26/01/2021 RAP/RCha/EST/18(2021)

EUROPEAN SOCIAL CHARTER

18th 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 01/01/2016- 31/12/2019

Report registered by the Secretariat on

16 December 2021

CYCLE 2021

EUROPEAN SOCIAL CHARTER
(REVISED)

18th Report of the Republic of Estonia
On the accepted provisions

For the reference period 01/01/2016 – 31/12/2019

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

For the period 2016–2019 made by the Government of Estonia in accordance with Article C of the Revised European Social Charter, on the measures taken to give effect to the accepted provisions of the Revised European Social Charter, the instrument of ratification or approval of which was submitted on September 11th, 2000.

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

Table of contents

Part I – 3. RESC All workers have the right to safe and healthy working conditions

Article 3 – The right to safe and healthy working conditions

With a view to ensuring the effective exercise of the right to safe and healthy working conditions, the Parties undertake, in consultation with employers' and workers' organisations:

1. to formulate, implement and periodically review a coherent national policy on occupational safety, occupational health and the working environment. The primary aim of this policy shall be to improve occupational safety and health and to prevent accidents and injury to health arising out of, linked with or occurring in the course of work, particularly by minimising the causes of hazards inherent in the working environment;

a) Please provide information about policy formulation processes and practical arrangements made to identify new or emerging situations, that represent a challenge to the right to safe and healthy working conditions; also provide information on the results of such processes and of intended future developments.

The occupational health and safety (OSH) policy is developed by the Ministry of Social Affairs in cooperation with Labour Inspectorate, social partners and other stakeholders (e.g. occupational health doctors). All the amendments to the OSH law and strategic plans are discussed with stakeholders. Regular tripartite discussions take place with the representatives of employers, trade unions and government, where also the OSH issues are discussed.

The main strategic objectives in OSH are stated in the Welfare Development Plan 2016–2023, where the main policy instruments are the following:

- Support to workers and employers in implementing OSH rules, improving working environments, coping with new working environment risks and preventing employee's loss of ability to work.
- Enhance monitoring of the work environments to identify and eliminate violations related to the work environment.
- Make OSH legislation clearer and compatible with the changing labour market situation and economy.
- Reduce employer's administrative burden.
- Make state supervision and counselling activities more efficient.

The process of developing the new Welfare Development Plan for the next period have started in 2020. The aim of the process is to identify in cooperation with the stakeholders the main problems in the field of OSH and establish the key actions in order to improve the working environment in companies and prevent occupational health problems. In order to identify the OSH focus areas, the results of the state supervision on OSH, different scientific studies and the opinions of stakeholders are taken into account.

b) With particular reference to COVID-19, provide specific information on the protection of frontline workers (health-care staff including ambulance crews and auxiliary staff; police and other first responders; police and military personnel involved in assistance and enforcement; staff in social-care facilities, for example for older people or children; prison and other custodial staff; mortuary services; and others involved in essential services, including transport and retail; etc.). Such information should include details of instructions and training, and also the quantity and adequacy of personal protective equipment provided to workers in different contexts. Please provide analytical information about the effectiveness of those measures of protection and statistical data on health outcomes.

Related to COVID-19 epidemic the following measures were implemented for the protection of frontline workers (health-care facilities personnel, social-care workers, police and border guards, essential services workers and volunteers, including energy and IT personnel, transport workers, water and food providers, retail workers, pharmacy personnel and others):

1) arrangement of the frontline and essential services workers priority testing (according to the list of vital services in the Emergency Act https://www.riigiteataja.ee/en/eli/516052020003/consolide), totally tested over 15 000 workers;
2) health care workers randomized selection study to detect and prevent spread in health care facilities (totally tested over 2,500 healthcare professionals);
3) started but not completed seroepidemiological study among health care professionals;
4) arrangement of wide testing in nursing - and social care homes (long-term care facilities);
5) developed guidelines and recommendation for hospitals, emergency service, long-term care facilities (nursing homes), for essential business preparedness, cleaning and disinfection, for using PPE;
6) additional provision of personal protective equipment (PPE) for primary health care and long-term care facilities personnel.
7) started with infection control counselling, guidance and training in long-term care facilities.

Prison provides prison officials and employees with protective equipment and disinfection products together with instructions for use. All cases and situations when wearing a surgical or other PPE (personal protective equipment, for example eye protection, isolation gowns and respirators) is compulsory, are listed separately for prison officials, employees, prisoners, criminal defence counsels, representatives who are advocates, ministers of religion, notaries and consular officers of country of nationality to prisoners.

Intense screening of entrants and restrictions on entry:

1) Every person who enters the prison is instantly checked with a non-contact thermometer and in case of suspected fever, cough or other symptoms of the virus, the person is not allowed to enter. Prison officials or employees who exhibit coronavirus symptoms are immediately tested using the laboratory-based SARS-CoV-2 RNA tests. Tests are carried out by prisons' medical departments. Analyses are carried out by hospital laboratories outside the prison. Prisons also do random testing to prison officials using the laboratory-based SARS-CoV-2 RNA tests.
2) All guided prison tours and similar activities are cancelled or suspended.
3) Prisons minimize personnel and their movement between different units in order to keep the contact with prisoners to a minimum.
4) All contact visits to prisoners are suspended in all prisons, except visits by criminal defence counsels, representatives who are advocates, ministers of religion, notary and consular officers of country of nationality to prisoners. These meetings take place in a secure room, where the visitors and the prisoner are separated from each other by a glass. In addition,

access is continuously guaranteed for independent monitoring bodies (National Preventive Mechanisms: Prison Committees, Chancellor of Justice and CPT) who can access all prison facilities, including rooms where persons are kept in quarantine.

5) Transfers of prisoners are suspended in Viru Prison with some exceptions, such as transfers between closed and open prison, transfers to court and to necessary proceedings, if the court or prosecutor decides to hold a hearing in court.
6) All arriving prisoners are checked for the temperature with a non-contact thermometer in the prisoner transfer van before being admitted to the prison. All prisoners who arrive in prison are separated from other prisoners, even when they do not have symptoms of the virus. All new prisoners will be placed to the quarantine ward where they have to stay for 14 days. In case prisoner shows no symptoms after that period, he/she will be taken to their department. In case of exhibiting any symptoms of the virus, the prisoner will be placed to the quarantine ward. Prisoners with coronavirus symptoms are immediately tested, testing is carried out as described before by using the laboratory-based SARS-CoV-2 RNA tests. If the test result should turn out to be positive, the prisoner will be placed to the infection ward.
7) All unnecessary contacts (sport activities, social programs and classroom training) has been suspended in all prisons after first cases of positive COVID-19 cases were found. Isolation and protective isolation units have been established for COVID-19 positive prisoners and for inmates, who are at most risk due to their health status.
8) Prison staff canteen is being used separately by each ward's staff and the prison officials have also got an option to get their food in the takeaway containers. The canteen is always disinfected between the visits.
9) Prison officials are required to report immediately the prison's medical department and the Prison Department of the Ministry of Justice about every person with symptoms of the virus.

2. to issue safety and health regulations;

a) Please provide detailed information on the regulatory responses adopted to improve occupational safety and health in connection with known and also evolving or new situations (including as regards stress and harassment at work; work-related substance use and employer responsibility; strictly limiting and regulating electronic monitoring of workers; mandatory digital disconnection from the work environment during rest periods – also referred to as "digital detox"; health and safety in the digital and platform economy; etc.) and about regulatory responses to newly recognised forms of professional injury or illness (such as work-related self-harm or suicide; burn-out; alcohol or other substance use disorders; post-traumatic stress disorders (PTSD); injury and disability in the sports entertainment industry, including in cases when such injury and disability can take years or even decades to become apparent, for example in cases of difficult to detect damage to the brain; etc.).

On 1 January 2019 amendments to the Occupational Health and Safety Act came into force. One of the amendments to the Act was regarding the psychosocial hazards. The term "psychological hazards" was replaced with the term "psychosocial hazards" in the Occupational Health and Safety Act. The definition of the term is specified in greater detail in the Act, as are the measures applied for preventing damage to health caused by psychosocial hazards.

According to the amendment, psychosocial hazards are work involving a risk of an accident or violence, unequal treatment, bullying and harassment at work, work not corresponding to the abilities of an employee, working alone for an extended period of time and monotonous work and other factors related to management, organisation of work and working environment that may affect the mental or physical health of an employee, including cause work stress. Compared to the

previous regulation, the treatment of psychosocial hazards is now broader and also includes the social aspects of the working environment, such as relationships with co-workers, managers and third parties, unequal treatment of employees (incl. due to differences in race, skin colour, gender, age, religious, political or other beliefs, sexual orientation, national or ethnic origin, disability, or other circumstances, such as reduced ability to work, chronic illness or other differences arising from an employee's state of health), bullying, harassment (including sexual harassment) and violence at work.

