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EUROPEAN SOCIAL CHARTER

14th National Report on the implementation of the European Social Charter

submitted by

THE GOVERNMENT OF ESTONIA

Articles 3, 11, 12, 13, 14 and 30

for the period 01/01/2012 - 31/12/2015

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EUROPEAN SOCIAL CHARTER

(REVISED)

14th Report of the Republic of Estonia on the Accepted Provisions

For the reference period 2012-2015

Articles 3, 11, 12, 13, 14, 30

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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.

Developments in the national policy

During the period 2012 - 2015 the national policy on occupational health and safety was based on the following strategic documents:

Occupational Health and Safety Strategy for 2010-2013.

According to Action Plan of Health and Safety Strategy, the relevant fields of activity, goals and some of the results achieved in 2012-2015 are presented subsequently:

Field of Activity	Goal	Result
Legal environment	The legislative framework of OHS issues is up to date and effective	Ongoing work
	Employers have access to well functioning tools that help to comply with legislation	An electronic tool named Tööbik www.toobik.ee was elaborated in 2011-2015. It is designed for small and medium-sized enterpises (SME-s) and enables to conduct the risk assessment easier and manage good working environment.
Awareness raising	Awareness of different stakeholders has increased	Ministry of Social Affairs (MoSA) has drawn up 36 instructions on work environment for different fields of activity, such as commerce, office work, construction work, etc. The instructions provide descriptions of sector-specific problems and their solutions, as well as general aspects of work environment and performance of risk assessment. The Labour Inspectorate has over the years published tens of brochures and leaflets about the work environment issues for different target groups and sectors. Materials can be found here

		http://www.ti.ee/est/meedia-truekised-statistika/teavitustegevus/truekised/ The Working Life Portal www.tooelu.ee comprises information on work environment and risk assessment. The handbook for students – „Occupational Health and Safety Guide for vocational schools“ – was published in 2012. It provides an overview of the working environment and the health risks prevention methods for young person who enteres into worklife.
Well functioning OHS networks		Estonia is a member of The Baltic Sea OSH Network and The European Network for Workplace Health Promotion. In the begining of 2015 there were more than 250 members/enterprises who belonged to Estonian branch of this network, named TET Network. Health-promoting work main lines of action are: • the physical, mental and social improvement of the working environment • promoting employee health • development of the organization as a whole • place-health support for cooperation • social responsibility sharing TET Network supports organizations working environment, development and health of workers at raising awareness and bringing together the various agencies and organizations of professionals to share best practices.
Training of personnel, who shall ensure a good working environment at the workplace, and OSH service`s specialists	Training of work environment specialists	The Labour Inspectorate has organized trainings on health and safety at work for representatives of SME-s and for work environment specialists. These training programs were financed by the European Social Fund and they were free for the participants. During the years 2009-2014, 3656 work environment specialists and representatives of SME-s attended the training courses. In addition Labour Inspectorate has carried out different seminars and inforamation

		days on work environmental issues, where has participated over 14 000 people.
	in-service training of occupational health specialists	In the years of 2012-2014 the Ministry of Social Affairs carried out the several training courses to the occupational health specialists. For example: Electromagnetic fields in the working environment, 2012; Chemical risks in the working environment, 2012; Psychosocial risks in the working environment, 2012; Indoor climate in the workplace, 2013; Radiations in the working environment, 2013; Protection of upper respiratory, 2013; Nanoparticles in the working environment, 2014; The usage of individual protective devices, 2014.
Development of occupational health services	The qualification requirements of OHS specialists are clear	Under the leadership of the Estonian Vocational Chamber the professional standards for occupational health services providers – ergonomists, work hygienists and work psychologists – have been composed during 2012-2013. The specialists from Tartu University, Tallinn Technical University, Estonian University of Life Sciences and from the MoSA`s working life development department were taking part in this work.
New risks in work environment are well managed		On 1 April 2016, the new Government of the Republic regulation of electromagnetic fields in the workplace entered into force. A lot of training activities are carried out during 2016 concerning the implementation of this regulation by different parties - as labour inspectors, who carry out surveillance of the working environment, as well as occupational health physicians, who make medical surveillance of workers. Training also provides for employers and work environment specialists, who are present in the working

		environment with stronger electromagnetic fields.
Services providing measurements of parameters of risk factors in work environment are well accessible to employers		Activities have been started to make measurements of parameters of risk factors in the working environment easier and cheaper for the employer. According to the new regulation of the electromagnetic fields at the workpace, the employer is not obliged to order the electromagnetic field measurements only from the accredited analytical laboratory, but may also use the person who complies with the measurement requirements to ensure the value of the trust.

National Health Plan 2009-2020.

The goals and actions in the field of occupational health and safety are described in the The National Health Plan at the present time. This plan has been reviewed and modified annually. For example, the priorities for 2016 are:

1) arragement of the campaigns on occupational health and safety at work;

2) collection and transfer of best OHS practices;

3) organization of the vocational trainings to occupational health specialists;

4) raising the quality of the assessment of work related health risks;

5) development of cooperation between the various disciplines of the health care providers in order to ensure the prevention of diseases and effective treatment;

6) strengthening the supervision of the work environment by raising efficiency and effectiveness of the Labour Inspectorate.

Welfare Development Plan 2016–2023

Today and in the future occupational health and safety activities will be regulated in the Welfare Development Plan. The Welfare Development Plan focuses on the strategic objectives of labour market, social protection, gender equality, and equal treatment policies for 2016–2023.

The motivation and capability of people to remain active in the labour market depend on the quality of working life and the impact of working conditions on people's health and work ability. Therefore, the priority of the Development Plan is to support participation in the workforce and

a long-term working life. One of the main objective of the Welfare Development Plan is high employment rate and a high-quality working life. The related sub-obejective is: “Correlation between the demand and supply of the workforce ensures a high level of employment, and high-quality working conditions support long-term participation in working life”. This sub-objective also covers all the relevant occupational health and safety policy instruments.

According to the Welfare Development Plan the main policy instruments related to occupational health and safey are:

1) the capacity of working life participants must be increased for the implementation of rules for working environment, including for coping with new working environment risks, and for the prevention of the employee’s loss of ability to work;

2) the monitoring of the work environments shall be enhanced to identify and eliminate violations related to the work environment;

3) the legal framework regulating the working environment must be made clearer and compatible with the changing labour market situation and economy;

4) monitoring, outreach, and counselling activities must be made more efficient;

5) employers must be supported in improving working environments and conditions and in preventing employees’ loss of work ability, including reducing the employer’s occupational health and safety management burden;

6) greater attention shall be paid to shaping the work safety culture for the participants in working life, including compiling a risk analysis, assessment of new risks, and to the safety in using flexible forms of work;

7) the possibility of developing a compensation system for an incapacity for work shall be analysed to motivate preventing work interruptions and to encourage returning to work, including analysing the principles of the occupational health system and for compensating incapacity for work due to the employee’s health damage in order to enable early intervention.

EU Strategic Framework on Health and Safety at Work 2014-2020

According to the EU strategy Estonia has to take into account the following objectives in designing OSH policy and relevant legislation:

1) facilitate compliance with OSH legislation, particularly by micro and small enterprises;
2) better enforcement of OSH legislation;

3) simplify existing OSH legislation and eliminate unnecessary administrative burden;

4) take into account the ageing of the workforce, emerging new risks, prevention of work-related and occupational diseases;

5) collect reliable statistical data on work-related accidents and diseases, occupational exposures, work-related ill-health, and to analyse the costs and benefits in this area.

The report 2009-2011 states that educational institutions participate in implementing the Strategy for 2010- 2013.

The Committee asks that the next report give concrete examples of the State's involvement in knowledge activities (analysis of sectorial risks, elaborate standards, issue guidelines) and of the design of certification schemes and training modules (how to work, how to minimise risks for oneself or others.

Answer

All kind of activities toward to the raising awareness of a healthy working environment is very important and are continuously in progress. Some examples:

1) OSH training in different school levels

The training curricula of vocational schools for all studies includes modules of learning on occupational health, work- and environmental safety and corresponding assessment criteria. As a result of studies, the student should know the primary health and safety rules and be able to link them to his/her choice of specialty. Basic and secondary schools concerning occupational safety and health issues as optional. However, one of the independently compiled reseach project shall focus on health and safety at work.

2) Training of working environment specialists, who are responsible for the health and safety at the workpkace. *Look the table of the Occupational Health and Safety Strategy 2010-2013 (above).*

3) Training of health and safety representatives at the workplace.

According to the Minister of Social Affairs decree „Procedure for Training and In-service Training regarding Occupational Health and Safety" the training of working environment represenatatives, working environment council members and persons holding first aid at the

workplace may be provided only by the training institutions registered in the Ministry of Social Affairs. As of 2016, the registered number of training institutions in this area was 130.

4) Vocational training of occupational health specialists in the universities.

Estonian universities educate consistently the occupational health doctors (Tartu University), work hygienists and -psychologists (Tallinn University of Technology), ergonomists (University of Life Sciences in Tartu). Health Care High Schools in Tartu and Tallinn educate occupational health nurses as well. In addition, many of student`s research works are dedicated to the working environment and occupational health and safety issues.

5) In-service training of occupational health specialists. *Look the table of the Occupational Health and Safety Strategy 2010-2013 (above).*

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.

The measures taken

The activities of the Ministry of Social Affairs (MoSA) in the field of occupational health, 2012 - 2015

The MoSA has drawn up 36 instructions on work environment for different fields of activity, such as commerce, office work, construction work, etc. The instructions provide descriptions of sector-specific problems and their solutions, as well as general aspects of work environment and performance of risk assessment.

The MoSA has prepared a manual for vocational schools, in which an overview is given of risk factors in the work environment and possibilities of preventing damage to health due to them.

An electronic tool for working environment, named Tööbik, has been developed. Tööbik enables an enterprise to administer data related to its work environment, to conduct risk assessment, to maintain necessary data bases and to use reminders, so that necessary actions could be timely complied with.

The Month of Ergonomics (including Conference on Ergonomics) was held in 2012 and 2013. The conference was free for the participants and provides good knowledge in various topics related to ergonomics.

The Health and Safety at Work Network inside Estonia was re-established in 2012. The aim of the network is the development of the field of occupational health and safety issues by providing a framework for institutions that enables the use of health and safety information, experience and knowledge in a more efficient way among the network members.

The activities of the Labour Inspectorate 2012-2015

Estonian Labour Inspectorate participates in different fairs (around 20 fairs per year) with the goal to talk about the issues related to occupational health and safety and provide relevant publications. These can be sector-based fairs (eg agriculture, transport) or very specific ones. For example, 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 puts together and distributes information materials about work safety.

Magazine Working life

Estonian Labour Inspectorate issues magazine on work life. This magazine is delivered electronically and on paper to a wide list of recipients from all sectors. One of the main topics of the magazine is occupational health and safety. First newsletter was published in 2009 (6 issues per year). More than 3011 people had joined the mailing list for the newsletter by the end of the year 2014.

Newsletter for start-up enterprises

The purpose of the newsletter for start-up enterprises is first and foremost to help employers understand the need for the management of work environment and to guide their activities in establishing safe and healthy working conditions and proper labour relations. The newsletter is distributed electronically on a quarterly basis to new enterprises registered in Estonia. The newsletter for start-up enterprises is available on the Labour Inspectorate website in both Estonian and Russian, as well as in the form of a booklet.

Working Life portal

Inspectorate also runs a web portal that covers all topics related to working life for both employers and employees. The Working Life Portal was opened in 2012 and updated in 2013. The Working Life Portal comprises information on work environment provided by different state institutions, so that users have all the necessary information at one portal. In addition to information, the new portal provides its users also several options, for instance how to find service-providers, training courses, audio-visual training aids, etc. Additionally, there are several social media sites where people can find information and ask questions. All questions will be answered promptly.

Best practices

A database of best practises was created to improve the dissemination of information, which will contain examples of the best practises of companies. There are more than 261 examples of best practices in the database right now. In 2015, the Labour Inspectorate was released a collection of best practices covering all practices that are collected 2010-2015.

Brochures, leaflets and other materials produced by the Labour Inspectorate

The Labour Inspectorate has published in last years a lot of brochures, leaflets, manuals, for example: "Resolution of labour disputes at Labour Dispute Committees"; "Dangerous chemicals in the work environment", "A recruit", "The Labour Inspectorate", "Stress at work", "Use of scaffolding and ladders", "Organisation of working, driving and rest time of drivers of motor vehicles“, "Youth at work", “Young Employee’s Guide: What to Consider When Starting Work/Employer’s Guide: What to Consider When Employing a Young Employee”, “Occupational Safety in Wood and Furniture Industry”, “Temporary Agency Work” and the leaflet “Occupational Disease: Information and Investigation”, “Financial Claims in Labour Relations”, “Official Travel and Posting Employees”, “Personal Protective Equipment: An Investment into Future”, “Management for Drivers: Working, Driving, and Rest Time: a Guide”, “Ask for an Employment Contract”, and “Termination of an Employment Contract”, as well as in the booklet on the work of the Labour Inspectorate: “Labour Inspectorate – Making Working Life Better!”, “Young Employee’s Guide: What to Consider When Starting Work/Employer’s Guide: What to Consider When Employing a Young Employee”, “Occupational Safety in Wood and Furniture Industry”, “Temporary Agency Work” and the leaflet “Occupational Disease: Information and Investigation”.

Posters: “Newfound energy! Exercises for people with a desk job”, “New-found energy! Exercises for people with a standing job”, “Safe work with hazardous chemicals”.

Educational films: "Slippery surfaces", "Risk assessment", "Working and rest time", "Safe use of work equipment", "Working at height", "Training and Instruction" (http://tooelu.ee/et/Kasulikku/Videod http://tooelu.ee/et/Taskuhaaling/Taskuhaaling).

Poadcasts: “Working with a tool”, “Safety guide”, “Hazardous chemicals”, “Coaching and training”, “Personal Protective Equipment”, “First Aid” (http://tooelu.ee/et/Taskuhaaling/Taskuhaaling/1/#podcast4).

Radioshow “Working minutes”

The radio show "Working minutes" is aired in Kuku radio every Monday at 10:00 to 10:15. The show shares practical tips on topical issues for both employers and employees.

Campaigns and activities

National communication and training activity of the Labour Inspectorate of Estonia takes place with the support of the European Social Fund (ESF). The Programme is called: “Reduction of work-related health risks and improvement of labour relations 2010 – 2014“.

Estonian Labour Inspectorate conducts campaigns on occupational health every year in order to raise awareness, change behaviours and enhance the safety culture in Estonian companies. Below is a list of campaigns that focused on occupational health and safety.

2010: Work related stress – psychosocial risk factors, Know your rights – healthy and safe working conditions, Preventing risks together.

2010: Chemical safety campaign – risk assessments of chemicals, improper storage and inadequate extraction system.

2011: Personal Protective Equipment campaign – personal protective equipment (PPE) use in the workplace, intended to emphasize the need to use them and to introduce non-use of the potential consequences.

2012: SLIC Campaign on psychosocial risks at work in 2012 – raise awareness about psychosocial risks at wok (In Estonia we focused to hospitals).

2012: The campaign "Know your rights, health and safe working conditions " – reduce accidents and deaths job.

2012: Occupational safety campaign "Internal Audit of the working environment management

enterprise " – direct employers to think more action, what they can do to better organize your work.

2012: social Campaign "Know your rights, prefer labour contract " – social protection, vocation, the employer's duty to ensuresafe and healthy working environment.

2013: New employees – to introduce rights and obligations of employers and employees, the importance of the guidance.

2012–2013: Working together for risk prevention (EU-OSHA) – prevention is about managing work-related risks with the ultimate aim of reducing the number of work-related accidents and occupational illnesses.

2014: Posted workers: raising awareness among posted workers about their rights and obligations.

2014–2015: Slips and trips on the same level (SLIC) – slips and trips prevention, Healthy Workplaces Manage Stress (EU-OSHA) – support and guidance for workers and employers in managing work-related stress and psychosocial risks.

2015: The social campaign “Know your rights – Young employee”. The goal of the campaign was to increase the awareness of work environment and work relations in young people (persons aged 18–25 about to start their first job).

National target inspections

2012:

Target inspection on psychosocial risk factors:

- There were 74 inspections in the 37 different clinics and health care institutions. Inspectors found 16 infringements and gave 108 improving advices.
- Target inspection on management of health and safety at work:
- There were 174 inspections during this campaign. Inspectors found 661 infringements and wrote 553 requirement notices. In 14 cases inspectors gave warnings of penalty payments. Penalty payment enforced in 2 cases. Work was suspended on 1 case and the use of work equipment was forbidden in 45 cases.

Target inspection of construction sites:

- This target inspection was carried out during one day and inspectors visited 65 different construction sites. Inspectors found 176 infringements. In 27 cases was need for suspend the work or forbid the use of work equipment.

Labour relations and compliance with OSH requirements in corporate chains:

- There were 17 inspections and inspectors found 79 different infingements.

2013:

Organisation of occupational health service at enterprises:

- There were 85 inspections and this target inspection clarified different problems in health surveillance system in Estonia.

Use of dangerous chemicals:

- There were 65 inspections and inspectors found 138 infringements. Inspectors gave 219 oral improvement advices.
- Target inspection of construction sites in spring and autumn.
- In addition an inspection and information campaign “New employees at the company“ was conducted all over Estonia. There 164 inspections made by labour inspectors. They gave 50t oral advices and found 608 infringements.

2014:

- Target inspection on slips and trips;
- Target inspection of wood and furniture industry;
- Target inspection on investigations of work accidents;
- Target inspection on health examination;
- Target inspection on night work;
- Target inspection of the public sector.

2015:

- Dental medicine target inspections - Target inspections conducted in enterprises resulted in increased awareness in the employers in this field of the necessity of managing occupational health and safety. Companies in this field turned insufficient attention to occupational health and safety requirements.
- Target inspections of store chains - In the course of this target inspection campaign, stores of the Selver chain were visited in 2015. 31 of 44 stores were inspected.

- Target inspection of night work - A target inspection of night work was conducted in Pärnu. The inspection targeted nightclubs, bars, casinos, and pubs. The focus was on the management of the occupational health and safety of employees working in the nighttime. Despite the low number of inspections (15 enterprises were inspected in total), the number of detected violations was high, with an average 5.2 violations per enterprise.
- Target inspection of media enterprises - In the course of the target inspection of media enterprises, occupational health labour inspectors visited television and radio companies and newspaper offices (for a total of 20 visits). An average of 5.8 violations were identified per visit, which is not a good result.

Labour Inspectorate's advisory service

Alongside state supervision and informational activities, the Labour Inspectorate's advisory service plays an important role in increasing the safety and quality of working life. The advisory service is directed to all parties of labour relations (hereinafter also called clients) who mainly include employees, employers, and professional associations. Labour Inspectorate's advisory service includes:

- advice given over the information line (640 6000),
- responding to clarification requests received on the e-mail address jurist@ti.ee,
- face-to-face counselling sessions at 25 locations over Estonia, and
- counselling at enterprises or their places of activity.

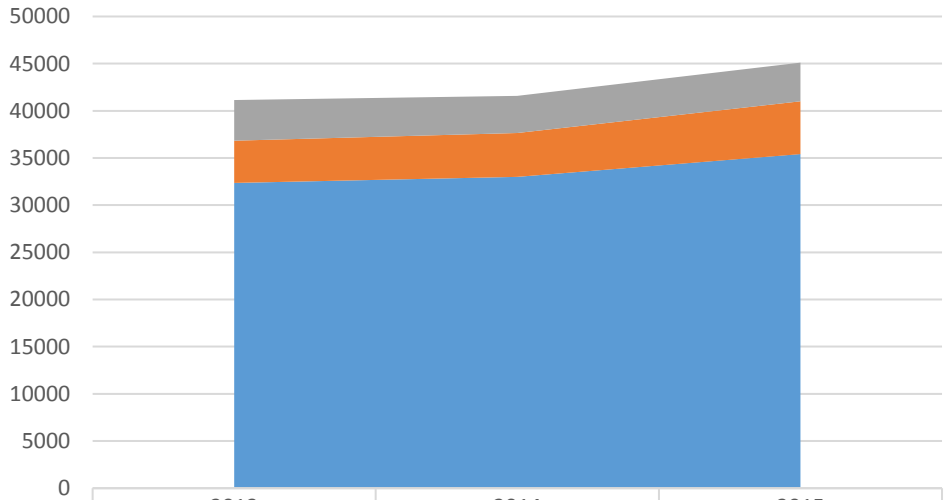
The counsellors mainly include counselling lawyers and work environment specialists, or labour inspectors and labour inspector-lawyers giving advice at the office.

The purpose of the advisory service is to enable parties to labour relations to act consciously in compliance with legal acts regulating labour relations and occupational health and safety; to promote law-abiding behaviour in labour relations and thus prevent the violation of legal acts, damage to health, and labour disputes. Another goal is the maintenance and improvement of work capacity in working-age employees, including supporting employer in developing the work environment, increasing the participation in the labour market of persons with reduced work capacity and preventing early retirement, and ensuring the sustainability of work capacity support measures.

The information line has been operating for eight years and the demand for the service is continuously high. Information line works every weekday from 9:00 to 16:30. Counselling lawyers answer the information line, directing the call to a labour environment consultant or a secretary, if necessary. Caller can choose from two languages – estonian and russian.

For four years now, people have been able to write the Labour Inspectorate and ask for advice by e-mail at jurist@ti.ee. The same address can also be used for occupational health and safety advice from a work environment consultant. Similar to the information line, a single e-mail address can be used for information on all aspects of working life.

Those seeking to receive direct information on labour relations or occupational health and safety can receive counselling at our offices. The reception takes place in regional offices and counselling offices all over Estonia (25 towns total).



	2013	2014	2015
face-to-face counselling	4325	3931	4099
e-mail	4475	4664	5586
information line	32359	32985	35423

New initiative: From year 2015 the Labour Inspectorate offer corporate working environment counselling service.

The Labour Inspectorate has set its aims of helping employers and employees and, in addition to being a supervising authority, also being a counselling institution and using penalties as a last resort. By changing the working environment according to the guidelines from the counsellor, you will achieve a better working environment, and it's also cheaper and less painful if the changes are made before an accident happens. A better working environment motivates employees to work better, to be loyal and recommend the company to their friends as well. It also helps to gain more popularity among your clients.

Counselling is aimed at the development of safety culture in companies, not searching for violations. The objective is to reach the point where the competency of evaluating health and safety at work in the company will grow and therefore damage to the health of employees will be avoided and their ability to work will be sustained. In accordance with the wishes and needs of the employer the working environment counselling may cover the whole working environment or just a specific area. A working environment counsellor's task is to find, in cooperation with the employer's representative(s), any workplaces and activities that should be improved, and to provide recommendations for possible solutions.

The counsellor will not conduct state supervision over the company (as a labour inspector) and will not issue a precept. The counsellor also won't prepare any documents (e.g. risk analyses, safety instructions, etc.) and won't instruct employees individually.

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

Some activities that also may concern to health and safety at work

In the course of 2014-2015 the principles of **the working abilty reform** were developed in Estonia. These principles are:

1) bringing persons with reduced working ability back to labour market and help them to cope in the market;

2) prevention of loss of working ability and motivate people to take active part in social life;

3) lending employers a hand to help them improve working environment to employ persons with reduced working ability and keep them employed.

The reform started from the beginning of 2016 and will create a new performance of the working ability support system. The aim of the amendments is to change attitudes towards people with reduced working ability and to help them find and keep a job.

Research in the field of occupational health and safety

2012 – reseach „The seniors in the labor market"

2012 – reseach „The use of dangerous chemicals at the workplace"

2013 – reseach „Satisfaction with the occupational health service" (conducted by the Health Board)

2014 – reseach „Working conditions for temporary agency work“

2015 – regularly, after 5 year conducted research of Estonian Working Life (previous reseach was conducted in 2009). The main idea of the research is to cover important topics and problematic aspects of Estonian working life, employment relationships and working conditions. The collected data by the research is used for scientific analysis of working life and political analysis of legislation regarding working life.

The main conclusions of the occupational health topics in 2015 were:

- 2.4% of the employees have had accident at work;
- 15% of the employees have had health issues caused by work;
- 16% of the employees have experiences stress related to work;
- 54% of the organizatios have a working environment representative;
- 98% of the organizations have persons who deal with working environment;
- risk assessment has been conducted in 89% of the organizations;
- employees' health surveillance has been conducted in 75% of the organizations;
- health promotion is carried out in 77% of the organizations.

Consultation with employers' and workers' organisations

According to the TNO Report (p. 37), the absence of effective, functional, institutionalised social dialogue on occupational health and safety is a major concern. *The Committee asks that the next report provide information on the amendments to the Act of 16 June 1993 on employees' representatives introduced by the Act of 13 December 2006 which transposed Directive No. 2002/14/CE of the European Parliament and of the Council of 11 March 2002 establishing a general framework for informing and consulting employees in the European Community.*
The Committee asks for information on any steps taken to increase the number of work environment representatives and work environment councils in undertakings. It then asks for concrete examples of the involvement of the Advisory Committee of Working Environment in shaping occupational health and safety policy in practice. Pending receipt of this information, the Committee defers its conclusion on this point.

Answer

Directive 2002/14/EC is covered by Employees' Trustee Act (2006). This Act regulates the activities of an employees' trustee in representing the employees, who authorised him or her, in relations with the employer and the employees. A trustee is an employee of an employer who is elected by the general meeting of the employees of the employer (hereinafter general meeting) as their representative in the performance of the duties arising from the law in relations with the employer.

The approach of the working environment (health and safety) representative and working environment council is given in the Occupational Health and Safety Act (TTOS). According to § 18 of the TTOS in an enterprise with at least 50 employees, a working environment council (WEC) shall be set up at the initiative of the employer and it shall comprise an equal number of representatives designated by the employer and representatives elected by the employees. There was aproximately 1740 enterprises with more than 50 employees in Estonia in 2014 where the WEC shall be established.

Working environment representative is a representative elected by employees in occupational health and safety issues. In an enterprise which employs 10 employees or more, the employees can elect a working environment representative from among themselves. If an enterprise employs less than 10 employees, the employer is required to consult with the employees in matters of occupational health and safety.

To elect working environment representatives, an employer shall call a general meeting of employees in which all employees may participate either directly or through a person authorised by an unattested authorisation. An election is deemed to have been held if at least 50 per cent of all employees participated therein. The election procedure shall be provided by a collective agreement or any other written agreement between the employer and employees.

The employees' representatives into WEC shall be elected pursuant to the same procedure.

The Labour Inspectorate has right to control if a general meeting in above mentioned question has been arranged by employer, and if the collective agreement consists election procedure of working environment representatives. If not, the Labour Inspectorate has 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 statistical data collected by Labour Inspectorate the working environment representatives are present in 54% of enterprises visited by labour inspectors (2015).

At the present time the involvment of social partners in shaping occupational health and safety policy in practice will take place on a regular basis through working groups and steering committees. For example, social partners participate in the steering committee of the National

Health Plan 2009-2020 and the Welfare Development Plan 2016-2023 twice a year. The Steering Committee is responsible for managing development plan and its implementation, including confirming the development objectives, measures and implementation plan, and the annual reports.

Also in 2015 social partners were involved in mapping the main problems related to the occupational health and safety policy in Estonia. The results of two studies related to occupational health and safety were discussed with the social partners. In 2015 four meetings took place.

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.*

Developments in the legal framework, 2012-2015

There have been no significant changes in OSH legislation.

However, the Occupational Health and Safety Act[1] (TTOS) was amended in 2014. The amendment changed the order of registration of nonmedical occupational health service providers. Today in order to act as a nonmedical occupational health service provider, a legal person or a sole proprietor must submit a notice of economic activities specified in the General Part of the Economic Activities Code Act. In addition to the information included in a notice of economic activities, a notice of economic activities shall set out the following information:

1) the occupational health service being provided;

2) the name of the occupational health specialist;

3) the contact details of the occupational health specialist (phone number, e-mail address);

4) information concerning the occupational health specialist's diploma certifying his or her professional competence or concerning his or her certificate of specialisation or in-service training, above all the speciality, certificate number, place and date of issue as well as period of validity thereof;

5) a legal person's or a sole proprietor's written statement that an occupational health specialist is working for the legal person or sole proprietor under a contract;

[1] Occupational Health and Safety Act § 19^1 (2): https://www.riigiteataja.ee/en/eli/520062016004/consolide

6) a legal person's or a sole proprietor's written statement that the person meets the requirement provided for in subsection 19 (3) of this Act.

In order to provide occupational health services which include the performance of the duties of an occupational health doctor and an occupational health nurse, the provisions of the Health Services Organisation Act shall apply[2].

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.

According to EC decision K/2011/9200 Estonia compiled in 2014 the **Country Summary Report** on practical implementation of 24 EU occupational safety and health Directives in Estonia. The aim of this report was a mapping of the implementation of the OSH Directives in Estonia and in EU as a whole, and it was based on a desk-study and interviews with national stakeholders.

Collective agreements.

There are 814 collective agreements between employers and employees registrated in Estonia up to september of 2015. The occupational health and safety aspects are included in 86% of the agreements. The most common OHS topics in the agreements are:

1) medical examination of employees, evaluation of their state of health and organisation of medical rehabilitation for employees at the expense of the employer (in 54% of the agreements);

2) co-operation in the name of a safe working environment between employer and employees and involving employees into the planning and organisation of occupational health and safety activities and in the choice and application of new technology and work equipment (in 38% of the agreements);

3) health promotion activities at the workplace, i.e. healthy food possibilities, vaccination against illness, different sport activities at the expense of the employer (36%).

By type of work activities, there are 54 active collective agreements in the construction sector, 8 agreements in the mining sector and 16 agreements in the agriculture, fishing and wood industry sector.

[2] Health Services Organisation Act: https://www.riigiteataja.ee/en/eli/502022016002/consolide

Risks covered by the regulations

It asks that the next report provide full information on any amendments to the legislation and regulations adopted during the reference period which specifically cover the risks listed in the general introduction to Conclusions XIV-2.

Question 1

The Committee asks in particular for information on any measures adopted to transpose Directive 2008/46/EC of the European Parliament and of the Council of 23 April 2008 amending Directive 2004/40/EC of the European Parliament and of the Council of 29 April 2004 on the minimum health and safety requirements regarding the exposure of workers to the risks arising from physical agents (electromagnetic fields).

Question 2

The Committee asks that the next report provide full, up-to-date information on changes in the legislation and regulations which occurred during the reference period. It also asks for information on any measures adopted to incorporate into domestic law the exposure limit of 0.1 fibres per cm3 introduced by Directive 2009/148/EC of the European Parliament and of the Council of 30 November 2009 on the protection of workers from the risks related to exposure to asbestos at work.

The level of ratification of relevant ILO Conventions is very low, the Committee asks for information on the Government's intention to change the situation in that regard.

The Committee also asks for information about the Government's intentions concerning the ratification of ILO Conventions No. 115 on Radiation Protection (1960) and No. 162 on Asbestos (1986).

Temporary workers

To determine whether temporary workers, interim workers and workers on fixed-term contracts are actually afforded the same level of protection by their contractual employer in practice, it asks that the next report include concrete examples on the way in which these workers are

provided information on hazards, training on safe working methods, medical examination when rehired or reassigned to new tasks.

Question 3

The Committee also asks for information on whether temporary workers, interim workers and workers on fixed-term contracts have a right to representation at work.

Question 4

To determine whether all workers are actually afforded the same level of protection in practice, The Committee asks that the next report provide information on any restrictions to the implementation of the current legislation and regulations based on the number of employees.

Answer to question 1

The Government regulation No 44 „Occupational health and safety requirements in working environments affected by electromagnetic fields, limits of electromagnetic fields and procedure for measuring electromagnetic fields", adopted on 1 April 2016, which takes over the directive **2013/35/EU** (repealing the directive 2004/40/EC on the minimum health and safety requirements regarding the exposure of workers to the risks arising from physical agents (electromagnetic fields)).

Answer to question 2

The Government regulation No 224 "Occupational health and safety requirements from the risks related to exposure to asbestos at work", adopted on 11 October 2007; Para 2 stipulates the limit value of the exposure limit of 0.1 fibres per cm^3 introduced by Directive **2009/148/EC** of the European Parliament and of the Council of 30 November 2009 on the protection of workers from the risks related to exposure to asbestos at work (codified version of previous directives of asbestos).

Answer to questions about the ratification level of ILO Conventions.

The ratification of any OSH conventions in Estonia is coordinated by the tripartite social dialogue body – The ILO Council of Estonia. The Council makes proposals and develops a position in relation to the new ILO conventions and recommendations in the application on the basis of Article 19 of the ILO Constitution, and proposes the application of non ratified ILO Conventions and recommendations in legislation and practice. In recent years Estonia has ratified the following relevant conventions: Maritime Labour Convention (MLC), Work in Fishing Convention (No 188), Protocol of 2014 to the Forced Labour Convention, 1930 (P029).

There are some ILO OSH conventions that had not been ratified by Estonia yet:

1) Promotional framework for occupational safety and health convention, 2006 (no. 187) and recommendation, 2006 (no. 197);

2) Safety and health in construction convention, 1988 (no. 167) and recommendation, 1988 (no. 175);

3) Safety and health in mines convention, 1995 (no. 176) and recommendation, 1995 (no. 183);

4) Convention No. 115 on Radiation Protection (1960);

5) Convention No. 162 on Asbestos (1986).

The provisions of these non ratified conventions are also covered by relevant regulations in Estonia. The most general principles of the **Convention 187** are included in the health and safety legislation in Estonia, basing on TTOS. It includes all components listed in the Art 4 in this convention with the relevant framework for implementing the national policy on occupational health and safety. The goals and actions in the field of occupational health and safety are described in the National Health Plan 2009-2020 and Welfare Development Plan 2016-2023.

The general principles of Conventions 115 and 162 are covered with Governement of the Republic regulations as follows: the requierments concerning work **in construction –** Government of the Republic Regulation No 377 „Occupational health and safety requirements at construction site“ adopted on 8 December 1999; amended 2009); **in mining** – Government of the Republic Regulation No 223 „Occupational Health and Safety Requirements for Extraction of Mineral Resources“. Adopted on 18 June 2004); **work with asbestos** – Government regulation No 224 "Occupational health and safety requirements from the risks

related to exposure to asbestos at work", adopted on 11 October 2007). Workers **radiation protection** is covered by Radiation Act (2004, amended 2016).

Estonia has transposed all EU OHS directives, e.g the Framework Directive 89/391 and the associated individual directives.

Temporary workers. In which way these workers are provided information on hazards, training on safe working methods, medical examination when rehired or reassigned to new tasks?

There are no differences in OSH requirements between temporary and regular workers in Estonian law. According to TTOS § 13 (1) 13 before an employee commences work or changes jobs, arrange for the employee to receive occupational health and safety instructions and training corresponding to the employee's position and occupation. Instruction or training shall be repeated if the work equipment or technology is changed or upgraded. The principles of the health control of workers are regulated in the regulation 24.04.2003 nr 74 of Minister of Social Affairs "The procedure of medical examination of workers".

Answer to question 3

Have the temporary workers, interim workers and workers on fixed-term contracts have a right to representation at work?

Yes, according to TTOS § 12 (1), 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. This provision also applies to the representation of the interests of rental workers during working at the user undertaking.

Answer to question 4

Are there any restrictions to the implementation of the current legislation and regulations based on the number of employees – home, domestic and self-employed workers?

There are no restrictions to the implementation of the current legislation and regulations based on the number of employees in TTOS, all workers are afforded the same level of protection in practice. If a home worker or domestic worker and his or her employer have concluded employment contract, then they are protected by law in the event of damage to health related to work. According to TTOS § 12 (1) the employer shall ensure the conformity with occupational health and safety requirements in every work-related situation.

TTOS covers basic requirements to self-employed person according to Council Recommendation 2003/134/EC. According to TTOS § 12 (7) and (8), a sole proprietor (*self-employed worker*) shall ensure the soundness and correct use of the work equipment, personal protective equipment and other equipment belonging to him or her in every work situation. 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.

