009	10,698	2,458.8	…	98.5	1.5	…
2010	10,814	1,519.6	...	97.0	2.8	0.2
2011	11,295	1,678.6	...	97.1	1.3	1.7
Day centre services						
2008	58,447	5,743.6	7.1	86.3	4.1	2.4
2009	55,753	5,450.3	8.5	86.2	2.4	2.9
2010	54,091	4,513.0	9.6	81.7	1.9	6.9
2011	51,361	4,537.5	10.1	82.6	2.2	5,1
Domestic service						
2008	6,530	4,823.6	1.7	97.7	0.5	0.0
2009	6,140	4,744.0	1.9	98.0	0.1	0.0
2010	6,225	4,368.8	2.8	97.2	0.0	…
2011	6,116	4,546.7	3.2	96.6	0.2	0.1
Homeless shelter service						
2008	1,055	521.8	0.9	99.1	–	...
2009	1,092	521.3	0.5	99.3	–	0.2
2010	1,202	501.2	0.7	98.8	–	0.5
2011	1,355	476.3	1.4	98.4	0	0.1
Care in family						
2008	612	1,203.4	0.1	5.5	93.2	1.2
2009	527	1,049.1	0.1	4.2	94.7	1.0
2010	519	1,022.4	0.1	2.1	94.5	3.3
2011	471	1,075.0	0.3	5.9	87.6	6.2
Guardianship						
2008	1,794	3,700.3	–	–	100.0	–
2009	1,640	3,706.8	–	–	100.0	–
2010	1,595	3,791.4	–	–	100.0	–
2011	1,525	3,827.3	–	–	100.0	–
Welfare of disabled adults[4]						
2008	21,079	10,215.7	–	100.0	–	–
2009	18,324	9,836.9	–	100.0	–	–
2010	14,611	7,797.8	–	100.0	–	–

2011	13,518	5,806.5	–	100.0	–	–
Welfare of disabled children[4]						
2009	1,023	779.8	–	–	100.0	–
2010	1,025	882.7	–	–	100.0	–
2011	1,087	975.8	–	–	100.0	–
Child care service						
2009	926	841.0	…	84.0	16.0	–
2010	1,218	1,017.2	…	81.4	18.6	–
2011	1,405	1,363.6	…	85.4	14.6	–
Personal assistant service						
2008	401	475.7	2.7	80.9	16.4	…
2009	356	445.2	4.8	89.5	5.6	0.1
2010	344	493.5	4.1	91.6	3.5	0.8
2011	387	505.7	4.2	84.6	10.0	1.2
Support person service[5]						
2008	774	387.6	…	90.2	7.2	2.7
2009	916	290.0	0.1	76.4	21.7	1.8
2010	798	268.8	0.5	85.6	10.3	3.7
2011	831	378.0	0.7	65.8	7.9	25.6

[1] Expenses directly related to provision of service and recovery of expenses.

[2] Until 2008, it was called the welfare services for adults with special psychological needs. The number of service users show the whole number of users of different types of welfare services (24-hour services and support services), not the single number of service users.

[3] From 2006, the basis for the statistics is the decisions of medical expert assessment departments of the Estonian National Social Insurance Board of providing a person a service, made based on the applications submitted by persons, and paying for the service within the limits of the respective year. A person might submit more than one application during the period.

[4] The number of service users as of the end of the year. The expenses of 2010 and 2011 only include support for caregivers for caring for a disabled person and social tax paid for caregivers.

[5] Up to 2008, The number of service users (during one year) includes persons and families, depending on the target group of the service, in 2009 it only includes persons. The indicator published in previous collections reflected both the number of support person service users and expenses and the users of service of sending a child being in a substitute home temporarily to a family and expenses.

Sources: the Ministry of Social Affairs, the Estonian National Social Insurance Board

Services provided by the local authorities are all free except for institutional care.

Social Welfare Act (hereinafter SWA) § 45 (1) states that a person may be charged a fee for social services provided to the person or his or her family. A fee charged for a service depends on the extent and cost of the service and the financial situation of the person and family receiving the service. The charging of a fee from a person for social services shall be decided by the authority which provides or pays for the service.