In order to prevent damage to health arising from a psychosocial hazard, the employer shall take measures, including adapt the organisation of work and workplace to suit the employee, optimise the employee's workload, enable breaks to be included in the working time for the employee during the working day or shift and improve the enterprise's psychosocial working environment

During the reporting period no amendments to the OSH law have been made regarding work-related substance use. According to the Occupational Health and Safety Act, the employers is required to suspend an employee from work if he or she is under the influence of alcohol, narcotics or toxic or psychotropic substances and therefore an employee is prohibited to work while under the influence of alcohol, narcotics or toxic or psychotropic substances.

There have been no amendments to the law regarding occupational injury and illnesses. According to the Occupational Health and Safety Act, an occupational accident is damage to the health of an employee or death of an employee which occurred in the performance of a duty assigned by an employer or in other work performed with the employer's permission, during a break included in the working time, or during other activity in the interests of the employer. An occupational disease is a disease which is brought about by a working environment hazard specified in the list of occupational diseases or by the nature of the work. Therefore, the cases that were stated in the question, could be occupational accidents or diseases, if the causal link to working environment is established. The case may be considered occupational accident or diseases even if the actual damage becomes apparent later.

In case of monitoring workers, the Regulation (EU) 2016/679 of the European Parliament and of the Council of 27 April 2016 on the protection of natural persons with regard to the processing of personal data and on the free movement of such data, and repealing Directive 95/46/EC (General Data Protection Regulation) and the Estonian Personal Data Protection Act have to be followed. There are no differences or special provisions in the OSH legislation.

Concerning mandatory digital disconnection from the work environment during rest periods, according to the Employment Contracts Act, the employer is not allowed to contact employees during rest times and holidays. Therefore, the employee has the right to disconnect.

b) If the previous conclusion was one of non-conformity, please explain whether and how the problem has been remedied. If the previous conclusion was deferred, please reply to the questions raised.

In 2017 conclusions, the Committee concluded that the situation in Estonia is in conformity with Article 3§2 of the Charter pending receipt of the information requested below.

The Committee points out that under the terms of Article 3§2 of the Charter, regulations concerning health and safety at work must cover work-related stress, aggression and violence specific to work, and especially for workers under atypical working relationships (Statement of Interpretation on Article 3§2 of the Charter, Conclusions 2013). The report does not provide any information on this point. The Committee nevertheless notes that, according to the information provided in a joint report

from the European Foundation for the Improvement of Living and Working Conditions and the EU-OHSA on Psychosocial risks in Europe (2014), the need to take psychosocial risks or mental health into consideration when dealing with OSH is highlighted in Estonian legislation. The Committee invites the authorities to comment on this observation in the next report.

The Estonian OSH legislation highlights the need to take into consideration psychosocial risks at workplace. On 1 January 2019 amendments to the Occupational Health and Safety Act came into force. The aim of introducing changes into the Occupational Health and Safety Act was to improve the protection of employees. The term "psychological hazards" was replaced with the term "psychosocial hazards" in the Occupational Health and Safety Act; the definition of the term is specified in greater detail, as are the measures applied for preventing damage to health caused by psychosocial hazards. The new definitions also cover among other factors the risk of an accident or violence, unequal treatment, bullying and harassment at work and any other factors that may cause work related stress or other health problems. The amendment was described in more detail under the previous point.

In its previous conclusion (Conclusions 2013), the Committee asked for information on the transposition of Directive 2009/104/EC of the European Parliament and of the Council of 16 September 2009 concerning the minimum safety and health requirements for the use of work equipment by workers at work. It also asked for detailed information on the implementation of preventive measures geared to the nature of the risks identified during mandatory workplace risk assessment, as well as any schedule for compliance. The report does not provide any information on this point. The Committee reiterates its questions.

The Directive 2009/104/EC is transposed into the Estonian legislation by the Occupational Health and Safety Act and more specifically by the Government Regulation "Occupational health and safety requirements in relation to work equipment". There have been no major changes made to the regulation during the reporting period.

The employer has the obligation to ensure that work equipment is suitable for the work to be carried out and corresponds to the dimensions of the body and the physical and mental abilities of its operator. The employer also has to prepare safety instructions for the work to be carried out and for the work equipment used and organise training for employees.

The Labour Inspectorate carries out inspections at workplaces on the bases of the work equipment regulation.

The Committee asks that the next report indicate the international or EU standards on protection against hazardous substances and agents which the legislation and regulations issued and/or amended during the reference period are designed to incorporate.

During the reporting period, regulations issued under the Occupational Health and Safety Act were amended in relation to amendments made to EU Directives concerning the protection against dangerous substances at workplace.

The following EU directives have been transposed or will be transposed to the Estonian OSH legislation in the coming years.

- Directive (EU) 2017/2398 of the European Parliament and of the Council of 12 December 2017 amending Directive 2004/37/EC on the protection of workers from the risks related to exposure to carcinogens or mutagens at work. - Have been transposed into Estonian law.

- Directive (EU) 2019/130 of the European Parliament and of the Council of 16 January 2019 amending Directive 2004/37/EC on the protection of workers from the risks related to exposure to carcinogens or mutagens at work. - Have been transposed into Estonian law.
- Commission Directive (EU) 2017/164 of 31 January 2017 establishing a fourth list of indicative occupational exposure limit values pursuant to Council Directive 98/24/EC, and amending Commission Directives 91/322/EEC, 2000/39/EC and 2009/161/EU - Have been transposed into Estonian law.
- Directive (EU) 2019/983 of the European Parliament and of the Council of 5 June 2019 amending Directive 2004/37/EC on the protection of workers from the risks related to exposure to carcinogens or mutagens at work. - Will be transposed into Estonian legislation by 11.07.2021.
- Commission Directive (EU) 2019/1831 of 24 October 2019 establishing a fifth list of indicative occupational exposure limit values pursuant to Council Directive 98/24/EC and amending Commission Directive 2000/39/EC. - Will be transposed into Estonian law by 20.05.2021.

Regulations of the Government of the Republic "Requirements for the use of hazardous chemicals and materials containing such chemicals" and "Occupational health and safety requirements for the handling of carcinogenic and mutagenic chemicals" were amended in relation to the enforcement of the listed directives.

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 asks whether workers are protected up to a level at least equivalent to that set in the Recommendations by the International Commission on Radiological Protection (ICRP Publication No. 103, 2007).

The question concerns the protection against radiation. The protection against ionizing radiation is regulated in the Radiation Act. The Radiation Act is in compliance with the Council Directive 2013/59/Euratom laying down basic safety standards for protection against the dangers arising from exposure to ionising radiation.

According to the Act, in order to protect the workers who are exposed to radiation the employer (holder of the radiation practice licence) has the obligation to among other requirements comply with the radiation safety principles, prepare the rules necessary for carrying out radiation works and instructing exposed workers, and ensure updating of these rules upon commissioning of new technology or equipment, organise medical examination of exposed workers. In the case of high-risk radiation practice licences or if the holder of a radiation practice licence has more than ten exposed workers, designation of a radiation safety specialist is mandatory. A radiation safety specialist is a person with technical competence in the issues connected to relevant radiation practices who may be designated the person in control of compliance with radiation safety requirements at the undertaking by the holder of radiation practice licence.

A holder of a radiation practice licence is required to ensure that exposed workers receive radiation safety training and instructions which take into account the nature of work and the conditions at workplace.

A holder of radiation practice licence is required to ensure medication surveillance of workers upon employment and at least once a year after commencement of work. If the result of medical surveillance establishes before commencement of work that the worker is unfit for that specific position, the worker shall not be employed in this position.

According to the Act, persons under the age of 18 years are not allowed to perform any radiation works.

In the case of any activities in the case of which natural radiation sources may cause exposures to workers or members of the public in excess of the effective dose limits established for members of the public on the basis of this Act, the Environmental Board shall have the right to demand from the employer:

1) submission of radiation safety assessments;
2) organisation of monitoring of the doses resulting from exposures;
3) taking into account of the assessed exposure when organising work schedules;
4) informing of workers of the health risks related to their work and appropriate guidance;
5) implementation of special measures for the protection of the health of female workers during pregnancy and, if necessary, during breastfeeding;
6) taking of appropriate measures in order to prevent the opportunity that any workers and members of the public incur any doses which exceed the effective dose limit of members for the public or minimize it.

The Committee asks for information in the next report on the measures making it possible to check and ascertain whether the protection provided by the regulations for self-employed workers, home workers and domestic staff is applied in practice.

Labour Inspectorate carries out state supervision, during which the requirements set out for self-employed workers could also be controlled, if the self-employed workers are working alongside employers` employees. According to the Occupational Health and Safety Act, if a sole proprietor works at a workplace concurrently with one or several employees of an employer, he or she shall notify the employer who organises the work or, in the absence of such employer, the other employers of the hazards relating to his or her activities and shall ensure that his or her activities do not endanger other employees. The employer who organises the work or, in the absence of such employer, the other employers shall inform the sole proprietor of the hazards related to the operation of such enterprise and of the measures for avoiding such hazards, and who shall in turn inform its employees of the hazards present at the workplace and instruct them in ways to avoid such hazards before they commence performance of their duties. Also, the measures relating to rescue operations and provision of first aid and employees responsible therefor must be made public.

In addition, the Labour Inspectorate may carry out inspections based on complaints and hints.