If an occupational accident occurs with a sole proprietor in a situation where he/she works at a workplace concurrently with one or several employees of an employer, all acts related to an occupational accident provided in TTOS § 22 and 24 shall be performed by the employer who organises the work or with whom the sole proprietor has a contractual relationship.

Article 3 § 3 – Provide for the enforcement of such 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), Law Enforcement Act, passed 23.02.2011. 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. Labour Inspectorate collaborates with the Police Authority and the Tax and Customs Board, conducting joint inspections. 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 2012 – 614 900;
- in 2013 – 621 300;
- in 2014 – 624 800;
- in 2015 – 640 900

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

- in 2012 – 48 004;
- in 2013 – 49 690;
- in 2014 – 51 503;
- in 2015 – 53 422.

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 2013 - 4183 work accidents happened according to the data submitted to the Labour Inspectorate, in 3388 cases of which employees suffered from a minor bodily injury, in 775 cases a serious bodily injury and in 20 cases the employee died as a result of the work accident. Compared to 2012 the number of registered accidents at work has increased by 26 cases.

The ratio of work accidents per 100 000 employees decreased by 0,5%. The ratio is related to the number of employed, aged 15-74 in the county and field of activity. Based on the data on 2013 the number of employed in Estonia was 621 300 (in 2012 - 614 900). Thus, 673 work accidents were registered per 100 000 employees in 2013, including 545 minor accidents at work, 125 serious and 3 fatal accidents at work (in 2012 - 676 accidents at work in all, including 541 minor, 132 serious and 2 fatal work accidents).

In the fields of activities in processing industry the largest number of accidents at work per 100000 employees were registered: in timber industry (2191), food industry (1769) and metal industry (1159). From other sectors the percentage was the largest in water supply (1533), administrative and support activity (1273) and public administration and national defense sector (1041).

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

Number of registered accidents at work by the severity, 2012–2015

	2012	**2013**	**2014**	**2015**
Total number of accidents at work, including	4,157	4,183	4,644	4,774
minor	3,329	3,388	3,733	3,800
serious	813	775	895	958
resulting in death	15	20	16	16

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.

Number of accidents at work by areas of activity, 2012 – 2015

Accidents at work by principal activity	2012	2013	2014	2015
TOTAL				
Employees	614 900	621 300	624 800	640 900
Accidents at work	4,157	4,183	4,644	4,774
resulting in death	15	20	16	16
Accidents at work per 100,000 employees	676	673	743	745
Agriculture, hunting, fishery, and forest management				
Employees	27 600	26 500	24 100	25 000
Accidents at work	150	163	190	176
resulting in death	2	0	1	1
Accidents at work per 100,000 employees	543,5	615,1	788,4	704,0
Mining industry				
Employees	4 900	4 800	4 200	3 100
Accidents at work	41	30	29	29
resulting in death	1	1	1	2
Accidents at work per 100,000 employees	836,7	625,0	690,5	935,5
Processing industry				
Employees	115 500	116 400	114 000	120 600
Accidents at work	1 318	1 429	1 501	1 541
resulting in death	2	5	0	4
Accidents at work per 100,000 employees	1141,1	1227,7	1316,7	1277,8

Electricity, gas and water supply				
Employees	12 500	10 100	11 200	10 600
Accidents at work	44	69	66	55
resulting in death	0	0	0	0
Accidents at work per 100,000 employees	352,0	683,2	589,3	518,9
Construction				
Employees	58 200	56 600	58 700	61 800
Accidents at work	354	360	365	410
resulting in death	4	6	5	3
Accidents at work per 100,000 employees	608,2	636,0	621,8	663,4
Wholesale and retail, repair of motor vehicle, motorcycles, personal utility articles, and household appliances				
Employees	79 100	81 100	81 200	83 900
Accidents at work	407	396	439	463
resulting in death	0	1	0	0
Accidents at work per 100,000 employees	514,5	488,3	540,6	551,8
Hotels and restaurants				
Employees	18 800	23 400	25 800	26 100
Accidents at work	165	151	200	175
resulting in death	0	0	1	0
Accidents at work per 100,000 employees	877,7	645,3	775,2	670,5
Transportation, warehousing, communications				

Employees	51 000	46 900	50 800	46 700
Accidents at work	320	346	352	342
resulting in death	4	4	6	4
Accidents at work per 100,000 employees	627,5	737,7	692,9	732,3
Information and communications				
Employees	18 500	19 700	22 100	26 300
Accidents at work	13	13	17	16
resulting in death	0	0	0	0
Accidents at work per 100,000 employees	70,3	66,0	76,9	60,8
Financial intermediation, real estate				
Employees	21 600	21 900	19 700	19 800
Accidents at work	44	40	43	55
resulting in death	0	0	0	0
Accidents at work per 100,000 employees	203,7	182,6	218,3	277,8
Professional, scientific and technical activities				
Employees	23 200	26 200	26 700	25 500
Accidents at work	30	29	31	28
resulting in death	0	0	0	0
Accidents at work per 100,000 employees	129,3	110,7	116,1	109,8
Administrative and support service activities; compulsory social insurance				
Employees	21 300	22 700	18 800	18 600
Accidents at work	299	290	305	298

resulting in death	0	2	0	0
Accidents at work per 100,000 employees	1403,8	1277,5	1622,3	1602,2
Public administration and national defence; compulsory social insurance				
Employees	40 100	43 000	45 100	42 400
Accidents at work	511	451	617	655
resulting in death	2	1	0	1
Accidents at work per 100,000 employees	1274,3	1048,8	1368,1	1544,8
Education, health and social welfare				
Employees	96 300	92 500	93 600	99 700
Accidents at work	377	341	379	391
resulting in death	0	0	1	0
Accidents at work per 100,000 employees	391,5	368,6	404,9	392,2
Arts, entertainment				
Employees	14 900	17 100	16 600	14 200
Accidents at work	68	52	86	109
resulting in death	0	0	1	1
Accidents at work per 100,000 employees	456,4	304,1	518,1	767,6
Other public, social and personal services				
Employees	11 400	12 400	12 300	16 700
Accidents at work	16	23	24	31
resulting in death	0	0	0	0
Accidents at work per 100,000 employees	140,4	185,5	195,1	185,6

Source: the Labour Inspectorate

Accidents at work resulting in death by areas of activity, 2012-2015

	Number of accidents at work				Accidents at work per 100,000 employees			
	2012	2013	2014	2015	2012	2013	2014	2015
Agriculture, hunting	0	0	1	0	0,0	0,0	6,2	0,0
Forest management	2	0	0	1	28,2	0,0	0,0	12,8
Fishery	0	0	0	0	0,0	0,0	0,0	...
Mining industry	1	1	1	2	20,4	20,8	23,8	64,5
Processing industry	2	5	0	4	1,7	4,3	0,0	3,3
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	4	6	5	3	6,9	10,6	8,5	4,9
Wholesale and retail; motor vehicles and morotcycles repair	0	1	0	0	0,0	1,2	0,0	0,0
Transportation and warehousing	4	4	6	4	7,8	8,5	11,8	8,6
Accommodation and catering	0	0	1	0	0,0	0,0	3,9	0,0
Information and communications	0	0	0	0	0,0	0,0	0,0	0,0
Financial and insurance activities	0	0	0	0	0,0	0,0	0,0	0,0
Real estate activities	0	0	0	0	0,0	0,0	0,0	0,0

Professional, scientific and technical activities	0	0	0	0	0,0	0,0	0,0	0,0
Administrative and support service activities	0	2	0	0	0,0	8,8	0,0	0,0
Public administration and national defence	2	1	0	1	5,0	2,3	0,0	2,4
Education	0	0	1	0	0,0	0,0	1,8	0,0
Healt and social welfare	0	0	0	0	0,0	0,0	0,0	0,0
Arts, entertainment	0	0	1	1	0,0	0,0	6,0	7,0
Other service activities	0	0	0	0	0,0	0,0	0,0	0,0
Total	**15**	**20**	**16**	**16**	**2,4**	**3,2**	**2,6**	**2,5**

Source: the Labour Inspectorate

Serious accidents at work by areas of activity, 2012-2015

	Number of accidents at work				**Accidents at work per 100,000 employees**			
	2012	**2013**	**2014**	**2015**	**2012**	**2013**	**2014**	**2015**
Agriculture, hunting	33	36	34	30	171,0	203,4	209,9	180,7
Forest management	4	5	9	7	56,3	69,4	128,6	89,7
Fishery	2	1	3	0	153,8	62,5	333,3	...
Mining industry	21	10	7	11	428,6	208,3	166,7	354,8
Processing industry	266	258	317	323	230,3	221,6	278,1	267,8
Electricity, gas, steam and conditioned air supply	3	4	6	5	32,6	56,3	74,1	65,8
Water supply; sewerage, waste and pollution handling	5	10	14	7	151,5	333,3	451,6	233,3

Construction	96	99	87	119	164,9	174,9	148,2	192,6
Wholesale and retail; motor vehicles and morotcycles repair	68	63	72	71	86,0	77,7	88,7	84,6
Transportation and warehousing	77	86	90	86	151,0	183,4	177,2	184,2
Accommodation and catering	17	11	15	25	90,4	47,0	58,1	95,8
Information and communications	3	2	3	4	16,2	10,2	13,6	15,2
Financial and insurance activities	2	2	3	3	18,3	19,6	36,6	31,6
Real estate activities	8	7	8	12	74,8	59,8	69,6	116,5
Professional, scientific and technical activities	6	5	7	11	25,9	19,1	26,2	43,1
Administrative and support service activities	37	44	49	57	173,7	193,8	260,6	306,5
Public administration and national defence	69	45	69	80	172,1	104,7	153,0	188,7
Education	35	43	44	40	56,6	76,6	80,0	66,0
Health and social welfare	40	31	37	43	115,9	85,2	95,9	110,0
Arts, entertainment	15	8	17	17	100,7	46,8	102,4	119,7
Other service activities	6	5	4	7	52,6	40,3	32,5	41,9
Total	**813**	**775**	**895**	**958**	**132,2**	**124,7**	**143,2**	**149,5**

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 2013 the Labour Inspectorate received notifications of diagnosis of occupation diseases (OD) concerning 56 employees and notifications of work-related diseases (WRD) concerning 190 cases.

By fields of activity of enterprises 43% of cases of an OD and also a WRD were diagnosed in the sector of processing industry. Unsatisfactory work environment has often caused an OD most often at workers of wood industry, textile industry and food industry. From other fields of activity we can bring out occupations related to agriculture, hunting, forestry sectors and also trade. The majority of notifications on work-related diseases concerned employees of processing industry – metal, food processing, textiles and wood industry. From other fields of activity we should name trade and construction sector.

Registered occupational diseases and illnesses caused by work in Estonia, 2012-2015

	Number of occasions				**Per 100,000 employees**			
	2012	**2013**	**2014**	**2015**	**2012**	**2013**	**2014**	**2015**
Contraction of occupational desease	57	56	56	50	9,3	9,0	9,0	7,8
Illnesses caused by work	172	190	138	128	28,0	30,6	22,1	20,0

Source: The Labour Inspectorate

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

- **in 2012** – 4,616 / 3,132 / 166,233;
- **in 2013** – 4,360 / 3,008 / 139,855;
- **in 2014** – 4,805 / 3,235 / 149,413;
- **in 2015** – 5,347 / 3,838 / 97,581.

Non-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.

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.

Infringements proceeded by the Labour Inspectorate, 2012-2015

	Number of infringements	**Worned with penalty payment**	**Enforced penalty payment / sum**
2012	12,280	680	25/ 4,485 EUR
2013	11,815	672	80/ 18,490 EUR
2014	13,840	488	36/ 13,780 EUR
2015	17,611	628	47/ 8,690 EUR

Source: the Labour Inspectorate

For example: in the year **2013**, 209 cases of misdemeanour matters were heard in the course of inspection of safety and health at work and labour relations, of which in 86 cases misdemeanour proceedings were initiated against a legal person and in 123 cases against natural persons. During the year fines were imposed 192 times in all, in the amount of 34 812 euros, of which 77 times to legal persons in the amount of 21 770 euros and 115 times to natural persons in the amount of 13 042 euros. The majority of the fines imposed to legal persons were related to the result of investigation of accidents at work and cases of occupational diseases. The largest fine imposed to a legal person for violation of the requirements of health and safety at work was 600 euros and to a natural person 60 penalty units or 240 euros.

Misdemeanours proceeded by the Labour Inspectorate, 2012-2015

	Number of misdemeanours proceeded	Number / sum of fines imposed
2012	326	301 / 63,473 EUR
2013	209	192 / 34,812 EUR
2014	200	177 / 41,010 EUR
2015	156	150 / 43, 575 EUR

The Committee also asks for information on steps taken to reduce the high level of fatal accidents and the increasing cases of occupational disease

Estonian Labour Inspectorate conducts campaigns on occupational health every year in order to raise awareness, change behaviours and enhance the safety culture in Estonian companies.

The main priority of the Labour Inspectorate was and is decrease of serious or fatal occupational accidents. To ensure this, the plans included increase of the volume of state supervision and intensification of supervision or improvement of quality.

Work environment inspections are conducted, based on the risk score of companies. This is calculated, based on the risk level assigned to the area of activity of the company, the last time of visit to the company, results of former inspections, number of employees and the number of occupational accidents, occupational diseases and work-related disorders. Each specific company has their own risk score, based on which the companies and authorities with higher risk score are selected for inspection.

Inspections of occupational health aimed to change the thinking of employers and employees in the inspected companies. Work should be performed so that health is good even after several decades, understanding that occurrence of physical overburden is usually unnoticed. However, it may be hard to achieve improvement of already deteriorated health.

A major task of the Labour Inspectorate in addition to supervision and counselling is prevention and information in the field of occupational health and safety and labour relations, with the objective to make work environment safe and increase the quality of work.

The Committee notes the very low number of fines imposed in relation to the number of reported infringements and the very low amount of fines imposed, even in misdemeanour proceedings, given that paragraphs 27.1 and 27.2 of the OHS Act provide for maximum fines of €2 600 and €2 000, respectively. In order to gauge the deterrent nature of the penalties in practice, and given the persistent level of under-reporting, the Committee asks for comments in the next report on the number of convictions to imprisonment as a result of proceedings under paragraphs 197 and 198 of the Penal Code.

The labour inspector initiates a misdemeanour procedure, if an act with attributes of misdemeanour has been perpetrated. Misdemeanour procedure is conducted pursuant to the Penal Code and the Code of Criminal Procedure.

The number of misdemeanour procedures conducted by the officials of the Labour Inspectorate and the amounts of imposed fines and penalty payments are not directly corresponding with the situation of safety culture in Estonia. The number and character of detected violations as well as assessments of labour inspectors (i.e. inspections based on assessment lists) show that sanctions should be applied in higher extent. The reason of their non-application is, from one side, that employers eliminate the detected shortages as soon as possible, while also the labour inspectors have still the attitude that their work should cover supervision as well as consultation of the employer. Therefore they always do not want to initiate a misdemeanour procedure.

According to the Penal Code[3] (§ 197 and 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 punishable by a pecuniary punishment or up to three years' imprisonment.

Proceedings according to Penal Code, made by the Labour Inspectorate, 2012-2015

According to the Penal Code	2012	2013	2014	2015
proceedings	3	1	0	0

[3] https://www.riigiteataja.ee/en/eli/521062016004/consolide

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.

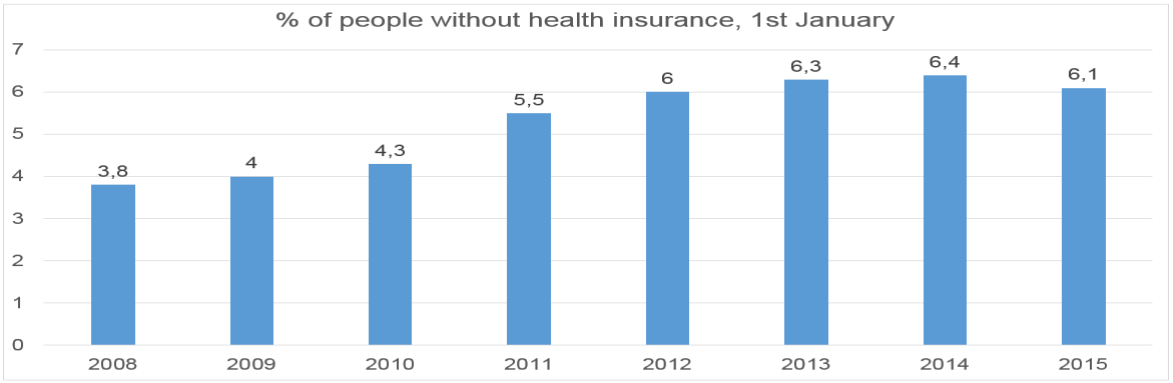
All health-related actions in Estonia are based on the National Health Plan 2009-2020 (NHP)[4], that was adopted in 2008. Its main targets are increasing life expectancy and healthy life years, there is also a target to reduce the gender gap in life expectancy.

NHP has 5 strategic areas each with their own sub-objectives: increasing of social cohesion and equal opportunities, ensuring healthy and safe development for children, shaping an environment supporting health, facilitation of healthy lifestyles and ensuring the sustainability of the health care system.

Access to health care

At the beginning of 2015, 93.9% of the population was covered by mandatory health insurance offered by the Estonian Health Insurance Fund (EHIF). The share of uninsured population (6,1% in 2013) in comparison with previous year (6,4% in 2014) has decreased slightly after it has increased gradually since 2008.

Health insurance coverage in Estonia, 2008–2015



Source: Estonian Health Insirance Fund

[4] Available here in English: http://www.sm.ee/sites/default/files/content-editors/eesmargid_ja_tegevused/Tervis/Aruanded/rta_2009-2020_2012_eng.pdf

Entitlement to coverage is based on residence in Estonia and entitlement rules of specific groups, which includes the employed, children and retired persons, are defined by law. It is not possible to opt out of insurance. The only group excluded from coverage is the prison population, whose health care is organized and paid for by the Ministry of Justice. Those covered by mandatory health insurance fall into four main categories: those who are eligible for coverage without contributing, such as children and pensioners; those whose contributions are paid from their wages by employers (13% of wages); those who are covered by contributions from the state; and those who are covered on the basis of international and voluntary agreements. All insured persons are entitled to the same benefits. The uninsured (6,1% of population) are mostly among the working-age population between 20 and 60 years who are economically inactive (but not registered as unemployed) or working abroad. The uninsured are entitled to emergency ambulance care, emergency primary care and emergency hospital care financed from state budget. Most of local municipalities also cover primary and special care services for their uninsured citizens. For example capital city Tallinn (where almost 1/3 of our population lives) has developed separate system for uninsured persons financed by city government. Harm reduction services are free to everyone and financed from state budget:

- HIV and TB treatment (incl. complications and related illnesses),
- youth sexual counselling, STD diagnostic up to age 25 (incl.)
- methadone replacement treatment and rehabilitation services for those who want to quit,
- smoking cessation and syringe exchange service.

All registered unemployed persons are covered by health insurance since 2009.

Recent reforms

During 2012-2015 some previously uncovered groups have been able to obtain coverage:

- artists and creative persons through Creative Persons and Artistic Associations (*Health Insurance Act*[5]*, HIA: persons for whom the state, local authority or, based on the Creative Persons and Artistic Associations Act, an artistic association is required to pay social tax*)

[5] Available in English here: https://www.riigiteataja.ee/en/eli/ee/514062016008/consolide/current

- persons, receiving remuneration or service fees through several and/or short contracts under the law of obligation through summarizing their social tax (*HIA: persons receiving remuneration or service fees on the basis of a contract for services, a mandate or a contract under the law of obligations for the provision of any other services, which is concluded for a term exceeding one month or for an unspecified term, who are not entered in the commercial register as self-employed persons and for whom the other party to the contract must pay social tax each month on the basis of clause 9 (1) 2) of the Social Tax Act in the amount calculated on the basis of at least the monthly rate established in the state budget for the given budgetary year*);
- spouse participating in activities of undertaking of self-employed person (*HIA: persons for whom social tax is paid by a self-employed person registered in the commercial register is their spouse who has been entered in the register of taxable persons as the spouse participating in the activities of the undertaking of the self-employed person*)
- coverage has been extended to persons older than 63 enjoying temporary international protection with health insurance. (Social Tax Act[6]: *unemployed persons enjoying international protection residing in Estonia who are of pensionable age for the purposes of § 7 of the State Pension Insurance Act and who do not receive a state pension granted in Estonia.*)

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 2009-2020

NHP performance and implementation is planned and monitored on 3 levels: operational decisions are made yearly, manifesting in yearly action plans and action reports. Every other year a performance report is prepared, helping to evaluate the effectiveness of current measures and inspiring possible adjusting of measures and indicators to better contribute to the goals and objectives of NHP. The status of public health is re-evaluated and the current performance thoroughly scrutinized every four years, resulting in possible changes not only in

[6] Available in English here: https://www.riigiteataja.ee/en/eli/ee/513062016008/consolide/current

tasks and measures, but also possibly in strategic objectives, as the challenges and gaps in health policy change. The changes are endorsed by a quadrennial implementation plan. NHP tracks 44 indicators spread across 5 thematic areas.

Green Paper on Alcohol Policy

Green Paper on alcohol policy[7] was approved by the Government of the Republic in February 2014; the document determines the goal of national alcohol policy of the Republic of Estonia – reducing alcohol-related health and social damages and establishing a safe growth environment for children and adolescents – and the measures to be adopted to reach these goals. The Green Paper measures are intended to reduce consumption of absolute alcohol per capita per annum below the limit of 8 litres. Inter-ministerial committee was established to implement the measures.

Based on the Green Paper, in 2014 a number of wide-based development efforts to treat alcohol addiction were prepared. First of all, NIHD developed a programme „Kainem ja tervem Eesti“ (More Sober and Healthier Estonia) (approved in January 2015), which will bring 10 million additional euros to the development of addiction treatment and early identification of abuse and development and implementation of short counselling over the next 6 years; the funding will be made available by the European Social Fund. Second, development of treatment guideline for patients with alcohol consumption disturbances was launched under the leadership of NIHD; the document is was finished in 2015.

Green Paper on Tobacco Policy

The Green Paper on tobacco policy[8] was approved by the Government of the Republic in January 2014. A monitoring programme was developed to implement the measures, specified in the Paper on tobacco policy and to follow the progress of the implementation. A tobacco policy work group was established to observe the implementation of the Green Paper in its respective sphere of responsibility. The work group met twice in 2014. In October 2014, a draft

[7] Available here in English: http://sm.ee/sites/default/files/content-editors/eesmargid_ja_tegevused/Tervis/Tervislik_eluviis/alkoholi_roheline_raamat-19.02.14_12_en.pdf

[8] Available here in English: http://sm.ee/sites/default/files/content-editors/eesmargid_ja_tegevused/Tervis/Tervislik_eluviis/tubakapoliitika_roheline_raamat_18_12_13_12_en.pdf

act for the amendment of the Tobacco Act and related acts was submitted to the Government of the Republic; the document deals with ban on sales of tobacco-free products, ban on advertising of products, related to tobacco products and ban on sale of products, related to tobacco products, to minors; limits on quantities of handled tobacco products and penalties for the handling of such tobacco products were established. In essence, Measure 6, specified in the Green Paper on tobacco policy was implemented and assumption of the new tobacco products directive to the Estonian legislation was started.

„Suitsuprii klass“ (Smoke Free Class) competition, organized by NIHD, was one of the many preventive measures. 85% (in 2013, 82%) of the participants completed the competition successfully; all the students of the given classes remained smoke free. Compared to the last academic year, both the number of the participants of the competition and successful performers has increased. In addition, target group was given an overview of evidence-based intervention measures; this represented one of the activities undertaken to make preparations for the launching of anti-tobacco campaigns of 2015.

Green Paper on Nutrition on Physical Activity

A green paper on nutrition and physical activity is currently under development in the Ministry of Social Affairs in cooperation with all other relevant ministries.

White Paper on Drug Prevention Policy

Under the leadership of the Ministry of the Interior and on order of the drug prevention commission of the Government of the Republic, preparation of the drug use reduction policy (the white paper[9]) started in 2013. The Government of the Republic approved the White Paper in early 2014. This document serves as the basis for determination of the course of action for curbing the availability of drugs, prevention of use, and treatment of addicts. The White Paper was compiled as a result of extensive consultations, through co-operation between experts of different fields and other parties interested; it summarizes the policy recommendations of the drug prevention commission of the Government of the Republic that should be considered in the action plans of the NHP and other relevant sectorial development plans. In parallel with compilation of the White Paper, thematic work groups under the Government commission

[9] Available in English here: https://www.siseministeerium.ee/sites/default/files/dokumendid/Ennetus/white_paper_on_drug_policy_estonia_2014.pdf

discussed field-specific subjects with participation of experts in the field and representatives of institutions. In 2014, work groups specialized in supply reduction, addiction treatment and rehabilitation, re-socialization and primary prevention convened, and the results were presented at a meeting of the Government commission.

Please 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).

In 2014, life expectancy at birth was 77.2 years for men and women, respectively, 72.3 and 81.5 years. In comparison to the 2012 data (76.5 years) life expectancy at birth has increased by an average of 0.7 years.

Life expectancy at birth, 2012–2014

		2012	2013	2014	2015
Life expectancy at birth	Total	76.5	77.3	77.2	77.7
	Males	71.4	72.7	72.3	73.1
	Females	81.2	81.3	81.5	81.9

Source: Statistics Estonia

Hospitals and bed fund

By 31.12.2015, there were 55 hospitals with 7,317 beds in Estonia, including 4,462 active treatment beds.

- 3 regional hospitals – 2,355 beds;
- 4 central hospitals – 1,700 beds;
- 11 general hospitals – 1,761 beds;
- 3 rehabilitation hospitals – 174 beds;
- 21 long-term nursing care hospitals – 742 beds;
- 9 special hospitals – 260 beds;
- 4 local hospitals – 325 beds.

In 2015, there were:

- Treatment beds of tuberculosis – 142 (in 2012 – 181);
- Psychiatric treatment beds – 748 (in 2012 – 730);
    - Adults – 682 (in 2012 – 683): psychiatry – 578 (in 2012 – 556) and acute psychiatry – 104 (in 2012 – 127);
    - Psychiatry of children – 66 (in 2012 – 47);
- Treatment beds of oncology – 134 (in 2012 – 128);
- Treatment beds of long-term nursing care – 1,965 (in 2012 – 1,769).

During the period of 2012–2015, the number of treatment beds of children psychiatry, rehabilitation, oncology, veneral and dermatological diseases and long-term nursing care has increased.

Source: the National Institute for Health Development

Number of new cases (incident cases), 2012–2015

Year	Number of new cases	Per 100,000 population
2011	2,424,067	182 612.3
2012	2,367,298	178 975.2
2013	2,489,084	188 853.5
2014	2,426,542	184 591.8

Source: the National Institute for Health Development

There were 2,426,542 incidental cases (excl. cancers) registered in 2014 (in 2011 – 2,424,067cases). Compared to 2011, the total number of registered incidental cases has remained at the same level.

The most registrations:

	Number of new cases		Per 100,000 population	
	2011	2014	2011	2014
Respiratory illnesses	626,163	553,860	47 170.8	42 133.2
o the most first incident cases were: acute bronchitis and bronchitis	78,584	70,311	5 920.0	5 348.7
Musculoskeletal and connective tissue illnesses	229,236	249,950	17 269.0	19 014.2

Injuries, intoxications and other certain consequences of the impact of external causes	254,922	240,834	19 204.0	18 320.7

Source: the National Institute for Health Development

The death rate has decreased slightly in 2012 1168.1 per 100,000 population to 1159.5 2015. The main reasons for deaths are cardiovascular diseases, neoplasms and injuries. Compared to 2012 the number of cardiovascular diseases deaths and injuries are decreased but the number of neoplasms deaths has increased.

Death cases and rates per 100,000 population by ICD-10, 2012–2015

Death causes by ICD-10		Death cases				Death rates per 100,000 population			
		2012	2013	2014	2015	2012	2013	2014	2015
All causes	**Total**	**15 450**	**15 244**	**15 484**	**15 243**	**1 168.07**	**1 156.60**	**1 177.90**	**1 159.51**
	Males	7 610	7 232	7 451	7 217	1 233.08	1 174.90	1 212.23	1 172.45
	Females	7 840	8 012	8 033	8 026	1 111.20	1 140.57	1 147.75	1 148.12
Infectious and parasitic diseases (A00-B99)	Total	126	108	124	113	9.53	8.19	9.43	8.60
	Males	89	75	66	70	14.42	12.18	10.74	11.37
	Females	37	33	58	43	5.24	4.70	8.29	6.15
..tuberculosis (A15-A19, B90)	Total	35	23	25	21	2.65	1.75	1.90	1.60
	Males	29	18	16	16	4.70	2.92	2.60	2,60
	Females	6	5	9	5	0.85	0.71	1.29	0.72
..HIV-disease (B20-B24)	Total	53	47	45	44	4.01	3.57	3.42	3.35
	Males	38	35	34	33	6.16	5.69	5.53	5.36
	Females	15	12	11	11	2.13	1.71	1.57	1.57
Neoplasms (C00-D48)	Total	3 702	3 732	3 860	3 903	279.88	283.16	293.64	**296.90**
	Males	1 995	1 989	2 046	2 078	323.26	323.13	332.87	337.59
	Females	1 707	1 743	1 814	1 825	241.94	248.13	259.18	261.07
Endocrine, nutritional and metabolic diseases (E00-E90)	Total	154	171	166	158	11.64	12.97	12.63	12.02
	Males	66	68	59	58	10.69	11.05	9.60	9.42
	Females	88	103	107	100	12.47	14.66	15.29	14.31
Diseases of the blood and blood-forming organs (D50-D89)	Total	15	20	18	26	1.13	1.52	1.37	1.98
	Males	7	3	8	7	1.13	0.49	1.30	1.14

	Females	8	17	10	19	1.13	2.42	1.43	2.72
Mental, behavioural disorders (F00-F99)	Total	135	107	109	102	10.21	8.12	8.29	7.76
	Males	94	70	72	68	15.23	11.37	11.71	11.05
	Females	41	37	37	34	5.81	5.27	5.29	4.86
..mental and behavioural disorders due to use of alcohol (F10)	Total	100	64	61	61	7.56	4.86	4.64	4.64
	Males	80	54	53	54	12.96	8.77	8.62	8.77
	Females	20	10	8	7	2.83	1.42	1.14	1.00
..drug dependence and toxicomania (F11-F16, F18, F19)	Total	0	0	1	2	0.00	0.00	0.08	0.15
	Males	0	0	1	2	0.00	0.00	0.16	0.33
	Females	0	0	0	0	0.00	0.00	0.00	0.00
Diseases of the nervous system and sense organs (G00-H95)	Total	278	292	280	325	21.02	22.15	21.30	24.72
	Males	133	142	145	149	21.55	23.07	23.59	24.21
	Females	145	150	135	176	20.55	21.35	19.29	25.18
Diseases of the circulatory system (I00-I99)	Total	8 357	8 259	8 219	7 965	631.82	626.63	625.24	**605.88**
	Males	3 505	3 266	3 321	3 157	567.93	530.59	540.30	512.88
	Females	4 852	4 993	4 898	4 808	687.70	710.79	699.82	687.78
Diseases of the respiratory system (J00-J99)	Total	448	507	544	533	33.87	38.47	41.38	40.54
	Males	302	336	366	329	48.93	54.59	59.55	53.45
	Females	146	171	178	204	20.69	24.34	25.43	29.18
Diseases of the digestive system (K00-K93)	Total	541	561	571	620	40.90	42.56	43.44	47.16
	Males	273	313	326	340	44.24	50.85	53.04	55.24
	Females	268	248	245	280	37.98	35.30	35.01	40.05
....alcoholic liver disease (K70)	Total	151	167	180	221	11.42	12.67	13.69	16.81
	Males	95	119	131	164	15.39	19.33	21.31	26.64
	Females	56	48	49	57	7.94	6.83	7.00	8.15
.....cirrhosis of liver (K74)	Total	75	69	69	71	5.67	5.24	5.25	5.40
	Males	42	44	46	27	6.81	7.15	7.48	4.39
	Females	33	25	23	44	4.68	3.56	3.29	6.29

Diseases of the skin and subcutaneous tissue (L00-L99)	Total	7	15	11	21	0.53	1.14	0.84	1.60
	Males	4	5	4	9	0.65	0.81	0.65	1.46
	Females	3	10	7	12	0.43	1.42	1.00	1.72
Diseases of the musculo-skeletal system and connective tissue (M00-M99)	Total	42	45	40	43	3.18	3.41	3.04	3.27
	Males	15	12	13	19	2.43	1.95	2.12	3.09
	Females	27	33	27	24	3.83	4.70	3.86	3.43
Diseases of the genito-urinary system (N00-N99)	Total	128	126	121	131	9.68	9.56	9.21	9.97
	Males	59	58	52	61	9.56	9.42	8.46	9.91
	Females	69	68	69	70	9.78	9.68	9.86	10.01
Complications of pregnancy, childbirth and puerperium (O00-O99)	Total	1	1	0	0	0.08	0,08	0.00	0.00
	Males	0	0	0	0	0.00	0.00	0.00	0.00
	Females	1	1	0	0	0.14	0.14	0.00	0.00
Certain conditions originating in the perinatal period (P00-P96)	Total	22	12	14	16	1.66	0.91	1.07	1.22
	Males	10	5	7	9	1.62	0.81	1.14	1.46
	Females	12	7	7	7	1.70	1.00	1.00	1.00
Congenital malformations and chromosomal abnormalities (Q00-Q99)	Total	36	23	29	20	2.72	1.75	2.21	1.52
	Males	19	11	16	9	3.08	1.79	2.60	1.46
	Females	17	12	13	11	2.41	1.71	1.86	1.57
Symptoms, signs and ill-defined causes (R00-R99)	Total	308	307	442	405	23.29	23.29	33.62	30.81
	Males	142	154	229	199	23.01	25.02	37.26	32.33
	Females	166	153	213	206	23.53	21.78	30.43	29.47
Injury and poisoning (V01-Y89)	Total	1 150	958	936	863	86.94	72.69	71.20	**65.65**
	Males	897	725	721	656	145.34	117.78	117.30	106.57
	Females	253	233	215	207	35.86	33.17	30.72	29.61

Source: Statistics Estonia

Number of first-listed cancer diagnosis has increased during the years, constituting 25,6% of all registered deaths in 2015 and 24% in 2012.

Main death causes of malignant neoplasms in 2015 were:

- malignant neoplasms of respiratory organs (C30-39);
- malignant neoplasm of colon and rectosigmoid junction (C18, C19);
- malignant neoplasms of lymphoid/haemotopoietic tissue (C81-C96).