Currently, each local authority decides independently, whether and how individual or family financial situation is taken into account when charging fees for social services. Therefore, in Estonia the practice of charging for social services varies from one local government to another. The terms and conditions of charging fees are specified by a local government according to local government legislation. In 2011, Praxis Center for Policy Studies Foundation and TNS Emor conducted a study which revealed that the needs of a person are considered by case basis - each case is reviewed individually, searching for the best solution at optimal cost. Thus it can be said that although general rules are defined by local government legislation, in practice the services are provided mostly by case basis. Thus it can be said that although the general rules are defined by local government legislation, in practice the provision of services occurs mostly case by case basis. The charging practices largely depend on the specifics of services. The more common the service and the greater the number of persons in need of that service, the more likely that the provision of that service is governed by legislation, which means that the case by case approach is less common. However, the more a service required consideration of the specific needs of those who need it, the less there are those who need the service, the more often case-by-case or softer approach is used. The service specifics will definitively determine the fee - in case of long term services with clearly developed content, such as general care homes, child care require periodic fees, short-term services with varying content (domestic services, personal assistance service) require a fixed or unit-based fee. The charging practice also depends on

whether and in what form the local government provides the service - whether they provide it themselves, buy it in as needed or delegate it to the third sector.

As a rule, all the local governments offer general care services and many of them also have housing services for a charge. Many services have established a symbolic fee to emphasize the contribution of those in need in the payment of these services. 24-h care has the highest personal cost-sharing rate. In 2011, the personal cost-sharing amounted to 65.6% of the total costs of the services.

The local authorities often use local legislation to determine the extent of free service. Recipient co-payments are required in its excess. This is often the case in provision of domestic and social transport service. In many local municipalities, the cost-sharing for personal assistance will increase proportionally on hourly basis.

Social Welfare Act § 45 states that cost-sharing fee may be charged for social services. Cost-sharing fee charged depends on the extent and cost of the service and the financial situation of the person and family receiving the service.

In case of estimated need for service, the extent of cost-sharing may not be an obstacle in the receipt of service, i.e. person's need for assistance must be met regardless of their financial situation. If a person's financial situation does not allow for charging for social services, such services must be provided for free.

As to quality control, there are specific safety and hygiene regulations for each type of service, particularly for children's homes. Responsibility for checking the quality of services lies with the County Governor. Quality control of social rehabilitation services is carried out by a social affairs committee in co-operation with the County Governor. Fines may also be imposed on these services where there are clear breaches. The Committee asks whether there are regular inspections.

The social services quality control is described in previous Estonian report on this article. There have been no significant legislative changes in the organization of supervision since then. The Social Welfare Act tasks the county governor with the duty to monitor the quality of social services provided in their administrative jurisdiction. The quality of social services is primarily assessed in terms of legislative requirements for service providers, personnel and premises where social services are provided. According to the Social Welfare Act, the county

governor must submit their monitoring report to the Government at least once a year. In case of violations, the county governor has the right to impose sanctions from precept and suspension of permit to the claim of penalty payment. (For details, see Estonia - Annual Report 2008). If necessary, the Ministry of Social Affairs has used additional letter to request county governors' supervision, for example in 2012, a request to carry out monitoring of foster care service was made. Rehabilitation service and services provided for people with special psychiatric needs are supervised by the Social Insurance Board. Supervisory official posts have been established with the Social Insurance Board. Supervisory official supervises institutions in accordance with annually approved work plan, and carries out additional inspections based on complaints.

Monitoring arrangements are not fixed by law, which is why each county governor will decide by themselves, whom, where and how to inspect. Therefore, the county supervision practices vary somewhat. The Social Welfare Department of the Ministry of Social Affairs has developed voluntary guidelines and forms for better organization of supervision. Guidelines and forms are available on the Ministry's website (http://www.sm.ee/tegevus/sotsiaalhoolekanne/sotsiaalteenuste-jarelevalve.html).

Supervision is either routine or extraordinary. Extraordinary supervision is performed as needed. County governor may initiate supervision procedure on the basis of a complaint, but they also have the right to initiate a supervision procedure in cases where a complaint has not been submitted. If challenge proceedings result in precepts to social service providers, it will be followed up by an inspection.

The practice of routine supervision varies by county depending mainly on the means of county governments (personnel load, financial resources).