3. to provide for the enforcement of such regulations by measures of supervision;

a) Please provide statistical data on prevalence of work-related death, injury and disability including as regards suicide or other forms of self-harm, PTSD, burn-out and alcohol or other substance use disorders, as well as on epidemiological studies conducted to assess the long(er)-term health impact of new high-risk jobs (e.g. cycle delivery services, including those employed or whose work is managed through digital platform; performers in the sports entertainment industry, including in particular contact sports; jobs involving particular forms of interaction with clients and expected to use potentially harmful substances such as alcohol or other psychoactive products; new forms of high-yield high-stress trading; military and law enforcement; etc.) and also as regards the victims of harassment at work and poor management.

Table 1. Registered occupational accidents and work-related health problems in Estonia, 2016-2019

	2016	2017	2018	2019
Registered occupational accidents per 100,000 employed persons	790	790	780	640
Fatal occupational accidents per 100,000 employed persons	4,0	0,9	1,8	2,2
Registered occupational diseases per 100,000 employed persons	6,1	5,6	7,4	5,1
Registered diseases caused by work per 100,000 employed persons	14,7	11,8	8,3	8,5

Source: Labour Inspectorate

Table 2. Workers' assessment of unequal treatment at work (%)

	2009	2015
Total	24	26
Payment	14	13
Distribution of tasks	11	12
Distribution of work-related information and possibilities of participation	10	11
Attitudes of colleagues and administration	8	10
Work related acknowledgement	9	11
Promotion, career possibilities	5	6

Source: Statistics Estonia, Working Life Survey

There are no comparative statistics and no analyses about relations between working conditions and suicide or other forms of self-harm, PTSD, burn-out and alcohol or other substance use disorders; and there are no epidemiological studies conducted to assess the long-term health impact of high-risk jobs.

b) Please provide updated information on the organisation of the labour inspectorate, and on the trends in resources allocated to labour inspection services, including human resources. Information

should also be provided on the number of health and safety inspection visits by the labour inspectorate and the proportion of workers and companies covered by the inspections as well as on the number of breaches to health and safety regulations and the nature and type of sanctions.

The activities of the Labour Inspectorate are planned annually. Additionally, the Minister of Social Affairs and the Director-General of the Labour Inspectorate have signed a mandate, which agreed on the directions of supervision and also indicators to assess the effectiveness of the activities of the Labour Inspectorate. The mandate has been signed for five years from 2019.

The Labour Inspectorate carries out general inspections and targeted inspections. For example, 4650 visits to workplaces in 3398 organisations took place in 2019. 15% of all workers were covered with these inspections.

Also, there are 10-12 different targeted inspections with a different focus every year. All targeted inspections are carried out within a month or during three months. After the targeted inspections the Labour Inspectorate sends a letter with recommendations to all employers of the sector, therefore increasing awareness among all employers in the sector.

In addition to the general and target inspections, complaints and hints about problems in working environment are the basis of inspections in certain organisations or economic sectors.

The number of visits has decreased slightly during the reporting period. This is due to the fact that several structural changes in the organisation of state supervision took place during this period. For example, sector-based teams of inspectors were formed in order to allow inspectors to specialize in a specific area of inspections (for example construction sector, etc.) and therefore increase the quality of inspections. Also, the advisory component was added to the inspection process, which means that inspectors are focusing on supervision as well as advising the employer on how to improve the working environment during the visits to workplaces. Therefore, more focus was put on the quality of inspections rather than the quantity in the previous years and this increased the duration of a single inspection slightly. The changes made to the organisation of inspections have increased the satisfaction of employers on the work done by the Labour Inspectorate.

In addition to the state supervision, the Labour Inspectorate provides consultations services to employers and employees and organises various information events and compiles information materials in order to increase employees' and employers' awareness of occupational health and safety.

It is also important to note that changes have been made during the reporting period in the methodology of collecting statistics on inspections. If previously each visit to the company`s different locations were counted as a different visit, then now visits made to the different locations of the same company are counted as one visit (one inspection).

Table 3. Statistics on state supervision

	2016	2017	2018	2019
Total number of enterprises	120 450	127 622	131 650	133 784
Total number of employed persons	644 600	658 600	664 700	671 300
Registered workplaces that could be selected for labour inspection	54 177	54 652	56 683	59 803

(enterprises with at least 1 employee) (Workplaces)				
Total number of enterprises visited	4435	3775	3643	3398
Number of labour inspection visits to workplaces during the year (Cases)	5927	5177	5128	4650
Labour inspection visits per inspector (Rate)	114	101	102	96
Number of workers covered by the inspections	80 685	95 263	124 771	97 509
The proportion of workers covered by the inspections	13%	14%	18%	15%
Number of labour inspectors	52	51	50	48
The budget of Labour Inspectorate (million euros)	2,14	2,19	2,62	2,73
The number of breaches to occupational health and safety regulations and sanctions				
Number of infringements	21 827	17 686	18 181	15 472
Number of OSH improvement notices issued*	2272	1668	1684	1671
Number of suspended work	171	165	174	198
The use of work equipment was forbidden	173	228	307	116
Fines issued / Total fines issued (€)	187 / 57 542	197 / 78 680	98 / 43 754	36 / 18 250
Misdemeanour proceedings conducted**	197	203	105	57

**The number of OSH improvement notices issued to employers has decreased because there have been less violations that can not be resolved within 5 days (smaller violations). In such cases, when the violations are resolvable within 5 days, the inspector does not issue a formal OSH improvement notice.*
*** The number of misdemeanour proceedings conducted decreased in 2019, because of the court proceedings and judgements arising from earlier proceedings. According to the court, the law was basically not enforceable due to the special identity description 'employer' included in the composition. The amendments to the law have been made and they entered into force on 30 July 2020, which means that the Labour Inspectorate is able to conduct misdemeanour proceedings as before.*
Source: Labour Inspectorate

c) Please indicate whether Inspectors are entitled to inspect all workplaces, including residential premises, in all economic sectors. If certain workplaces are excluded, please indicate what arrangements are in place to ensure the supervision of health and safety regulations in such premises.

The Labour Inspectorate is entitled to inspect all workplaces in all the economic sectors, with the exception of residential premises. Inspectors are entitled to inspect the residential premises only, if the owner (employee) has allowed it, because the privacy of the person has to be respected.

When working from home, all the occupational health and safety requirements have to be followed. A guidance on how to follow occupational health and safety requirements in case of telework was published in 2019. It is available in English in here: https://www.tooelu.ee/en/Employer/Working-environment/Organizing-working-environment/Teleworking.

d) If the previous conclusion was one of non-conformity, please explain whether and how the problem has been remedied. If the previous conclusion was deferred, please reply to the questions raised.

In 2017 conclusions, the Committee concluded that the situation in Estonia is not in conformity with Article 3§3 of the Charter on the ground that the labour inspection system, insofar as it concerns occupational health and safety, is inefficient. Below are answers to the questions of the Committee to explain the situation.

The Committee previously deferred its conclusion (Conclusions 2013) and, in view of the persistent under-reporting, asked for information on the implementation of Government Regulation No. 75 in practice, in particular how many non-fatal accidents were investigated by the Labour Inspectorate; whether physicians were aware of their reporting obligations in practice; whether steps were taken to counter potential arrangements between employers and workers; and whether sanctions were applied to employers or physicians in the event they fail to meet their reporting obligations. The report does not provide the information requested. The Committee reiterates its questions.

The under-reporting of occupational accidents has decreased during the reporting period, in 2019 the reporting rate was 58.5% (for example in 2010 in was only 38.3%). The employers are more aware of the obligation to report occupational accidents to the Labour Inspectorate, as are the doctors of their obligation no notify Labour Inspectorate of occupational accidents. During the reporting period, the Labour Inspectorate issued a number of articles and instructions to inform employees of the risks associated with under-reporting of accidents at work (including the loss of health benefits) in order to increase the reporting of occupational accidents.

Pursuant to the Occupational Health and Safety Act, Labour Inspectorate is obliged to investigate all fatal occupational accidents. Each case having caused serious health damage is reviewed and the investigation decision is made based on the case. The decision of investigation need is based on the risk principle and caused consequence. Therefore, all (100%) fatal occupational accidents and 16% of all serious occupational accidents are investigated. However, the total of all registered occupational accidents that are investigated is approximately 3,5% of cases.

It is also important to note, that in 2019 amendments were made to the Occupational Health and Safety Act regarding the reporting of occupational accidents. Since 2019, an employer is no longer required to report to Labour Inspectorate of minor accidents that do not leave an employee temporarily incapacitated for work. The employer is, however, still required to investigate all occupational accidents. The employer is required to report Labour Inspectorate of all occupational accidents that result in a temporary incapacity for work, serious bodily injury or death.