Neoplasms mortality rates per 100 000 population, 2012–2015

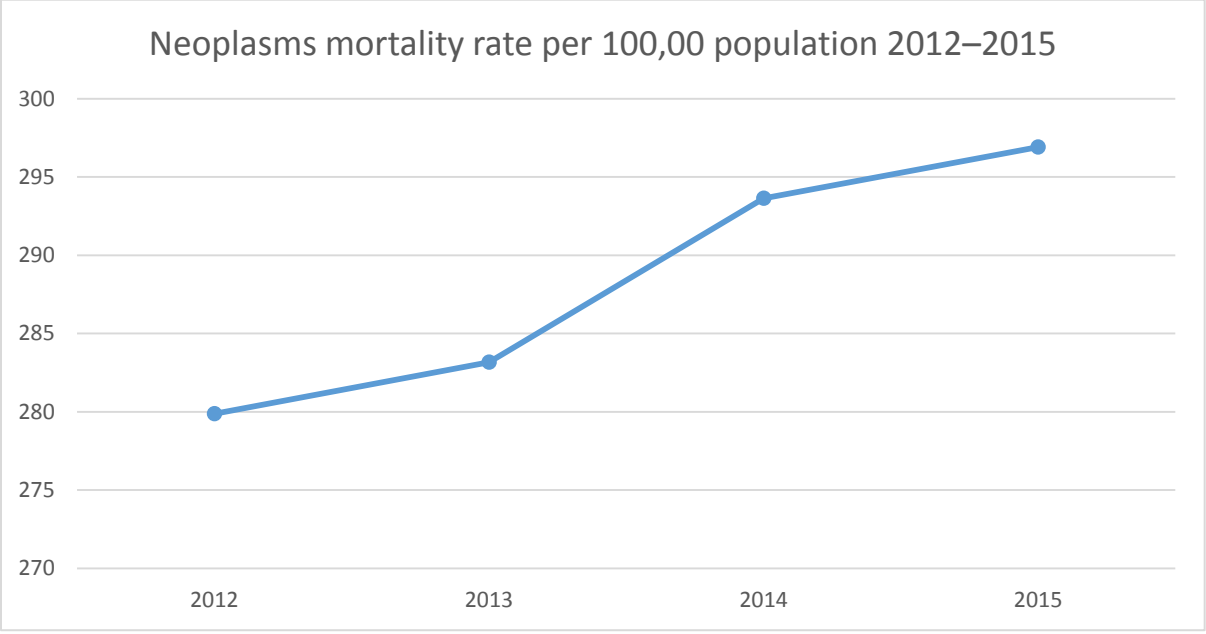
Death causes by ICD-10		**Death cases**				**Death rates per 100,000 population**			
		2012	**2013**	**2014**	**2015**	**2012**	**2013**	**2014**	**2015**
Neoplasms (C00-D48)	Total	3 702	3 732	3 860	3 903	279.88	283.16	293.64	296.90
	Males	1 995	1 989	2 046	2 078	323.26	323.13	332.87	337.59
	Females	1 707	1 743	1 814	1 825	241.94	248.13	259.18	261.07
..malignant neoplasms (C00-C97)	Total	3 643	3 663	3 785	3 817	275.42	277.92	287.93	290.35
	Males	1 966	1 969	2 007	2 050	318.56	319.88	326.53	333.04
	Females	1 677	1 694	1 778	1 767	237.69	241.15	254.04	252.77
....malignant neoplasm of lip, oral cavity and pharynx (C00-C14)	Total	111	99	92	93	8.39	7.51	7.00	7.07
	Males	95	77	77	77	15.39	12.51	12.53	12.51
	Females	16	22	15	16	2.27	3.13	2.14	2.29
....malignant neoplasm of oesophagus (C15)	Total	77	47	74	70	5.82	3.57	5.63	5.33
	Males	58	32	57	60	9.40	5.20	9.27	9.75
	Females	19	15	17	10	2.96	2.14	2.43	1.43
....malignant neoplasm of stomach (C16)	Total	281	290	308	276	21.24	22.00	23.43	21.00
	Males	163	168	169	149	26.41	27.29	27.50	24.21
	Females	118	122	139	127	16.72	17.37	19.86	18.17
....malignant neoplasm of colon and rectosigmoid junction (C18, C19)	Total	289	310	332	340	21.85	23.52	25.26	25.86
	Males	123	137	159	152	19.93	22.26	25.87	24.69
	Females	166	173	173	188	23.53	24.63	24.72	26.89
....malignant neoplasm of colon (C18)	Total	251	269	290	297	18.98	20.41	22.06	22.59
	Males	106	121	135	132	17.18	19.66	21.96	21.44
	Females	145	148	155	165	20.55		22.15	23.60
....malignant neoplasm of colon and rectosigmoid junction (C19)	Total	38	41	42	43	2.87	3.11	3.20	3.27

	Males	17	16	24	20	2.75	2.60	3.91	3.25
	Females	21	25	18	23	2.98	3.56	2.57	3.29
....malignant neoplasm of rectum and anus (C20, C21)	Total	133	148	121	131	10.06	11.23	9.21	9.97
	Males	79	71	56	70	12.08	11.53	9.11	11.37
	Females	54	77	65	61	7.65	10.96	9.29	8.73
....malignant neoplasm of liver and intrahepatic bile ducts (C22)	Total	95	96	83	102	7.18	7.28	6.31	7.76
	Males	48	57	42	66	7.78	9.26	6.83	10.72
	Females	47	39	41	36	6.66	5.55	5.86	5.15
....malignant neoplasm of pancreas (C25)	Total	211	259	251	238	15.95	19.65	19.09	18.10
	Males	107	131	108	110	17.34	21.28	17.57	17.87
	Females	104	128	143	128	14.74	18.22	20.43	18.31
....malignant neoplasms of respiratory organs (C30-39)	Total	737	716	753	724	55.72	54.32	57.28	55.07
	Males	559	527	564	547	90.58	85.62	91.76	88.86
	Females	178	189	189	177	25.23	26.91	27.00	25.32
.....malignant neoplasm of larynx, trachea, bronchus and lung (C32-C34)	Total	717	694	736	701	54.21	52.66	55.99	53.32
	Males	547	512	554	533	88.63	83.18	90.13	86.59
	Females	170	182	182	168	24.09	25.91	26.00	24.03
....malignant melanoma of skin (C43)	Total	49	52	62	61	3.70	3.95	4.72	4.64
	Males	20	28	28	25	3.24	4.55	4.56	4.06
	Females	29	24	34	36	4.11	3.42	4.86	5.15
....malignant neoplasm of breast (C50)	Total	267	213	253	243	20.19	16.16	19.25	18.49
	Males	2	4	2	3	0.32	0.65	0.33	0.49
	Females	265	209	251	240	37.56	29.75	35.86	34.33
....malignant neoplasm of cervix uteri (C53)	Total	72	63	65	59	5.44	4.78	4.95	4.49
	Males	0	0	0	0	0.00	0.00	0.00	0.00
	Females	72	63	65	59	10.20	8.97	9.29	8.44
....malignant neoplasm of other parts of uterus (C54, C55)	Total	48	61	50	56	3.63	4.63	3.80	4.26
	Males	0	0	0	0	0.00	0.00	0.00	0.00
	Females	48	61	50	56	6.80	8.68	7.14	8.01
....malignant neoplasm of ovary (C56)	Total	91	83	114	101	6.88	6.30	8.67	7.68

	Males	0	0	0	0	0.00	0.00	0.00	0.00
	Females	91	83	114	101	12.90	11.82	16.29	14.45
....malignant neoplasm of prostate (C61)	Total	256	258	269	292	19.35	19.58	20.46	22.21
	Males	256	258	269	292	41.48	41.91	43.76	47.44
	Females	0	0	0	0	0.00	0.00	0.00	0.00
....malignant neopsasm of kidney (C64)	Total	142	138	126	154	10.74	10.47	9.59	11.72
	Males	85	81	76	80	13.77	13.16	12.37	13.00
	Females	57	57	50	74	8.08	8.11	7.14	10.59
....malignant neoplasm of bladder (C67)	Total	90	115	97	100	6.80	8.73	7.38	7.61
	Males	69	81	70	74	11.18	13.16	11.39	12.02
	Females	21	34	27	26	2.98	4.84	3.86	3.72
....malignant neoplasms of lymphoid/haemotopoietic tissue (C81-C96)	Total	285	318	289	316	21.55	24.13	21.99	24.04
	Males	129	147	135	149	20.90	23.88	21.96	24.21
	Females	156	171	154	167	22.11	24.34	22.00	23.89
.....leukemia (C91-C95)	Total	144	147	124	130	10.89	11.15	9.43	9.89
	Males	75	71	62	60	12.15	11.53	10.09	9.75
	Females	69	76	62	70	9.78	10.82	8.86	10.01

Source: Statistics Estonia

Diagram 2: Neoplasms mortality rate per 100,000 population, 2012–2015



The number of consumers of tobacco products was constant since 2008, there was slight decrease among regular smokers. According to the 2014 data smoking among adults is decreased.

Smoking in 2012–2015 (percent of adult population, age group 16–64)

	Non-smokers	Former smokers	Occasional smokers	Regular everyday smokers
2008	43.0	22.9	7.9	26.2
2010	42.1	23.8	8.0	26.2
2012	41.9	23.9	8.2	26.0
2014	42.7	27.9	7.3	22.1

Source: Health Behaviour survey among Estonian Adult Population

Cardiovascular diseases mortality rate is decreasing, but it still constitutes 52,3% of all registered deaths in 2015 and 54,1% in 2012.

Main death causes of cardiovascular diseases in 2015 were:

- ischaemic heart diseases (I20-I25);
- hypertensive diseases (I10-I15);
- cerebrovascular diseases (I60-I69).

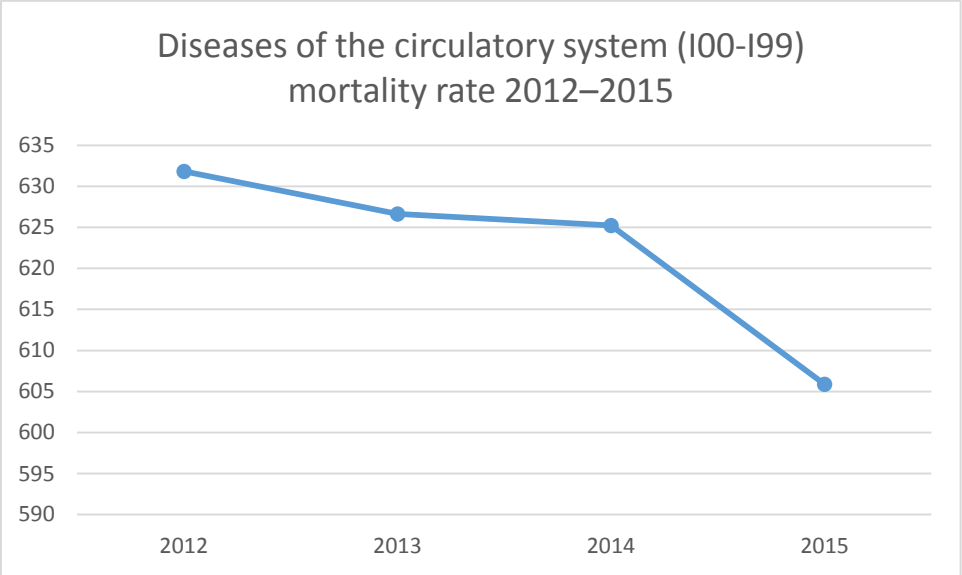
Cardiovascular diseases mortality rates per 100 000 population, 2012–2015

		Death cases				Death rates per 100,000 population			
		2012	**2013**	**2014**	**2015**	**2012**	**2013**	**2014**	**2015**
Diseases of the circulatory system (I00-I99)	Total	8 357	8 259	8 219	7 965	631.82	626.63	625.24	605.88
	Males	3 505	3 266	3 321	3 157	567.93	530.59	540.30	512.88
	Females	4 852	4 993	4 898	4 808	687.70	710.79	699.82	687.78
..chronic rheumatic heart diseases (I05-I09)	Total	26	30	18	16	1.97	2.28	1.37	1.22
	Males	7	7	5	2	1.13	1.14	0.81	0.33
	Females	19	23	13	14	2.69	3.27	1.86	2.00
..hypertensive diseases (I10-I15)	Total	2 155	2 275	2 595	2 730	162.92	172.61	197.41	207.67
	Males	737	759	875	901	119.42	123.31	142.36	146.37
	Females	1 418	1 516	1 720	1 829	200.98	215.81	245.75	261.64
..ischaemic heart diseases (I20-I25)	Total	3 966	3 532	3 075	3 175	299.84	267.98	233.92	241.52
	Males	1 767	1 497	1 354	1 373	286.31	243.20	220.29	223.05
	Females	2 199	2 035	1 721	1 802	311.67	289.70	245.90	257.78

..acute myocardial infarction subsequent (I21-I22)	Total	528	489	456	504	39.92	37.10	34.69	38.34
	Males	297	238	241	263	48.12	38.67	39.21	42.73
	Females	231	251	215	241	32.74	35.73	30.72	34.48
..other coronary diseases, except rheumatic and valvular disorders (I30-I33, I39-I52)	Total	702	798	817	784	53.07	60.55	62.15	59.64
	Males	396	393	413	353	64.17	63.85	67.19	57.35
	Females	306	405	404	431	43.37	57.66	57.72	61.65
..cerebrovascular diseases (I60-I69)	Total	1 048	1 204	935	842	79.23	91.35	71.13	64.05
	Males	416	445	355	341	67.41	72.29	57.76	55.40
	Females	632	759	580	501	89.58	108.05	82.87	71.67

Source: Statistics Estonia

Diagram 3: Cardiovascular diseases mortality rate per 100,000 population, 2012–2015



Compared to year 2007, the incurrence of new cases of HIV infection has dropped by more than half (from 47.3 new cases to 20.5 per 100,000 population). However, since 2012 there have been slight changes – from 23.9 new cases in 2012 to 20.5 per 100,000 population in 2015.

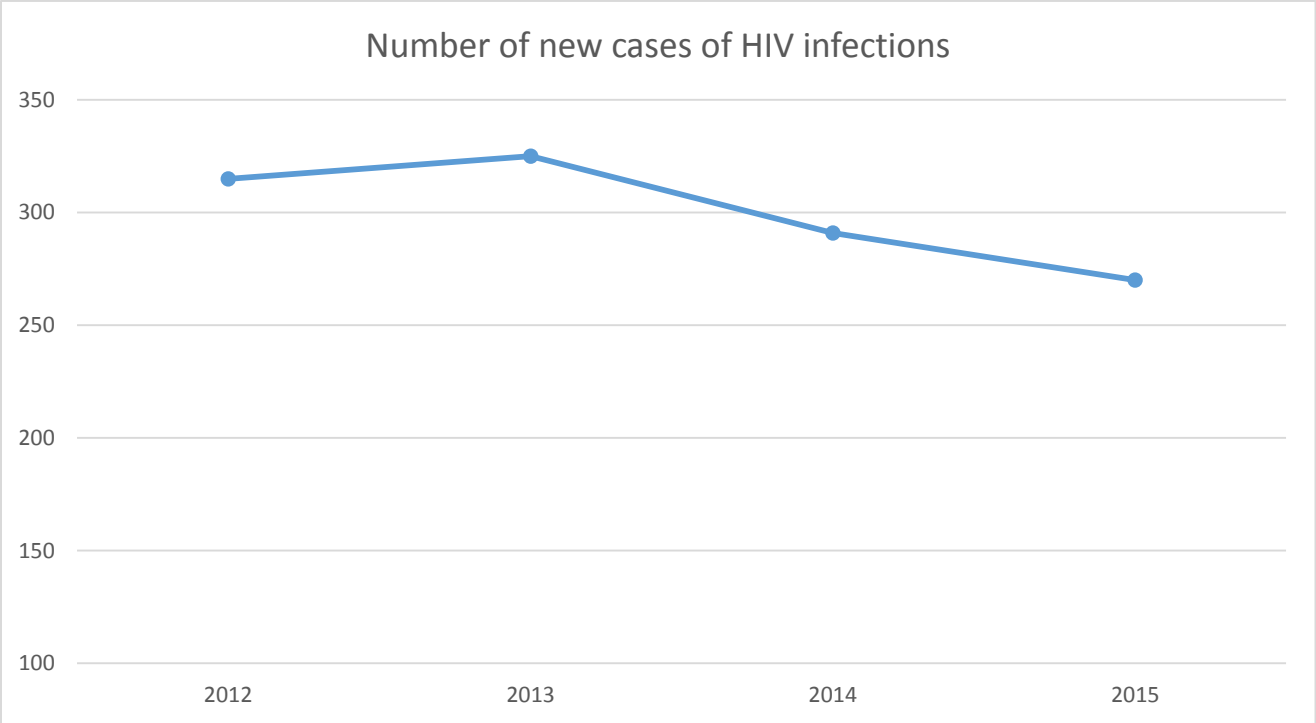
New cases (incident cases) and death cases of HIV infection, incidence and death rates per 100 000 population, 2012–2015

	Incident cases	Incidence rate per 100,000 population	Death cases	Death rate per 100,000 population

	2012	2013	2014	2015	2012	2013	2014	2015	2012	2013	2014	2015	2012	2013	2014	2015
Total	315	325	291	270	23,9	24,7	22,2	20,5	53	47	45	44	4.01	3.57	3.42	3.35
Males	209	200	181	167	33,9	32,5	29,5	27,1	38	35	34	33	6.16	5.69	5.53	5.36
Females	106	125	110	103	15,1	17,8	15,7	14,7	15	12	11	11	2.13	1.71	1.57	1.57

Source: Health Board, Statistics Estonia

Diagram 4: New cases of HIV infection, 2012–2015



According to the database of the Statistics Estonia, 67 children of 0–14 years of age died in 2015.

Deaths numbers of infants, 2012–2015

	2012	2013	2014	2015
Total of perinatal deaths	62	61	59	70
Early neonatal deaths (0-6 days)	18	10	13	16
Dead-born	44	51	46	54
Coefficent of perinatal deaths per 1,000 births	4.4	4.5	4.4	5.0
Early neonatal per 1,000 live births	1.3	0.7	1.0	1.2
Coefficent of dead-born per 1,000 births	3.1	3.8	3.4	3.9

Source: Statistics Estonia

Causes of death of children of 0–14 years of age by ICD-10, 2012–2015

	2012	2013	2014	2015
All causes	79	66	73	67
Certain infectious and parasitic diseases (A00-B99)	1	2	2	1
Neoplasms (C00-D48)	7	6	8	10
Endocrine, nutritional and metabolic diseases (E00-E90)	1	0	0	0
Diseases of the blood and blood-forming organs (D50-D89)	0	0	0	0
Mental and behavioural disorders (F00-F99)	0	0	0	0
Nervous system and sense organ disorders (G00-H95)	5	1	9	2
Diseases of the circulatory system (I00-I99)	1	2	2	4
Diseases of the respiratory system (J00-J99)	4	3	3	3
Diseases of the digestive system (K00-K93)	0	4	0	2
Diseases of the skin and subcutaneous tissue (L00-L99)	0	1	0	0
Diseases of the musculo-skeletal system and connective tissue (M00-M99)	0	0	0	0
Diseases of the genitourinary system (N00-N99)	0	1	0	0
Certain conditions originating in the perinatal period (P00-P96)	22	12	14	16
Congenital malformations, deformations and chromosomal abnormalities (Q00-Q99)	21	12	13	9
Symptoms, signs and ill-defined causes (R00-R99)	4	0	4	2
Injury and poisoning (V01-Y89)	13	22	18	18

Source: *Statistics Estonia*

Main causes for death of children of 0–14 years of age in 2015 were:

- Accidents and intoxications – 18 events;
- Conditions in the perinatal period – 16 events;
- Tumours – 10 events;
- Congenital anomaly – 9 events.

The following causes of maternal mortality are forwarded to the National Institute for Health Development, registry of death causes:

Causes of maternal mortality, 2012–2015

Cause	2012	2013	2014	2015
Pregnancy, childbirth and the puerperium (O00-O99)	1	1	0	0
pregnancy with abortive outcome (O00-O08)	0	0	0	0
Certain conditions originating in the perinatal period (P00-P96)	22	12	14	16
birth trauma (P10-P15)	0	0	0	0

Source: Statistics Estonia

The share of health expenditure has been slightly increased stable during the years, constituting 6.1% of GDP in 2014 and 5.8% of GDP in 2012.

Healthcare expenditures, 2011–2014

	2012	2013	2014	2015
The share of current health expenditure in GDP, %	5.8	6.0	6.2	6.5
The share of public sector health care schemes in GDP, %	4.5	4.5	4.7	4.9
The share of household out-of-pocket payment in current health expenditure, %	21.5	22.6	22.7	22.7
The share of household out-of-pocket payment in GDP, %	1.3	1.4	1.4	1.5
Current health care expenditure in current prices, thousand euro	1 044 012.7	1 136 017.4	1 222 759.3	1 320 671.3
Government schemes and compulsory contributory health care financing schemes, thousand euro	800 342	858 937	924 727	999 785

Source: the National Institute for Health Development

The Commitee notes that there exists a National Strategy for the Prevention of Heart and Vascular diseases 2005-2020, as well as a National Stategy for HIV and AIDS 2006-2015. It asks to be kept informed on the implementation of the latter given the high HIV incidence and prevalence in Estonia.

The National HIV and AIDS Prevention Strategy for 2006–2015 ended with the year 2015 and all the activities from the strategy have been integrated into the application plan 2013–2016 of the National Health Plan 2009-2020. The whole strategy facilitated the achievement of the National Health Plan, limiting the spreading of HIV infection and ensuring high-quality treatment to people with AIDS. The general objective of the strategy was to achieve a permanent tendency of decrease in spreading of HIV infection. An evaluation of the National HIV and AIDS Prevention Strategy for 2006-2015 is currently under way.

The activities in the National Health Plan include an objective to decrease the number of new HIV cases to 20 per 100,000 people by year 2015, and to prevent extension of the epidemic with the help of strategic activities (including keeping the share of pregnant women infected by HIV under 1% of all the pregnant women). Areas of activity to stop the spreading of the HIV epidemic and decrease the influence of the epidemic are the following: prevention activities

among various target groups, HIV testing and counselling; prevention, treatment and welfare services aimed at people infected with HIV and with AIDS; surveillance, monitoring and evaluation and development of human and organisational resource. Data on HIV-related deaths and new infections is included with other data in the previous section.

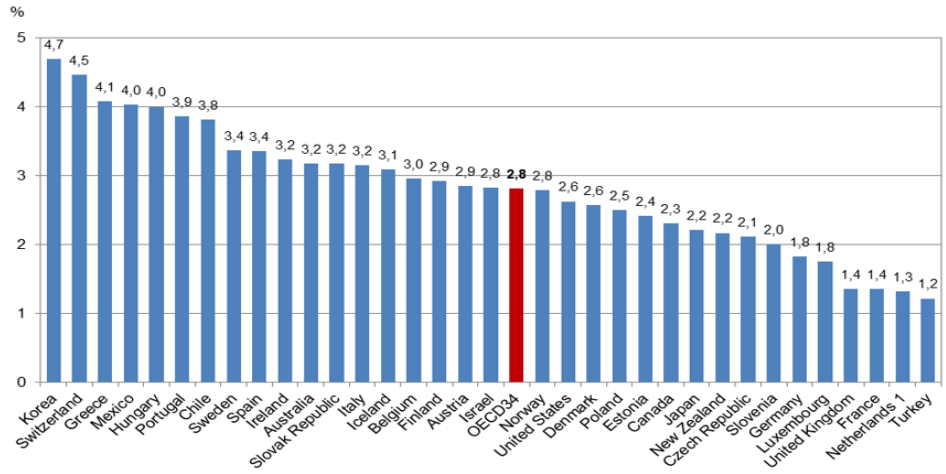
The following actions with regard to HIV/AIDS are included in the NHP 2013-16 action plan:

- Increasing of the knowledge of the population about HIV infection and ways of spreading thereof, improvement of knowledge, life skills and attitudes promoting secure sexual behaviour
- Offering services of harm reduction, counselling, testing and treatment in regard to safer drug consumption and safe sexual behaviour in order to stop the spreading of HIV infection, also to prisoners
- Ensuring of professional training, in-service training and safety instruction for people subjected to risks in their professional activities
- Ensuring of the availability of antiretroviral medicines, including the planning and organisation of public procurements and delivery of medicinal products to therapy centres
- Supporting of the database of HIV positive patients
- Surveillance of HIV infection, concurrent infections and risk behaviour, and evaluation of interventions

According to this source, this growing out-of-pocket expenditure may hinder access to health care for low-income population groups. As a consequence, health financing has become more regressive over recent years. The Committee asks the next report to provide information on the consequences of this regressive public health financing on access to health care.

Out-of-pocket-payments (OOPP) consist of direct payments for health care services incl. dental care services, medicinal products incl. pharmaceuticals. During the last financial crisis, the OOPP share of total health expenditures decreased because OOPP fell in line with spending in the economy. Starting from 2011, the OOPP share of total health expenditures has increased from 17,6% in 2011 to 23,8 % in 2014. This is slightly higher than EU average. Meanwhile out-of-pocket medical spending as a share of final household consumption in Estonia compared with OECD countries average is lower (Estonia 2,4%, OECD 34 is 2,8%)

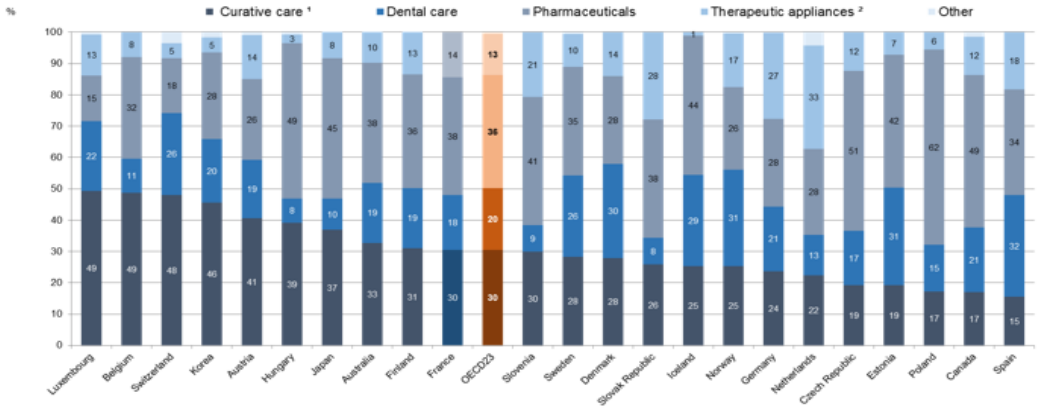
Out-of-pocket medical spending as a share of final household consumption, 2013 (or nearest year)



Source: Health at Glance 2015

Medicinal products account for the highest share of OOPP expenditure (50-60% in 2000-2012 and 48,% in 2014) of which 56% is OOP payments for prescription drugs (2014). The second highest cost category is health care services (22-34% in 2000-2012 and 18% in 2014) including dental care (19-27% in 2000-2012).

Shares of out-of-pocket medical spending by services and goods, 2013 (or nearest year)



Source: Health at Glance 2015

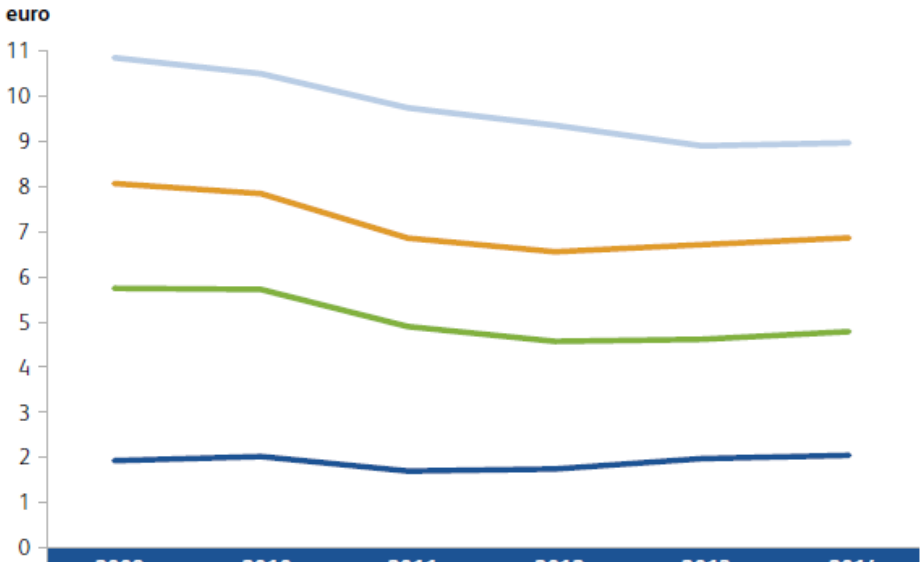
In comparison with OECD average (30%) the share of curative care is lower in Estonia (19% and share of dental care (OECD 20%, Estonia 31%) and share of pharmaceuticals higher (Estonia 42%, OECD 36%).

Some services, such as inpatient nursing care and abortion, have a statutory cost-sharing requirement that has been approved by the government as a fixed proportion of the service price.

National health Plan sets a target to keep OOPP under the 25% from health expenditure.

Implementation of the policy to prescribe an active ingredient has been successful – 86% of the prescriptions issued by doctors in 2014 were based on the active ingredient. This means that any further decrease in out-of-pocket expenses for pharmaceuticals can occur as a result of the informed decisions patients made with the help of pharmacists.

Starting from 2012, the campaigns to promote the use of generic pharmaceuticals ("Choose the cheapest medicine") where carried out by the Estonian Health Insurance Fund (EHIF) targeted to the population. According to data from 2014 - even though increasingly innovative and more and more expensive pharmaceuticals are taken into use, the average cost of prescription for patient has slowly decreased starting from 2009 and the out-of-pocket expenses of insured persons when purchasing prescription pharmaceuticals have remained stable. Same time the financing required for reimbursement of pharmaceuticals has increased as well as the number of reimbursed prescriptions. (EHIF Annual report, 2014[10])



	2009	2010	2011	2012	2013	2014
50% discount rate	10,85	10,50	9,74	9,36	8,91	8,97
75% discount rate	8,07	7,85	6,86	6,56	6,71	6,86
90% discount rate	5,75	5,72	4,90	4,57	4,62	4,79
100% discount rate	1,93	2,02	1,70	1,75	1,98	2,05

Figure 16. Average cost of prescription for patient, euros

The Committee considers that waiting times continue being an area of concern, and asks to be kept informed of further developments in this area, notably whether a structural change of healthcare personnel is envisaged as a means of improving efficiency.

[10] Available in English here: http://haigekassa.ee/sites/default/files/uuringud_aruanded/haigekassa_aastaraamat_2014_eng.pdf

Waiting times

Access to care is regulated by a decree of the Minister of Social Affairs. Requirements for accessibility describe the maximum waiting time. Decisions about waiting time targets for ambulatory specialist, day care and inpatient care is delegated to the EHIF Supervisory Board and are revised regularly. The maximum waiting times for specialist (not emergency) care is six weeks for ambulatory specialized care and eight months for inpatient care and day surgery. Some interventions have longer maximum waiting times: for example, a year and a half for cataract surgery, two and a half years for large-joint endoprotheses, one year for cochlear implants and eight months for cardiac surgery. The EHIF has set the objective of managing waiting lists in cooperation with partners according to the terms and conditions of the contract. The EHIF collects provider-level data on waiting times broken down by specialty (in some case by procedure) and reason on a quarterly basis (on a monthly basis for public sector hospitals). According to a series of surveys conducted by EHIF in 2013, the lack of medical doctors in some specific areas rather than limited financial resources has become the main hindrance to timely access to care.

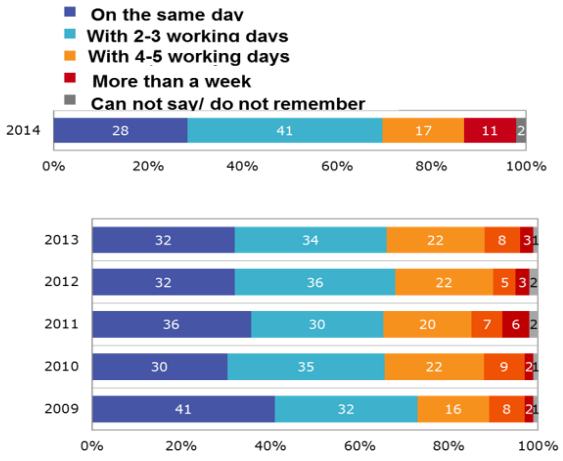
However, there are large differences between hospitals. As waiting list data is updated regularly, patients are free to move to a shorter queue.

According to the Estonian patient satisfaction survey (2014), access to the family physician or nurse services has been stable in last few years. 28% of patients got family physician or nurse appointment on the same day, 41% within 2-4 working days, 17% 4-5 working days – so 87% patients got to GP-s appointment with 4–5 working days or faster.

Access to family physician or nurse % patients who have visited family physicians in last 12 months

Please think about your last visit to family physician center. How fast after registration did you get to the appointment (family physician or nurse)?

87% patients got to GP-s appointment with 4–5 wortking days or faster.



Source: Patients (with health insurance) sadisfaction survey, 2009–2014

In 2014, 25% of patients (20–30%) got to specialist care appointment within a week. 53% (48–59%) of patients got to specialist care appointment within a month. 43% (37–48%) of patients

had to wait more than a month. There hasn't been any statistically significant change in specialist care access since 2009.

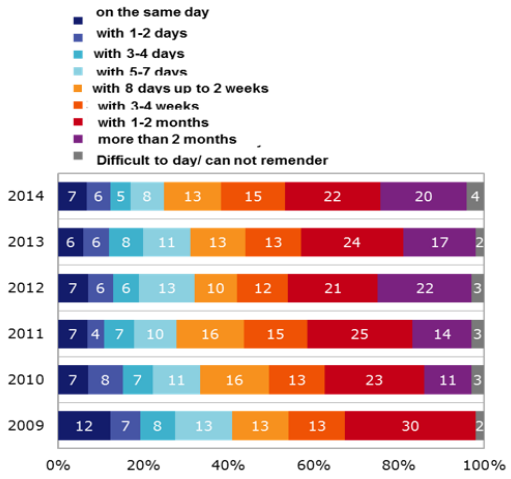
Access to specialist care: how fast did you get to the appointment in last time when you registered to see specialist 2009–2014, % of patients who have visited specialist care in last 12 months

How fast did you get to appointment in last specialist care visit?

In 2014 25% of patients (20–30%) got to specialist care appointment with a week. 53% (48–59%) of patients got to specialist care appointment with a month.

43% (37–48%) of patients had to wait more than a month.

In 2013 31% of patients got to appointment witha a week, 57% with a month and 41% had to wain more than a month.



Source: Patients (with health insurance) sadisfaction survey, 2009–2014

Actions

Innovative solutions such as e-consultation and e-visits were included into EHIF services basket in 2013. These services are financed as usual visits and enable to avoid unnecessary visits to the specialist and save the time of patient and specialist. The scale of specialities covered as well as healthcare providers included into the new system increases gradually.

Central e-registering system for all public sector hospitals is in the process of implementation. It will enable hospitals to have a better overview of the real on-line occupancy rate and gives patients the possibility to compare waiting times by different providers.

Strengthening primary care and its more effective "gate keepers" role to reduce the pressure to the special and hospital care is the main goal of a project of building the network of primary health care centres with multi-professional teams of specialists in every centre. The project is funded from European Regional Development Fund and started in the end of 2015.

Reorganizing hospital sector and networking between big competence centres and small county hospitals helps to assure necessary ambulatory specialist care and day care in rural areas.

Human and financial resources

Numbers of Estonian medical staff for physicians are around EU average and for nurses and midwives slightly below the EU average.

Estonia's health system is largely publicly financed through an earmarked tax on wages (the social tax). Financing of health care system mainly from the payroll employment taxation in the condition of ageing population needs changes in coming decade. In the report made with cooperation with WHO in 2010 ((Responding to the challenge of financial sustainability in Estonia's health system, 2010, WHO, EHIF, MoSAE)) assessing Estonian health financing policy, with health sector revenue and expenditure trend projections from 2010 to 2030, that examined the impact of a range of demographic, labour market, macroeconomic and health system factors under different scenarios, several scenarios were analysed. All scenarios found that health expenditure will consume a greater share of national wealth in future, but health system factors – technological development and utilization patterns – were shown to have a much larger impact on expenditure than demographic factors such as population ageing. The 2010 report brings out that the public revenue base for the health sector should be broadened to ensure that the system is better able to achieve its objectives now and in the longer term. Although no concrete decisions have been made to change the current health financing architecture by the government, the presented analysis and proposals triggered a public debate among stakeholders and raised awareness of the issue.

Actions

Competitive wages-policy of health professionals – the increase of salaries in health sector has been during last 2-4 years has been higher (~10%) than in other sectors (~6%).

Gradually increasing the training amounts of health professionals according to surveys about labour market situation for doctors, nurses and pharmacists.

Start-up grants for new doctors who start working in rural areas of Estonia.

State financed courses for health professionals, who intend to go back to health care from other sectors and needs training for that.

In its previous examination of Article 11, the Committee adopted a general question addressed to all States on the availability of rehabilitation facilities for drug addicts, and the range of facilities and treatments. As the report does not address this issue, the Committee requests that information be included in the next report.

The activities of the National Strategy for the Prevention of Drug Addiction up to 2012 have been integrated into the action plan 2013–2016[11] of the National Health Plan 2009–2020.