Document based checks are carried out for child-care and foster care service providers when activity permits are issued and for technical aid service providers on conclusion of contracts. Childcare and foster home service providers are required to notify county government of any changes in the conditions of service provision or in personnel, in compliance with the requirements set out in the Social Welfare Act. Document based checks on technical aid service (based on submitted invoices) are generally performed on monthly basis.

In general, comprehensive supervisory procedures are performed once a year, based on priorities set. The objects of and the time periods for routine supervision are generally set in the surveillance plan. The Ministry's voluntary guideline provides routine supervision in 3 years at all the county administrative area care providers. Many county governments follow

this recommendation. If the supervision proceedings result in precepts for the service provider, a a posteriori control will follow.

Article 14 § 2 - Public participation in the establishment and maintenance of social welfare services

1) Please describe the general legal framework. Please specify the nature of, reasons for and extent of any reforms.

In last report, Estonia gave a comprehensive overview of the principles of free sector involvement. Volunteer work in social welfare (except victim support service, of which Estonia gave a comprehensive overview in previous report) is not regulated at the legislative level.

Involvement of civil society is guided from the good practice of involvement approved by the Government on 29.12.2011, involvement handbook for officials and non-governmental organizations and from the Ministry of Social Affairs civil society development plan 2011-2014.

The good practice of involvement highlights the importance of involving interest groups and public in decision-making on topics that involve them, to ensure the best possible quality and legitimacy of decisions. The good practice of involvement sets the general principles for involvement and explains the principles for interest group and public involvement, provides the requirements for planning the involvement of ministries and for informing of involvement options, for clarifying the involvement process to interest groups, for using various communication channels, for providing feedback and informing of results and for evaluation involvement process.

Involvement handbook for officials and non-governmental organizations was developed in 2009. Handbook is intended to support decision-makers in the making of various decisions, design of new services or products and for implementation of other projects. Involvement handbook explains the theoretical background of involvement and, using practical examples, provides recommendations on how to successfully carry out the involvement process from start to end.

The objective of the Civil Society Development Plan 2011-2014 is to ensure favourable conditions for civic engagement, the organization of civil society and the strengthening of the partnership between participants in the civic education, organization of civil society and initiative and the creation of networking, charity and philanthropy, involvement, strengthening

citizens' associations as partners in provision of public services, financing of citizens' associations from state budget and organization of statistics and research information needed to assess the development of civil society. In the framework of Development Plan, a number of activities are carried out to strengthen the above-mentioned areas, for example in social field:

- training and counselling for social care professionals on the further use of civic education opportunities for the prevention of exclusion and the improvement of individual and family coping options

- using legal perspective to analyze the trends in recent years, such as the provision of public services by citizens' associations, those involved in social enterprises or community service provision, charitable associations and their operation

- analysis of needs and opportunities and planning for further development of activity and collaboration capabilities of citizens' associations and participation in social processes

In addition to areas with greater experience, the local governments also hold and interest in transfer of public services in the areas where the citizens' associations are not yet seen quite as capable: social services, hobby education, crime prevention and upkeep. These estimates also refer to necessary development activities - first areas require primarily guidelines and systematic support materials. At the same time, local government feel the need for stronger governmental regulation.

For addition. In December 13, 2012 the Government approved Impact Assessment Methodology, which explains how to follow in practice the requirements set in both policy developments approved by the Riigikogu up to 2018 and the Rules and Regulations for Good Legislative Drafting approved by the Government. In addition to the above, the Government is currently developing instructional materials for development plan writers with the focus on five priority areas and including specific guidance on how to assess the impact of development plan in progress in these areas.

2) Please indicate the measures taken (administrative arrangements, programmes, action plans, projects, etc.) to implement the legal framework.

Ministry of Internal Affairs is responsible for the development of the third sector in Estonia. In 10.07.2010, the Government took note of the concept Contracting-Out of Public Services to Non-Profit Organizations, which is aimed at unifying common principles for service delivery. The concept aims to improve the quality and accessibility of services and to contribute to the capabilities of both local governments and service providers. According to the Ministry of Internal Affairs, nearly 60% of local governments delegate the provision of public services to private or third sector. Delegation is most prevalent in social (44%), sports (15%) and culture (10%) areas.