Table 4. Statistics on occupational accidents

	2016	2017	2018	2019
Number of occupational accidents	5098	5209	5170	4275

Number of occupational accidents investigated by the Labour Inspectorate	256	218	191	197
Notified occupational accidents investigated (fatal and serious accidents) (%)	24%	19%	17%	17%
The percentage of occupational accidents reported in Labour Inspectorate out of all occupational accidents that result in over 3 days of absence from work *(estimated by the Statistical Office of Estonia based on the Labour Force Survey)*	53,1%	57%	58,9%	58,5%

Source: Labour Inspectorate

The Committee notes from the report that the number of occupational diseases (57 in 2012 and 50 in 2015) and illnesses caused by work (172 in 2012 and 128 in 2015) decreased during the reference period. The Committee understands this to mean that occupational diseases, illnesses caused by work, and work-related illnesses together comprise the meaning of occupational diseases in the meaning of the Charter, and asks the Government to confirm. It also asks for information on the legal definition of occupational diseases; the mechanism for recognising, reviewing and revising of occupational diseases (or the list of occupational diseases); the incidence rate and the number of recognised and reported occupational diseases during the reference period (broken down by sector of activity and year), including cases of fatal occupational diseases, and the measures taken and/or envisaged to counter insufficiency in the declaration and recognition of cases of occupational diseases; the most frequent occupational diseases during the reference period, as well as the preventive measures taken or envisaged.

According to the Occupational Health and Safety Act an occupational disease is a disease which is brought about by a working environment hazard specified in the list of occupational diseases or by the nature of the work. The list of occupational diseases shall be established by the minister responsible for the area. The list of occupational diseases is an open-ended list on diseases. The regulation is available in Estonian: https://www.riigiteataja.ee/akt/897867?dbNotReadOnly=true

An illness caused by work is an illness caused by a working environment hazard and not deemed to be an occupational disease. A work-related illness is an occupational disease or an illness caused by work.

An occupational disease is diagnosed by an occupational health doctor who determines the state of the employee's health and gathers information concerning the employee's current and previous working conditions and the nature of his/her work. For such purpose, an occupational health doctor requires from an employer (employers) the decisions concerning previous medical examinations administered to the employee, and the results of the risk assessment of the working environment or explanation from the employer concerning the employee's working conditions and nature of work during such period and from an employee a statement of his or her medical records.

An occupational health doctor informs the employer, Labour Inspectorate and the doctor who referred an employee to him or her of the employee's occupational disease in writing or in a format, which can be reproduced in writing no later than within five days after diagnosing the disease.

The employer is required to investigate all occupational disease cases. If necessary, the Labour Inspection also carries out an investigation. The purpose of an investigation of an occupational disease is to ascertain the circumstances of the occupational disease and reasons therefor and to determine the measures for preventing the recurrence of a similar event.

Table 5. Number of registered occupational diseases by fields of activity, 2016-2019

Fields of activity	2016	2017	2018	2019	Total
Agriculture	5	2	3	3	13
Forestry	2	1			3
Mining		1		1	2
Metal industry	2	5	2	5	14
Wood industry	4	7	2	1	14
Paper industry				1	1
Furniture industry	3	1	3	2	9
Chemical industry	3	1	2	3	9
Textile industry	4	7	4	2	17
Food production	5	5	1	6	17
Water supply			1		1
Construction	1		3	1	5
Trade	2	1	1	1	5
Education	1	1			2
Transport, storage	2	2	2	2	8
Accommodation and food service				1	1
Administrative service	1	1			2
Health care	2		24	2	28
Other activities	2	2	1	3	8
Total	**39**	**37**	**49**	**34**	**159**

Source: Labour Inspectorate

Table 6. Causes of registered occupational diseases, 2016-2019

	2016	2017	2018	2019	Total
Physical hazards		1	1	2	4
Chemical hazards	4	4	7	7	22
Biological hazards	4	1	21	3	29
Physiological hazards	31	31	20	22	104
Total	**39**	**37**	**49**	**34**	**159**

Source: Labour Inspectorate

In 2019-2020 an analysis on the occupational health services (employees' medical examination) was carried out. The aim of the analysis was to determine the main problems in the Estonian system and develop measures to improve the quality of the service. Based on the analysis proposals are being made in order to improve the Estonian system of occupational health services, to better protect employees` health at workplace and to prevent occupational diseases in the future.

The report indicates an increase in the number of enterprises inspected during the reference period (from 3,132 in 2012 to 3,838 in 2015) and in the number of visits (from 4,616 in 2012 and 5,347 in 2015). However, this trend is not matched by the number of workers covered by inspection visits (166,233 in 2012 and 97,581 in 2015) and the proportion of workers indicated in the report (27% in 2012 and 15% in 2015). The Committee reiterates its request on steps taken to stop the persistent decrease in the number of workers covered by inspection visits.

During the reporting period of 2016-2019 the number of workers covered by the inspections have increased. The slight decrease in 2019 was due to the fact that more focus was put on the inspections in micro and small enterprises.

The reasons for the slight decrease in the number of inspections carried out were described under the previous point.

Since 2019 the Labour Inspectorate have been developing a new information system, which increases the efficiency of inspections, allows for automated supervision and saves time. The new system allows Labour Inspectorate to cover more companies and workers with the inspections and helps Labour Inspectorate to communicate with companies faster and more effectively. The new system is operational since the first quarter of 2020 and is being further developed in the coming years.

The new information system provides also tools for employers, which make it easier for employer to comply with OSH requirements. For example, there will be a tool for risk assessment. In addition, the idea is to also incorporate tools for the management of employee training, health examination, investigation of occupational injuries and diseases into the new information system in the future.

Table 7. Number of workers covered by the inspections

	2016	2017	2018	2019
Number of workers covered by the inspections	80 685	95 263	124 771	97 509
The proportion of workers covered by the inspections	13%	14%	18%	15%

Source: Labour Inspectorate

The Committee notes, according to figures published by ILOSTAT, that the number of labour inspectors remains stable (38 in 2012, 37 in 2013 and 2014, and 39 in 2015), the average number of labour inspectors per 10,000 employed persons was 0.6 during the reference period, the number of labour inspection visits to workplaces during the year increased slightly from 3,771 in 2012 to 4,246 in 2015, and the average of labour inspection visits per inspector also increased during the reference period (from 99.2 in 2012 to 108.9 in 2015). The Committee requests the next report to explain why the numbers of workplace inspections which are stated in the report and those published by ILOSTAT are different.

The Labour Inspectorate data on workplace inspections are in line with the data from ILOSTAT. As the Labour Inspectorate's priority is to reach ever more companies having several subdivisions, the number of labour inspection visits is higher than the number of companies involved. For example, in 2019 there were 4650 visits in 3398 different companies. The number of visits to workplaces (4650 in 2019) is in line with the statistics presented by ILOSTAT.

The Committee considers that in the reference period, labour inspection structures were not sufficiently developed in practice to establish that there is an efficient labour inspection, and that in absolute terms, the number of fines imposed and the amounts involved remain too low to have a dissuasive effect. Therefore, the situation is not in conformity with the Charter on the ground that the labour inspection system, insofar as it concerns occupational health and safety, is inefficient.

As was described under previous points, the Labour Inspectorate have put more focus on increasing the quality of inspections during the reporting period. The organisation of inspections has changed and new information system is in development, which allows to further increase the efficiency of the inspections.

In 2019 the amendments to the Occupational Health and Safety Act regarding misdemeanour entered into force. The amendment specified misdemeanour elements in the Occupational Health and Safety Act and increased fine rates. With the amendment, the maximum term of punishment of a legal person was increased up to 32,000 euros (as opposed to the previously enforced fine rates of 2,000 and 2,600 euros). The elevated fine rates are used to motivate employers to be more diligent in complying to occupational health and safety requirements. During the reporting period 2016-2019 the average amount of fine imposed increased from 308€ up to 507€.

It is also important to note, that penalising based on misdemeanour proceedings has never been the aim of the Labour Inspectorate, instead, proceedings to impose a fine are primarily implemented if the violation has been ongoing for a long period of time, affects many employees, or has put to risk the life or health of a person and it is no longer possible to eliminate the violation. For years, the Labour Inspectorate has been proceeding from the principle that if an issue in the working environment can be eliminated by applying other measures, no penalties are imposed. This method has served its purpose.

In addition to state supervision, Labour Inspectorate provides consultation services for employers and employees, which is an important tool to promote safety culture in general and improve working environments in companies.

Part I – 11. RESC Everyone has the right to benefit from any measures enabling him to enjoy the highest possible standard of health attainable

Article 11 – The right to protection of health

With a view to ensuring the effective exercise of the right to protection of health, the Parties undertake, either directly or in cooperation with public or private organisations, to take appropriate measures designed inter alia:

1. to remove as far as possible the causes of ill-health;

a) Please provide overall and disaggregated statistical data on life expectancy across the country and different population groups (urban; rural; distinct ethnic groups and minorities; longer term homeless or unemployed; etc.) identifying anomalous situation (e.g. particular areas in the community; specific professions or jobs; proximity to active or decommissioned industrial or highly contaminated sites or mines; etc.) and on prevalence of particular diseases among relevant groups (e.g. cancer) or blood borne infectious diseases (e.g. new cases HIV or Hepatitis C among people suffering from substance use disorders or who are held in prison; etc.).