[11] Available in English here: http://www.sm.ee/sites/default/files/content-editors/eesmargid_ja_tegevused/Tervis/taiendatud_rta_2013-2016_rakendusplaan_eng_8.04.15.pdf

The strategy was a national multi-disciplinary long-term strategy of combating drugs, which as a whole was aimed at decreasing the psychological, social and physical damages caused by drugs. The strategy had an integrated approach to drug demand (prevention, treatment, rehabilitation) and supply of drugs (activities of various power structures: police, customs, border guards), covering six fields: prevention, treatment and rehabilitation, harm reduction, supply reduction, drugs in prison and surveillance of the drug situation.

Activities in the NHP 2013-2016 action plan include:

- Coordinated activity for prevention of drug addiction and reduction of handling of narcotic substances through the Drug Prevention Committee of the Government of Estonia
- Creation of a system of addiction treatment and addiction rehabilitation functioning between different fields of administration; development of relevant legislation.
- Supplementation of the legislation and implementation thereof in development and provision of drug addiction treatment, rehabilitation and follow-up services and counselling services (including harm reduction)
- Creation of national legislation to collect the necessary information for an early warning system (for new psycho-active substances) and exchange thereof between various institutions
- Creation of a personalised drug addiction treatment database including information that can be used to obtain an adequate idea of the situation of drug addiction in the country and to plan interventions.
- Enhancing national and international cooperation regarding supervision
- Increasing of the awareness of drug addiction and drugs in the society as a whole and in risk groups
- Mapping of training needs and training of specialists associated with prevention of drug addiction, harm reduction, treatment and addiction rehabilitation, including personnel of prisons and detention establishments
- Development and provision of drug addiction treatment, rehabilitation and follow-up services (including harm reduction) and counselling services
- Organisation of treatment and addiction rehabilitation for convicted people with drug addiction problems whose imprisonment has been substituted with treatment or rehabilitation
- Decreasing of the market of illegal narcotic and psychotropic substances and medicines through control activities and other measures with a purpose to increase the number of discovered drug cases and quantities confiscated

- Ensuring a functioning system against import of drugs into the country and prisons
- Increasing of the discovery and solving of drug crimes. Handling of drug crimes takes place so that their adjudication is based on analysis and is aimed at the discovery of more dangerous (fatal)substances
- Increasing of the efficiency of supervision of service providers of treatment and addiction rehabilitation regarding the fulfilment of the requirements provided in the Health Care Services Organisation Act and the Medicinal Products Act and in the legislation established according to those by healthcare service providers and healthcare professionals (including violations of requirements governing the issuing of prescriptions for medicinal products
- Supervision of handling of medicinal products by service providers of addiction treatment(including Methadone substitution therapy)
- Carrying out evaluation, surveillance and scientific research in the field of drug addiction

The main drug addiction treatment method is opioid substitution therapy (OST), but inpatient addiction treatment, long-term rehabilitation are also used. OST is provided in 9 locations across the affected areas in Estonia and funded at the state level.

Number of OST clinics and people enrolled 2012-15

	2012	**2013**	**2014**	**2015**
Total number of OST clinics nationwide	9	9	9	9
Number of people enrolled in OST programme nationwide	1 157	1 166	919	620

Source: National Institute of Health Development, Ministry of Social Affairs (NHP 2009-2020)

The decline in the number of people enrolled in OST is due to problems with data collection. The data is not personalised, previously patients that had used other narcotics while on OST were disqualified from the program and often re-joined it in the same year leading to them being counted as a new patient, this is not the case anymore.

Needle exchange services 2012-15

	2012	**2013**	**2014**	**2015**
Total number of contacts with clients	150 427	153 745	134 356	129 719
Total number of recurring clients	6 713	6 677	6 305	5 550
Total number of new clients	1 319	849	583	649

Total number of needles received	1 436 642	1 395 870	1 308 762	1 388 053
Total number of needles given out	2 228 082	2 183 933	2 110 527	2 136 691

Source: National Institute of Health Development

Needle exchange services are also provided in 36 places in Estonia (14 stationary centres and 22 outreach locations). In addition to needle exchange skin disinfectant wipes, pregnancy tests and condoms are given out. Counselling services are also provided by social workers and psychologists.

State funded short term (2-4 weeks) inpatient drug addiction treatment for adults is available in Tallinn and in 2015 47 patients finished this service. After short term treatment all patients are also offered outpatient aftercare lasting up to 3 months.

Long term rehabilitation service is provided in two state funded centres. One of them provides service only for men (26 places) and the second one both for men and women (altogether 40 places). In 2015, 147 patients received rehabilitation service from which 28 finished successfully.

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.

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.

Life expectancy has increased from the beginning of 2008 by an average of 2.9 years (74.3 years in 2008 and 77.2 years in 2014). In comparison with the years 2008–2011 and 2012–2014 the increase of life expectance had been slight accordingly 3.1 years and 0,7 years. It is important to note that difference between the life expectancy of men and women have been decreased (10.5 years in 2008 and 9.2 years in 2014).

According to the performance report of the second period (2013–2014[12]) of the National Health Plan for 2009–2020 the following positive trends of goals and sub-goals (strategic objectives) can be highlighted:

- the decline trend of the disability-free life expectancy has slowed down;
- the relative share of long-term unemployed among the workforce has dropped;
- the share of children rating their health as very good has steadily increased;
- indicators, related to health behaviour of children (use of alcohol and tobacco) have improved to a certain extent;
- the number of fatal occupational accidents has dropped;
- large share of population engages in various physical activities on regular bases;
- number of new incidents of tuberculosis is declining;
- injury death rate has dropped at the expense of deaths resulting from poisoning;
- patients' contribution to total health care expenditures remains within the set limits.

The most important challenges to be addressed are the following:

- restoring the growth of life expectancy and disability-free life expectancy;
- the share of individuals suffering from chronic diseases and restricted everyday activities among the population increases;
- social stratification is increasing;
- there are major gender, regional and socio-economic disparities in health indicators;
- suicide rates among children and adolescents do not decrease; suicidal trends among the elderly show an increase;
- new cases of diseases in mental and behavioural disorders among children and adolescents;
- mortality among children and adolescents aged 0–19, incl. injury death rate, does not show a decrease;
- morbidity and mortality from respiratory diseases demonstrates an increase;

[12] http://sm.ee/sites/default/files/content-editors/eesmargid_ja_tegevused/Tervis/rta_2013-2014._aasta_tulemusaruanne_eng.pdf

• number of working days, lost as the consequence of occupational accidents, is increasing;

• vaccination among children under the age of 2 years shows a steady decline;

• overweight and obesity (starting already from childhood!)

• the use of alcohol, drugs and smoking;

• high share of multi-resistance forms of tuberculosis;

• the number of new cases of HIV is not decreasing;

• recourses of health care personnel (especially, nursing care personnel);

• accessibility of health care, incl. dental services;

• satisfaction with the quality of health care shows a decline.

3) Please supply any relevant statistics or other information

Please see the answer for Article 11 § 1. Information on Screening is provided below.

As the report contains no information on these matters, the Committee asks the next report to provide up-to-date information on screening programmes available throughout the country.

Neonates are screened for phenylketonuria, hypothyroidism and hearing within the first week of their birth. In 2012 phenylketonuria and hypothyreosis screening was passed by 14,039 neonates; hearing screening was conducted on 13,915 neonates. In 2013 13,692 neonates participated in phenylketonuria and hypothyreosis screening, hearing screening was conducted on 13,764 neonates. In 2014 phenylketonuria and hypothyreosis screening was passed by 13,559 neonates; hearing screening was conducted on 14 273 neonates.

Pregnant women in specific risk groups are also screened for hereditary and chromosome diseases. Starting from 2015, the screenings for both pregnant women and neonates have been integrated into the package of services provided for monitoring pregnancies and neonates.

Screening programmes for breast and cervical cancers are financed by the Estonian Health Insurance Fund and coordinated by the National Institute for Health Development and Cancer Screening Registry. The target group for breast cancer since 2002 is insured women aged 50–

62 and for cervical cancer since 2003 is insured women aged 30–55 . Other screening activities are carried out during regular health service provision. Most of the cytological cervical tests (80%) are performed during regular health examinations. A mammography bus offers tests in counties to increase the availability and participation rates of screening.

In 2014, 60,692 women were included in cervical cancer screening sample; in the beginning of the year there were also 10.6%, of individuals with no insurance who did not receive the invitation. Invitations were also not sent to women living abroad and those who already suffer from cancer (in total, 3,872 women). Breast cancer screening sample included 65,534 women in 2014, 9% were not covered by health insurance. Invitations were sent to 55,253 women; invitations were not sent to those who had recently attended examination, women living abroad and those who were already treated for breast cancer. Compared to 2013, participation in screening increased somewhat – in 2014, the involvement in cervical cancer screening totalled 50.3% and in breast cancer screening – 57.6%. The respective indicators of 2013 were 49% and 53%. In addition, two mammography buses were used in rural areas and this resulted in 66.1% coverage. In rural areas, the participation in breast cancer screenings remains higher than in larger centres.

In 2016, a new screening for colorectal cancer started, the target group is insured men and women aged 60–69. The patients involved in the screening will be screened again after every 2 years thereafter.

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.

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.

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.

29.4% of adult population (age group 16–64) are smokers and 22.1% are regular everyday smokers. In comparison to the 2012 data smoking among adults is decreased (34.2% of adult population were smokers 8,2% were regular everyday smokers).

Consumption of absolute alcohol per capita started to decrease during the recession, starting from 2009, but shows a growth tendency again as the economy started to restore in 2011 and remained stable until 2014. In 2015, Estonians consumed 8.7 litres of absolute alcohol per capita per year, which is 1.6 litres less than in 2012. The year characterized by largest consumption of alcohol was 2007, when Estonians consumed 12.6 litres of absolute alcohol per capita per year.

Alcohol consumption in 2012–2015 (litres of alcohol at 100% vol. per person in a year):

	Litres of alcohol at 100% vol. per person in a year
2012	10.3
2013	10.0
2014	9.9
2015	8.7

Vaccination among children among the 2 years shows a steady decline.

Childhood immunization – coverage among 2 years old (%), 2012–2015

	Diphtheria and tetanus	Pertussis	Poliomyelitis	Measles, mumps and rubella	Hepatitis B	*Haemophilus influenzae* type B
2012	94,6	94,6	94,6	93,6	94,7	95,1
2013	94,8	94,8	93,7	94,7	95,1	95,0
2014	94,5	94,5	94,5	93,4	94,1	95,0
2015	94,0	94,0	94,0	93,2	93,4	94,1

It asks the next report to provide updated information on environmental protection measures and policies and their implementation, as well on air pollution levels and trends, or cases of pollution of drinking water or food poisoning during the reference period.

Water

Environmental protection measures to prevent pollution of drinking water and deterioration of the quality of water intended for drinking water production are set in Water Act. Measures include formation of sanitary protection areas around water abstraction points and limiting access and activities within these areas depending on the volume of water intake.

The sanitary protection area of a water intake structure is the land and water area surrounding the water extraction place where special requirements exist to prevent the deterioration of water characteristics as well as to protect the water intake constructions. The extent of a sanitary protection area is set by law and is following:

- 50 m from a water well if one water well extracts water from a groundwater layer;
- 50 m to both sides from the axis of a row of water wells, 50 m from the farthest water wells of the row and the area between water wells in a row of water wells if water is extracted from a groundwater layer by two or more water wells;
- 200 m upstream from the water extraction place, 50 m downstream and 50 m to both sides from the water extraction place along the line drawn crossways with the shore of a water body and passing the water extraction place if water is extracted from a watercourse (river);
- water area of a waterbody plus a bank zone as broad as 90 m if water is extracted from a body of standing water (lake).

A sanitary protection area shall not be formed if less than 10 m3 of water is extracted per day for the needs of one immovable. Detailed maintenance requirements for such a water extraction place have been elaborated and set by the degree of the Minister of the Environment.

Environment Board may decrease a sanitary protection area of a water intake structure:

- up to 10 m if less than 10 m3 of water is extracted per day and is used to up to 50 persons needs;
- to 30 m if more than 10 m3 of water is extracted per day and the groundwater layer is well protected
- up to 10 m if less than 50 m3 of water is extracted per day and the groundwater layer is well protected and reduction of sanitary protection area is approved by Health Board.

A sanitary protection area may extend up to 200 m from the water extraction place if water extraction from groundwater exceeds 500 m3 per day. Environmental Board on the basis of the project of a water intake structure shall establish the boundaries for such a sanitary protection area.

A sanitary protection area for surface water body is a water area of waterbody plus shore area at least 90 meters, if water abstraction is more than 500 m3 per day. Boundaries of such sanitary protection area is set by Environmental Board.

The detailed procedure for the formation and design of the sanitary protection area of a water intake structure is set by the degree of the Minister of Environment. The procedure mentioned shall also provide the informing of a local government of the formation of the sanitary protection area of a water intake structure.

In the sanitary protection area of a groundwater intake structure with a width of either 30 or 50 m, economic activity is prohibited, except the service of water intake constructions; forest maintenance; mowing of meadow areas and water monitoring. In the sanitary protection area of a groundwater intake structure either over 30 or 50 m, the following is prohibited: land treatment by sewage sludge; establishment of burial sites; construction and expansion of facilities prescribed for waste processing or storage, except in the territory of ports; extraction of mineral resources and driving a power-driven vehicle outside designated roads and driving an all-terrain vehicle, except for state monitoring, work related to the management of a protected natural object or the performance of maintenance work in a green zone of a densely populated area, transportation of watercraft needed for fishing activities by a person holding the right to fish as a professional activity or for recreation, for collecting reed and gathering seaweed, and for forestry work and agricultural work on profit-yielding land.

In the sanitary protection area of the water intake structure of watercourses and bodies of standing water, on the water intake structures of North-eastern Estonia and the town of Narva on the river Narva, and on the part of the water intake structure of the city of Tallinn on lake Ülemiste, economic activity is prohibited, except the service of water intake constructions; forest maintenance; the mowing of meadow areas and water monitoring. On other water bodies the same is prohibited as in the sanitary protection area of a groundwater intake structure either over 30 or 50 m.

The owner or possessor of a water intake structure may prohibit the presence of persons not connected with the service of the water intake construction at the equipment of the water intake construction and at the part of the water area of the water body that is in the sanitary protection area of the water intake structure. Only the people who perform duties related to environmental supervision; health protection; service of water intake constructions; forest maintenance; mowing of grass plants and water monitoring may be present in a sanitary protection area. If in the sanitary protection area of a water body for the purpose of the maintenance of water intake constructions, a water body or the sanitary protection area itself, it is necessary to carry out work not mentioned above, a permit for it shall be issued by the local government in agreement with the Environmental Board.

Besides the abovementioned preventive measures stated in law and inspected by Environmental Inspectorate, huge investments have been done during the period 2012-2015 to build new and reconstruct old drinking water treatment facilities as well as building new and reconstructing old pipelines in order to meet the strict quality requirements of drinking water and broadening the amount of population connected to drinking water that corresponds to requirements. Investments, including EU funds, state funds and water companies` own funds made so far have been resulted that the population rate that is connected with central drinking water supply systems and therefore supplied with drinking water that meets all the requirements rose from 88% in 2012 to 98% in 2015.

Air

The Ministry of the Environment is responsible for ambient air policy in Estonia. Since the beginning of measurements, the amount of small particulate matter in air has shown a steady decrease. A major decrease took place in 2008 when EU directive 2008/50/EC on ambient air quality and cleaner air for Europe went into effect. The main causes of small particulate matter are vehicle traffic, including snow tires wearing down roads, the use of sand and salt on roads during the winter as well as the burning of wood for heating homes.

When evaluating the health risks of particulate matter, it is important to consider the specific chemical elements and size of the particles. In Estonia this is done according to EU directive

2004/107/EC relating to arsenic, cadmium, mercury, nickel and polycyclic aromatic hydrocarbons in ambient air. The amount of SO2 in ambient air has shown a steady decrease thanks mainly to tough regulations on the sulphur content in fuels.

Even though the average amount of particulate matter has gone down in all urban monitoring stations, 24h maximum values have gone up in most monitoring stations. Other factors contributing to lower particulate matter in 2015 may include an unusually warm winter leading to less heating using wood and less sand and salt for treating icy roads.

All in all, the amount of particulate matter has gone down in Estonia over the years, some chemical compounds faster than others. In more problematic areas, the ambient air has been studies in more detail and action plans have been developed to deal with the problems. In 2017, the new Atmospheric Air Protection Act will come into effect, this law has new regulations for unpleasant odours and guidelines for action for reducing them.

Food

The Ministry of Rural Affairs develops requirements and legislation and organises national inspection and monitoring of the food chain. In order to ensure food safety, the Ministry develops legislation related to food hygiene, food additives and contaminants and labelling, food contact materials and articles, novel foods and genetically modified organisms and other food groups or participates in the development of this legislation in the European Union decision-making process. Since the food safety legislation is mostly harmonised at EU level and is directly applicable to the member states, then national legislation mostly establishes requirements and procedures for the implementation of those rules. This would include among others requirements for the registration or approval of food businesses, competencies for the official control and sanctions in the case of infringements.

For the vast majority areas official controls are performed by the Veterinary and Food Board, an authority under the Ministry of Rural Affairs. The Veterinary and Food Board releases annual reports on their work on their website[13], unfortunately these are currently only available in Estonian. In 2015, a total of 11 500 checks were performed at food businesses and approximately 5200 food samples were taken. The number of non-compliant samples were 3.4% from the total number of samples, which is the slight increase compared to 2014 (2.5%).

The Committee asks to be kept informed of initiatives and developments in the field of waste management.

[13] http://www.vet.agri.ee/?op=body&id=320

The Ministry of the Environment is responsible for waste management policy in Estonia. Waste management is based on the hierarchy of waste management, i.e. the principle of minimising the effect of waste management on the environment as much as possible. The highest ranking solutions in the hierarchy should be given priority. Methods of recovery include preparation for reuse, recycling of materials and other recovery (energy recovery and back-filling of the mineral materials). Landfill disposal is considered to be the last solution in the hierarchy.

The National waste management plan (NWMP) for 2014–2020 mainly focuses on modern product design, clean resource-saving production and the recycling of already produced materials. Frugality, innovation, comfort and effectiveness – all four keywords that best capture the mood in the area of waste for the next seven years. The previous national Waste management Plans had to focus due to the actuals situation much more to the improving of the disposal sites situation, i.e. practical implementation of the EU Landfill Directive (LFD - 1999/31/EC). On period 2002-2007 the number of non-hazardous waste dumping sites was reduced from 150 to 6, whereas NWMP for 2008-2013 focused on rapid reduction of the landfilling of municipal and other comparable waste – between 2010 and 2013 did the share on landfilling of municipal waste drop from 70 % to 7%, with that Estonia achieved also targets set in LFD for the reduction of disposal of the bio-degradable waste for 2020.

Estonia has set a goal for 2020 to recycle at least 50 % of household paper, metal, plastic and glass waste. Estonia produces 288 kg of municipal waste per capita. Recycling of municipal waste is at 32 % of its total mass and only 7 % is landfilled.

In recent years, recovery of waste has escalated increasingly. Extended producer's responsibility and producers responsibility organisations (PRO) have taken responsibility on several waste streams from 2005. The PRO-s have established networks for collecting and recovering electronic equipment waste as well as battery and accumulator waste, old tires and packaging. In addition, the number of collection and demolition sites for end-of-life vehicles complying with environmental requirements has also increased.

The amounts being landfilled are decreasing thanks to the obligation to collect waste separately and the limits to landfilling bio-waste; but most visibly because of economic instruments in use – the landfill tax for non-hazardous, including municipal waste, is today near 30 €/t, which have delivered strong enough signal to the waste sector – please find alternatives to the disposal. Quiet massive investments have been launched on 'the polluter pays' principle, i.e. without public sector support, thus so far mainly to the Waste-to-Energy (WtE) and mechanical-biological treatment (MBT) facilities. Although investments with the public support have made mainly on recycling sector, this needs further attention on coming years.

In addition to recovery operations, actions supporting the avoidance/reduction of waste production are becoming increasingly important, gapping the connection between economic growth and waste production.

Estonia continuously produces a large amount of waste including hazardous waste from the oil shale industry. New and better solutions for reducing and recycling waste are also being explored in this area.

One of the largest tasks Estonia must tackle is reducing the amount of oil shale waste. In 2007–2011, more than 85% of waste was industrial waste and 79% of the total amount of waste generated was related to oil shale extraction and the power industry. A large proportion of industrial waste also comes from the wood and cement industry, this is mainly sent to recycling.

New methods for reusing and recycling waste, such as producing building materials from old tires, rubber mats and plastic waste, are continuously being developed. Biogas is produced from manure, slurry, landfill gas, sludge and bio-waste. The recovery incl. recycling (i.e. up to the certified construction material) of waste rock, generated on oil-shale enrichment processes, has also significantly increased – in 2010 and 2011 around 70% of waste rock was recovered in comparison to the previous 20%. For Estonia, the most important task is to find more capacities to increase the recovery, including recycling, of oil shale waste.

The Committee asks if there plans to extend smoke-free environments to other public places such as bars, restaurants, discos and pubs

Smoking in these places is not prohibited, but is allowed only in smoking rooms with special requirements:

In the following places, smoking is allowed only in a smoking room or smoking area:

- the premises of state and local government authorities;
- the premises of institutions of higher education;
- the premises of cultural institutions;
- the premises of recreation centres;
- the premises of agencies or enterprises providing health services;
- local trains, long-distance trains and passenger ships;
- rooms where a game of chance, betting or a totalizator is organised;
- the office premises and other public premises of enterprises;
- sports halls and sports facilities and recreational facilities.

A smoking room is a room located in a building or a vehicle to which the following requirements apply:

- the room is designated with verbal information which permits smoking or with a corresponding symbol, and information in Estonian stating that minors are not allowed to stay in smoking rooms in a visible place and in reasonable size;
- information “Suitsetamine kahjustab tervist!” [Smoking harms health!] is displayed in the room in Estonian in a visible place and in reasonable size;
- the room is negatively pressurised;
- air outflow in the room is not less than 8.4 litres per second per square metre, and if the room is not used, the air outflow may be reduced to 25 per cent of the normal air exchange;
- the air outflow ventilation system is separate and continuous or connected to other continuously operating air outflow systems by a separate duct.

A smoking area is an area located in a building or a vehicle without barriers which has a local ventilation system and to which the following requirements apply:

- the area is designated with verbal information which permits smoking or with a corresponding symbol, and information in Estonian stating that minors are not allowed to stay in smoking areas in a visible place and in reasonable size;
- information “Suitsetamine kahjustab tervist!” [Smoking harms health!] is displayed in the area in Estonian in a visible place and in reasonable size;
- an effective ventilation system ensures the movement of air from the smoking area directly into the outdoor environment.

Starting from 1st of June 2017 indoor smoking areas will be prohibited and smoking will be allowed only in smoking rooms.

And in respect of drugs, the Committee asks to be kept informed on the implementation of the National Strategy for the Prevention of Drug Addiction up to 2012, namely on its impact concerning trends in drug consumption.

The final report of the national strategy for prevention of drug addiction until year 2012 has been finalized[14]. The report concludes the following:

- The proportion of people aged 15–64 who have used drugs at least once in their life has increased: from 15% in 2003 to 21% in 2008.

[14] Summary available in English here: https://www.sm.ee/sites/default/files/content-editors/ners_l6pparuanne_kokkuv6te_en.pdf

- If in 1995, 7% of students aged 15−16 had tried some type of illegal drug, and in 2011 the respective number was 32%.
- The number of injecting drug users decreased by 56% in 2005–2009.
- Most common injected drugs are Fentanyl and Amphetamine but it is very common that several drugs are consumed simultaneously.
- According to the Causes of Death Registry, a total of 948 persons died as a result of using drugs in 1999–2011. In terms of this indicator, Estonia holds the first place in Europe.

Prevention

In 2012, the general goal of the strategy in terms of primary prevention was as follows: the number of cases of first-time users of drugs has started to decrease and the age is showing a tendency of increase. Based on the results of the 2011 ESPAD, this general goal has partly been achieved.

One of the main activities in this field is the provision of drug prevention education in general education schools through the shaping of life skills. Personal education is included in the national study programme as a mandatory subject in all levels of education, covering teaching of life skills and drug prevention. Another major area of activity is informing the population of the risks connected with drugs. Ministry of Education and Research has distributed information on drug prevention through the information and counselling centres operating in counties and larger towns. The main activities of the National institute of health Development in 2007–2012 included the development of various information material on drugs aimed at both children and parents. A website www.narko.ee was launched in 2006.

Therapy and rehabilitation

Up to date information is provided in response to a question under Article 11 § 1

Harm reduction

Up to date information is provided in response to a question under Article 11 § 1

Drugs in prison

The Ministry of Justice and its subdivisions were responsible for the implementation of activities connected with drugs in prison. In terms of prisons the strategy's goals were as follows: a functioning control system has been established to prevent access of drugs to prisons, and systematic therapy and in-prison rehabilitation is provided to drug addicts to ensure continuing drug-free lifestyle after release from prison. This goal was achieved by 2012.

At the moment of preparation of the strategy there were no drug-free departments in the Estonian prison system (except for Viljandi prison), therapy and rehabilitation programmes for addicts, and prison personnel had not received relevant training for working with drug addicts. Camp-type prisons were common, the architectural style of which complicated the provision of relevant surveillance. In terms of activities listed in the strategy which have been carried out, it is clear that the goals set for 2012 have been almost fully met.

The prison service has created departments of addiction rehabilitation in prisons for re-socialising addicts. In the past, the provision of therapy in prisons to addicts only included therapy with non-opiate medicines but as of 2008, Methadone therapy is also available in the Estonian prisons. At the end of the 3rd quarter of 2012, there were 896 persons diagnosed3with addiction in the Estonian prisons, i.e. 27.7% of the total number of prisoners. The proportion of opioid addicts remains the largest.

White Paper on Drug Prevention Policy

In the field of drug addiction, under the leadership of different ministries, preventive activities and/or provision of treatment and rehabilitation services by NIHD continued. Under the leadership of the Ministry of the Interior and on order of the drug prevention commission of the Government of the Republic, preparation of the drug use reduction policy (the White Paper) started in 2013. The Government of the Republic approved the White Paper in early 2014. This document serves as the basis for determination of the course of action upon curbing the availability of drugs, prevention of use, and treatment of addicts. The White Paper was compiled as a result of extensive consultations, through co-operation between experts of different fields and other parties interested; it summarizes the policy recommendations of the drug prevention commission of the Government of the Republic that should be considered in the action plans of the NHP and other relevant sectorial development plans. In parallel with compilation of the White Paper, thematic work groups under the Government commission discussed field-specific subjects with participation of experts in the field and representatives of institutions. In 2014, work groups specialized in supply reduction, addiction treatment and rehabilitation, re-socialization and primary prevention convened, and the results were presented at a meeting of the Government commission.

As compared to 2012 and 2013, the number of drug overdose-induced deaths has decreased significantly in 2014. Whereas 170 people died because of a drug overdose in 2012, the respective figure for 2013 was 111 and in 2014 – 98; 86 were men and 12 – women. Such a decrease is mainly attributable to successful police work upon elimination of fentanyl (as the main cause of overdoses) from circulation, but also launching of a naloxone programme on behalf of NIHD.

In order to provide treatment, rehabilitation, and counselling services to adults and minors, NIHD concluded contracts with health care and social welfare institutions in different regions of Estonia. Provision of outpatient counselling services for persons with addiction problems and their close ones was continued with support of ESF programme funds in different regions of Estonia (Ida-Viru, Lääne-Viru, Harju, Tartu). In 2014, social, experiential, and psychological counselling and psychotherapy services were provided to 464 people.

NIHD financed the total of 16 inpatient rehabilitation places for minors and supported education and training work with adolescents in inpatient care at the Tallinn Children's Hospital. In addition, provision of counselling services for adolescents and parents based on SA Tallinn Children's Hospital and OÜ Corrigo was financed.

In 2014, implementation of the programme "Naloksooni kasutamine narkootikumide üledoosidest tingitud surmade ennetamiseks" (Use of Naloxone for Prevention of Drug Overdose-induced Deaths) was continued. In addition to the two service providers who started in 2013, three more joined in 2014; trainings on the use of naloxone were organized in seven locations. In total, 131 trainings were offered in 2014; 729 individuals who passed the training successfully were issued pre-filled naloxone syringes. There were 169 cases of naloxone re-issues.

The Committee asks to be kept informed on measures for the control of communicable diseases.

In 2012, the goal of the national programme for prevention of tuberculosis was achieved – to decrease initial contraction of tuberculosis by 2012 to 20 cases per 100,000 inhabitants (in 2012, the incidence of initial contraction totalled to 17.5 new cases per 100,000 inhabitants whole in 2011 the respective figure was 19.8). In 2013-2015, contraction of TB remained under control and the number of new TB cases decreased constantly. The TB incidence rate per 100,000 inhabitants in 2014 was 15.6. In detail in 2014 246 TB cases were registered in the TB register, of which 205 were new, 31 relapses and 10 TB recurrence treatment cases. For the first time, TB morbidity rate (all cases) remained below 20, i.e. 18.7 TB cases per 100,000 inhabitants. Both the total number of MDR-TB cases and of TB/HIV double diagnosis cases decreased. A sub-goal of the programme was to achieve decline of the share of MDR-TB cases among new BK+ pulmonary tuberculosis cases, which dropped to 19.4% in 2014. Another sub-goal of the programme was to keep the TB epidemic among people living with HIV under control. While in 2013 12.1%, it was 9.2% in 2014 (96.6% of TB patients were tested). Initial contraction of tuberculosis continued to drop also during the 2015 and was 12.8. Preparations were made to develop new guidelines for diagnosing and treatment of TB, with the involvement of the Estonian Respiratory Society, National Institute for Health Development and Estonian

Health Insurance Fund and this work is still ongoing. Tuberculosis prevention and control activities are a part of the National Health Plan for 2013–2016.

With regard to immunization, the decreasing trend of immunization has become obvious over the period of five years. In 2012, the coverage of immunization of children up to the age of 2 years dropped, compared to 2011, with respect to all the vaccines, involved in the immunization plan. The recommended level by WHO, 95%, was not achieved for nine diseases. Vaccination coverage against diphtheria, tetanus, whooping cough, poliomyelitis and haemophilus infection, type B, remained around 94.6% in 2012 (in 2011 – 94.9%), and for B-viral hepatitis – at 94.7% (in 2011 – 95%) and mumps, rubella and measles – at 93.6% (in 2011 – 93.9%). The coverage level among two year old children remained below the recommended level in Tallinn, Harju, Hiiu, Pärnu and Valga counties. Vaccination against tuberculosis still remains at high level; in 2012, 97.9% (in 2011– 97%) of children aged from 0 to 11 months were vaccinated.

In 2012-2015, there were no extraordinary outbreaks or epidemics of infectious diseases in Estonia. Up to date data on immunization coverage is available in the table above.

In 2013, to protect the population against tuberculosis infection, the draft Act to Amend the Communicable Diseases Prevention and Control Act was prepared, the legislative proceeding of which continued in 2014 and came into force in the end of 2015. The amendments of the Act specify co-operation between the Police and health care service provider upon execution of involuntary treatment with respect to a person suffering from an extremely dangerous communicable disease (incl. tuberculosis) if the whereabouts of the infectious person are unknown. Several meetings have been arranged with the Social Insurance Board for implementation of the agreement that as a rule, tuberculosis patients will not be granted incapacity benefit for a period exceeding six months, in order to motivate the patients to follow the treatment regimen.

The amendments of the Act also specify immunisation requirements and financing, communicable diseases-related health control, and organisation of reference laboratory operation.

In 2013, the risk analysis of epidemic emergencies was updated. The official immunisation-related website www.vaktsineeri.ee was made available in Russian. Preparations for implementation of the e-immunisation passport project were launched. Preparations to introduce e-immunization passport were continued in 2014 and 2015. In 2013, amendments to the national immunisation schedule were prepared, according to which the immunisation schedule was supplemented from 1 July 2014 by vaccination against rotavirus infection.

The outbreak of Ebola virus that started in December 2013 in Guinea developed into epidemics that ravaged three West-African countries in 2014, being the biggest of the known Ebola epidemics in the world. WHO treated the situation as a public health emergency of global importance. The outbreak of Ebola virus in West-Africa resulted in additional work load for the communicable diseases sector (the Health Board and the Ministry of Social Affairs) that involved communication, development of guidelines and recommendations, planning the readiness for the introduction of the disease and also international information exchange and co-ordination.

The Committee asks the next report to also include figures or trends on the number of accidents.

Injury related mortality rate is decreasing, but it still constitutes 5,7% of all registered deaths in 2015 and 7,4% in 2012.

Main death causes of injuries in 2015 were:

- suicides (X60-X84);
- accidental poisoning by alcohol (X45);
- accidental falls (W00-W19).

In 2013, a task force led by the Government Office was established to analyse the causes of injuries/injury deaths and propose measures to prevent them more efficiently. In 2015, the task force concluded its work by presenting a report to the Government, where they made suggestions about actions that should be put in force to tackle the high mortality in injury related deaths. It was decided that the Ministry of Social Affairs of Estonia will be the main coordinator of injury prevention field. It was also decided that all relevant ministries and institutions will follow the recommendations of the task force and plan and carry out the proposed actions by year 2020. The task force made recommendations to reduce all types of injuries (self-harm, accidental poisonings, accidental falls, injuries due to a mechanical force, violence, drownings and suffocations etc). Yearly, Ministry of Social Affairs consults with all relevant partners to decide whether there is a need for additional actions and if so, proposes to include these actions to relevant strategies. Ministry of Social Affairs reports yearly about the state of actions and progress made to the Government.

Alcohol consumption is a relevant risk factor for many injury types. There is a long-term programme on introducing early alcohol dependency identification and brief intervention into primary care going on since 2009. In 2015 a comprehensive project was launched to improve the availability and quality of treatment of alcohol use disorders, also a treatment guideline was adopted and published. Yearly awareness campaigns to reduce harmful use of alcohol were carried out in the years 2012-2015, also alcohol-specific parenting programmes where

launched. Alcohol excise rate was raised by 5-10% every year to reduce the availability of alcohol among population.