This concept aims to promote and unify both the delegation principles from local governments to NGOs and to agree on the general coordination of development activities for NGOs. In addition, this is used in the implementation of plans developed by ministries and in the development of guidelines and instructional materials for the delegation of public services by local governments.

The objective of delegation is to improve the quality and accessibility of service and to increase the general capacity needed for the provision of public service. To improve the delegation of services, the Ministry of Internal Affairs developed instructions, which were used, for example, in the preparation of indicative guidance on the social services in local governments, completed in 2011 (see this article § 1 (2)).

Estonia provided a detailed overview of the involvement of NGOs (including the principles, major processes (information days, seminars, conferences, discussions), work groups, committees, etc), were provided in the previous report (see article 14 §2 question 2).

In addition to existing committee on the policy for the elderly, a body for co-operation including representatives of ministries and the representative organizations of persons with disabilities was formed in March 2012. The main task of the body of cooperation is to ensure a consistent and mutual exchange of information and effective collaboration between the ministries and the representative organizations of people with disabilities. For example, the body for co-operation has to express opinions and make recommendations to the Government to protect the interests and needs of people with disabilities and to be involved in the decision and policy-making and legislative drafting processes in various areas.

The social area supports the free sector in the provision of services primarily through projects with open calls for application, funded by Gambling Tax Council and the European Social Fund.

Gambling Tax Council supports both major projects (annual projects) and small projects (can be submitted each month) in the fields of social welfare, family, elderly and disabled.

The open calls for applications in Measures Supporting the Employment by the European Social Fund have supported projects which reduce the social welfare burden and support the employment of working-age people in developing services such as:

- development and provision of care services directed to elderly, disabled or suffering from dementia (day and home care services), provision of personal assistance services for people with disabilities

- compensation of child care costs for families with social or economic problems or with disabled child and the development and provision of child care and monitoring services

- development and provision of counselling services

- provision of support person services for persons of working age 15-64 (incl.) who need help due to disability, illness or situation which greatly complicates their daily coping, or for persons leaving foster home or released from custody.

3) Please provide pertinent figures, statistics or any other relevant information to demonstrate the participation of the voluntary sector to the provision of social services, as well as the effective access of individuals to these services.

The number of non-governmental organizations among service providers has stayed around 80-90 constituting around a quarter of all service providers.

Table 75: Participation of non-governmental organizations in providing social services, in 2008–2011 (by the end of a year)

	2008	2009	2010	2011
Total number of institutions providing service[1]	321	328	341	345
number of NGOs of them	80	85	90	90
Percentage of NGOs of all service providers, %	24.9	25.9	26.4	26.1

[1] Institutions providing rehabilitation service is excluded. As the provision of rehabilitation service is organized by Estonian National Social Insurance Board and as the service providers are mainly institutions of health field, then those institutions are not reflected by this table. According to the submitted data, 26 NGOs provided rehabilitation service (26.5%) out of 98 institutions in 2011.

Source: The Ministry of Social Affairs, the Estonian National Social Insurance Board of the data about institutions providing rehabilitation service.

According to the report, there are no official statistics on the participation of the civil society in the provision of social services neither in voluntary work. The Committee asks the next report to provide for information on this point.

Voluntary workers contribute a lot to provision of social services, around three fourths of them participate in provision of day centre services. Although the number of volunteers changes during years, then the total number of volunteers has increased during 4 recent years reaching 600 in 2011.

Table 76: Participation of volunteers in providing social services, in 2008-2011 (during a year)

Type of service	Number of volunteers			
	2008	2009	2010	2011
Shelter home service	51	27	34	91
Homeless shelter service	0	1	0	0
Day center services	384	409	443	451
Support person service	60	50	36	61
incl. haing passed training of support person	36	41	19	47
TOTAL	495	487	513	603

Source: the Ministry of Social Affairs

As to the involvement of civil society in framing social services policy, voluntary organisations co-operate with authorities, in particular for the preparation of laws and statutory amendments but also for development strategies and guidelines. This is for example the case in the ongoing reform of the Social Welfare Act. The Committee asks the next report to provide for information on the achievement of the legislative process.

The Social Welfare Act does not include provisions on the volunteer work in social welfare area. Requirements to victim support volunteers are included in the previous report by Estonia.