Table 8. Life expectancy at birth by type of settlement / settlement region, sex and age group

		2016	2017	2018	2019
Type of settlement / settlement region	Sex				
City and town settlement region	Total	..	79,04	79,24	79,73
	Males	..	74,21	74,55	75,16
	Females	..	83,02	83,11	83,45
Rural settlement region	Total	..	77,25	77,16	77,55
	Males	..	73,09	72,93	73,46
	Females	..	81,73	81,78	81,92
Urban settlements	Total	78,30	..	..	..
	Males	73,31	..	..	..
	Females	82,42	..	..	..
Rural settlements	Total	77,33	..	..	..
	Males	73,26	..	..	..
	Females	81,65	..	..	..

Source: Statistics Estonia, http://andmebaas.stat.ee/Index.aspx

Table 9. Life expectancy at birth by sex and county

	Harju county	Hiiu county	Ida-Viru county	Jõgeva county	Järva county	Lääne county	Lääne-Viru county	Põlva county	Pärnu county	Rapla county	Saare county	Tartu county	Valga county	Viljandi county	Võru county
Males and females															
2015/2016	78.99	78.78	74.84	75.92	77.51	77.77	76.62	77.43	77.94	78.00	78.90	79.29	77.08	77.61	77.15
2016/2017	79.23	78.25	74.97	76.60	78.40	77.85	76.60	77.81	78.70	77.61	78.60	79.47	76.74	77.68	77.91
2017/2018	79.22	78.18	75.50	77.28	77.63	78.47	77.30	77.90	78.49	77.72	77.68	79.90	77.01	77.38	77.49
2018/2019	79.80	79.00	75.70	77.53	77.33	79.20	77.71	78.15	78.70	78.12	77.92	79.83	76.95	77.53	77.70
Males															
2015/2016	74.47	74.21	69.50	71.12	73.00	73.38	71.73	72.44	73.33	74.45	74.61	74.89	72.26	72.46	72.30
2016/2017	74.81	74.91	69.63	71.73	73.42	73.40	71.79	73.06	74.45	73.67	73.94	74.37	72.35	73.65	72.84
2017/2018	74.88	75.27	70.21	72.35	72.88	73.82	72.52	72.84	74.03	73.07	73.41	75.07	72.26	73.55	72.73
2018/2019	75.50	75.62	70.52	72.77	73.15	74.99	73.36	72.65	73.93	73.87	73.70	75.31	72.99	73.52	73.45
Females															
2015/2016	82.74	83.13	79.72	80.87	81.78	82.18	81.37	82.74	82.24	81.64	83.04	83.04	81.82	82.86	82.00
2016/2017	82.87	81.21	79.93	81.69	83.37	82.21	81.40	82.85	82.49	81.46	83.37	84.04	81.01	81.59	83.18
2017/2018	82.82	80.81	80.56	82.45	82.30	82.88	82.00	83.54	82.54	82.57	82.05	84.17	81.85	81.01	82.42
2018/2019	83.37	82.02	80.56	82.58	81.35	83.06	81.82	84.42	83.20	82.46	82.23	83.84	80.84	81.40	82.02

Source: Statistics Estonia, http://andmebaas.stat.ee/Index.aspx

Table 10. Life expectancy at birth by sex and nationality

		2016	2017	2018	2019
Estonians	Males and females	78,73	79,14	78,96	79,36
	Males	74,19	74,55	74,49	75,00
	Females	82,82	83,25	83,00	83,26
Non-Estonians	Males and females	76,54	76,76	77,48	78,05
	Males	71,53	71,78	72,55	73,26
	Females	80,95	81,27	81,92	82,33

Source: Statistics Estonia, http://andmebaas.stat.ee/Index.aspx

Table 11. Life expectancy at birth by sex and education level

		Males and females	Males	Females
2017	Primary or basic education	72,82	67,55	77,64
	Secondary education	77,42	72,959	82,47
	Higher education	81,38	77,10	84,79
2018	Primary or basic education	72,82	67,78	77,50
	Secondary education	77,47	73,12	82,42
	Higher education	81,73	77,47	85,08
2019	Primary or basic education	72,95	67,94	77,16
	Secondary education	78,08	73,77	82,90
	Higher education	82,40	77,96	85,90

Source: Statistics Estonia, http://andmebaas.stat.ee/Index.aspx

b) Please also provide information about sexual and reproductive health-care services for women and girls (including access to abortion services) and include statistical information about early (underage or minor) motherhood, as well as child and maternal mortality. Provide also information on policies designed to remove as far as possible the causes for the anomalies observed (premature death; preventable infection by blood borne diseases; etc.).

On 2nd September 2016, a treatment guideline "Treatment of preterm labor and the perinatal period of the premature neonate" was approved by the Supervisory Board of treatment guidelines. The aim of the guideline is to harmonize the principles of clinical treatment of premature childbirth and the perinatal period of a premature newborn in Estonia, to improve the quality of perinatal care in this field of health care, and to ensure evidence-based health care management. The treatment guideline covers the main treatment principles and organizational aspects of preterm birth and the perinatal period of the newborn.

On 28th May 2019, a treatment guideline "Child health monitoring guideline" was approved by the Supervisory Board of treatment guidelines. The aim of the guideline is to ensure uniform assessment of the child's development, support and early detection of health and developmental disorders, and to provide the necessary assistance to the child and the family. The target group of the treatment guideline is newborns and children up to 19 years of age.

Table 12. Underage live births by woman's age group, 2010–2019

	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019
10–14 years old	0	1	1	1	2	2	5	1	2	2
15–17 years old	174	161	121	141	114	96	77	75	61	59
Total	174	162	122	142	116	98	82	76	63	61

Source: National Institute for Health Development, Estonian Medical Pregnancy Information System, https://statistika.tai.ee/pxweb/en/Andmebaas/Andmebaas__01Rahvastik

Table 13. Deaths of 0–17 year-olds per 100,000 children of the same age

	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019
Number of deaths	47,0	34,0	35,7	32,4	34,8	34,6	29,8	28,7	26,1	22,7

Source: Statistics Estonia

Table 14. Infant deaths, 2010–2019

	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019
Number of deaths	53	36	50	28	36	35	33	32	23	22

Source: Statistics Estonia

Table 15. Number of induced abortions per 100 live births

	2015	2016	2017	2018	2019
Total (rate)	35,2	32,3	29,6	26,7	27,0

Source: National Institute for Health Development, Estonian Medical Pregnancy Information System, https://statistika.tai.ee/pxweb/en/Andmebaas/Andmebaas__01Rahvastik

Table 16. Abortions by type and woman's age group, 2016–2019

	Year	Spontaneous abortion	Voluntary termination of pregnancy	Medically-indicated termination of pregnancy	Criminal abortion	Other and missed abortions
All age groups (total)	**2016**	486	4323	186	0	1301
	2017	549	3829	188	0	1225
	2018	541	3620	201	0	1265
	2019	496	3580	192	0	1294

10–14	2016	**2**	**11**	**5**	**0**	**2**
	2017	0	3	4	0	1
	2018	0	8	5	0	0
	2019	0	3	1	0	0
15–17	**2016**	7	129	2	0	9
	2017	1	108	6	0	5
	2018	8	103	3	0	8
	2019	3	106	1	0	11
18–19	**2016**	18	240	3	0	27
	2017	12	191	2	0	22
	2018	11	185	2	0	13
	2019	7	152	1	0	12
20–24	**2016**	58	841	19	0	111
	2017	59	739	9	0	97
	2018	63	613	18	0	93
	2019	53	672	14	0	86
25–29	**2016**	112	1027	50	0	319
	2017	140	900	48	0	293
	2018	120	823	42	0	268
	2019	110	792	38	0	225
30–34	**2016**	130	937	49	0	354
	2017	148	863	45	0	324
	2018	131	867	60	0	354
	2019	128	863	53	0	377
35–39	**2016**	88	761	37	0	296
	2017	112	708	50	0	312
	2018	128	691	44	0	345
	2019	119	665	57	0	368
40–44	**2016**	58	347	15	0	166
	2017	67	289	19	0	154
	2018	73	303	23	0	168
	2019	60	289	21	0	190

45–49	2016	**12**	**29**	**6**	**0**	**16**
	2017	8	28	5	0	17
	2018	7	27	4	0	16
	2019	15	37	6	0	24
50 and older	**2016**	0	0	0	0	1
	2017	0	0	0	0	0
	2018	0	0	0	0	0
	2019	0	0	0	0	1
Age unknown	**2016**	1	1	0	0	0
	2017	2	0	0	0	0
	2018	0	0	0	0	0
	2019	1	1	0	0	0

Source: National Institute for Health Development, Estonian Medical Pregnancy Information System, https://statistika.tai.ee/pxweb/en/Andmebaas/Andmebaas__01Rahvastik

c) If the previous conclusion was one of non-conformity, please explain whether and how the problem has been remedied. If the previous conclusion was deferred, please reply to the questions raised.

In 2017 conclusions, the Committee concluded that the situation in Estonia is in conformity with Article 11§1 of the Charter, pending receipt of the information requested below.

As regards maternal mortality, the Committee notes from the data provided in the report that there were 23 cases of death registered in 2012 compared to 12 cases in 2013, 14 cases in 2014 and 16 cases of death in 2015. The Committee asks that the next report contain updated data on the maternal mortality rate.