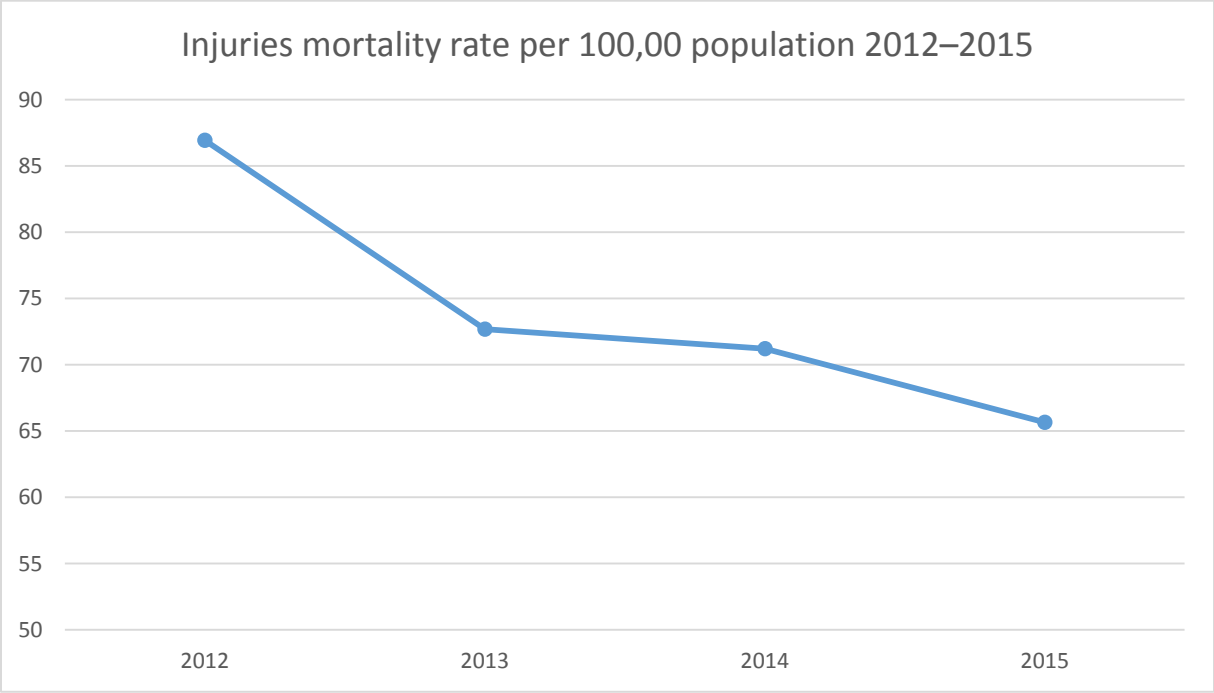
Mortality rates of injuries per 100 000 population by ICD-10, 2012–2015

Death causes by ICD-10		Death cases				Death rates per 100,000 population			
		2012	2013	2014	2015	2012	2013	2014	2015
Injury and poisoning (V01-Y89)	Total	1 150	958	936	863	86.94	72.69	71.20	65.65
	Males	897	725	721	656	145.34	117.78	117.30	106.57
	Females	253	233	215	207	35.86	33.17	30.72	29.61
..accidents (V01-X59)	Total	775	626	612	581	58.59	47.50	46.56	44.20
	Males	606	476	467	430	98.19	77.33	75.98	69.86
	Females	169	150	145	151	23.95	21.35	20.72	21.60
....transport accidents (V01-V99)	Total	89	90	89	78	6.73	6.83	6.77	5.93
	Males	65	61	62	51	10.53	9.91	10.09	8.29
	Females	24	29	27	27	3.40	4.13	3.86	3.86
....accidental falls (W00-W19)	Total	101	107	98	119	7.64	8.12	7.46	9.05
	Males	66	82	69	81	10.69	13.32	11.23	13.16
	Females	35	25	29	38	4.96	3.56	4.14	5.44
....accidental drowning (W65-W74)	Total	48	38	62	35	3.63	2.88	4.72	2.66
	Males	34	26	51	27	5.51	4.22	8.30	4.39
	Females	14	12	11	8	1.98	1.71	1.57	1.14
..exposure to smoke, fire and flames (X00-X09)	Total	50	42	45	52	3.78	3.19	3.42	3.96
	Males	36	29	32	33	5.83	4.71	5.21	5.36
	Females	14	13	13	19	1.98	1.85	1.86	2.72
.....exposure to excessive natural cold (X31)	Total	74	50	45	34	5.59	3.79	3.42	2.59
	Males	65	37	36	27	10.53	6.01	5.86	4.39
	Females	9	13	9	7	1.28	1.85	1.29	1.00
....accidental poisoning (X40-X49)	Total	331	219	217	205	25.02	16.62	16.51	15.59
	Males	276	176	175	168	44.72	28.59	28.47	27.29
	Females	55	43	42	37	7.80	6.12	6.00	5.29
......accidental poisoning by alcohol (X45)	Total	143	102	116	112	10.81	7.74	8.82	8.52
	Males	113	80	88	90	18.31	13.00	14.32	14.62

	Females	30	22	28	22	4.25	3.13	4.00	3.15
..suicide (X60-X84)	Total	235	209	236	195	17.77	15.86	17.95	14.83
	Males	190	162	188	159	30.79	26.32	30.59	25.83
	Females	45	47	48	36	6.38	6.69	6.86	5.15
..homicide (X85-Y09)	Total	63	52	41	42	4.76	3.95	3.12	3.20
	Males	46	34	32	32	7.45	5.52	5.21	5.20
	Females	17	18	9	10	2.41	2.56	1.29	1.43
..event of undermined intent (Y30-Y34)	Total	59	57	36	40	4.46	4.32	2.74	3.04
	Males	47	47	29	32	7.62	7.64	4.72	5.20
	Females	12	10	7	8	1.70	1.42	1.00	1.14

Source: Statistics Estonia

Diagram 3: Injuries mortality rate per 100,000 population, 2012–2015



Article 12 – The right to social security

Article 12 § 1 – Existence of a social security system

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.

The following acts regulate the field of social security 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.

Number of persons covered with social security scheme, 2015

	Number of insured persons	Population	Percentage, %	Notes
...of the population is covered by health insurance[15]	1,237,336	1,315,944	94.0	
...of active population is covered by sickness insurance	615,333[16]	1,315,944	46.8	

[15] Report of the Code of Social Security.

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

...of active population is covered by unemployment insurance	612,216	1,315,944 (the whole population) 683,200 (total number of employed and unemployed persons)	89.6 (of the total number of employed and unemployed persons)	Insured from 16 years of age to retirement age
...of old-age pensioners are covered by pension system				About 99% of old-age pension age people (men and women 63+) are insured with pension system[17]
...of people covered by pension system	417,244[3]	1,315,944	31.7	31.7% of the population is entitled to some kind of pension.

....of people from 0-19 years of age are covered by family benefit scheme	252,439[1]	1,315,944[2] (the whole population) 271,383 (0-19 years of age)	93.0	93% of children from 0-19-years of age reveice child allowance

Number of insured persons at Estonian Health Insurance Fund (end of the year)

- in 2011 1,245,469 (94.0% of population);
- in 2012 1,237,104 (93.7% of population);
- in 2013 1,231,203 (93.6% of population);
- in 2014 1,232,819 (93,9% of population);
- in 2015 1,237,336 (94,0% of population);

Unemployment allowance recipients, 2012-2015

In 2015 24 791 registered unemployed persons received unemployment allowance. It is 9,2% 2012. In 2015 31% of new registered unemployed persons received unemployment allowance (2012 – 27%).

	2012	2013	2014	2015
Unemployment allowance recipients	27 307	26 902	24 008	24 791
New unemployment allowance recipients	19 759	20 332	18 155	20 060
New unemployment allowance recipients as a shere of new registered uneployed persons	27%	29%	29%	31%

Source: the Estonian Unemployment Insurance Fund

Unemployment insurance benefit recipients, 2012-2015

The number of unemployment insurance benefit recipients increased 1,4% during the period of 2012-2015. In 2015, 33% of newly registered unemployed persons recieved unemployment insurance benefit (2012 – 27%).

	2012	2013	2014	2015
Unemployment insurance benefit recipients	26 163	27 637	26 216	26 533
New unemployment insurance benefit recipients	19 830	20 228	19 213	21 937
New unemployment insurance benefit recipients as a share of new registered uneployed persons	27%	29%	30%	33%
Average unemployment insurance benefit payment (in euros)	283	313	337	342

Source: the Estonian Unemployment Insurance Fund

Pensions

Pension is increased by indexation

Value of national pension index

Since the 1st of April, 2011 it is 1,000
Since the 1st of April, 2012 it is 1,044
Since the 1st of April, 2013 it is 1,050
Since the 1st of April, 2014 it is 1,058
Since the 1st of April, 2015 it is 1,063

Source: the Estonian National Social Insurance Board

Changes in the base value of pension, value of a year and limit of national pension (EUR)

Date	Value of a year	Base value of pension	Limit of national pension
01.04.2011	4,343	114,6575	128,45
01.04.2012	4,515	120,2069	134,10
01.04.2013	4,718	126,8183	140,81

01.01.2014	4,964	134,9093	148,98
01.04.2015	5,245	144,2585	158,37

Source: the Estonian National Social Insurance Board

Amounts of old-age pension, pension for incapacity for work and national pension (EUR per month)

	1.04.2011	**1.04.2012**	**1.04.2013**	**1.04.2014**	**1.04.2015**
Average old-age pension (in case of 44-years service period)	305.75	318.87	334,41	353,33	375,04
Old-age pension in case of 30-years service period	244.95	255.66	268,36	283,83	301,61
Old-age pension in case of 15-years service period	179.80	187.93	197,59	209,37	222,93
National pension	128.45	134.10	140,81	148,98	158,37
Minimum pension for incapacity for work in case of 100% 40% loss of capacity for work:					
... of 100% loss	244.95	255.66	268,36	283,83	301,61
... of 40% loss	97.98	102.26	107,34	113,53	120,64

Source: the Ministry of Social Affairs

The number of pension recipients by types of pension (end of the year)

	2012	2013	2014	2015
Pension type				
Total number of pension recipients	409937	413585	414689	417244
Share of pensioners in population, %	31,1%	31,4%	31,6%	31,7%
Total number of old-age pension recipients	299755	302546	302820	303598
early-retirement pension	21685	23014	25276	25512
Superannuated pension recipients	2572	2563	2596	2762
Recipients of pension for incapacity for work	94096	95503	96656	98368
Survivor's pension recipients (families)	7085	6452	5962	5569
Total number of national pension recipients	6429	6548	6655	6947

Source: The Estonian National Social Insurance Board

Average fixed pension by types of pension (in EUR)

	2012	2013	2014	2015
Pension type				
Total number of pension recipients	276,6	288,6	304	322
Old-age pension recipients	312,9	327,4	345,1	365,6
early-retirement pension	249,1	260,3	273,9	289,8
Superannuated pension recipients	332,7	356,2	382,1	408,5
Recipients of pension for incapacity for work	180,7	187,6	197	208,4
Survivor's pension recipients (families)	151	158	167,1	178,9
National pension recipients	104,4	107,7	112,9	119,5

Source: The Estonian National Social Insurance Board

Expenses on State pension insurance 2012 -2015 (thousand EUR)

	2012	2013	2014	2015
Pension type				
Total expenses for State pensions	1360757,3	1428898	1512721,6	1611936,6
Old-age pensions	1127033,5	1181084,8	1249956,6	1332458,2
early-retirement pensions	63644,3	69628,8	77711	86468,9
Superannuated pensions	9414,1	10102,9	11187,9	12397,8
Incapacity for work pensions	203001,7	216692,9	230300,8	245146,2
Survivor's pensions	13275	12606,2	12306,5	12206
National pensions	8033	8411,2	8969,8	9727,9

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.

Amounts of state family benefits, in 2012 and 2016 (in EUR)

Type of benefit	2012	2016
Birth allowance, single allowance		
Per child	320	320
In the case of a multiple birth of 3 or more children, per child	320	1000
Adoption allowance, single allowance	320	320
Child allowance, per month		
1st child	19.18	50
2nd child	19.18	50
3rd and subsequent child[1]	57.54	100
Childcare allowance, per month[2]		
for child up to 3 years of age	38.35	38.35
for children aged 3–8 years in families with a child under 3 years	19.18	19.18
for children aged 3–8 years in families with 3 or more children	19.18	19.18

supplementary childcare allowance for a child up to 1 year of age	6.40	6.40
Parental allowance of a family with 7 and more children, for one parent per month[3]	168.74	168.74
Single parent's child allowance, per month[5]	19.18	19.18
Allowance for a child in guardianship or in foster care, per month	191.8	240
Conscript's child allowance, per month[6]	47.95	47.95
Start in independent life allowance, single allowance[7]	383.47	383.60

Receivers of state family benefits and parental benefit, 2012–2015 (number of people receiving the allowance at the end of the year, in case of single benefits total during the year)

Benefit type	2012	2013	2014	2015
Birth allowance				
1st child	5915	5958	5901	6052
2nd child	7570	7480	7399	7520
multiple births	239	203	206	231
Adoption allowance, children	38	40	32	28
Child allowance, children				
1st child	160419	158585	157603	157731
2nd child	70317	70565	71267	72354
3rd and subsequent child	21519	21625	21845	22354
Childcare allowance, children				
for child up to 3 years of age	22617	21262	20480	20077
for children aged 3–8 years in families with a child under 3 years	9567	9123	8809	8345
for children aged 3–8 years in families with 3 or more children	9397	10195	10824	11258
Parental allowance of a family with 7 and more children, families	146	141	143	133
Single parent's child allowance, children	21106	20010	19035	17848
Single parent's child allowance, families	17553	16632	15843	14869
Allowance for a child in guardianship or in foster care, children	1807	1783	1745	1672
Allowance for a child in guardianship or in foster care, families	1457	1425	1381	1326
Conscript's child allowance, children	30	23	23	22
Start in independent life allowance	117	94	88	61
Parental benefit	17706	17345	16881	17066

Source: the Social Insurance Board

Expenditure on state family benefits and parental benefit, 2012–2016 (thousand euros)

Benefit type	2012	2013	2014	2015
Birth allowance				
1st child	1893	1906,5	1888,2	1936,7
2nd child	2422,9	2394	2368,8	2409,3
multiple births	154,1	131,8	131,9	148
Adoption allowance	12,1	12,7	10,1	8,8
Child allowance				
1st child	37346,8	36872,6	36535,5	85499,1
2nd child	16263,1	16290	16395,6	38966,6
3rd and subsequent child	14917	17486,8	20136,8	26733,7
Childcare allowance				
for child up to 3 years of age	10330,3	9922,3	9430,8	9117,7
for children aged 3–8 years in families with a child under 3 years	2190,9	2237,4	2129,3	2017,8
for children aged 3–8 years in families with 3 or more children	2226,2	2369,1	2529,6	2665,1
Parental allowance of a family with 7 and more children	301,5	297,3	287,2	335,1
Single parent's child allowance	5001,6	4769,5	4522,8	4259,2
Allowance for a child in guardianship or in foster care	4271,5	4155	4094,2	4971,7
Conscript's child allowance	17,2	15,2	12,3	14,7
Start in independent life allowance	45	36,4	34	23,6
Parental benefit	159519	157268,8	164928,1	179350,6
Total	256912,2	256165,4	265435,2	358457,7

Source: Social Insurance Board

The Committee notes from the report that according to the paragraph 7 (1) of the Labour Market Services and Benefits Act, the Unemployment Insurance Fund will make a decision to terminate registration of the unemployed if the latter refuses, without a good reason to accept suitable work.

The Committee asks in this regard whether unemployment allowance or unemployment insurance benefit will be also withdrawn in this case and whether there is a reasonable initial period where the unemployed may refuse unsuitable employment offer without losing unemployment benefit.

To be precise, according to the paragraph 7 (1) 6) of the Labour Market Services and Benefits Act, the Unemployment Insurance Fund will make a decision to terminate registration of the unemployed if the latter refuses, without a good reason, to accept suitable work for the third time.

The right to receive both unemployment allowance and unemployment insurance benefit derives from being registered as unemployed. This means, that a person, who's registration as unemployed has been terminated, cannot receive any labour market benefit or service.

However, the suspension and premature termination of payment of unemployment allowance takes place long before termination of registration of the unemployed due to not accepting suitable work, without a good reason, for the third time.

More precisely, the suspension and premature termination of payment of unemployment allowance are regulated in paragraphs 32 and 33 of the Labour Market services and Benefits Act. According to its provisions:

- The payment of unemployment allowance is suspended for a period of ten days if the unemployed person refuses suitable work for the first time without a good reason (paragraph 32 (1));
- The payment of unemployment allowance is suspended prematurely if the unemployed person refuses, without a good reason, to accept suitable work for the second time (paragraph 33 (3)).

The termination of payment of unemployment insurance benefit is regulated in paragraph 13 of the Unemployment Insurance Act and takes place if a person refuses, without good reason, to accept suitable work (paragraph 13 (1) 2)) i.e. the unemployment insurance benefit is withdrawn upon the first refusal of suitable work.

After the permanent suspension of unemployment allowance or unemployment insurance benefit, the unemployed is still registered as unemployed and still has a right to receive labour market services and is covered with health insurance.

The suitable work notion is defined in paragraph 12 of the Labour Market services and Benefits Act:

According to paragraph 12 (3) provisions:

Work suitable for an unemployed person during the first twenty weeks after registration as unemployed is deemed to be employment:

1) which is not contraindicated due to health reasons;

2) in the case of which the journey from the place of residence to the place of work of the person by public transport will not take longer than two hours a day and will not cost more than 15 % of the person's monthly wages;

3) which corresponds to the education, profession and earlier work experience of the unemployed person, and

4) for which a salary of at least 60 % of the person's average monthly income subject to social tax but not less than two times the minimum wage established under subsection 29 (5) of the Employment Contracts Act is offered. In calculating a person's average income of one month subject to social tax, the first three months out of the six months before registration of the person as unemployed shall be taken into account.

According to paragraph 12 (4) provisions:

Work suitable for an unemployed person as of the twenty first week after registration as unemployed is deemed to be employment:

1) which is not contraindicated due to health reasons;

2) which may be temporary;

3) in the case of which the journey from the place of residence to the place of work of the person by public transport will not take longer than two hours a day and will not cost more than 15 % of the person's monthly wages;

4) for which a salary, upon full-time employment, is higher than the unemployment insurance benefit received by the person for the same period but not lower than the minimum monthly wage established under subsection 29 (5) of the Employment Contracts Act is offered, and

5) which need not correspond to the education, profession or earlier work experience of the unemployed person.

The committee asks what is the minimum level of sickness and maternity benefits

Minimum level of sickness benefit

The sickness benefit is one of types of the benefit for temporary incapacity for work established in clause 50 (3) 1) of the Health Insurance Act. The size of the sickness benefit and it's is calculation is regulated in paragraphs 54 and 55 of the Health Insurance Act. In case of sickness Health Insurance Fund pays sickness benefit as of the 9th day (paying of the sickness benefit from the 4th to the 8th sickness day is done by employer) of sickness, the rate of the benefit is 70% of a person's average income per calendar day. The average income of a person is calculated on the basis of the social tax paid for the insured person during the calendar year preceding the calendar year of the date on which release from the performance of their duties commenced as specified in the certificate of incapacity for work, divided by 365.

The minimum level of sickness benefit is applied in case of insured employed and self-employed persons, for whom social tax was not paid during the calendar year serving as the basis for calculation of their average income per calendar day. Depending on the employment status – employed (I) or self-employed (II) – the calculation basis of the minimum level is different.

(I) – Employed persons

If the person is working on the basis of an employment contract or as official (clauses 5 (2)1) and 2) of the Health Insurance Act,) the clause 55 (3) of the same Act for the calculation of minimum level is applicable:

The average income per calendar day will be deemed to be equal to the negotiated wage of the employee divided by 30, but not more than the amount of the minimum monthly wage established by the Government of the Republic and divided by 30. Calculation of average income per calendar day is based on the negotiated wage of the employee or the minimum monthly wage established by the Government of the Republic as applicable on the date preceding the date on which the release from the performance of duties commenced as specified in the certificate of incapacity for work. The corresponding minimum monthly wage rate is 430€ in 2016.

Example:

As in 2016 the minimum monthly wage rate is 430€, the average income per calendar year of an insured employed person, for whom the social tax was not paid in 2015, would be deemed to be equal:

430€ / 30 days or 14,33 € a day.

In case of sickness, the rate of the sickness benefit would be

70% * 14,33€ a day or 10,03€ a day

As the sickness benefit is paid by Health Insurance Fund starting from the 9th day of release from working duties, for a sickness leave that lasts 31 day a person would get 23*10,03€ or 230,69€.

(II) – Self-employed persons:

If the person is

- a member of the management or controlling body of legal person (clause 5 (2) 4)),
- receiving remuneration or service fees on the basis of a contract for services, a mandate or another contract or other contracts under the law of obligations for the provision of services (clause 5 (2) 5)),
- entered in the commercial register as a self-employed person or a spouse participating in the activities of the undertaking of the self-employed person (clause 6 (3) and (3^1).

the clause 55 (6) of the same Act for the calculation of minimum level is applicable:

If social tax was not paid for an insured person during the calendar year serving as the basis for calculation of his/her average income per calendar day, the average income per calendar day will be deemed to be equal to the monthly rate provided for in § 2^1 of the Social Tax Act, divided by 30. Calculation of average income per calendar day is based on the of the monthly rate provided for in § 2^1 of the Social Tax Act in force on the date preceding the date of the release of the person from performing duties, engaging in economic or professional activities or participating in the activities of the undertaking of a self-employed person. The corresponding minimum monthly rate is 390€ in 2016.

Example:

As in 2016 the minimum monthly social tax rate is 390€, the average income per calendar year of an insured self-employed person, for whom the social tax was not paid in 2015, would be deemed to be equal:

390€ / 30 days or 13,00 € a day.

In case of sickness, the rate of the sickness benefit would be

70% * 13,00€ a day or 9,10€ a day

As the sickness benefit is paid by Health Insurance Fund starting from the 9th day of release from working duties, for a sickness leave that lasts 31 day a person would get 23*9,10€ or 209,30€.

The exact minimum level of sickness benefit is provided in the table above.

<u>Minimum level of maternity benefit</u>

Maternity benefit is one of types of the benefit for temporary incapacity for work established in clause 50 (3) 2 of Health Insurance Act. It is paid to the insured woman on pregnancy or maternity leave (working as employed or self-employed is an eligibility precondition for receipt).

The minimum level of maternity benefit is applied in case of insured employed and self-employed persons, for whom social tax was not paid during the calendar year serving as the basis for calculation of their average income per calendar day. The rules for calculation basis are the same as the ones applied in case of sickness benefit. Precisely, in case of an employed person the average income per calendar day will be deemed to be equal to the negotiated monthly minimum wage, in case of a self-employed person – monthly minimum social tax rate.

In case of pregnancy and maternity leave Health Insurance Fund pays maternity benefit starting from the 1st day of pregnancy and maternity leave, the rate of the benefit is 100% of a person's average income per calendar day.

Examples:

(I) Employed person

As in 2016 the minimum monthly wage rate is 430€, the average income per calendar year of an insured employed person, for whom the social tax was not paid in 2015, would be deemed to be equal:

430€ / 30 days or 14,33 € a day.

In case of pregnancy, the rate of the maternity benefit would be

100% * 14,33€ a day or 14,33€ a day

As the maternity benefit is paid by Health Insurance Fund starting from the 1th day of release from working duties, the maternity benefit paid for a period of 31 days would be 31*14,33€ or 444,23€.

(II) Self -employed person

As in 2016 the minimum monthly social tax rate is 390€, the average income per calendar year of an insured self-employed person, for whom the social tax was not paid in 2015, would be deemed to be equal:

390€ / 30 days or 13,00 € a day.

In case of pregnancy, the rate of the maternity benefit would be

100% * 13,00€ a day or 13,00€ a day

As the maternity benefit is paid by Health Insurance Fund starting from the 1th day of release from working duties, the maternity benefit paid for a period of 31 days would be 31*13,00€ or 403,00€.

If a woman is not meeting the eligibility precondition for receipt of maternity benefit (not working as employed or self-employed), she would have a right to parental benefit as of the birth of the child (clause 2 (4) of Parental Benefit Act). The minimum monthly amount of parental benefit may be:

- Equal to minimum monthly wage (if a person has social tax record for the calendar year prior to the date on which the right to receive benefit arises);

- Equal to the benefit rate, which is not smaller than the rate in force or the minimum monthly wage which was in force in the previous calendar year (if a person has no social tax record for the year prior to the date on which the right to receive benefit arises). The benefit rate usually corresponds to minimum monthly rate of social tax.

Minimum unemployment allowance as well as the minimum unemployment insurance benefit are manifestly inadequate (as its levels remain below Eurostat at-risk-of-poverty rate).

The minimum unemployment allowance rate is regulated by law. According paragraph 31 (1) of the Labour Market Services and Benefits Act the daily rate which is the basis for the calculation of unemployment allowance is established by the state budget for a budgetary year. However the 31-fold daily rate shall not be less than 35 per cent of the minimum monthly wage rate established on the basis of subsection 29 (5) of the Employment Contracts Act in force on 1 July of the year preceding the budgetary year.

The minimum unemployment insurance benefit is also regulated by law. The insured person is always entitled to at least the unemployment insurance benefit in minimum amount which is set at half of the national minimum wage of the previous budgetary year (paragraph 9 (5) of the Unemployment Insurance Act). For the purpose of establishing the minimum wage daily rate per the minimum monthly wage rate is divided by 30.

Thus, both minimum unemployment allowance and the minimum unemployment insurance benefit rate depend on the minimum monthly wage rate. The unemployment allowance is 35 % and the minimum unemployment benefit is 50 % of the minimum monthly wage established for the previous budgetary year. In Estonia, the minimum wage established by the Government is actually negotiated between Estonian Trade Union Confederation and Estonian Employers'

Confederation. The amount negotiated is approved by the Government on the basis of subsection 29 (5) of the Employment Contracts Act.

Example:

As in 2015 the minimum wage was 390€ a month, minimum unemployment allowance and minimum unemployment insurance benefit daily rates in 2016 amount for:

Unemployment allowance daily rate: 390€/31 day*0,35 or **4,41€**;

Minimum unemployment insurance benefit daily rate: 390€/30 day * 0,5 or **6,5€**.

Although Estonia agrees that the minimum rates of unemployment allowance and unemployment insurance benefit remain below Eurostat at-risk-of-poverty rate, it should be taken into account that the unemployed always have access to subsistence benefit and needs-based family benefit, that guarantee the income in the extent of subsistence level. **The subsistence level** is established on the basis of minimum consumption costs on food, clothing and footwear and other goods and services for primary needs. In 2016 the **subsistence level** a person living alone or the first member of a family is 130 euros per month; the same is valid for every minor-age member of a family. The subsistence level for the second member and every subsequent member of a family is 104 euros per month. **Subsistence benefit** is established so that it would ensure that a person living alone or a family would have guaranteed income in the extent of the subsistence level, together with the family members' incomes, after paying the fixed costs of the dwelling.

In order to better address the poverty prevention issue the Ministry of Social Affairs is undertaking a detailed study of minimum benefits covering all the fields of social insurance and in-cash social aid benefits. The analysis should provide a complete methodological approach for designing income-related benefit schemes and suggest the minimum levels of social insurance benefits, that would correspond to the standards established by the European Code of Social Security. On this basis policy proposals will be done. The study should be completed by the end of 2017.

The following table gives an overview of changes in minimum amounts of main social security benefits and minimum wage in 2012-2016, in euros

	2011*	2012	2013	2014	2015	2016
Minimum monthly wage	278,02	290	320	355	390	430
Minimum monthly rate of social tax		278,09	290	320	355	390
Unemployment allowance daily rate		2,11	3,27	3,62	4,01	4,41
Unemployment allowance 31-fold daily rate		65,41	101,37	112,22	124,31	136,71
Minimum unemployment insurance benefit daily rate		4,63	4,83	5,33	5,91	6,5
Minimum unemployment insurance benefit 31-fold daily rate		143,53	149,73	165,23	183,21	201,5
Minimum level of sickness benefit 31 day on sickness leave**						
I – Employed		155,69	171,79	190,46	209,30	230,69
II – Self-employed		149,25	155,69	171,79	190,46	209,30
Minimum level of maternity benefit 31 day period***						
I-Employed		**299,67**	**330,67**	**366,83**	**403**	**444,33**
II-Self-employed		**287,29**	**299,67**	**330,67**	**366,83**	**403**
National pension		**134,10**	**140,81**	**148,98**	**158,37**	**167,40**

*- for year 2011 only the minimum monthly wage is given as a calculation reference for daily rates in force in 2012.
**- Health Insurance Fund pays sickness benefit as of the 9th day (paying of the sickness benefit from the 4th to the 8th sickness day is done by employer) of sickness, the rate of the benefit is 70% of a person's average income per calendar day.
***- Health Insurance Fund pays maternity benefit as of the 1st day of pregnancy and maternity leave, the rate of the benefit is 100% of a person's average income per calendar day.

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 2015 of the Committee of Experts on the Application of Conventions and Recommendations of the International Labour Organisation GC(2016)5 involving the implementation of the social security code in Estonia (covers period 01.07.14 – 30.06.15) was as follows: " the Committee finds that national law and practice continue to give full effect to all Parts of the Code which have been accepted (Parts II–V and VII–X), subject to providing complementary information with respect to the level of periodical payments.

Estonia submitted the inquired information to the Council of Europe on the 31st of July, 2016 with the 11th detailed annual report of the European Code of Social Security.

Please see also an overview of changes in minimum amounts of main social security benefits and minimum wage in 2012-2016, provided as the answer to the Committee within the Charter report.

Article 12 § 3 – Development of the social security system

During the report period 1.1.2012-31.12.2015 Estonia was preparing the work ability reform establishing a new support system for people with decreased work ability that comprises both new in cash work ability allowance and services. The new system would gradually replace incapacity for work pension system. Also changes to the duration of sickness benefit were prepared. As both changes were introduced to the legislation in 2016 (1st of July 2016 and 1st of January respectively) the details will be provided in the next report.

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

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.

More explanation on the status of social security agreements is given within the Social Charter report as a reply to the Committee's conclusion that the situation is not in conformity with Article 12§4 of the Charter on the ground that equal treatment in matters of social security entitlement.

On equal treatment between nationals and nationals of other States Parties in respect of social security rights shall be ensured through the conclusion of bilateral or multilateral agreements or through unilateral measures.

The Committee concludes that the situation is not in conformity with Article 12§4 of the Charter on the ground that equal treatment in matters of social security entitlement is not guaranteed between Estonian nationals and nationals of all other States Parties (no agreements envisaged with Albania, Andorra, Armenia, Bosnia and Herzegovina, "the former Yugoslav Republic of Macedonia", Montenegro, Serbia and Turkey).

First of all, Estonia has made important amendments to the provisions of State Pension Insurance Act, that will enter into force on the 1st of January 2018. Starting from this date all the old-age pensions and survivor's pensions earned in Estonia will be exported all over the

world. This means that pensions earned in Estonia both by Estonian nationals and nationals of all other States Parties will be paid out also outside EU, EFTA and other countries, covered with pension agreements. These amendments are an important contribution to the resolution of the problem brought up by the Committee.

Until the entry into force of the amendments named above the situation with agreements in social security is the following:

An important principle upon which the priorities regarding concluding the bilateral agreements in social security field are established in Estonia is the number of foreign citizens residing in Estonia and that of Estonian citizens residing abroad. As there is no citizen of Andorra residing in Estonia (and no citizen of Andorra were residing in Estonia or had a residence permit within last 5 years), no agreement with Andorra is envisaged in the nearest future.

As Albania, Bosnia and Herzegovina, Macedonia, Montenegro and Serbia have concluded Stabilisation and Association Agreements with European Union, Estonia applies to the citizens of these countries equal treatment provisions in the field of social security included in corresponding agreements.

In case of Armenia the EU - Armenia Partnership and Cooperation Agreement that provides equal treatment for labour conditions is applied in Estonia.

Turkey has also concluded an Association Agreement with EU. To this agreement the decision 3/80 is associated, which guarantees the application of the social security schemes of the EU Member States to Turkish workers and their family members and also which provides for equal treatment for all social security benefits.

The Committee concludes that equal treatment is not guaranteed with regard to access to family allowances in respect of nationals of all other States Parties (no agreements with Albania, Andorra, Armenia, Bosnia and Herzegovina, "the former Yugoslav Republic of Macedonia", Montenegro, Serbia and Turkey. The draft agreement with Georgia does not cover family allowances). At the same time, the Committee agrees that the requirement applied in Estonia for the child concerned to reside on the territory of the State concerned is compatible with Article 12§4 and with its Appendix. However, as not all the countries apply such a system, the States which impose a child residence requirement are under an obligation, in order to secure equal treatment within the meaning of Article 12§4, to conclude within a reasonable period of time bilateral or multilateral agreements with those States which apply a different entitlement principle.

To that date we have no information that any of the listed countries - Albania, Andorra, Armenia, Bosnia and Herzegovina, Georgia, "the former Yugoslav Republic of Macedonia",

Montenegro, Serbia and Turkey – do not apply the residence requirement to the payment of family benefits. However, some of the countries (e.g. Georgia) restrict the payment of family-benefits to those families most in need (apply means-tests). As in principle, the Estonian family benefits' system is designed to be the partial reimbursement of expenses relating to the care, raising and education of children, the standard level of the expenses in local context (net amount to pay by a family that takes into consideration services provided free of charge) is taken in consideration while establishing the amount of cash benefits. Thus, exporting the family benefits to the children living in the countries where the means-test is applied, would lead to the need of conducting a detailed evaluation of benefits and services locally available in order to adjust the benefit level. As this task represents an important administrative burden and as there is no reason to question the legitimacy of means-test imposed by a country of residence, Estonia does not foresee concluding agreement covering family benefits or taking unilateral measures to provide family benefits to persons residing abroad.

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 parliament of Estonia (Riigikogu) passed a new wording of the Social Welfare Act on the 9. of December 2015, the new act came into force on the 1. January 2016. During the reference period (01.01.2012 – 31.12.2015) social assistance was provided on the basis of the Social Welfare Act, passed on the 8. of February, 1995.

In Estonia 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 authorities (rural municipalities and city governments). The number of local authorities has decreased during the reference period from 226 to 213 local authorities due to merging voluntarily.

The main social benefit for the people in need is the subsistence benefit, which is paid by the local authorities from the funds of the state budget. Subsistence benefit is a monthly benefit. A person living alone or a family has the right to receive a subsistence benefit, if the monthly net income, after the deduction of housing expenses 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.

Supplementary social benefit is paid from the funds of the subsistence benefit for the subsistence benefit recipients whose members of the family are all minors (i.e single parents). Whereas the amount of the subsistence benefit are differential, since they depend on family composition, income of the family during particular month and housing expenses payable in given month, the amount of the supplementary social assistance is set to 15 EUR per month.

Additionally, local authorities may pay supplementary social benefits from a local authority budget under the conditions and pursuant to the procedure established by the local government.

Amendments to the Social Welfare Act with regard to social assistance, which have been implemented during the reference period, are described below.

The subsistence level was raised as of 2014 from the previous 76,7 EUR to 90 EUR for a person living alone and to the first member of a family for each budgetary year. In order to improve the situation of needy families with children, the subsistence level for minor children was raised as of 2015 from the previous 80% to 100% of the subsistence level of the first member of the family. The subsistence level of the second and each subsequent adult member of a family continues to be 80% of the subsistence level of the first member of the family. So as of 2015 equivalence scales 1.0:0.8:1.0 are used instead of the previous 1.0:0.8:0.8. In terms of amounts, subsistence level for children was raised in 2015 from the previous 72 EUR to 90 EUR. In 2016, the subsistence level was set to 130 EUR.

In 2013 a new state social benefit was established for needy families with children. Needs-based family benefit is granted to a family if at least one member of a family is a child receiving child allowance on the basis of the State Family Benefits Act, provided that the average monthly net income of the family is below the income threshold of needs-based family benefit or if the family receives subsistence benefit. The income threshold of needs-based family benefit is established by the Riigikogu (Parliament) each budgetary year by the state budget and it is based on the relative poverty threshold as last published by Statistics Estonia. Therefore equivalence scales 1.0:0.5:0.3 are used: the first person in the family (i.e. the applicant) is assessed at 100%., each following family member is assessed at 50% (if 14 years or older) or 30% (if under 14 years) of the income threshold for the first member of the family. In July 2013 - December 2014 the monthly amount of needs-based family benefit was 9,59 EUR per month for families with one child receiving child allowance, and 19,18 EUR per month for families with at least two children receiving child allowance. As of 2015 the amonts were raised substiantilly: 45 EUR per month for families with one child receiving child allowance, and 90 EUR for families with at least two children receiving child allowance. Similarly to the subsistence benefit, needs-based familily benefit is paid by the local authorities from the funds of the state budget. The needs-based family benefit is paid for three consecutive months. When a family who receives needs-based family benefit applies for the subsistence benefit, the needs-based family benefit is not calculated as income and vice versa. As the subsistence level is lower than the income threshold of needs-based family benefit, the majority of families who apply for the subsistense benefit also receive the needs-based family benefit.