Unfortunately, there has been a mistake in our previous report. In the table „Causes of maternal mortality, 2012–2015“ (page 54 of the report for reference period 2012-2015) only the first two lines indicate the numbers for maternal mortality. The remaining lines indicate featus and new-born infant mortality. The numbers referred to in the Committee's question indicate the deaths during the perinatal period, not maternal mortality.

Table 17. Maternal mortality (deaths by cause), all age groups, 2000 – 2011

	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011
Complications of pregnancy, childbirth and puerperium (O00-O99)	5	1	1	4	4	2	1	0	0	0	1	1
..pregnancy with abortive outcome (O00-O08)	2	1	0	0	0	0	0	0	0	0	0	0

Source: National Institute for Health Development, Causes of Death Register,

https://statistika.tai.ee/pxweb/en/Andmebaas/Andmebaas__01Rahvastik

Table 18. Maternal mortality (deaths by cause), all age groups, 2012 – 2019

	2012	2013	2014	2015	2016	2017	2018	2019
Complications of pregnancy, childbirth and puerperium (O00-O99)	1	1	0	0	2	0	0	0
..pregnancy with abortive outcome (O00-O08)	0	0	0	0	0	0	0	0

Source: National Institute for Health Development, Causes of Death Register,
https://statistika.tai.ee/pxweb/en/Andmebaas/Andmebaas__01Rahvastik

The Committee wishes to receive updated information in the next report on the evolution of the situation with regard to out-of-pocket payments and the impact of the measures taken to reduce these payments.

Health care spending in Estonia was 6,7% of GDP in 2018, from this 24,5% was out-of-pocket payment (OOP). The out-of-pocket payments share from total health expenditures has increased in 2018 24,5% compared to 2017 (23,6%)[1]. The rise on OOPs compared to 2017 is partially explained due to changes in the methodology. In addition, it is prognosed that the dental care reform has also had an impact on total OOPs with motivating people to use the service more, but also having a co-payment when doing so.

In 2018, the share of out-of-pocket payment for medicines was 34% and for dental care 28%. To decrease the share of out-of-pocket payment there has been several developments:

1) reducing the out-of-pocket payments of pharmaceuticals. In 2016 there was campaign to promote the use of generic pharmaceuticals carried out by Estonian Health Insurance Fund (EHIF) and the policy to prescribe an active ingredient implemented with the pharmacists. The share of out-of-pocket payment decreased in 2016 by 12,6% per one description compared to 2010.

2) from the beginning of 2018, supplementary benefit for pharmaceuticals is automatic and insured persons will receive supplementary benefit along with the usual pharmaceutical benefit, at the time of purchase of the product at the pharmacy. The benefit applies to expenses that exceed 100 euros per calendar year. In the past, the benefit applied to expenses starting from 300 euros. In addition to the supplementary benefit for pharmaceuticals, the so-called “prescription fee” also changed from the beginning of 2018. As of 2018, a prescription fee of 2,5 euros is set for all prescriptions. It used to be 1,27 euros for the 100%, 90% and 75% discount rate, and 3,19 euros for the 50% discount rate per prescription. First results show that in 2018, the number of people who received supplementary benefit for pharmaceuticals increased from 3,000 insured to 134,000 insured persons. Due to the change in the supplementary benefit for pharmaceuticals system, the number of patients who spent more than 250 euros per year on prescription drugs decreased by 95%, i.e. from 24,000 to 1,000.

3) reducing the out-of-pocket payments of dental care. From 1st July 2017 adult insured persons are also covered by dental care benefit for primary dental care services and form 1st January 2018 also for non-financial benefit for dentures. This benefit can people use at EHIF’s contract partners. Due to the change in the dental care benefits amount of

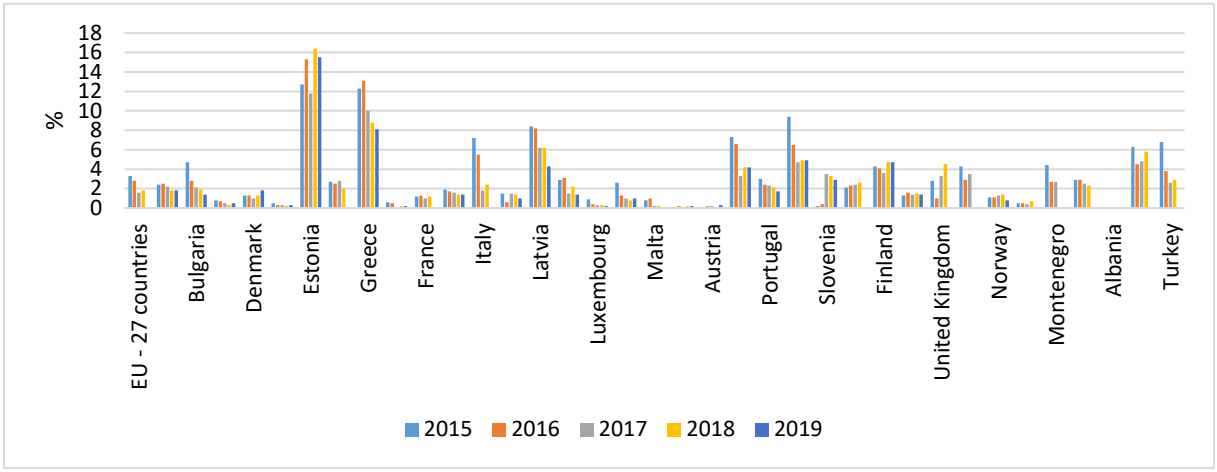
[1] Partial this increase is to do the changes in the methodology of out-of-pocket payment calculation.

treatment cases increased in 2018 3 times, i.e. from 116 192 to 346 073 EHIF will reimburse dental care to adults with health insurance up to 40 euro per year, but 50% of the invoice will be paid by the patient. Some groups of insured persons dental care benefit increase up to 85 euros per year[2]. In this case the benefit will be taken into account at the time of payment to the dentist. The patients themselves pay at least 15% of the price of the services.

The Committee asks to be informed on the trends in waiting times and whether the measures taken have had any impact on reducing the waiting times.

Decisions about waiting time targets for ambulatory specialist, day care and inpatient care is delegated to the EHIF Supervisory Board. The maximum waiting times requirements have not changed during the observable period. From 2018 the EHIF budget receiving additional allocations from the state budget, which is calculated from the old age pensions of non-working pensioners. This is meant to improve accessibility to health care, nonetheless, there is no supporting data whether it actually has had an impact on accessibility.

Figure 1. Self-reported unmet need for medical care – too expensive or too far to travel or too long waiting list



Source: Eurostat[3]

Like the figure 1 shows the self-reported unmet need for medical care is changing over time – this has increased until 2018 and thereafter decreased.

Estonian citizens assessments according the research "Estonian citizens assessments for health and medical care in 2019[4]" shows that access to health care should be further improved – in 2019 57% of citizens are satisfied with access to health care. According to the results of 2019 survey, 24% of the respondents who visited a specialist doctor in the last 12 months had an appointment within five working days and 48% within up to four weeks. Slightly more than half (53%) of responders are very satisfied or rather satisfied with the speed of access to a specialist's appointment. 47% of the population (15 years and older) had to wait more than four weeks.

[2]In the group belong: pregnant women and mothers of children under one year of age, old age pensioners, persons receiving pension for incapacity for work, persons with partial or no work ability, persons over 63 years of age, persons with increased need for dental care.

[3] Eurostat: https://ec.europa.eu/eurostat/databrowser/view/tespm110/default/table?lang=en

[4] Eesti elanike hinnangud tervisele ja arstiabile, 2019, Population assessment of health and healthcare (only in Estonian) https://www.haigekassa.ee/haigekassa/eesti-haigekassa/uuringud-ja-analuusid

According to this research, people are more satisfied with being able to see a family doctor or nurse - 68% of respondents were able to get an appointment in up to three days and 82% were satisfied with their availability.

The analysis „Development of monitoring methodologies for person centred health care“ (2019)[5] found that 23-32% of survey respondents did not go to the health care worker with their health problem due to the long waiting time. Estimates differ by region - according to the people from Southern Estonia population (6–19%) has better access than North-Eastern Estonia (20–42%) and Northern Estonia, including Tallinn (27–56%). There were significantly fewer people who said they did not go to a healthcare professional because the healthcare professional was too far away (4.6-9.9% of respondents), too expensive (4.1-9.2%) or the person did not have health insurance (0.6-3.9% of respondents). At the same time, it was mainly pointed out that there was no need to consult a healthcare professional because the problem could be handled by themselves (55–66%) or the problem was not serious enough to turn to a health care professional (43–54%).

As of 1 January 2020, approximately 145 000 appointments have been registered to all the waiting lists of EHIF's contractual partners in specialized medical care, 79% of which are in the waiting lists of hospitals included in the Hospital Network Development Plan (HNDP) and 21% at procurement partners. The share of bookings for waiting lists at non-HNDP partners has increased by 3% over the year. Compared to the same time in previous year, more appointments have been registered for outpatient care waiting lists (more at the non-HNDP partners) in specialized medical care. The number of people waiting for day care and inpatient treatment has decreased.

Table 19. Appointments registered in specialized medical care waiting lists as of 1 January 2020

	1 January 2019		1 January 2020		Change compared to 1 January 2019
	Number of appointments in waiting lists	**Waiting list within max. time allowed time**	**Number of appointments in waiting lists**	**Waiting list within max. time allowed time**	**Number of appointments in waiting lists**
Outpatient care*	114 331	51%	121 832	50%	7 501
Day care	10 055	81%	9 395	82%	-660
Inpatient care	14 979	76%	13 649	81%	1 330
Total	**139 365**	**56%**	**144 876**	**55%**	**5 511**

*Infertility treatment has been excluded from the waiting times for outpatient treatment in 2018, as according to the decision of the EHIF's Supervisory Board, for infertility treatment the maximum waiting time is 8 months, whereas it is 42 days for other specialities.
Source: Estonian Health Insurance Fund

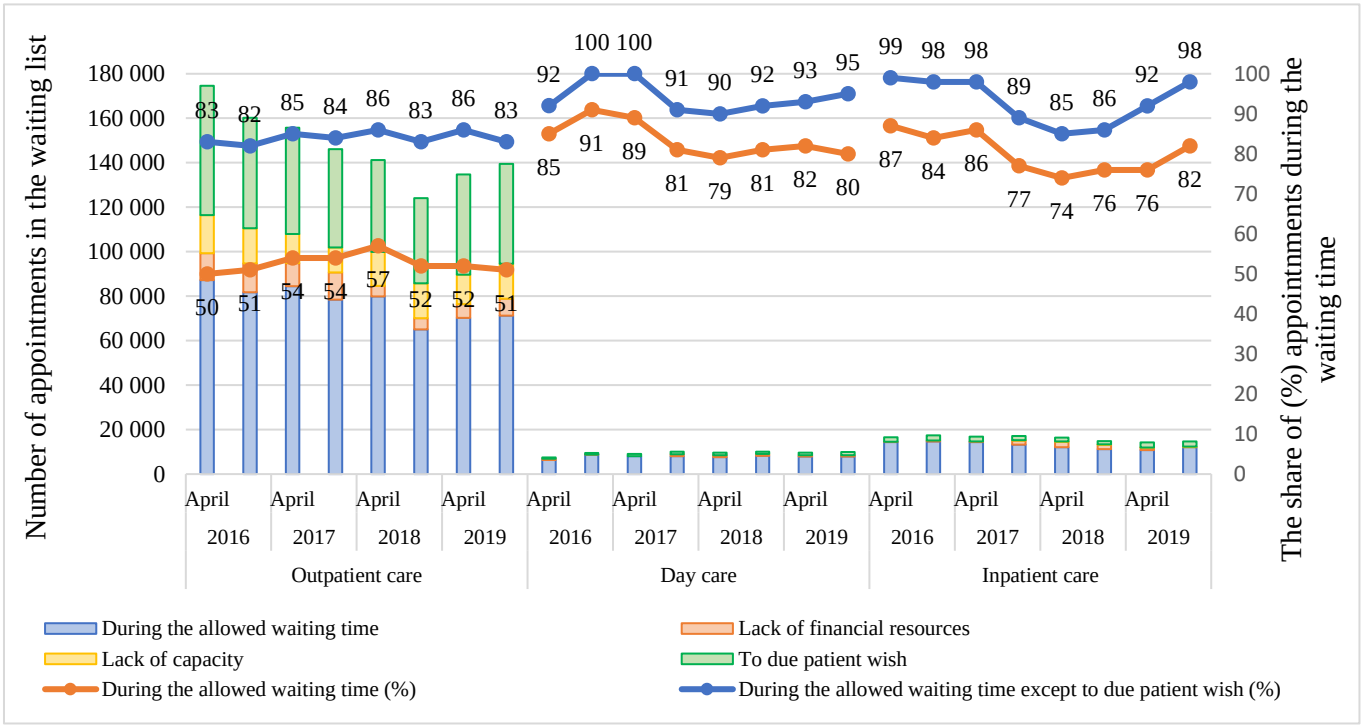
In the HNDP hospitals, the total number of appointments registered in the outpatient waiting list has increased by 6%, by a greater extent in central hospitals. As for specialties, the HNDP hospitals have more appointments registered in the waiting lists for orthopaedics, neurology and less for internal medicine and general surgery. The share of outpatient appointments within maximum allowed waiting time has decreased at the HNDP hospitals (from previous 42% to 40%). Due to the shortage of physicians, basically just as many patients are waiting in the waiting lists of HNDP hospitals as a year ago (12% of all those in waiting lists). Due to low capacity of a hospital, the patients have to wait longer (over 42 days) for their appointment at Ida-Viru Central Hospital and

[5] Kallaste, E., Järve, J., Sõmer, M., Lang, A., Inimkeskse tervishoiu seiremetoodika väljatöötamine, CentAR, 2019. Available (only in Estonian): https://centar.ee/wp-content/uploads/2019/12/Inimkeskse_tervisesusteemi_seiremetoodika_Loppraport_Toimetatud-1.pdf

Pärnu Hospital. By specialties, the shortage of doctors at the HNDP hospitals is the biggest in ophthalmology and orthopedics. The total number of planned appointments registered at the HNDP hospitals on day care waiting lists has decreased by 5% (general surgery and otorhinolaryngology), and on inpatient care by 9% (general surgery, otorhinolaryngology). More and more surgeries are performed in day care instead of inpatient care[6].

During the period of 2016-2109 in the outpatient treatment, almost 50% of the appointments exceed the allowed waiting time in the ambulatory care and the main reason is the wish of patient (will to see a specific doctor, etc.), then lack of capacity and lack of financial resources. Excluding the patient's reason, the share of appointments over the maximum waiting time in outpatient care was about 17%. In day care and inpatient treatment, about one-fifth of appointments are over the maximum waiting period. Again, most of them are due to patient reasons - without them, 5-10% of appointments are over maximum waiting time in day care and 1-15% in inpatient care. Most of the appointments that exceed the maximum waiting time are in the speciality where the referral is not required. This data needs to be interpreted with caution, because it is reported by the service providers to EHIF and may not take into account the time a person needed to wait before the hospital could provide an available time for consultation or procedure.

Figure 2. Appointments number in the waiting list of spezialised medical care (2016–2019)

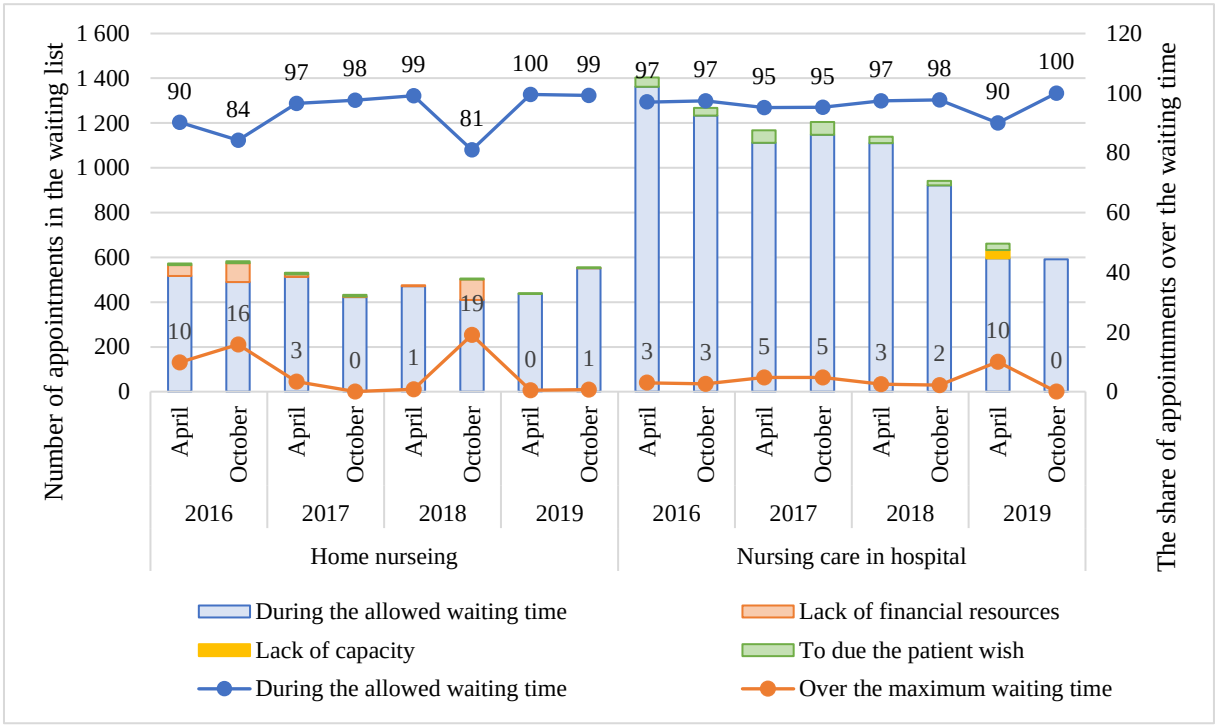


Source: Estonian Health Insurance Fund

In home nursing, the number of appointments in the waiting list has decreased by 46% in two years, in the case of inpatient nursing by 41% (Figure 3), while the number of appointments over the allowed waiting time has increased by 1%. In 2019, no waiting times are allowed in the home nursing. In the past, they were, and the main reason was the lack of financial resources. In the case of inpatient nursing care, the number of appointments that is above the maximum waiting time has decreased. In the past, the main reason has been patient will.