Many specifications and amendments with regard to the subsistence benefit entered into force in 2015 (most as of January 2015, some as of June 2015). For example, the list of incomes not included in the income of a person living alone or a family upon calculating a subsistence benefit was broadened with additional provisions, including periodic benefits paid from local authority budget funds which are dependent on family income or granted to compensate for the cost of a specific service and needs-based special allowance and allowance paid from a special allowance fund established by an educational institution, paid on the basis of the Study Allowances and Study Loans Act. According to the Social Welfare Act, in force at the end of 2015, the following is not included in the income when subsistence benefit is calculated:

- single benefits paid out of the funds of the state budget or local budget;
- periodic benefits paid from local government budget funds which are dependent on family income or granted to compensate for the cost of a specific service;
- benefits paid on the basis of the Social Benefits for Disabled Persons Act, except for the disabled parent's allowance;
- student loan granted with security guaranteed by the state;
- grants and transport and accommodation benefits paid on the basis of the Labour Market Services and Benefits Act or from the structural assistance funds;
- needs-based study allowance, needs-based special allowance and allowance paid from a special allowance fund established by an educational institution, paid on the basis of the Study Allowances and Study Loans Act;
- child allowance for the third and each subsequent child paid on the basis of the State Family Benefits Act in the amount of 45 euros for each child receiving child allowance;
- needs-based family benefit paid on the basis of Social Welfare Act.

In addition as of January 2015 local authorities were given the possibility to make a discretionary decision not to include grants paid for a specific purpose or benefits paid to cover specific expenses or loss in the income of a person living alone or a family. These amendments were motivated by specific cases where it was not possible to use the income received for everyday living expenses.

In 2015 amendments entered into force also with regard to the housing expenses compensated from the funds of the subsistence benefit. The list of housing expenses compensated was supplemented with repayment of loan taken for renovation of the apartment building. The amendment was made in order to enable to cover all the communities that people

living in apartment buildings have to cover. As of June 2015, the list of housing expenses which are taken into account upon calculation of the subsistence benefit, stands as follows:

- rent;
- the administration costs of the apartment building, including costs related to repairs;
- repayment of loan taken for renovation of the apartment building;
- the cost of services of supplying water and leading off waste water;
- the cost of thermal energy or fuel consumed for supply of hot water;
- the cost of thermal energy or fuel consumed for heating;
- the costs related to consumption of electricity;
- the cost of 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;
- the fee for the transport of municipal waste.

As explained in the previous report, these housing expenses are taken into account within the limits of socially justified standards of dwellings and limits set by the local authorities.

In order to prevent misuse, the amendments of 2015 also specified that rent is not taken into account upon the calculation of a subsistence benefit if the lessor and lessee are married to each other or ascendants and descendants related in the first and second degree.

The subsistence benefit regulation includes distinctions with regard to students. This means that the students are considered members of a family, if their residence in the population register coincides with the residence of their family members. In 2015 it was specified that the distinctions apply only to those students who are up to 24 years of age. This means that students who are 25 years of age or older, now receive subsistence benefit in more favourable conditions. Also it was specified that the distinctions of students do not apply in case the student is married or a parent or a guardian of a child. This principle was practiced already before but now it is stated also in the law. With regard to students an amendment which entered into force in 2015 concerned housing expenses. Namely a provision was added to the Social Welfare Act which enables to cover the housing expenses of a student as an additional

expense, so that for each student that lives apart from the family (in a dormitory, rental apartment etc) the socially justified standard for dwelling calculated for the family is increased by the socially justified standard for the dwelling calculated for one family member (i.e by 18 m^2). This amendment enables to cover housing expenses for a family with a student or students more than before.

In 2015, the Social Welfare Act was also supplemented with provisions according to which a subsistence benefit applicant who is granted a subsistence benefit to cover housing expenses is required to ensure payment of such expenses. In case a subsistence benefit applicant who received subsistence benefit to cover housing expenses in the previous month has not paid such expenses, the local authority has the right to pay the housing expenses out of the subsistence benefit granted to the person. The purpose of these provision is to guarantee that the housing expenses are paid, so that the beneficiaries would not face the risk of losing their home. In practice there used to be a few cases where the beneficiaries of subsistence benefit were not willing to pay for the housing expenses, although they received subsistence benefit also for covering housing costs. In these circumstances the local authority now has the right to intervene.

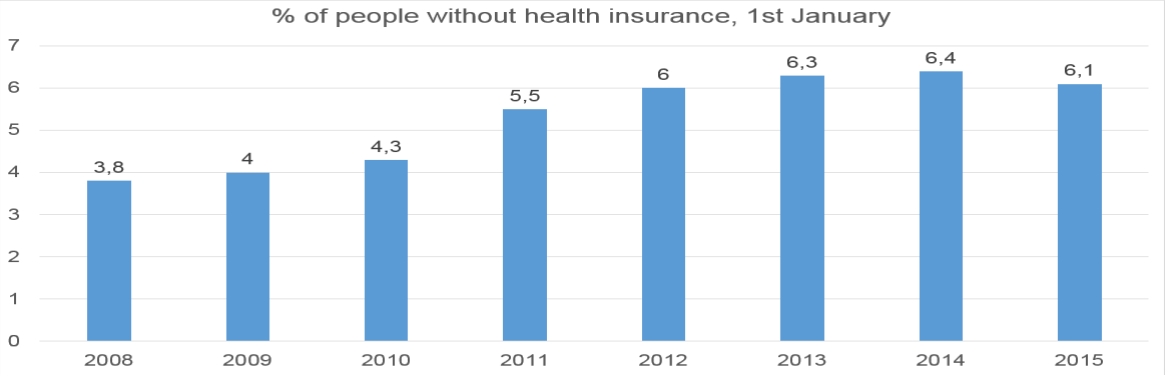
One of the provisions which enables the local authority not to grant a subsistence benefit, was also supplemented in January 2015. Now it is *expressis verbis* stated that the local authority has the right to refuse to grant a subsistence benefit to a person between the age of 18 and the pensionable age with ability to work who is not working or studying and who is not registered as unemployed with the Estonian Unemployment Insurance Fund. The reference to not being registered as unemployed with the Estonian Unemployment Insurance Fund was not stated before. The purpose of this amendment is to emphasise the importance of seeking employment, when the person applying for a subsistence benefit is unemployed.

Medical Assistance

As mentioned in the previous report, the most vulnerable groups continue to be covered by health insurance, equal to an insured person.

At the beginning of 2015, 93.9% of the population was covered by mandatory health insurance offered by the Estonian Health Insurance Fund (EHIF). The share of uninsured population (6,1% in 2013) in comparison with previous year (6,4% in 2014) has decreased slightly after it has increased gradually since 2008.

Health insurance coverage in Estonia, 2008–2015



Source: Estonian Health Insirance Fund

The uninsured (6,1% of population) are mostly among the working-age population between 20 and 60 years who are economically inactive (but not registered as unemployed) or working abroad. The uninsured are entitled to emergency ambulance care, emergency primary care and emergency hospital care financed from state budget. Most of local municipalities also cover primary and special care services for their uninsured citizens. For example capital city Tallinn (where almost 1/3 of our population lives) has developed separate system for uninsured persons financed by city government. Harm reduction services are free to everyone and financed from state budget:

- HIV and TB treatment (incl. complications and related illnesses),
- youth sexual counselling, STD diagnostic up to age 25 (incl.)
- methadone replacement treatment and rehabilitation services for those who want to quit,
- smoking cessation and syringe exchange service.

All registered unemployed persons are covered by health insurance since 2009.

Recent reforms

During 2012-2015 some previously uncovered groups have been able to obtain coverage:

- artists and creative persons through Creative Persons and Artistic Associations (*Health Insurance Act*[18]*, HIA: persons for whom the state, local authority or, based*

[18] Available in English here: https://www.riigiteataja.ee/en/eli/ee/514062016008/consolide/current

on the Creative Persons and Artistic Associations Act, an artistic association is required to pay social tax)

- persons, receiving remuneration or service fees through several and/or short contracts under the law of obligation through summarizing their social tax (*HIA: persons receiving remuneration or service fees on the basis of a contract for services, a mandate or a contract under the law of obligations for the provision of any other services, which is concluded for a term exceeding one month or for an unspecified term, who are not entered in the commercial register as self-employed persons and for whom the other party to the contract must pay social tax each month on the basis of clause 9 (1) 2) of the Social Tax Act in the amount calculated on the basis of at least the monthly rate established in the state budget for the given budgetary year*);
- spouse participating in activities of undertaking of self-employed person (*HIA: persons for whom social tax is paid by a self-employed person registered in the commercial register is their spouse who has been entered in the register of taxable persons as the spouse participating in the activities of the undertaking of the self-employed person*)
- coverage has been extended to persons older than 63 enjoying temporary international protection with health insurance. (Social Tax Act[19]: *unemployed persons enjoying international protection residing in Estonia who are of pensionable age for the purposes of § 7 of the State Pension Insurance Act and who do not receive a state pension granted in Estonia.*)

Emergency care continues to be provided for both insured and uninsured persons and is funded from the state budget as described in the previous report.

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

2012	6,481,155 eur
2013	6,583,837 eur
2014	7,165,295 eur

[19] Available in English here: https://www.riigiteataja.ee/en/eli/ee/513062016008/consolide/current

2015	7,100,961 eur

Source: The Ministry of Social Affairs

The Committee asks to confirm that the social aid available to individuals and and families in need also applies to elderly people.

According to the Social Welfare Act valid before and during the reference period, the subjects who have the right to receive social services, social benefits and other assistance, are:

- permanent residents of Estonia;
- aliens residing in Estonia on the basis of residence permits or right of residence;
- persons enjoying international protection staying in Estonia.

Every person staying in Estonia has the right to receive emergency social assistance.

The Social Welfare Act does not include any restrictions to receiving social services and social benefits based on age of the persons. Therefore we can confirm that also elderly people do have the right to receive social aid, including the subsistence benefit. With regard to the subsistence benefit, elderly people who are at pensionable age, do not have to participate in active labour market measures nor be registered as unemployed with the Estonian Unemployment Insurance Fund.

As of 2016 a new wording of Social Welfare Act came into force, together with a new act called General Part of the Social Code Act. This new act became the umbrella act for different acts in the field of social protection. The paragraph listing the subjects of social welfare was transferred to the General Part of the Social Code Act.

Also we would like confirm all aliens residing in Estonia on the basis of a residence permit or a right of residence, have the possibility to apply and receive the subsistence benefit and other social assistance measures, regardless of the fact whether they are temporary or permanent residents of Estonia. However, as regards temporary residents, the fact that the person has received subsistence benefit, might hinder his/her opportunities of lengthening the temporary residence permit or obtaining a long-term residence permit. Namely according to the Aliens Act, one of the conditions of acquiring a residence permit is a sufficient legal income. Legal income is defined by the Aliens Act as lawfully earned remuneration for work, parental benefits, unemployment benefits, income received from lawful business activities or property, pensions,

scholarships, means of subsistence, benefits paid by a foreign state and the subsistence ensured by family members earning legal income. This means that subsistence benefit and other means-based social benefits are not considered as legal income.

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

As explained in the previous report, the principle of subsidiarity is the basis for providing welfare services and social benefits. Therefore the main providers of welfare services and benefits are local authorities and the state organizes those welfare services that are complex and thus unreasonable to provide on the local level.

Whereas as of summer 2013 a new needs-based family benefit was established, the Ministry of Social Affairs organised information days in the first half of 2013 in all of the counties for the social workers of local authorities and to workers of county governments. The information days focused on the regulation of needs-based family benefit, but included also questions and sharing practices with regard to the subsistence benefit. During the reference period, the ministry also regularly sent out informative e-mails and official letters to the social workers of local authorities and to workers of county governments regarding legislative changes and developments. The staff of the social welfare department of the ministry also considers it a regular work to communicate with the social workers of local authorities and also the staff of county governments, to answer their questions and give opinions.

During the reference period, there were also developments done in the social services and benefits registry. Additional functionalities were added for processing the applications of needs-based family benefit and also for the purpose of granting food aid to the most deprived. Developments in the social services and benefits registry concerned also the area of child protection. In addition, data exchange was implemented with the Estonian Unemployment Insurance Fund with regard to the unemployment status of the applicants and with the Tax and Customs Board with regard to the income of the applicants of social assistance. Preparatory work in connection with data exchange started also with many other databases. The ultimate goal is that the person does not have to provide the same information to the state many times. Instead the state databases communicate with each other via x-road to receive the necessary information.

As regard social benefits, local authorities continued to pay in addition to the state financed subsistence benefit and needs-based family benefit also supplementary social benefits from a

local authority's budget under the conditions and pursuant to the procedure established by the local authority.

As mentioned already in the previous report, the on the 26th of April 2012, the Government endorsed an updated competiveness plan "Eesti 2020" (Estonia 2020). One of the goals set is strategy is to reduce the rate of relative poverty after social transferences. The base level for the document was year 2010 with a relative poverty rate (60% of median income) of 17,5% after social transfers. The goals in the document are set to 16,5% in 2015 and to 15% in 2020. The data for 2015 has not yet been published. However in 2014 the relative poverty rate after social transfers was 21,6% in 2014. The increase in the rate has been the result of continued increase in the employment and incomes. The rate of absolute poverty has decreased in the reference period from 8,7% in 2010 to 6,3% in 2014.

In the development plan of the Ministry of Social Affairs the assistance of persons in need is always one of the topics addressed, by bringing out the goals and actions needed to achieve them. Since the development plan is updated yearly and is meant for next four years, the contents of the development plan slightly changes. However the purpose of having the subsistence level in line with the overall cost of living continues to be a priority. Paying subsistence benefit in a way which avoids the formation of poverty trap is also a timeless principle.

In June 2016 the Government of Estonia endorsed a new development plan in the policy field of social protection and equal opportunities. The document is called Welfare Development Plan 2016-2023. The process of drafting the development plan was led by the Ministry of Social Affairs. Although the document addresses years 2016- 2023, the preparatory work and drafting the development plan started already during the reference period. Namely the decision to have a new strategy was made by the Government already in June 2014. The Welfare Development Plan focuses on the strategic objectives of labour market, social protection, gender equality, and equal treatment policies. The Development Plan was compiled due to the need to establish a unitary strategic basis for the policy-making of the aforementioned spheres, which would, at the same time, take into account the needs of people, society, and economy, the challenges arising from demographic and socio-economic trends, international commitments, and the capability of the state.

Another development plan relevant in connection with this Article is the Strategy of Children and Families 2012-2020. As already mentioned in the previous report, this development plan

was endorsed by the Government on the 21st of October 2011. The Strategy includes strategic objectives aimed at guaranteeing an improvement in the well-being of children and families and in their quality of living. This Strategy is the basis for improving the lives of children and families and achieving an increase in population. One of the strategic objectives of the strategy is the following: Estonia has a system of combined benefits and services that supports the adequate economic coping of families and offers them permanent security. This means that in addition to supporting families based on the principle of universality, the state offers additional measures to children with bigger needs and their families. As mentioned above, needs-based family benefit was implemented as of June 2013. Both the universal child benefit and the needs-based family benefit have been increased during the reference period. According to the coalition agreement the universal child benefit will continue to be increased till 2019. The increasing of universal child benefits together with many other measures are brought out also in the implementing plan of the strategy for 2015-2019.

As a continuation to the purposes of the Strategy of Children and Families 2012-2020, the Ministry of Social Affairs published a green book on family benefits, services and parental leave in 2015. The purpose of the document was to propose policy suggestions to the Riigikogu, the government and publicity, which would help solve the tasks Estonia faces - supporting of economic coping of families, combining work and family life and increasing the birth rate. For compilation of the green book, three studies were ordered from private sector experts.

According to the information provided to the Governmental Committee, a survey on the use of subsistence benefit and its impact on alleviating poverty was ongoing, with a view to elaborating new policy measures and possibly increasing the subsistence level.

One of the studies used as an input for the green book on family benefits, services and parental leave, was put together by experts from the Praxis Centre for Policy Studies Foundation in 2013-2014. The subsistence benefit and means-tested family benefit were among benefits analysed. The purpose of the study was to conduct a comparative quantitative analysis of policy instruments in order to find policy measures that most effectively reduce poverty among children and at the same time do not discourage the labour supply of parents. The study focused on cash benefits and subsidized child care services. The microsimulation model EUROMOD with data from the Estonian Social Survey 2011 was used to simulate the impact of various policy changes on the absolute and relative poverty measures, budgetary expenditures and marginal tax rates for the year 2015. The study ranked policy changes

regarding their cost-effectiveness in poverty reduction and impact on work incentives. As regards the needs-based family benefit, the study suggested that instead of using the past poverty line in determining eligibility for the benefit, 125% of absolute poverty line could be used. The absolute poverty line depends on the development of actual prices and therefore would better reflect changes in the cost-of-living, whereas the relative poverty line depends on past income distribution. Since the benefit is quite new, the Ministry of Social Affairs has planned for 2016-2017 the analysis of the benefit. Therefore to this day the eligibility criteria has not been changed. According to the study, the most cost-effective policy measures to reduce absolute poverty among children were changes in the subsistence benefit system; either additional top-ups for families with children or increasing child's weight in the formula of subsistence benefits. In accordance with the suggestions of the study, child's weight in the formula of the subsistence benefits was increased from 0,8 to 1.0 as of January 2015. Hopefully the changes in means-tested benefits together with the increase of universal family benefits will reduce the poverty rate of children. According to the Strategy of Children and Families 2012-2020, the goals of children's relative poverty rate after social transfers are set to 17% in 2015 and 16,5% in 2020.In 2014 the relative poverty rate of children (0-17 years of age) after social transfers was 20,0% (compared to 19,5% in 2010) and the absolute poverty rate was 9,1% (compared to 11,4% in 2010).

A separate survey focusing on subsistence benefit was published in 2011. The survey focused on subsistence benefits and its impact on household income poverty in 2005-2010 and was ordered by the Ministry of Social Affairs. The data analysed in the survey covered years 2005 – 2010 first quarter, i.e the period that preceded to the setting up of the social services and benefits registry. Hereby we will point out some of the results of the survey. According the survey, the subsistence level of 2010 (63.91 EUR) was inadequate, since only 10% of the households came out of absolute poverty thanks to the subsistence benefit received. Pursuant to the survey, it is needed to guarantee a situation where the income of the families in need of social assistance is comparable to the absolute poverty threshold. The survey also brings out that employment is one of the biggest risk factors for subsistence. The proportion of household with unemployed members increased during the survey period. Although the number of beneficiaries decreased in the period January 2005 – August 2008 by almost four times, in September 2008 – February 2010 the number of beneficiaries of the subsistence benefit grew rapidly (almost 3,5 times). Although the housing costs and the total amounts of the subsistence benefit grew notably, the incomes of the beneficiaries grew only slightly. It became clear from the survey that in order to enhance the cooperation between social workers in local authorities and the consultants in the Unemployment Insurance Fund, there is a need for data exchange

in registries. As mentioned above, the data exchange between the social services and benefits registry has been implemented with the Estonian Unemployment Insurance Fund and also with the Tax and Customs Board. In order to lessen the work load of social workers, it was suggested in the survey to consider lengthening the time period of granting the subsistence benefit from one month to three months. As the number of beneficiaries of the subsistence benefit has decreased after the survey period, this suggestion has not been implemented. However it was decided to grant the needs-based family benefit for three months in order to avoid overburdening the social workers of local authorities.

The Committee takes note of the different programmes adopted and asks to be kept informed in the report of the results achieved.

As pointed out in the previous report, many welfare measures supporting employment have been conducted since 2007 with the support of European Social Fund (ESF).

For example, in the autumn of 2007 four regional training and information events took place, addressing welfare services that reduce care burden, and the objective of which was to harmonize in Estonian local governments the development of welfare services that supports access to employment and reduces care burden as well as to systematically train both the developers and providers of services. Additionally, in the framework of the programme 2007-2009, local government employees were trained at case management in order to develop the network based on case-by-case cooperation. Projects whose goals included also the provision of care services (day care and home care services) for at the elderly or disabled people were supported in order to allow the person with a care burden to enter or stay in the labour market. Provision of 24-hour care to disabled people or people diagnosed with dementia was also supported together with a project that developed social transport services. During the framework programme 2010-2013, instructional materials were developed for people caring for their family members.

Since 2012, the Estonian National Social Insurance Board implements a project that aims to improve coping and supports labour market participation (incl entering to the labour market, retaining the job or participation in the active labour market measures) of people with multiple needs and their families. The target group includes all working-age people and their family members who have more than one obstacle that hinders their employment and independent coping. Those obstacles could be debts, care burden, disability, long-term unemployment, missing vocational skills, lack of social skills, low motivation, health problems, alcoholism or drug addiction. Five regional case coordinators at the Social Insurance Board support local

government social workers to organise the case management network, solve complicated cases and direct people with coping difficulties to counselling services (psychological counselling, family counselling, debt counselling, legal counselling) at different service providers. Also, support person service is provided. All services are free of charge. In 2012 – 2015, 4427 people participated in the project. 91% of them (4029 persons) received at least one service. Nearly 50% of all service receivers (1972 persons) have entered to the labour market or retained their employment. By 2015, 85% of Estonian local authorities were involved in the project.

We will continue to provide support people's and their family members employment with the support of the European Structural Funds. For the next financing period until 2020, the following measures have been planned:

- the delivery of number of social welfare services (home services, care services (including interval and day care), social transportation, personal assistant service, support person service) will be increased;
- new innovative services (for example video and audio care service, alarm button service) will be piloted with the purpose to find innovative solutions and optimizing the use of time and financial resources;
- people and their families with multiple coping difficulties will be provided with social counselling services, including psychological counselling, family counselling, debt counselling, support person service, specialised social worker's (for example hospital social worker) counselling and specific expert counselling (for example legal counselling, clinical psychologists' counselling, psychiatrical aid and social pedagogue counselling);
- altogether, at least 10 500 persons with disabilities, elderly and their family members with care burden will be provided with social welfare services that support their employment possibilities (including retaining their job, starting to work) or entrance into the labour market services;
- several activities (for example trainings, supervision etc for social workers) have been planned to improve the quality of social services and social sector workers competences and to encourage more service providers to enter the market.

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 2012 – 2015 is indicated in the following table. The table shows that during the reference period, the number of subsistence benefit recipients and the number of acceded applications has steadily decreased. Also the funds spent on paying the subsistence benefit has gradually lessened. However the average sum of subsistence benefit has increased year by year.

General data about the subsistence benefit in 2011-2015

	2012	2013	2014	2015
The number of households that received subsistence benefit	21 585	19 320	16 571	14 605
The number of persons (number of household members) that received subsistence benefit	39 333	35 070	30 103	26 301
Number of satisfied applications	137 791	118 492	101 273	89 950
The proportion of beneficiaries of subsistence benefit in the population, %	3.0	2.7	2.3	2.0
The funds used for subsistence benefit, including supplementary allowance for families with one parent((in euros)	20 682 655	18 476 529	17 103 492	15 004 137
The average amount of benefit per one application (in euros)	150.10	155.93	168.89	166.81
The subsistence level (in euros)	76.7	76.7	90	90[1]

[1] As of 2015, the subsistence level of children is equal with the subsistence level of a person living alone of a first member of a household

Source: the Ministry of Social Affairs

The following table gives an overview of budgetary funds for subsistence benefit. The main benefit paid is the subsistence benefit. Additionally, supplementary allowance in the amount of 15 euros is paid to all the recipients of subsistence benefit if all members of the family are minors (i.e to single parent families). The supplementary allowance is paid together with the

subsistence benefit. The proportion of the sum spent on housing expenses grew until 2013 and started to decrease in 2014 due to the increased subsistence level. In 2015 the subsistence level for minors grew which lessened the proportion of the sum spent for housing expenses even more. In addition to the subsistence benefit, until the end of 2015, local authorities could pay other social benefits from the funds of the subsistence benefit, if the funds they had was sufficient to pay subsistence benefits.

Expenses on the payment of subsistence benefit in 2012-2015 (in euros)

	Sum paid for subsistence benefit (including supplementary allowance for families with one parent)	**Sum spent on housing expenses from the subsistence benefit**	**The proportion of the sum spent on housing expenses from the sum paid for subsistence benefit, %**	**Other social benefits from the budgetary funds for subsistence benefit**	**Total of the benefits from the budgetary funds for subsistence benefit**
2012	20 682 655	6 246 631	30.2	335 960	21 018 615
2013	18 476 529	6 047 146	32.7	402 815	18 879 344
2014	17 103 492	4 927 663	28.8	771 411	17 874 903
2015	15 004 137	3 927 321	26.2	539 087	15 543 224

Source: the Ministry of Social Affairs

As mentioned above, as of summer 2013 a new needs-based benefit was implemented for families with children. The following table gives a general overview of the needs-based family benefit.

General data about the needs-based family benefit in July 2013 – December 2015

	2013 2nd h-y	**2014**	**2015**
The number of households that received needs-based family benefit	4914	5 251	5 952
Number of satisfied applications	9 392	13 066	16 116
The number of payments made	20 457	39 179	47 542
The funds used for needs-based family benefit, in euros	313 832.75	599 538.03	3 436 335

Source: the Ministry of Social Affairs

The state allocates to the local authorities annually resources for the development of social services which support the improvement of the independent coping of persons in need of assistance, introduction of new social services and payment of additional social benefits. It is up to the local authorities to decide, how to use these funds (whether to payment of social benefit, for developing social services or for the administrative costs connected with social benefits and services. As the reporting forms for the usage of this benefit has been changed over the years, the following table gives an overview of the usage of these funds in 2015.

The usage of the support for social benefits and services, allocated to local authorities, in 2015, in EUR

The funds allocated to local authorities in 2015	**The funds used during 2015**	**The funds used for administ-rative costs connected with social benefits and services**	**The funds used for payment of social benefits**	**The funds used for providing and developing social services**	**The surplus of the funds at the end of year 2015 (taken into account the surplus of the funds allocated in previous years)**
2 948 413.00	2 807 377.80	649 750.30	1 762 944.66	394 682.84	1 003 976.72

Source: the Ministry of Social Affairs

According to the Social Welfare Act, local authorities have the right to pay supplementary social benefits under the conditions and pursuant to the procedure established by the local authority. In practice all local authorities pay some sort of supplementary social benefits from the local government budget. The Ministry of Social Affairs does not have a full overview of these benefits paid, but as the majority of local authorities use the social services and benefits registry to process these benefits, we do have some data regarding supplementary social benefits paid. The following table gives an overview of the supplementary benefits paid by local authorities in 2014 and 2015, relying on the data of the social services and benefits registry.

Supplementary benefits paid by local authorities in 2014-2015

	The number of appli-cations satisfied	The number of beneficiaries				The funds used for payments of supplementary benefits			
		Total	Persons at the age of 0-17	Persons at the age of 18-64	Persons aged 65 or older	**Total**	For persons at the age of 0-17	For persons at the age of 18-64	For persons aged 65 or older
2014	210 55	**92 639**	13092	46218	33329	**12 019 747**	2 594 934	6 928 996	2 495 817
2015	213 918	**95 522**	13 030	46 368	36 124	**12 041 182**	2 614 228	6 629 986	2 796 968

Source: the Ministry of Social Affairs

The following tables indicate the data of the submitted, satisfied and rejected applications filed to receive subsistence benefit and needs-based family benefit. As can be seen, the proportion of rejected applications for the subsistence benefit has a bit increased. The reasons for it could be associated with the fact that local authorities are now more motivated to process in the registry also the applications for which they know that the outcome is negative for the applicant. Namely the European Union food aid is given not only to the families which qualify for the subsistence benefit but also for some of the families who do not qualify for the subsistence benefit. Also the establishment of the needs-based family benefit may be behind for the increase of the applications for subsistence benefit. In addition local municipalities may have become more aware of the fact that they receive money from the state for each submitted subsistence benefit (and needs-based family benefit) application processed in the social services and benefits registry.

The statistics of submitted, satisfied and rejected applications of subsistence benefit in 2012-2015

	2012	**2013**	**2014**	**2015**
Number of submitted applications	142 324	123 817	105 931	95 484
Number of satisfied applications	137 791	118 492	101 273	89 950
Number of rejected applications	4533	5325	4658	5534

The percentage of rejected applications of all applications (%)	3.18%	4.30%	4.40%	5.80%

Source: the Ministry of Social Affairs

With regard to the needs-based family benefit, the increased percentage of rejected applications in 2015 is probably linked to the increased amount of the benefit which motivated more families to apply for the benefit.

The statistics of submitted, satisfied and rejected applications of means-tested family benefit in 2013-2015

	2013 June-December	**2014**	**2015**
Number of submitted applications	10 283	13 929	17 717
Number of satisfied applications	9 392	13 066	16 116
Number of rejected applications	891	863	1 601
The percentage of rejected applications of all applications (%)	8.7	6.2	9.0

Source: the Ministry of Social Affairs

As explained in the previous report, a 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 authorities. The Ministry of Social Affairs does not collect data about submitted challenges to county governors and the results of those.

The Committee asks in the next report to clarify whether the figures (according to which in 2011, out of 24 114 households which were granted subsistence benefit, 6784 corresponded to household whose head was a foreign national) correspond to both temporary and permanent residents, with a view to confirming that temporary residents have access to subsistence benefits on equal footing with Estonian nationals and permanent residents.

Hereby we confirm that the data submitted in the previous report in table 50 corresponds both to temporary and permanent residents. The social services and benefits registry, in use as of April 2010 does not distinguish whether the applicant for the benefit is a temporary or permanent resident. Hence the data regarding temporary and permanent residents is available

only in case the data of social services and benefits registry is compared against the data of the Population registry.

The following table brings out the beneficiaries of the subsistence benefit according to the nationality of the head of the household in the period 2012-2015. The data includes both permanent and temporary residents. As can be seen from the table, the majority of applications are submitted by citizens of Estonia, followed by people with undermined citizenship and citizens of Russian Federation. Somewhat smaller is the number of subsistence benefit recipients of the citizens of Latvia Ukraine and Lithuania. The proportion of subsistence benefit recipients of citizens of other countries is even smaller. As can be seen from the table, the citizens of the Republic of Sudan and Syrian Arab Republic have only as of lately become recipients of the subsistence benefit. This can be explained by the fact that people from Sudan and Syria have received international protection (refugee status) from Estonia during the last years. The residence permit for refugees is temporary, it is granted for three years. After that the residence permit can be lengthened for another three years (and after this period the person can apply for a permanent residence permit).

Number of satisfied subsistence benefit applications, households and members of household by citizenship of the applicant in 2012 – 2015

Country*	2012			2013			2014			2015		
	Number of satisfied applications	Number of households that received subsistence benefit	Number of persons that received subsistence benefit	Number of satisfied applications	Number of households that received subsistence benefit	Number of persons that received subsistence benefit	Number of satisfied applications	Number of households that received subsistence benefit	Number of persons that received subsistence benefit	Number of satisfied applications	Number of households that received subsistence benefit	Number of persons that received subsistence benefit
Total	**137 791**	**21 585**	**39 333**	**118 492**	**19 320**	**35 070**	**101 273**	**16 571**	**30 103**	**89 950**	**14 605**	**26 301**
Estonia	94 799	15 502	29 165	82 978	14 020	26 378	71 987	12 128	22 904	64 146	10 702	19 993
Undetermined citizenship	28 439	4 082	6 921	23 488	3 553	5 943	19 396	2 995	4 992	17 001	2 613	4 273
Russia	12 664	1 821	3 010	10 434	1 592	2 547	8 342	1 293	2 034	7 153	1 106	1 737
Latvia	728	107	237	651	97	209	610	87	191	712	93	205
Ukraine	593	100	196	436	77	149	411	71	114	424	79	159
Lithuania	194	25	32	158	22	28	141	22	32	116	18	26
Armenia	56	7	23	63	9	29	48	6	16	53	7	18
Sudan	-	-	-	-	-	-	32	7	7	49	12	14
Belarus	75	12	22	55	12	21	61	12	20	47	9	17
Georgia	19	3	8	29	6	15	27	4	9	25	3	6

Poland	27	4	7	20	2	2	19	3	4	25	5	14
Syria	-	-	-	1	1	1	27	5	5	25	4	12
Kazakhstan	60	6	8	40	7	11	27	4	4	24	4	4
Other countries	137	23	57	139	25	65	145	27	68	150	21	67

*the countries are aligned according to the number of applications satisfied in 2015

Source: The Ministry of Social Affairs

The increase of the relative poverty rate (60% of median income) has already been mentioned above. However the absolute poverty rate has during the reference period decreased. The following table gives an overview of the different poverty rates among age groups during the years 2011 – 2014.

Poverty rates according to age groups in 2011-2014

Poverty rates, %		**Persons aged 0-17**	**Persons aged 18-64**	**Persons aged 65 or older**	**The whole population**
2011	40% of median income	6.9	8.0	1.4	6.7
	50% of median income	10.9	12.6	4.3	10.9
	60% of median income	17.0	17.7	17.2	17.5
	Absolute poverty rate	9.4	9.5	1.6	8.2
2012*	40% of median income	8.3	9.1	2.4	7.9
	50% of median income	13.8	13.9	6.2	12.6
	60% of median income	18.5	19.7	27.0	20.7
	Absolute poverty rate	10.2	9,6	-**	8.4
2013	40% of median income	9.0	9.2	2.5	7.9
	50% of median income	14.5	14.1	8.0	13.1
	60% of median income	19.7	19.4	32.6	21.8
	Absolute poverty rate	9.7	8.6	-**	7.6
2014	40% of median income	9.4	8.2	2.7	7.4
	50% of median income	13.9	12.6	10.7	12.5
	60% of median income	20.0	17.9	35.8	21.6
	Absolute poverty rate	9.1	6.9	-**	6.3

* starting 2012 partially data based on registry is used. Therefore the change of data source has to be taken into consideration when the data is compared with the data of earlier years.

** the data was not received or was uncertain for publication

Source: Statistics Estonia

The data of different relative poverty thresholds in 2011-2014 are indicated in the following table. The data of 2015 has not yet been published. As can be seen, the poverty thresholds have increased during the reference period.

Relative poverty thresholds in 2011-2014

	2011	2012	2013	2014
Relative poverty rate 40% of median equivalent net income (euros per month)	200	219	239	263
Relative poverty rate 50% of median equivalent net income (euros per month)	249	274	299	329
Relative poverty rate 60% of median equivalent net income (euros per month)	299	333	361	394

Source: Statistics Estonia

The following table indicates the estimated minimum means of subsistence for 30 days of a household with one member in 2011-2015. The estimated minimum is considered as the absolute poverty threshold. As can be seen, the estimated minimum increased until year 2013 and thereafter has little by little decreased. Likewise the cost of minimal basket of food increased until 2013 and has remained stable after that.

Estimated minimum means of subsistence for 30 days of a household with one member and the cost of a minimal basket of food in 2011 - 2015 (in euros)

	2011	2012	2013	2014	2015
Estimated minimum means of subsistence / the absolute povery threshold	186.26	195.59	205.30	203.44	201.41
Cost of minimal basket of food	85.10	88.34	91.96	91.96	91.50

Source: Statistics Estonia

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 changes compared to the previous reference period. The political and social rights of persons are not restricted in relation to receiving social and medical assistance. The provisions of the Constitution, the Personal Data Protection Act and the Social Welfare Act, brought out in the previous report were relevant also in the period of 2012-2015.

As mentioned above, as of January 2016 a new wording of Social Welfare Act came into force, together with a new General Part of the Social Code Act, which is an umbrella act for different acts in the field of social protection. The confidentiality of social protection is now one of the principles of social protection which is regulated in the General Part of the Social Code Act.

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

The Data Protection Inspectorate, belonging to the jurisdiction of the Ministry of Justice, defends the following constitutional rights of people:

1) right to obtain information about the activities of public authorities;
2) right to inviolability of private and family life in the use of personal data;
3) right to access data gathered in regard to the person himself/herself.

Hence a data subject has a right of recourse to the Data Protection Inspectorate (or a court) if the data subject finds that his or her rights are violated in the processing of personal data.

The Data Protection Inspectorate publishes annual reports about its activities. According to the annual report of 2014, audit on medical spas (sanatoriums) was carried out as a joint activity of Baltic data protection inspectorates. In Estonia, the protection of personal data was audited in 12 spas. In addition, the inspectorate organised:

- data protection audits in the Lääne County Hospital and Tallinn Children's Hospital;
- with respect to adhering to the requirements of registering the processing of sensitive personal data, unannounced inspections to ten pharmacies was organised;

- with respect to the data quality in health care, the inspectorate participated in unannounced inspections carried out by the Health Board to three health care service providers.
- the requirements of secure forwarding and processing of sensitive personal data was inspected in the course of unannounced inspections to ten care homes.

According to the annual report of 2015, the Data Protection Inspectorate started the preparation of the guideline of using and forwarding data about persons needing healthcare and welfare aid. The completion of the manual is planned for 2016. The purpose of the guideline is to provide a practical material to help those moving data about persons in need between institutions (the welfare and child protection workers of local governments, the police, schools, kindergartens, healthcare personnel, etc.).

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 and 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.

No legislative changes compared to the previous reference came into force during the reference period with regard to providing assistance to the recipients of social assistance. According to the Social Welfare Act valid until the end of 2015, local governments provide social counselling services to the subsistence benefit applicants and their family members in need of assistance upon granting the subsistence benefit.

As previously mentioned, as of 2016 a new wording of the Social Welfare Act came into force. This act was drafted during the reference period and adopted by the Parliament on 9th of December 2015. According to the Social Welfare Act in force as of January 2016, upon the grant of a subsistence benefit, the local authority shall assess whether the applicant for the benefit or his or her family member needs other social welfare assistance in addition to the subsistence benefit. When the assistance granted to person is comprehensive, it is more likely that his/her need for assistance to cope in everyday life will decrease.

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

As pointed out in the answer for Article 13 § 1 question 2, many development documents have been adopted which include measures aimed at helping people to receive the assistance they need (The Strategy of Children and Families 2012-2020, the competiveness plan “Eesti 2020”, the Welfare Development Plan 2016-2023).

Also the measures conducted with the support of European Structural Funds have been described in the answer for Article 13 § 1 question 2. These measures are relevant also in the context of Article 13 § 3.

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

The organization of providing social services, emergency social assistance and other assistance as well as granting and paying social benefits continues to be the obligation of local governments. The number of local authorities decreased during the reference period from 226 to 213 local authorities.

The Ministry of Social Affairs has not collected data about the number of persons to whom the local authorities have provided social counselling. However, according to the Social Welfare Act valid during the reference period, social counselling has to be provided to the recipients of subsistence benefit and their family members. During the period of 2012-2015, 447 506 applications for subsistence benefit were satisfied.

The overall statistics concerning the project aimed at improving coping and supporting labour market participation of people with multiple needs and their families, has been brought out in the answer for Article 13 § 1 question 2. Namely during the reference period 4427 people participated in the project implemented by the National Social Insurance Board. 4029 people received at least one service. To be more exact, during 2012-2015:

- 2313 people received psychological counselling, in the amount of 17 002 hours;
- 1695 people received debt counselling, in the amount of 10 595 hours;
- 934 people received support person service, in the amount of 15 128 hours;
- 810 people received family counselling, in the amount of 4232 hours.

Out of the receivers of services, 36% entered to the labour market and 13% retained their employment. In addition 30% of the receivers of services proceeded to receive labour market services.

Since the arrangement of social services is the task of local authorities, the provision of many social services are financed from the local authorities budgets. The state organizes those social services that are complex and thus unreasonable to provide on the local level. The following table indicates the amount of expenses on social welfare from the state budget. As can be seen from the table, the expenses for social benefits have more or less stabilised as the expenses for social services have increased.

Expenses on the welfare from the state budget in 2012-2015, thousand euros

	2012	**2013**	**2014**	**2015**
Social welfare	78 455,3	77 494,3	74 289,8	79 911,6
Social benefits	23 000,8	21 347,1	20 781,1	21 845,8
Social services	37 304,6	40 537,0	46 058,1	52 870,4
Other expenses related to welfare	18 149,8	15 610,3	7 450,6	5 195,4

Percentage of welfare expenses %				
In GDP	0,44	0,41	0,38	0,39
In state budget[1]	1,21	1,00	0,96	0,96

[1] *Execution of the state budget by expenses*

Sources: the Ministry of Social Affairs, the Ministry of Finance, Statistics Estonia

Article 13 § 4 – Specific emergency assistance for non-residents

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

As described in the answer for Article 13 § 1 question 1, the Social Welfare Act valid until 31th of December 2015 stated that the subjects who have the right to receive social services, social benefits and other assistance, are:

- permanent residents of Estonia;
- aliens residing in Estonia on the basis of residence permits or right of residence; (this includes both temporary and permanent residents)
- persons enjoying international protection staying in Estonia.

In addition, according to the Social Welfare Act, every person staying in Estonia has the right to receive emergency social assistance. Therefore also for the citizens of other countries who do not live in Estonia on the basis of a residence permit or right of residence, emergency social assistance is guaranteed (for example people who stay in Estonia on the basis of a visa, but also people who do not have a legal basis to stay in Estonia). Emergency social assistance is defined by the Social Welfare Act as necessary social welfare measures in correspondence with the situation of a person without sufficient means of subsistence which guarantees the person at least food, clothing and temporary abode. The provision of emergency social assistance to an alien temporarily staying in Estonia is administered by the rural municipality or city government in whose administrative jurisdiction the person is staying at the time he or she is in need of assistance.

As of 2016 a new wording of Social Welfare Act came into force, together with a new act called General Part of the Social Code Act. The General Part of the Social Code Act became the umbrella act for different laws in the field of social protection. The paragraph listing the subjects of social welfare was transferred to the General Part of the Social Code Act. Therefore the principle that every person staying in Estonia has the right to receive emergency care is currently stated in the General Part of the Social Code Act.

According to the Act on Granting International Protection to Aliens, applicants of international protection who live in the accommodation centre or, for security reasons, outside the

accommodation centre and who do not work, have the right to receive financial support. The amount of financial supports to applicants of international protection equals to the subsistence level. Moreover, an applicant residing at the accommodation centre for asylum seekers was during the reference period paid a monetary benefit for urgent small expenses in the amount of 10 per cent of the rate of the subsistence level. The accommodation centre arranges also services for applicants of international protection: as necessary, the provision of accommodation, supply of foodstuffs or provision of food, supply of essential clothing and other necessities and toiletries, supply of money for urgent small expenses, access to medical examinations and necessary health services, essential translation services and Estonian language instruction, information regarding their rights and duties and transportation necessary for the performance of procedural acts.

Applicants for international protection are not entitled to health insurance, but they have the right to receive health care services listed in the Health Insurance Fund, with the exemption of services related to handling and transplantation of cells, tissues and organs and dental care of adults. However, emergency dental care and treatment prescribed by medical doctor is provided. The provision of health care services and medicinal products that are used to provide these services are financed from the state budget. The accommodation centre arranges, if necessary, access to medical examinations and necessary health services. The accommodation centre has entered into contract with selected health care service providers for that purpose. The specific situation of a vulnerable person and the special needs arising therefrom are taken account of in the international protection proceedings. Applicants for international protection with specific medical or psychological special needs are granted access to health care services, including mental health care services (psychological counselling, psychiatric aid etc).

Beneficiaries of international protection are entitled to, during their stay in Estonia receive health services on the same grounds provided by legislation as a permanent resident of Estonia. This means beneficiaries of international protection are entitled health insurance if they are engaged with employment, registered as unemployed or having equal status to the insured person (for example minor, pregnant women, students etc). In other cases, the person is non-insured resident and has right to emergency medical care, such as ambulance, emergency medicine and emergency hospital care services.

The Obligation to Leave and Prohibition on Entry Act provides the bases and procedure for the application to aliens of the obligation to leave Estonia and the prohibition on entry into Estonia. Among others, the act regulates the provision of food and medical care for persons to be expelled.

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

In Estonia 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 authorities. There are no studies done to assess the provision of emergency social assistance. However, larger local authorities do offer soup kitchens, shelters, night shelters etc. Smaller local authorities do not have shelters so in case of acute needs social housing may be offered.

For applicants of international protection the necessary services are provided by the accommodation centre, according to the provisions of the Act on Granting International Protection to Aliens.

Abode and food may be provided also by the Police and Border Guard Board, when they detect unlawful entry to the Republic of Estonia or when persons staying in Estonia without a legal basis are placed in a detention center on the basis of a judgment of an administrative court judge. In the detention center, the center, if necessary, will provide the person to be expelled with clothing without charge. The center organises the provision of food whereas as far as possible, persons to be expelled are permitted to observe the dietary habits of their religion at their expense. The person who ensures the provision of medical care in the detention center supervises the preparation of the menu of the detention center and the provision of food. At least once a week and upon reception into the detention center, persons to be expelled are provided with an opportunity to use a sauna, bath or shower. Once a month, hairdressing and barber's services is provided. Toiletries are provided by the detention center if the person to be expelled does not have these or funds to acquire these. A person to be expelled shall be ensured access to medical examination and necessary health services. The detention center has permanent treatment facilities for the supervision of the state of health of persons to be expelled. Health services in detention centers are provided by persons with family physician's qualifications pursuant to the provisions regulating the provision of specialised outpatient care.

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

The Ministry of Social Affairs does not collect regular statistics regarding the provision of emergency social assistance provided by the local authorities based on the nationality of the persons or the right of residence.

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.

Since 01.01.2016 the Estonian social welfare is regulated by two Acts – General Part of the Social Code Act and Social Welfare Act. Both legal acts were drafted during the reporting period of the current article.

The new **General Part of the Social Code Act** (adopted 9.12.2015, entered into force 1.01.2016)[20] forms single basis for the Estonian social protection system by establishing principles and organisation of social protection, organisational basis for providing benefits for social protection, the rights, obligations and liabilities of a person in applying social protection, social protection procedures, the organisation of social protection financing and the basis for managing the social protection information system. The Code creates legal basis to protect a person and a family by preventing, eliminating or reducing social risks integrally, particularly in case of unemployment, illness, motherhood, professional incapacity, old age, loss of a provider, upbringing children, falling victim to crime, special social need and difficulties in coping. As established by the Code, the objective of social protection is to support and increase person's independent living and social inclusion, create equal opportunities, achieve a high level of employment, prevent unemployment and support reconciliation of work and private life.

The Social Code frames principles of social protection – human dignity, person's ownership, solidarity, public authority's duty to explain and assist, confidentiality of social protection and cooperation. The Social Code thus forms the umbrella for other social protection regulations by assembling person's rights, obligations and liabilities in receiving social protection.

According to the Social Code, social protection has to be organised as a comprehensive system, which is based on ownership, cooperation, targeted provision of benefits based on a person's need and public interest, legal certainty and equal treatment, and sustainable and rational use of public funds. The parts of the social protection system are ownership of a person and a family; benefits organised and provided by the state and the local government; benefits organised in the form of insurance and other part of the social protection system provided by

[20] General Part of the Social Code Act is available at the State Gazette: https://www.riigiteataja.ee/en/eli/505022016003/consolide

law. Social protection benefits can be either in a form of cash (for example allowance) or in kind (mainly services).

The new **Social Welfare Act** (adopted 9.12.2015, entered into force 1.01.2016 with the transition period for local governments until 31.03.2016)[21] provides the organisational, economic and legal basis for social welfare, and regulates the relations relating to social welfare. The Act clearly establishes the principles of social welfare:

1) the needs of the person shall be taken into consideration first
2) such measures shall be preferred which are aimed at finding possibilities and increasing the ability of the person to organise his or her life as independently as possible
3) the person shall be advised about choosing and adjusting measures and, if necessary, about assistance provided by a specialist with appropriate professional training
4) the efficiency of implementation of measures from the viewpoint of the person in need of assistance and, if necessary, from the viewpoint of the family and community shall be taken as the basis
5) the person in need of assistance and, if necessary, his or her family members shall be involved in all the phases of the provision of assistance if the person has consented thereto
6) measures shall be ensured to be as accessible to a person as possible

For the first time, the Act aims to unify the quality of local government social services and establishes service-based minimum requirements to social services. The Act establishes a list of local government social services – domestic service, general care service provided outside the home, support person service, curatorship of adults, personal assistant service, shelter service, safe house service, social transport service, provision of dwelling, debt counselling service - their objectives, content, obligations of local authorities and requirements for service delivery.

More importantly, the Act sets the obligation that the person's need for aid has to be assessed and appropriate care has to be offered. The local government has the obligation to find the most suitable assistance to the person in need and if certain services are relevant then they must be in accordance with minimum requirements. The decision about the appropriate care

[21] The Social Welfare Act is available at the State Gazette website: https://www.riigiteataja.ee/en/eli/513072016001/consolide

and services must be done together with person and/or his/her relatives. If a person needs a long-time and diverse assistance which includes also the need to coordinate the cooperation between several organisations, the principle of case management shall be used and a case-plan needs to be established.

As in previous regulation, social services may be provided and financed by state or local governments. A fee may be collected from a person for social services provided to the person or his or her family. The fee collected depends on the extent and cost of the service and the financial situation of the person and family receiving the service. State provides and finances more complicated services as rehabilitation services, technical aids and special care services.

In 2012 Estonia has launched a major **reform of incapacity for work scheme**. The objectives of the reform are to increase the supply of workforce, reduce the health risks faced by employees, preserve working capacity and prevent unemployment as well as raise the competitiveness of the risk groups on labour markets. The reform entails a paradigm shift in the approach to disability and employment and is aimed at enabling disabled persons to participate in the labour market and prevent work incapacity through awareness and early intervention. Through the reform, the Government abolished the establishment of percentages of permanent incapacity for work, start assessing work capacity and increase the provision of labour market and supportive social services (rehabilitation, assistive technology, social services provided by local governments etc.), thus admitting persons with health damage in the labour market. The reform balances better the rights and obligations of persons with health damage, as they get more rights to receive help and support, but also an obligation to be active. First modifications of the reform were adopted[22] in 2014 entered into force in 2016.

Alongside with the improvement in the provision of labour market services, the improvement of provision and quality of social services forms the second important cornerstone of the reform. Within the framework of the reform, the quality and accessibility of local government social services will be upgraded (please see the description of the new Social Welfare Act above) and the provision of rehabilitation and technical aids will be improved.

During the reporting period, the following **amendments to the rehabilitation service** were prepared and adopted.

[22] On 19th November 2014 two legislation changes were adopted in Parliament: 1) Work Ability Benefit Act which regulates the assessment of work ability, work ability benefit and activation. 2) Social Welfare Act and Employment Services Act amendments which regulate social and vocational rehabilitation and technical aid scheme reorganisation.

In Estonia, the international concept of rehabilitation is divided between social welfare and health insurance schemes:

- rehabilitation is a social service targeted to disabled people with the aim to improve their independent coping and employment. The rehabilitation service is financed from general taxes through Social Insurance Board. Currently there is 114 rehabilitation service providers in Estonia.
- medical rehabilitation (that is internationally medical part of rehabilitation service) is a health care service that is appointed by a medical doctor and provided to all patients in case of certain disease condition. Medical rehabilitation service is financed from health insurance fund.

Analysis and statistics have indicated, that Estonian rehabilitation system has not been efficient and purposeful. It could have been characterised by complicated financing scheme, low fixed costs per person in a calendar year (up to EUR 1295 to disabled children and for up to EUR 448 to disabled adults) and too high costs for needs assessment and drafting of rehabilitation plan. The quality of rehabilitation service was deteriorated by long waiting lists (for example 9000 persons as of 1. January 2015) that prolonged the delivery of rehabilitation service, caused the increase of planning costs and decreased the results of the service.

In order to improve the quality and purposefulness of rehabilitation service, it has been divided into two since 2016:

- vocational rehabilitation is labour market service that enables individual job seeking, employment and vocational development
- social rehabilitation is social welfare service that supports everyday coping like independent living, education, participation in society and development of preconditions for employment

Such division enables to offer better targeted services that result in higher effectiveness. Persons with partial capability of work started to receive rehabilitation services that are linked with their (possible) employment. The maximum amount of services has been increased (up to 1500€) compared to current budget. The increase enables clients to receive services with shorter waiting list and in greater amount. Children, elderly and people incapable to work will receive services that increase their social coping.

More specifically, since 2016, the following changes in the social rehabilitation service have been implemented.

- Establishment of pre-evaluation (to be done by Social Insurance Board) enables to assess person's needs independently from service provider. It also helps to decrease the number of rehabilitation plans, including advice people with disabilities to apply for other services than rehabilitation (for example social services provided by local governments) and use rehabilitation programmes.
- Widening of the target group. In addition to people with disabilities, people with incapacity to work are entitled to social rehabilitation service.
- Widening the basis of rehabilitation service. In addition to the rehabilitation plan, the service is provided also on the basis of rehabilitation programme. Rehabilitation programme is a set of targeted individual and group rehabilitation activities for certain target group within fixed timeframe.
- Widening the number of components in rehabilitation service. In addition to physiotherapist, social worker, special pedagogue, psychologist and speech therapist services, the experience advisor as well as medical doctor and nurse's services were added to the service components list.
- Decrease of number of compulsory members of rehabilitation team from 5 to 3 is more in compliance with practice and help to decrease the administrative costs.
- Improve the quality of rehabilitation service by establishing a quality management system (since 2018) and requirement that at least one member of the rehabilitation team must have completed special rehabilitation training.
- Changes in financing system introduced framework agreements with service providers instead of current contracts under public law. Finances for the service provision were linked service recipients.

In 2015 the Ministry of Social Affairs initiated an expanded revision of rehabilitation services with the aim for future improvements. The new amendments of the rehabilitation system include the integration of medical, social and work related rehabilitation into one comprehensive, client-oriented system with the aim to provide services on time and smoothly. The improvement in coordination between medical, social and work related rehabilitation, including optimise services, avoids overlapping or traps in the provision of services and thus avoid unnecessary costs. Analyses and preparations are carried out in 2016-2017 with the view of full implementation of new system in 2018.

Major **changes in the provision of technical appliances** were carried out during 2014-2015 and implemented since 2016[23]. Within the new organisation, the provision of technical appliances is linked with the assessment of person's working capacity. The technical appliance granted by an expert with right competence (family practitioner, medical specialist or rehabilitation team) guarantees that the technical appliance corresponds to person's needs and supports person's coping. The European Social Fund Resources are used with the purpose to eliminate the waiting list for people at working age and to improve the access to technical appliances with higher quality and functionality. The qualification requirements to service providers are also implemented since 2016.

More specifically, the following amendments in the technical appliances system were prepared during the reporting period and implemented since 2016:

- service is organised by Social Insurance Board and thus the so far existing differences between counties are eliminated
- nation-wide budget and waiting list were established instead of county-based budgeting
- contracts with enterprises on amounts of services are abolished and the financing of technical appliances is directly linked to person
- description of lease-service together with quality requirements
- description of quality requirements for enterprises were established
- budget is planned for every product group separately

Future improvements of the technical appliances system for the forthcoming years include the awareness raising and counselling of all involved parties, improvement of cooperation between Social Insurance Board and enterprises, development of ICT systems to establish the electronic organisation of service in 2017.

- widening the scope of specialists who are entitled to prescribe the certificate for assistive technology.

[23] The new Regulation of Minister of Social Protection no 74 on list of technical appliances and their reimbursement by the state was approved on 21.12.2015. The Regulation is available at the State Gazette: https://www.riigiteataja.ee/akt/129122015041 (only in Estonian).

In the absence of new information in the report on equal and effective access to social services for lawful foreign residents, the Committee wishes to know wether the description provided in the conclusions is still accurate.

The provisions regarding the lawful legal residents have not been changed. According to the General Part of the Social Code Act, Estonian citizens residing in Estonia, as well as aliens residing in Estonia on the basis of a long-term residence permit or permanent right of residence, as well as aliens residing in Estonia on the basis of a temporary residence permit or temporary right of residence are entitled to the social services. In cases provided by the law, these rights may also apply to other persons.

Every person staying in Estonia has the right to receive emergency care on the basis provided by the law.

Access to social services and benefits of the beneficiaries of international protection is guaranteed on the same grounds as other permanent residents. This means that there are no time limits established for the application of services and benefits. The provision of services is needs-based.

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

Estonian social policy is in transformation towards supporting people for more independent living and participation in the society. The engagement in employment is a measurement of success of Estonian social policy. Estonian social policy emphasizes the importance of the locally available solutions and thus the social policy at large extent depends on the ability of the local level to meet the needs of their inhabitants, but the social policy needs to be supported by the improvements in other policy areas. Therefore Estonia do not focus only on the accessibility or quality of social welfare services, but is very much engaged in the regional reform preparations, transport arrangements, interaction between benefits and services and look at the ICT sector for integrative innovative solutions.

The most important result during recent years is the elaboration and adoption of the **Welfare Plan for 2016-2023** in March 2016. The preparations for the new strategic document started in 2014, when the Government approved the intention of drafting new welfare strategy. The elaboration of new strategy lasted from September 2014 until March 2016 under the leadership

of Ministry of Social Affairs and with the intense involvement of all relevant partners on state, local and non-governmental level.

The new Welfare Plan 2016-2023 establishes the mid-term roadmap for the social policy reforms. It is an unique situation as first time in our history the policies of labour and social welfare are joint under one umbrella. The main focus of the Strategy is on the prolongation of people's working life, support for independent living and coping as long as possible and to mitigate social risks.
Estonian social policy reforms aim to significantly increase the ratio between open care services users compared to 24 hours care users from current 1,4 to 2,2 in 2023 and significantly decrease the at risk of poverty rate (for more detailed information, please see report on Article 30).

The new Welfare Plan embeds the (already followed) principles of social welfare. The Estonian social welfare policy aims to promote people's working, independent coping and living in the usual environment (at home) as long as possible by the:

- provision of services and benefits according to people's actual needs
- provision of services that support independent coping in everyday environment
- development of community based services and flexible innovative solutions
- more attention on prevention
- enforcement of cooperation between local governments.

The most important areas of social welfare to develop are set on the basis of already existing practices:

1) Alleviation of care burden
2) Reorganisation of rehabilitation
3) Improving the quality and access of social services
4) Implementation of deinstitutionalsiation principles starting from special care
5) Improving the accessibility and implementing the universal design principle

According to the Statistics Estonia, approximately 30 000 women and 17 000 men have obligation to provide care.. 42% of caregivers are 65 years or older and 59% of caregivers provide care to disabled people more than three hours per day, that is considered excessive care burden. Approximately 17 400 people (approximately 2% of all people aged15-74) do not participate in the labour market due to care burden. Estonian current long-term care practice bases on family, relatives and neighbours and does not offer employment possibilities. Main

problems in alleviation of care burden are linked with missing services, poor availability of services, poor choices between services or lack of social guarantees for care providers.

In order to find solutions to the problem, the State Chancellery initiated an high-level **task force to alleviate the care burden**[24] in December 2015. The task force comprises of high-level representatives of state agencies, local governments, service providers, representatives of target groups and experts from the universities. The task force aims to map problems and existing possibilities to prevent care burden and provide social and health care services and, on the basis of the analysis, elaborate policy guidelines and solutions for prevention and decreasing the care burden to offer high-quality integrated social and health care services on both state and local level according to the actual demand and needs. The task force will submit its proposals to the Government in November 2017.

The availability and quality of social services is differs between local governments. In order to support the services provision and improvement in quality, the European Social Fund resources have been used since 2007. During the reporting period, the social welfare programme "Welfare measures supporting employment 2010-2013" was implemented with the aim to increase the labour market participation of people with social and economic coping problems and their family members. The main financed activities involved the provision of counselling services, that support employment, provision of rehabilitation programmes with the focus on employment, supporting young people who leave substitute care and increasing of competences of specialists and experts working in social sector and thereby the quality of social services.

The implementation of the new Social Welfare Act is supported by encouraging local governments for more intense cooperation through European Social Fund resources, that are used in order to develop joint provision of services and look for innovative solutions to decrease the care burden and improve the independent coping and participation in the labour market of people with special needs and theid working-age family members. To continue supporting of local governments in the provision of social services, additional funds (approximately 31 million EUR) during 2014-2020 are foreseen. With the European Social Fund support, in the forthcoming years:

[24] The task force website is: www.riigikantselei.ee/hoolduskoormus

- delivery of the number of social welfare services (home services, care services (including interval and day care), social transportation, personal assistant service, and support person service) will be increased.
- New innovative services (for example video and audio care service, alarm button service) will be piloted with the purpose of finding innovative solutions and optimizing the use of time and financial resources.
- Clients with multiple coping difficulties (including disability) will be provided with social counselling services, including psychological counselling, family counselling, debt counselling, support person service, counselling by specialised social workers (for example hospital social worker) and specialised expert counselling (for example legal counselling, clinical psychologists' counselling, psychiatrical aid and social pedagogue counselling).

Altogether, at least 10 500 persons with disabilities, elderly and their family members with care burden will be provided with social welfare services that support their possibilities of work (including retaining their job, starting to work) or entry into the labour market services.

One of the main preconditions to apply for funding, is the cooperation of local governments in the respective functional areas. This requirement helps local governments to prepare for merging and providing services in joint areas. For the ESF funding preparations, an analysis on joint provision of social services was carried out by Regional Development Centres[25]. The analysis mapped the current situation in providing social services by counties and the need for further developments. The proposals on functional areas, financial needs and possible cooperation forms the basis for local governments in the preparations for applications for funding of development on social services.

Since 2012, the Estonian National Social Insurance Board (with the support from ESF) implements a project "Integrated services through case management network for people with multiple needs"[26] that aims to improve coping and support labour market participation (incl entering to the labour market, retaining the job or participation in the active labour market measures) of people with multiple needs and their families. The target group includes all working-age people and their family members who have more than one obstacle (for example debts, care burden, disability, long-term unemployment, missing vocational skills, lack of social

[25] The analysis „Development of social services in counties 2016-2020" is available at the Ministry of Social Affairs website: http://www.sm.ee/sites/default/files/content-editors/Sotsiaal/mak_analuus_koond_toimetatud.pdf (only in Estonian)

[26] The information about the project is available: http://www.sotsiaalkindlustusamet.ee/projektid (only in Estonian)

skills, low motivation, health problems, alcoholism or drug addiction) that hinder their employment and independent coping. Clients with coping difficulties have possibility to receive counselling services – psychological counselling, family counselling, debt counselling, legal counselling, support person services, clinical psychologist services, psychiatric aid and social pedagogue services. The project follows case management principles set in the Social Welfare Act and develops cooperation between local governments and increases people's knowledge about their rights and possibilities for assistance. Since 2012, over 4500 people have participated in the project. 91% of all participants have received at least one service. 50% of all services receivers have entered to the labour market or retained their employment. By 2015, 85% of Estonian local governments were involved in the project.

The improvement of **quality of social services** has been the Estonian priority for several years. In order to assist local governments and service providers to implement the Social Welfare Act, the Ministry of Social Affairs, together with relevant stakeholders, elaborates service specific guidelines[27] in 2011. Since then, the list of guidelines has been lengthened (for example, with family reconciliation and alarm button service) and guidelines have been regularly updated according to the feedback received from local governments and service providers.

Estonia has several projects and activities, including with the support of European Social Fund that prepare and assist local governments in the implementation of minimum quality requirements of social services:

1) All ESF funded social welfare services have to meet certain minimum quality criteria.
2) Cooperation between municipalities is required in the application of ESF financing. Preference will be given to projects that promote the provision of services to a so called functional area (instead to a specific administrative area). Local governments and service providers will also be provided with consultation and training to improve the cooperation between municipalities.
3) Social work at the local level is promoted through the work of the regional case coordinators who provide support to local government social workers in dealing with complicated cases.
4) Trainings, supervision and other activities have been planned to improve quality of social services by increasing social sector workers competences.

[27] The guidelines are available at the Ministry of Social Affairs website: https://www.sm.ee/et/muud-toetused-ja-teenused#Sotsiaalteenuste%20soovituslikud%20juhised

5) Preparation to elaborate one general social services quality guideline and ten service specific quality guidelines that enable to evaluate the quality and purposefulness of social services have started. The quality guidelines help to choose the appropriate social services quality management tools for Estonia. The guidelines will be available since 2017 and where relevant, replace the previously elaborated ones (please see above).

Although the social services monitoring requirement has been effective since the first adoption of Social Welfare Act in 1995, the system of monitoring has not been effective in practice. County governments have the obligation to carry out yearly monitoring and submit the reports to the Government for information, but in practice the monitoring is irregular and has not helped to improve the quality of social services. In order to make the monitoring system effective and beneficiary for the improvement of quality of social services, the Ministry of Social Affairs has initiated the concept of advisory monitoring. Respective training curriculum together with monitoring guidelines for monitoring specialists has been ordered from Centre for Quality in Social Services at the Astangu Vocational Rehabilitation Centre[28]. The trainings started in September 2016.

During the reporting period, some additional functionalities were added to the social services and benefits register STAR. Data exchange was implemented with the Estonian Unemployment Insurance Fund with regard to the unemployment status of the applicants and with the Tax and Customs Board with regard to the income of the applicants of social assistance. Preparatory work of data exchange started also with many other databases. The ultimate goal is that the person does not have to provide the same information to the state many times. Instead the state databases communicate with each other via x-road to receive the necessary information.

Based on the Special Care Development Plan 2014-2020, approved by the Minister of Social Protection in September 2014[29], the state has assumed the obligation to prioritise the development of supportive services, focusing on community-based development of person-

[28] The Centre for Quality in Social Services was established in 2012 as EQUASS Competence Centre and has enlarged its duties since then. For more information: http://eng.astangu.ee/whatwedo/equass/

[29] The Special Care Development plan was approved by the Minister of Social Protection in September 2012. After the adoption of Welfare Development Plan 2016-2023, the Special Care Development Plan was directly incorporated with the Welfare Development Plan. The initial text of Special Care Development Plan is available at the Ministry of Social Affairs website: https://www.sm.ee/sites/default/files/content-editors/eesmargid_ja_tegevused/Sotsiaalhoolekanne/Puudega_inimetele/erihoolekande_arengukava_2014-2020.pdf

centred, high-quality services. Supportive services must enable prevention of people's need for 24-hour forms of services and must support the principles of deinstitutionalisation. The Development Plan ambitiously aims to increase the ratio of special care and welfare service slots to services that support independent coping and twenty-four-hour institutional care services from 1,1 in 2014 to 2,5 in 2020.

The state is oriented to **develop services for people with psychological special needs** more close to the community and to support the person's coping in his or her usual living environment as long as possible and as independently as possible. The state provides supported living, community living, everyday life support, supported employment and the 24-hour special care service, choosing the most suitable to keep a person active and preserve or immediately start restoring his or her everyday coping skills, in particular to prevent him or her from entering the 24-hour care service. A person should enter the 24-hour care service only as a last resort when all other measures to support the person have failed and the person's coping cannot be ensured by other services.

During 2007-2013, institutions for people with psychological special needs in four mansion buildings were closed and reorganised into 550 high-quality service placements in family-type houses in direct vicinity of settlements with the purpose that the clients of special social welfare institutions could participate in local day centres, work centres, gym halls and other activities. The plans for 2014-2023 include using the support of the European Regional Fund (with 56 million EUR) for improving the living, studying and working conditions of people with psychological special needs. For that purpose, the 24-hour service facilities with over 30 placements will be reorganised into smaller ones following the deinstitutionalisation principle, and additional 200 new supporting services places will be created.

Special Care Development Plan 2014-2020 (now incorporated to the Welfare Development Plan, please see above) aims to provide equal opportunities for self-realisation for people with special mental needs. The Development Plan also aims to develop special care services that are of high quality and adhere to deinstitutionalisation principles. More detailed goals and activities have been planned in three wider areas of special care:

1) adults with special mental needs are ensured with equal opportunities for self-realisation;
2) special care and welfare services comply with the principles of deinstitutionalisation;
3) special care and welfare services are of high quality and offered by qualified and professional service providers.

In 2015, the Ministry of Social Affairs initiated a project of reorganisation of special care services by following service design principles. The aim of the project is to develop supportive measures to enhance the coping of people with mental special needs according to the following values:

- community-based provision
- are of high-quality, person-oriented and enable to offer flexible support and assistance by taking into account the changes in people's capacity and need for assistance over time
- coherent to other systems
- support the activation and participation in the labour market of people with mental special needs and their family members
- enable to prevent the need for 24-hours care
- sustain person-orientation and avoid the establishment of institutional culture also in the provision of 24-hours care and services

By the end of the project in 2017, new services and their quality criteria, guidelines and standards will be elaborated. The new services will correspond to the needs of target groups and services will be flexible for different combinations in their provision.

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 **social service providers** has increased during the reporting period. The increase has occurred due to the fact, that state supports the development of services, that are provided out of institutions and in the usual living environment (ie at home) or closest possible to the home. For example, the state prioritises the development and esRtablishment of new service places of supportive special care services (for example everyday life support service, employment support service, supported living service etc) instead of establishment of new institutions. The number of welfare institutions for adults has increased due to the ageing population. The following table gives and overview of development of service providers during 2011-2015.

Number of social service providers 2011-2015 (at the end of the year)

	2011	**2012**	**2013**	**2014**	**2015**

Institutional welfare services for adults (excl. persons with special mental needs)	131	138	144	148	150
Special care services	100	106	104	119	127
Incl 24-hours care	34	38	39	41	46
Rehabilitation	103	116	114	116	119
Day care service[1]	109	107	104	99	96
Night shelter service for the homeless	11	12	11	11	11
Housing service	663	645	633	630	636
Support person service (persons)	291	382	413	505	...
Caregivers of disabled adults (persons)	12 541	12 018	11 308	10 611	9 953

[1] The users of day centre services are counted only once during the year, regardless of times and number of different services used by a person in a certain day centre.

... no data available

Source: Ministry of Social Affairs

The number of **service users** has increased due the fact, that the state has invested the shorten the waiting lists of number of services (for example rehabilitation, special care services, technical aids). The following table shows the main changes in service users during 2011-2015.

Social services users, 2011-2015**,** during the year

	2011	**2012**	**2013**	**2014**	**2015**
Institutional welfare services for adults (excl. persons with special mental needs)	5 769	6 130	6 333	6 810	7 121
Special care services (total)	5 304	5 573	6 057	6046	6261
Supportive special care services	3 261	3 055	3 400	3 891	4 365

24-hour special care services	2 782	3 159	3 388	3 138	3 214
Rehabilitation	13 538	15 733	16 766	16 911	16 142
Technical aids	57 760	57 196	64 420	67 966	73 445
Housing service	10 057	9 935	9 795	9 769	9 646
Day centre service	51 361	52 882	50 123	49 537	48 523
Home service	6 116	6 157	6 435	6 545	6 673
Shelters for homeless	1 355	1 544	1 405	1 497	1 508
Welfare services to disabled adults	14 566	14 095	13 347	12 605	11 982
Personal assistant service	378	386	389	360	344
Support person service	831	1 296	1 273	1 263	...

... no data available

Source: Ministry of Social Affairs

The number of **staff members of social welfare institutions** in the end of 2015 was over 6 311 . Nearly 25% of them are carers, social care workers and providers of nursing care and 34% are persons involved in teaching and development. The following table gives an overview of persons providing welfare services, by position and sex.

Hoolekandeasutuse personal soo ja ametikoha lõikes, 2011-2015[1] *(aruandeaasta lõpu seisuga)*

	2011[2]		**2012[2]**		**2013**		**2014**		**2015**	
	M	**F**	**M**	**F**	**M**	**F**	**M**	**F**	**M**	**F**
Management	58	286	62	288	62	283	53	313	61	301
Senior and mid-level specialists	45	280	37	269	34	271	35	275	35	293
Persons involved in teaching and development (educators, senior	159	1 876	156	1 861	156	1 981	160	2052	170	1 976

educators, activity leaders)										
Nurses	4	194	3	199	2	153	3	156	2	158
Social workers	4	170	5	168	6	158	7	153	6	163
Carers, providers of nursing care, social care workers	61	1 319	65	1 382	28	1 387	31	1 461	40	1 517
Psychologists, physiotherapists, speech therapists, doctors, pedagogues, vocational counsellors	13	98	14	95	9	92	15	125	13	159
Other personnel (economic, lawyers, catering, cleaning and other staff)	306	990	299	1 003	294	1 033	309	1092	297	1 119
TOTAL	**650**	**5 213**	**641**	**5 265**	**591**	**5 359**	**613**	**5 628**	**624**	**5 687**

Source: Ministry of Social Affairs

According to the Social Welfare Act, the social services may be **financed** from state budget, local government budget and other sources (different funds, donations etc). The fee may be collected from social services users. The amount of fee depends on the amount of services, cost of services and the economic situation of service users and their family members. The following table describes the financing of social welfare services, by types of services and sources of financing.

Tabel. Expenditure and financing sources of welfare services, 2011-2015

Type of service and year	Total expences (in Euros)	Financed by, (in Euros)			
		Person's own participation	Local governments	State	Other sources
Institutional welfare services for adults					
2011	34 211 944	22 431 795	11 426 954	217 446	135 749
2012	37 910 956	25 264 387	12 174 007	180 930	291 632
2013	41 439 586	28 305 798	12 839 271	177 480	117 037
2014	45 224 252	32 468 151	12 524 260	166 770	65 071
2015	49 789 879	36 696 686	12 892 385	143 001	57 807
Special care services (total)					
2011	22 998 558	5 385 924	1 915 136	15 575 759	121 739
2012	23 022 932	5 655 157	1 598 258	15 646 232	123 285
2013	25 794 431	6 531 577	1 817 531	17 284 322	161 000
2014	29 457 043	7 418 353	1 715 448	20 175 852	147 391
2015	31 214 586	7 992 859	1 198 360	21 884 380	138 988
Supportive special care services[3]					
2011	5 505 315	589 422	1 740 336	3 071 075	104 482
2012	5 262 597	587 785	1 450 315	3 113 388	111 109
2013	5 988 929	615 764	1 605 923	3 641 739	125 503
2014	6 493 291	671 525	1 405 867	4 287 719	128 180
2015	6 759 840	709 481	878 721	5 076 261	95 377
24-hours special care services[3]					
2011	17 493 244	4 796 503	174 800	12 504 684	17 257
2012	17 760 335	5 067 372	147 943	12 532 844	12 176
2013	19 805 502	5 915 812	211 609	13 642 584	35 497
2014	22 963 752	6 746 827	309 581	15 888 133	19 211

2015	24 454 747	7 283 378	319 639	16 808 119	43 611
Rehabilitation					
2011	6 600 046	-	-	6 600 046	-
2012	5 358 173	-	-	5 358 173	-
2013	7 514 906	-	-	7 514 906	-
2014	7 696 661	-	-	7 696 661	-
2015	8 143 252	-	-	8 143 252	-
Technical aids					
2011	9 256 577	2 667 058	-	6 589 519	-
2012	9 133 347	2 718 923	-	6 414 424	-
2013	10 798 336	3 306 577	-	7 491 759	-
2014	11 185 638	3 529 717	-	7 655 921	-
2015	12 946 496	3 984 673	-	8 961 823	--
Housing services					
2011	1 678 627	...	1 628 856	22 077	27 695
2012	1 770 253	...	1 692 909	21 684	55 660
2013	1 565 779	...	1 525 590	40 158	31 000
2014	1 672 488	...	1 622 655	36 532	13 300
2015	2 008 318	...	1 953 627	41 231	13 460
Day care services					
2011	4 537 473	459 401	3 747 384	97 861	232 827
2012	5 145 423	499 006	4 160 444	129 708	356 265
2013	5 441 766	574 453	4 499 582	77 679	290 052
2014	5 482 545	624 432	4 539 711	117 367	201 036
2015	6 316 675	694 071	5 316 225	105 364	201 016
Home services					
2011	4 546 662	145 432	4 391 314	7 166	2 750

2012	4 543 690	197 236	4 335 972	9 845	637
2013	4 988 744	212 508	4 764 495	11 288	453
2014	5 306 818	217 320	5 086 292	2 136	1 070
2015	5 721 539	248 935	5 468 126	680	3 798
Shelter services for homeless					
2011	476 264	6 836	468 740	-	688
2012	613 616	5 581	607 893	-	142
2013	701 032	8 341	691 328	-	1 364
2014	727 327	18 680	708 504	-	143
2015	764 957	7 841	757 116	-	-
Personal assistant service					
2011	505 654	21 083	427 893	50 615	6 063
2012	548 796	23 957	455 664	52 674	16 500
2013	621 507	30 903	520 580	41 765	28 259
2014	605 970	25 174	541 355	39 315	126
2015	563 658	20 484	508 842	34 332	-
Support person service					
2011	378 002	2 783	248 648	29 997	96 574
2012	466 636	917	381 743	49 276	34 700
2013	678 080	43 340	441 359	78 630	114 751
2014	1 049 964	16 292	654 882	327 344	51 445
2015	1 664 020	13 155	1 264 335	383 736	2 793
TOTAL					
2011	108 188 366	36 506 237	26 170 061	44 766 245	745 824
2012	111 536 754	40 020 321	27 005 148	43 509 178	1 002 106
2013	125 338 598	45 545 073	28 917 268	50 002 310	904 916
2014	137 865 749	51 736 471	29 108 555	56 393 750	626 973

2015	150 347 967	57 651 563	30 557 376	61 582 179	556 850

... no data available

- no financing

Source: Ministry of Social Affairs

Local governments have the main responsibility in providing assistance to the people in need. During the reporting period, the local government's social protection expenditures have increased. This is, again, caused by socioeconomic situation, ageing and need for investments. According to the statistics, the biggest share of social protection expenditure was the social protection of elderly, which, in average, forms slightly over 40% of total expenditure. The elderly are followed by children and families (approximately 22% of total expenditure) and social protection of the disabled people (around 16% of the total expenditure). The changes in local government expenditures in 2011-2014 are indicated in the following table.

Local government expenditures on social protection, 2011-2014, in Euros

	2011	**2012**	**2013**	**2014**
Social protection expenditure without subsistence benefit	**97 687 241**	**101 285 120**	**104 859 529**	**104 024 694**
Social protection of disabled people	**15 323 121**	**16 333 687**	**17 147 942**	17 198 644
Social welfare institutions for disabled people	3 543 325	4 297 259	3 728 596	4 603 648
Other social protection for disabled people[1]	11 779 796	12 036 428	13 419 346	12 594 996
Social protection of elderly	**40 160 494**	**39 721 295**	**45 240 000**	**42 880 412**
Social welfare institutions for elderly	25 803 234	25 625 523	32 164 015	29 347 064
Other social protection for elderly	14 357 260	14 095 772	13 075 985	13 533 349
Social protection of children and families	**21 732 719**	**22 937 113**	**23 681 499**	**24 390 255**
Substitute home[2]	5 543 651	..	..	..
Social welfare institutions for children and families	3 529 503	9 656 089	8 991 227	9 452 146
Other social protection for children and families	12 659 565	13 281 023	14 690 272	14 938 109
Other social protection expenditure	**20 470 908**	**22 293 025**	**18 790 087**	**19 555 383**

Social protection of the unemployed	3 252 262	2 770 591	1 287 016	607 194
Social protection in case of sickness	44 181	44 266	47 792	83 863
Social protection in case of loss of provider	70 102	70 541	76 903	74 968
Housing for social risk groups	992 885	373 815	498 979	569 909
Social welfare institutions for risk groups	2 765 545	3 942 166	2 818 880	3 203 538
Other social protection of risk groups	4 883 641	5 310 266	4 736 913	5 569 918
Other social protection, including administration	8 410 385	9 567 653	9 291 368	9 418 088
Other social protection, that is not mentioned above	51 907	213 727	32 237	27 904
Subsistence benefit	**24 449 706**	**21 788 945**	**19 679 115**	**18 617 425**
Social protection expenditures, including subsistence benefit	**122 136 947**	**123 074 065**	**124 538 644**	**122 642 120**
Total expenditures of local governments	1 296 277 065	1 426 801 353	1 562 604 162	1 520 494 970
Local government's share in total social protection expenditure, %	80,0	82,3	84,2	84,8
Including subsistence benefit	9,4	8,6	8,0	8,1
Excluding subsistence benefit	7,5	7,1	6,7	6,8
Social protection expenditure per person, in Euros				
Including subsistence benefit	92	93	94	93
Excluding subsistence benefit	74	77	80	79

Source: Ministry of Finance of Estonia, *http://www.fin.ee/kov-eelarved-ulevaated*

State budget expenditure on social insurance has been steadily increasing since 2011 amounting to 2,78 million Euros in 2013. Despite of the increase in total expenditure, the percentage of social protection expenditure in GDP has steadily decreased from 15,7% in 2011 to 14,8% in 2013. The initial estimations of Statistics Estonia show, that the slight decrease continued also in 2014, when the social protection expenditure formed 14,7% of GDP. The following table gives an overview of expenditure on protection in 2011-2013.

Total expenditure on social protection by type of expenditure, 2011–2013 (million euros)

	2011	2012	2013
Social benefits	2 583,14	2 661,61	2 776,82
sickness, health care	726,75	749,85	779,54
disability, incapacity for work	295,7	313,49	334,45
old age	1 119,29	1 170,03	1 227,65
survivors	14,08	13,28	12,61
family and children	319,29	304,78	306,94
unemployment	75,9	81,35	88,69
housing	8,1	7,78	7,40
social exclusion	24,03	21,05	19,54
Administration costs	28,68	31,89	31,84
TOTAL	2 611,82	2 693,49	2 808,66
Social protection expenditure share in GDP (%)	15,7	15,0	14,8

Source: Statistics Estonia

The report indicates, that there is an uneven geographical distribution of social services. Committee wishes the next report to indicate what are the impacts of this uneven distribution on effective and equal access to social services.

The preparations of work ability reform and surveys carried out for preparations of General Part of the Social Code Act assured, that access and quality of social services is geographically uneven. The lack of social services especially in the small local governments and with low population density may hinder the employment and quality care possibilities. For example, due to the lack of care services, the labour market participation of family members, who take care of their relatives is hampered and has a long-term effect on their income, poverty, sickness benefits and pensions in the longer run. To respond these challenges, the local government reform focuses on the improvement of accessibility and quality of social and other public

services. In addition, the results of the work of task force on the alleviation of care burden will concentrate on the improvement of accessibility of social services.

The Committee wishes to know how many complaints have been lodged at local level and how many have been dealt with.

The Ministry of Social Affairs does not collect information about the complaints lodged at local level. However, in the framework of yearly monitoring, the county governments may present the number of complaints submitted during the year, but this practice is not very common. Only few county governments submit the number of complaints. Most of the complaints are on the granting and payment of subsistence and other benefits.

Nevertheless, the low and scarce number of complaints indicates to the poor knowledge of persons in need and their family members about their rights. With the elaboration and dissemination of service-based quality guidelines (to be elaborated by the end on 2016) and other activities (information articles about social services, dissemination of information via Ministry's website, Facebook etc) the Ministry of Social Affairs has planned the raise of public awareness about their rights and possibilities. Also, the enforcement and empowerment of advocacy organisations will be supported.

Committee wishes the next report to indicate the ratio of staff to users.

The Ministry of Social Affairs does not monitor and publish requested information. The survey on social workers' qualifications that was referred in the previous report, was onefold and currently no repeat surveys are planned.

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.

The public participation in the establishment and maintenance of social welfare services is not regulated by the law. However, according to the Social Welfare Act, the service providers must meet established quality criteria.

The Act also establishes the obligation of family members, judges, police, prosecutors, employees of social welfare, health care and educational institutions and other persons to notify local authorities of the place of stay of person about the person or family in need for social assistance.

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

The involvement of public in the development and provision of social and other public services is of crucial importance. Information regarding the Government Communication Handbook[30] (elaborated in 2011, with later amendments) that provides instructions for planning and organisation of public inclusion and the Public Participation Handbook[31] that describes good inclusion practices and guidelines has been prepared for officials and NGOs has been presented in the previous reports. As previously, information days and conferences for specialists in social sector were organised, including discussions in all counties to support the implementation of new Social Welfare Act.

The Estonian Regional Development Strategy 2014-2020[32] sets out the goal of ensuring availability and accessibility of high-quality public services for different social groups and improve satisfaction with availability of public transport all over Estonia. Living independently

[30] The Government Communication Handbook is available at: https://riigikantselei.ee/sites/default/files/content-editors/Failid/valitsuskommunikatsiooni_kasiraamat_eng.pdf

[31] The *Public Participation Handbook* is available at: https://riigikantselei.ee/sites/default/files/kaasamine_avalikus_sektoris_ja_vabakonnas1.pdf

[32] The Estonian Regional Development Strategy and its Implementation Plan for 2014-2017 are available at the Government of the Republic website: https://valitsus.ee/sites/default/files/content-editors/arengukavad/eesti_regionaalarengu_strateegia_2014-2020.pdf

and being included in the community are cornerstones of the new Welfare Development Plan 2016-2023 which also includes the activities for raising public awareness about the rights and provision of social services and empowerment of people and representative organisations of different interest groups. The need for such activities derives directly from the fact that the number of complaints regarding the provision of social services provision and quality has remained very low during recent years. The service-based guidelines help to increase the public awareness about the rights and possibilities of target groups.

The financing of public participation is project-based. The Gambling Tax Council finances yearly and monthly projects in the fields of social welfare, active ageing and participation of disabled people in the society. For example, the Gambling Tax Board supports the yearly social worker's conferences and other forms of exchanging of best practices, but also some organisation's daily activities.

In 2012, the Estonian Social Enterprise Network was established. The network currently involves 48 of the top Estonian Social Enterprises. The network acts as:

1) advocacy organisation - advocating for an environment where social enterprises can maximize their potential in creating societal value (e.g. by having opportunities to take advantage of holistic and interrelated support measures);
2) supporter of social enterprises - providing direct (mainly non-financial) support for social entrepreneurs for either starting up or scaling up. Our programs for social enterprise development have concentrated on increasing sales and improving scope, quality and impact of their activities, using a variety of methods like design thinking and action learning.
3) developer and spokesperson of the field - supporting educational activities and research, participating in international cooperation, informing key stakeholders about social entrepreneurship.

During 2014-2015, the Gambling Tax Board and National Foundation of Civil Society have financed Development programme on social entrepreneurship and programme on increasing the potential of public services in social sphere through inclusion of volunteers[33]. The selected projects and their members received practical professional counselling and training in the establishment and development of social enterprises and inclusion of volunteers in their

[33] More information about the projects is available at the Social Enterprises Network website: http://sev.ee/esileht/projektid/

activities. Both projects aimed at developing new social enterprises in different activity fields of the Ministry of Social Affairs with the goal to support the employment and alleviate social problems. The majority of counties in Estonia were involved in the projects.

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 Ministry of Social Affairs does not collect official statistics regarding the voluntary sector participation in the provision of social services. However, in 2012 the Social Enterprises Network has carried out a survey[34] about the activity fields of social enterprises in Estonia. According to the survey, total of 38% of social enterprises have defined social welfare as their field of activity, while 7% of social enterprises are operating in the field of education. The remaining 54% are spread between various activity fields. The survey involved 125 organisations that have defined themselves as social enterprises. The potential number of social enterprises at that time was 800. According to the survey, social enterprises have significant growth potential in Estonia.

Voluntary sector may participate in the provision of social services, but this practice is rather scarce. Mostly, the volunteers are providing of one-to one services. For example, according to the statistics of Ministry of Social Affairs, the support person service is provided by the volunteers during 2011-2015:

	The number of people providing support person service during the year	incl the number of volunteers
2011	291	59
2012	382	63
2013	413	117
2014	505	51
2015	677	52

[34] The results of the survey are available at the Social Enterprises Network website: http://sev.ee/wp-content/uploads/2014/10/ANNEX-2.-Summary-of-the-results_ENG.pdf

Article 30 – The right to protection against poverty and social exclusion

Legal framework

The poverty is not defined in the Estonian legislation. According to the Estonian approach, the best way to alleviate poverty is the employment, that needs to be supported by relevant services and benefits. The subsistence benefit should remain the last and temporary resort in the alleviation of poverty, when the other measures have not proved to be effective.

The most important changes in legislation related to alleviation of poverty have been:

The establishment of new, needs-based family benefit scheme in 2013. From July 2013 to December 2014 the monthly amount of needs-based family benefit was 9,59 EUR per month for families with one child receiving child allowance, and 19,18 EUR per month for families with at least two children receiving child allowance. As of 2015 the amounts were raised substantially - 45 EUR per month for families with one child receiving child allowance, and 90 EUR for families with at least two children receiving child allowance.

The decision on the gradual raise of universal child allowances since 2015 (Euros per month):

	until 2014	**2015**	**2016-2017**	**2018**	**2019**
First and second child of the family	19,18	45	50	55	60
Third and each subsequent child of the family	76,7	100	100	100	100

The pensions do continuously increase over 5% per year. In 2016, the pension index was 5,7%. The average old-age pension in II quarter 2016 was 391,4 Eur. The value-added tax free pension in 2016 is 395 Eur per month. The Government has agreed to keep the average pension free of value-added tax.

In order to improve the financial coping of pensioners living alone, the Government agreed to pay additional support (115 Eur per year) since 2017.

In 2014, the subsistence level was raised from the previous 76,7 EUR to 90 EUR for a person living alone and to the first member of a family for each budgetary year. In 2016, the subsistence level was set to 130 EUR.

In order to improve the situation of needy families with children, the subsistence level for minor children was raised in 2015 from the previous 80% to 100% of the subsistence level of the first member of the family. The subsistence level of the second and each subsequent adult member of a family continues to be 80% of the subsistence level of the first member of the family. Thus, the subsistence level for children was raised in 2015 from the previous 72 EUR to 90 EUR and to 130 EUR in 2016.

The access to labour market services, especially for elderly and disabled people has been improved. According to the Labour Market Services and Benefits Act[35], all people from the age 55 until pensionable age are entitled to all labour market services. Since 2015 old age pensioners, who are registered as jobseekers at the Unemployment Insurance Fund are entitled to provision of information on the situation on the labour market, and of the labour market services and benefits, job mediation, labour market training, career counselling, work practice, business start-up subsidy, adaptation of premises and equipment and free use of special aid and equipment. In addition, the Employment Programme 2014-2015[36] establishes old age pensioners possibility to be supported in obtaining the qualification.

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

Strategic framework for alleviation of poverty and social exclusion in Estonia has been in place since 2010, when Estonia adopted the National Reform Programme “Estonia 2020”. The National Reform Programme, as other strategic documents in Estonia, is based on the strategic vision “sustainable Estonia 21”. Thus, the strategic framework for alleviation of poverty and social exclusion is following.

Strategic vision „Sustainable Estonia 21“aims to increase welfare and social inclusion in the society by 2030. For this active labor market measures will be developed, system of lifelong

[35] The Labour Market Services and Benefits Act is available at State Gazette: https://www.riigiteataja.ee/en/eli/530062015005/consolide

[36] The Employment Programme 2014-2015 is available at: https://www.riigiteataja.ee/akt/128042014003 (only in Estonian)

learning will be created, system of support measures to endorse the participation of excluded groups in the labor market will be created, abrupt worsening of the economic situation of the risk group will be avoided with through system of social security and family support and education system will debar the passing of poverty and social exclusion to the next generation.

National Reform Programme "Estonia 2020" is targeting to reduce at-risk-of-poverty rate to 15% by the year 2020. This will be achieved through measures which will increase the employment and the education level of the population. Special measures are foreseen for increasing the employment of disadvantaged groups in the labour market (including the elderly, disabled people and people with care burden etc), to improve the coping of families with children and revision of use of public resources in order to guarantee the public services long-term sustainability.

Activities to increase the participation of people with weaker competitiveness in education so that they can obtain qualification which also helps them to have better chances in the labor market will be implemented to achieve the objective of Lifelong Learning Strategy 2020 – equal opportunities to participate in lifelong learning and in studies. Support schemes for students (both in higher education and vocational training), including needs based support, loan schemes and grants system will be introduced and monitoring systems of the above mentioned measures will be elaborated.

Strategy of Chidren and Families 2012-2020 sets the goal to reduce the a-risk-of-poverty rate of children to 16,5% and to reduce the impact of transfers (incl. Pensions) on the at-risk-ofpoverty rate of children (aged 0-17) to 13 percentage points. These goals will be achieved through activities which support the employability of parents and development social protection system and services with the aim to support independent coping of families.

One of the objectives of the Youth development plan 2014-2020 (currently only in Estonian) – the risk of exclusion amount the young people is reduced – will be achieved through activities which increase the inclusion of youth and improve their employability.

To achieve specific objectives of the Development Plan for Active Ageing 2013-2020 (currently only in Estonian) - Older people are included in to the society and are socially active, older people are active in the labor market and satisfied with their working life and older people live longer, are healthy and coping well - a number of activities are implemented that help to prevent and reduce social exclusion, increase participation in the voluntary work, enhance older people's competitiveness in the labor market, reduce inactivity and unemployment,

promote attitude of healthy ageing and increase the accessibility and quality of health care and social welfare services.

In the framework of one of the sub-objectives of National Health Plan 2009-2020 - social cohesion has increased and inequality in health has decreased - activities which support the reduction of inequality in health through social-economical factors of influence and promote the development of public health and empowerment of communities and localities in health promotion will be implemented.

Program for improving peoples' financial planning skills 2013-2020 (available only in Estonian) will also support the measures (eg debt councelling) to be taken against poverty and social exclusion and increase coping.

The most important development plan in social policy – **Welfare Development Plan 2016-2023**[37] was adopted by the Government in March 2016. The Development Plan is the first social sector strategic document, that brings social and labour policy under one umbrella. The Development plan was elaborated during 2014-2016 with the wide involvement of all relevant stakeholders and social partners.

The welfare development plan establishes two main goals of Estonian labour and social policy:

- High employment rate and long and high quality working life
- Decrease of inequality and poverty, gender equality and higher social inclusion

Specific targets have been set to increase the employment rate of people aged 20-64 from 74,8% in 2014 to 76,3% in 2023, prolong working lives from current 36,5 years to 38 years in 2023, decrease the absolute poverty rate from 6,3% in 2014 to 5,8 in 2023 and the at-risk-of-poverty rate from 21,6% in 2014 to 15% in 2023, and decrease the gender pay gap from 22,5% in 2013 to 18,5% in 2023.

Specific objectives with relevant courses of action have established in four policy areas:

1) The demand and supply of the labour force is in compliance with the aim to increase employment rate and the quality of working conditions supports long-term participation in working life - helping people with reduced work capacity to the labour market,

[37] The Welfare Development Plan 2016-2023 is available at the Ministry of Social Affairs website: http://www.sm.ee/sites/default/files/content-editors/eesmargid_ja_tegevused/Sotsiaalse_turvalisuse_kaasatuse_ja_vordsete_voimaluste_arengukava_2016_2023/wdp.pdf

supporting employability of people with low qualification and preventing the decrease of work ability and fall-out from labour market (including work relations, working environment)

2) Adequacy of the social protection system enhances financial coping possibilities of people - improvement of pension system sustainability, establishment of additional measures for people with low incomes, improvement of synergy between benefits and services and development of ICT systems
3) Possibilities for independent coping, living in community and participation in society are widened due to effective legal protection and high-quality assistance – implementation of rehabilitation services reform, elaboration of support system to prevent and decrease the care burden, deinstitutionalisation and design of special care services, improvement of accessibility and quality of social services and improvement of accessibility and implementation of universal design principles
4) Men and women have equal rights, obligations, possibilities and responsibility in all spheres of life - monitoring of gender pay gap, elaboration of gender equality action plans, increasing the number of women among entrepreneurs and councils and boards of state-owned companies and foundations and supporting the decrease of gender pay gap through conscious choices in education and decrease of gender stereotypes

The action plan was elaborated and approved together with the Welfare Development Strategy. For each budgetary year, detailed programmes will be elaborated.

Reduction of poverty and social exclusion is also covered by the legislation. In 2011, the Government passed the Regulation on Rules for Good Legislative Practice and Legislative Drafting[38] that sets the framework for good practices of legislative process and aims to increase the quality of legislation. The Regulation states, that before passing any legislation, it is necessary to assess its social impact. Control questions have been developed which help to assess the impact of legislation to the peoples' economic situation, living standard, wellbeing, inequality, social exclusion and poverty.

A number of surveys regarding family policy have been carried out, that contributed to the green book on family benefits, services and parental leave that was published by the Ministry of Social Affairs in 2015. The purpose of the document was to propose policy suggestions to the Parliament, the Government and public with the aim to solve the tasks Estonia faces - supporting of economic coping of families, combining work and family life and increasing the birth rate.

[38] The Regulation is available at the State Gazette website: https://www.riigiteataja.ee/en/eli/508012015003/consolide

Social services, especially those that support independent living and coping and enhance employment opportunities for people needing assistance or their family members have contributed to the improvement of living standards (for more information about the respective measures, please see report on Article 14). The provision of food aid for people in need is described in the report on Article 13.

Information concerning poverty and social exclusion is regularly published by Statistics Estonia and it is also analyzed in various studies (for example studies about subsistence allowance, children, people with disabilities and older people)[39]. Statistical analyses made by European Commission (Eurostat), Statistics Estonia and Ministry of Social Affairs include evaluation of the impact of social benefits to the social protection systems and at-risk-of-poverty. Statistics Estonia publishes yearly in its public database data about relative poverty and its transitions braked down by age group and by type of the household.

Statistics

The scope of economic coping difficulties in society can be described by poverty, particularly absolute poverty, and more broadly, by the indicators of material deprivation that characterise material exclusion. In 2013, 8% or 104,700 people of the Estonian population lived below the absolute poverty line or with less than the estimated minimum means of subsistence. The severe material deprivation rate in the total population was 6.2% (81,140 people). In 2013, 22% or 288,600 people of the Estonian population lived in relative poverty or below the relative poverty line. Both – absolute poverty and at-risk-of poverty have decreased during last year, as in 2014, 21.6% of Estonia's population lived in at-risk-of poverty and 6.3% in absolute poverty. The following table describes recent changes in absolute poverty and at-risk-of-poverty rate during 2010-2014.

At-risk-of-poverty rate and absolute poverty rate by sex and age group, 2010-2014, %

		At-risk-of-poverty rate, %			**Absolute poverty rate, %**		
		Total	Men	Women	Total	Men	Women
2010	Total	17,5	17,6	17,4	8,7	22,0	22,5

[39] All analyses carried out by the Ministry of Social Afairs are available at the Ministry's website: http://www.sm.ee/et/uuringud-ja-analuusid#Sotsiaalvaldkonna%20uuringud%20ja%20anal%C3%BC%C3%BCsid (only in Estonian)

	0-17	19,5	19,3	19,8	11,4	26,1	23,0
	18-64	18	18,9	17,2	9,9	22,8	23,0
	65 and older	13,1	7,2	15,9	1,1	10,3	20,7
2011	Total	17,5	16,8	18,1	8,1	21,3	21,6
	0-17	17	17,2	16,8	9,4	24,1	22,4
	18-64	17,7	17,8	17,7	9,5	22	22,3
	65 and older	17,2	11,2	20,1	1,6	12,3	19,1
2012	Total	20,7	19,8	21,4	8,4	20,4	22,1
	0-17	18,5	19,5	17,4	10,2	21	21
	18-64	19,7	20,9	18,5	9,5	21,1	22,3
	65 and older	27	14,2	33,2	2,2	15,5	22,4
2013	Total	21,8	20,1	23,3	7,6	18,8	19,9
	0-17	19,7	20,1	19,4	9,7	19,8	19,2
	18-64	19,4	20,4	18,3	8,6	19,4	19,8
	65 and older	32,6	18,5	39,7	2,1	13,8	20,9
2014	Total	21,6	19,6	23,3	6,3	15	16,3
	0-17	20	20,8	19,1	9,1	15,5	14,4
	18-64	17,9	19	16,9	6,9	15,3	15,7
	65 and older	35,8	21	43,3	1,3	12,4	19,4

*) *partially register data from 2012 onwards. The change in data sources in 2012 should be taken into account when comparing data from previous years with those of the following years.*

Source: Statistics Estonia

According to the relative poverty indicator, a person is considered to be poor if his/her equalised disposable income falls below 60% of the national median equalised disposable income. In 2014, the median equalised disposable income stood at 7,889 euros per household member per year. The at-risk-of-poverty threshold (i.e. 60% of the median income) was 4,733 euros per consumer per year. In 2014, people with a monthly equalised disposable income below 394 euros were considered to live in relative poverty. According to the absolute poverty indicator, a person is considered to be poor if his/her equalised disposable income falls below the absolute poverty threshold (i.e. the subsistence minimum). In 2014, the absolute poverty

threshold was 203 euros per consumer per month. Table 30.1 shows the recent changes in yearly disposable income and poverty threshold

Equalised yearly disposable income and poverty threshold, 2010–2014 (in euros)

	2010	**2011**	**2012[a)]**	**2013**	**2014**
Mean equalised yearly disposable income	6 570,37	7 129,81	8 211,24	8 820,34	9 490,40
Median equalised yearly disposable income	5 597,89	5 987,21	6 662,76	7 212,04	7 888,75
Yearly at-risk-of-poverty threshold	3 358,75	3 592,33	3 997,66	4 330,22	4 733,25
Monthly absolute poverty threshold	174,82	186,26	195,59	205,30	203,44

[a)]partially register data from 2012 onwards. The change in data sources in 2012 should be taken into account when comparing data from previous years with those of the following years.

Source: Statistics Estonia

A comparison of the population groups reveals that in Estonia, absolute and relative poverty both threaten women, disabled people, and the unemployed the most. The unemployed have the highest risk of poverty. In 2013, 39% of the unemployed lived in absolute poverty and 59%, which is more than half of the unemployed, lived in relative poverty. The numbers have remained similar also in 2014 – 38,8% and 54,8% respectively.

Since income from wage labour grew the most, it was mostly the poverty of wage employees that was reduced. Social transfers did not follow step with the rapid wage increases, resulting in the retired, the unemployed and families dependent on social benefits becoming relatively poorer than others. In 2014, the at-risk-of-poverty rate of old-age pensioners grew 4.5 percentage points and the at-risk-of-poverty rate of those not at work – 2.8 percentage points.

Traditionally, social transfers help significant number of people out of poverty. In 2014, social transfers reduced relative poverty for 18% of the population: before social transfers 39.4% of the population lived in relative poverty, while after social transfers – 21.6%. Social transfers have the greatest impact on elderly people – 48% of the population aged 65 and older was brought out of relative poverty in 2014 thanks to these benefits.

The risk of poverty that is higher for women and increases with age indicates the feminisation of poverty. In 2014, the at-risk-of-poverty rate was 23.3% for women and 19.6% for men. Men's poverty, on the other hand, is deeper. For women, the absolute poverty rate was 5.4% and the relative median at-risk-of-poverty gap was 16.9%, whereas for men these indicators stood at 7.3% and 28.3%, respectively.

The main reason for this may be the huge gender pay gap in Estonia, which is also the biggest in the European Union, as well as due the economic inequality between the men and women in Estonia. Additionally, the notable difference in the life expectancy of men and women, as well as the changes in the structure of the household caused by this, also play a role. Thus, older women mainly form a one-person household whose relative rate of spending compared to their level of income is higher than that of, for example, households consisting of two (adult) persons. The feminisation of poverty refers to the need to assess the gender impact of social protection schemes.

Among unemployed, retired and other inactive persons, 38.5% lived below the at-risk-of poverty threshold in 2014 and 9.1% lived below the absolute poverty threshold. In 2014, the at risk-of-poverty rate of persons not at work was almost four times higher than that of employed persons. Among persons not at work, the poverty risk was the highest in the case of unemployed persons, with 54.8% of them living in relative poverty and 38.8% in absolute poverty. Among the employed population, 7.5% of wage employees lived in relative poverty and 1.9% in absolute poverty in 2014. For employed persons, poverty is mainly exacerbated by low wages, which are in turn related to a low level of education and part-time employment. Being self-employed, i.e. an entrepreneur, is another factor increasing the risk of poverty. In 2014, 33.3% of entrepreneurs lived in relative poverty and 15.3% in absolute poverty. The changes in poverty rates according to main labour status are listed in the following table.

At-risk-of-poverty rate and absolute poverty rate by main labour status and sex, 2010–2014, %

		At-risk-of-poverty rate			**Absolute poverty rate**		
		Total	Men	Women	Total	Men	Women
2010	Employed	7,9	6,8	9	3,7	3,2	4,3
	..wage employees	6,1	4,4	7,6	2,2	1,3	2,9
	..entrepreneurs	29,2	27,3	32,7	22,1	19,1	27,6
	Not at work	26,9	30,5	24,3	12,9	16,9	10,1

	..unemployed	52,1	54,8	48	35,9	36,6	34,9
	..old-age pensioner	14,9	9,5	17,5	1,4	..	1,5
	..other inactive	30	34,7	26,4	16,2	18,8	14,2
2011	Employed	8,3	6,6	10	3,8	3,6	4,0
	..wage employees	6,7	4,2	8,9	2,4	1,7	3,1
	..entrepreneurs	26,7	25,2	29,5	19,0	18,8	19,2
	Not at work	29	32,6	26,7	12,8	16,3	10,5
	..unemployed	55,5	62,1	47,2	38,3	43,5	31,6
	..old-age pensioner	19,6	14,1	22,3	2,3	..	2,8
	..other inactive	31,7	37,2	27,7	17,1	18,4	16,2
2012	Employed	10,9	11,2	10,6	4,8	5,4	4,1
	..wage employees	9,1	8,6	9,6	3,6	3,9	3,4
	..entrepreneurs	30,3	31,5	27,8	16,9	17,1	16,6
	Not at work	32,9	32,3	33,2	11,4	13,9	9,9
	..unemployed	51,9	53,2	50,4	33,7	35,7	31,4
	..old-age pensioner	29,2	17,9	34,5	2,8	2,3	3,1
	..other inactive	32	38,3	27,5	15,3	16,6	14,3
2013	Employed	11,8	11,7	11,9	4,9	5,4	4,5
	..wage employees	9,8	9,2	10,4	3,9	4,2	3,6
	..entrepreneurs	32,6	31,2	35,1	15,5	14,2	17,9
	Not at work	35,7	33,5	37,1	10,2	12,5	8,6
	..unemployed	54,4	55,6	52,3	35,2	33,7	37,8
	..old-age pensioner	35,6	23,8	41,6	2,9	3,5	2,6
	..other inactive	31,2	36	27,6	13,6	14,3	13,1
2014	Employed	10	10,6	9,4	3,3	3,9	2,6
	..wage employees	7,5	7,5	7,6	1,9	1,9	2
	..entrepreneurs	33,3	32,2	35,4	15,3	17,3	11,5

	Not at work	38,5	35,3	40,5	9,1	12,2	7,1
	..unemployed	54,8	59,2	48,3	38,8	43,4	32,1
	..old-age pensioner	40,1	27,5	46,4	1,9	..	1,7
	..other inactive	32,8	37,4	29,6	12,8	13,6	12,2

[a)]partially register data from 2012 onwards. The change in data sources in 2012 should be taken into account when comparing data from previous years with those of the following years.

Source: Statistics Estonia

The risk of relative poverty among the elderly (65 and older) as a whole is significantly higher than that of the whole population but the proportion of the elderly living in absolute poverty or below the estimated minimum subsistence level, compared to the whole population, is smaller.

The indicators of poverty and material deprivation of children aged 0–17 years and of people of working age (18–64 years) largely coincided, as children are mainly living in the households of people of working-age. Therefore, in 2013, a tenth of the children and working-age population lived in absolute poverty, approximately 7–8% lived in profound material deprivation, and one fifth of them lived below the relative poverty line.

In 2014, the relative poverty of families with many children and single-parent families increased. The at-risk-of-poverty rate of couples with at least three dependent children grew 3 percentage points year over year and 26.2% of these couples lived in relative poverty in 2014. The absolute poverty rate of families with many children also increased 3 percentage points year over year and stood at 15.0% in 2014. The at-risk-of-poverty rate of single-parent families rose from 37.2% to 38.8% year over year.

While the proportion of people living in absolute poverty and in profound material deprivation is more or less the same, in terms of disabled people, the severe material deprivation rate is significantly higher than that of absolute poverty. This may be due to the reduced opportunities of disabled people to earn an income, but it may also be caused by the additional costs arising from the disability, leaving them with less money for other expenses that the indicator considers.

In addition to material poverty and unemployment, social exclusion may also be caused by a low level of education. In Estonia, the share of people aged 25+ with basic or lower education has decreased a little year by year. In 2015, 14.1% of the population had a low level of education, which is 2.5 percentage points less than in 2010.

A person’s income is also closely related to health. In 2015, 27.6% of the people in the lowest income quintile considered their health to be poor or very poor, while the corresponding share for people in the highest income quintile stood at only 3.3%.