[6] https://www.haigekassa.ee/en/organisation/annual-reports-0

Figure 3. Nursing care appointments number in the waiting list (2016-2019)



Source: Estonian Health Insurance Fund

From the beginning of the crisis period (March 2020), the EHIF started to reimbursement distance consultations, which were aimed to reduce waiting lists for treatment. During the emergency situation, the number of distance consultations increased both at the primary level and in specialist care level. If at the primary level counselling by a family doctor or family nurse by telephone or e-mail was already in use, then in specialised medical care, the wider use of distance consultations were allowed for the first time. At the beginning of the emergency situation, in March, the number of appointments in primary care increased sharply due to remote consultations. The share increased 1.8 times in March compared to February, and 400 thousand remote consultations were provided per month in March and April. In May, the number of face to face contacts recovered step by step and the number of remote consultations decreased. In May, June and July, almost 300 thousand remote consultations were provided. In total, about 2 million remote consultations were provided from March to July.

From March to July, distance consultations constituted for 25% of all specialist appointments. The highest share was in March and April (49% and 57%, respectively). In May, due to the recovery face to face outpatient appointments, the share of distance consultations also decreased, accounting for 26% of all specialist consultations. In June and July, distance consultations accounted for 12% and 5% of all consultations, respectively.

Supportive information technology is crucial to improving access to healthcare. In 2019, a nationwide digital registry (DR) was established in Estonia. It is an application on the national patient portal (www.digilugu.ee), where patient can search, book, change and cancel specialist appointment in all health care institutions, who are connected with this system. It can only be used if the person has a digital referral or person wants to book an appointment for a specialty without a referral request. The digital registry is designed to ensure that people book, change and cancel appointments in a transparent, fast and convenient way, so that people receive treatment that meets their needs and is consistent.

The DR helps to contribute health resources more optimal way, as one digital referral can only make one reservation for one appointment and the service specified in the digital referral, and thus the health resource is not kept occupied by several reservations. Until now, it has been possible to

make several bookings with one referral and later cancel the others or simply let them be booked and not to show up at the appointment.

As it is convenient to book, change or cancel appointments with the DR, there has been a growing interest in the DR since it was launched, both among people and service providers. 69 health care providers have joined the created DR application (as of 27.07.2020).

The Committee asks that the next report contain information on the availability of mental health care and treatment services, including information on the prevention of mental disorders and recovery measures.

According to the National Institute for Health Development (NIHD), in 2019 there were 228 psychiatrists working in Estonia, including 24 child and adolescent psychiatrists (i.e. 16 psychiatrists per 100,000 inhabitants). According to the Health Insurance Fund, the number of mental health cases has not changed significantly in five years. However, looking at the diagnoses, it can be seen that the proportion of mood disorders, neuroses, disorders of physiological functions and behavioural and emotional disorders that usually began in childhood is increasing.

According to the NIHD, psychiatrists diagnosed a total of 23,640 new cases of outpatient psychiatric illness in 2019, of which 34% were neurotic, stress-related and somatoform disorders (e.g. anxiety disorders). A total of 94,603 people were consulted in 2019, of whom 9.6% were children aged 0–14.

The Ministry's main partner in mental health issues are NGO Peaasjad (Head matters) and Estonian-Swedish Institute of Mental Health and Suicidology, which leads the Mental Health and Welfare Coalition. In 2019, 20 mental health first aid trainings all over Estonia in cooperation with the Estonian Psychosocial Rehabilitation Association was carried out. NGO Peaasjad piloted a modern mental health prevention centre for 34 young people in Tallinn and Harju County and preventive intervention for 13 families with a parent with a mental disorder: Lets 'Talk About Children.

The coalition hosted a mental health fair and celebrated October as a mental health month with several workshops across Estonia.

The Committee asks that the next report contain information on dental care services and treatments (such as who is entitled to free dental treatment, the costs for the main treatments and the proportion of out-of-pocket paid by the patients).

According to Health Insurance Act dental care is reimbursed by Health Insurance Fund for**:**

- children and youths under the age of 19;
- people who need emergency care provided when postponing aid or not providing aid may cause the death or permanent injury to the patient. Whether or not a particular case calls for emergency care is decided by the dentist.

EHIF reimburses dental care to adults with health insurance up to 40 euro per year, but 50% of the invoice will be paid by the patient. The dental care benefit increases up to 85 euros per year:

- For pregnant women and mothers of children under one year of age
- For old age pensioners
- For persons receiving pension for incapacity for work
- For persons with partial or no work ability

- For persons over 63 years of age
- For persons with increased need for dental care

The benefit is taken into account at the time of payment to the dentist. The patients themselves pay at least 15% of the price of the services.

Once every three years, the Health Insurance Fund compensates old-age and disability pensioners, health insured persons over the age of 63 and persons with partial or no ability to work for dentures in the amount of 260 euros. Denture benefit is paid up to 260 euros over a three-year period. The benefit will be taken into account at the time of payment to the dentist.

Both health insured and uninsured adults have right to receive free dental care if emergency care is needed. Emergency care is provided for them in situations where the postponement of care or failure to provide care may cause the death or permanent damage to the health of the person requiring care. Whether the services provided can be regarded as emergency care is decided by the dentist.

Table 20. Dental care coverage of all children aged 0–14 and 15-years old and older (2015-2018)

	2015	2016	2017	2018
Coverage of 0–14 year olds	84,30%	78,5%	73,4%	73,2%
Coverage of 15-year olds and olders	44,3%	46,0%	47,6%	48,4%

Source: National Institute for Health Development, Statistics Estonia.
https://statistika.tai.ee/pxweb/en/Andmebaas/Andmebaas__01Rahvastik,
http://andmebaas.stat.ee/Index.aspx

Table 21. Data on the use and financing of dental care (2015-2019)

	2015	2016	2017	2018	2019
Dental care financing (eur)	22 599 045	23 304 458	29 156 906	48 779 194	54 751 708
Number of people (insured adults) who used dental care	170 566	169 287	168 092	167 367	171 975
Number of people (insured adults) who used dental care benefit	0	0	78 579	223 619	278 460
Number of people (insured adults) who used dental care benefit, share of (same age) population			7,3%	21,4%	26,6%

Source: Estonian Health Insurance Fund

More data on the use of dental care:

https://statistika.tai.ee/pxweb/en/Andmebaas/Andmebaas__03Tervishoiuteenused__01Vastuvotud/?tablelist=true.

2. to provide advisory and educational facilities for the promotion of health and the encouragement of individual responsibility in matters of health;

a) Please provide information about health education (including sexual and reproductive health education) and related prevention strategies (including through empowerment that can serve as a factor in addressing self-harm conducts, eating disorders, alcohol and drug use) in the community (life-long or ongoing) and in schools. Please also provide information about awareness and education in respect of sexual orientation and gender identity (SOGI) and gender violence.

Health education

a) Basic education

The Estonian basic education system is divided in three stages. Stage I includes grades 1-3, stage II – grades 4-6, stage III – grades 7-9.

In stage I, the focus is first and foremost on the social skills of students and the development of a positive attitude towards a healthy lifestyle (environmental and personal hygiene, nutrition, rest and sleep, time planning, etc). Skills on fulfilling a healthy lifestyle have an impact on mental well-being. Stages II and III of basic education is also based on the development of skills, values, and social aptitudes.

The curriculum of personal, social and health education is developed while keeping in mind suitability for different age groups. Estonian teachers have at their disposal pedagogic tools to consider the physical, cognitive, emotional, psychological, and social development and needs of students and can support students without judgment.

Sexual (including reproductive health) education is part of general education since 1996. The curriculum ensures the consistency of sexual education and access to health-related education. Consistency is key in changing and rooting attitudes, thus protecting children and youth. Sexual education is first and foremost focused on valuable skills, such as communication, decision-making, and coping with conflicts. These skills are directed towards preventing and decreasing risk behaviour (substance use, unsafe sexual relations, and violent behaviour).

The learning outcomes in each stage are the following:

Stage I (grades 1-3) – the student:

- is aware of the similarities and differences between genders;
- is aware of a healthy lifestyle, how to maintain physical and mental health; and values their importance;
- is aware of their right to refuse harmful behaviours and knows how to call for assistance in situations of danger.

Stage II (grades 4-6) – the student:

- knows how to act in situations of danger, and knows how to call for help in exercise situations;
- is aware of the physical and emotional changes happening during puberty, is accepting towards physical changes and is aware of personal care;
- is aware of the characteristics of sexual maturity and knows the link between primary sexual characteristics and reproduction;
- understands the dangers of communication through media to their behaviour and relations, and can assume responsibility for their words and actions:

- understands safety and cautious behaviour;
- can describe how to avoid common diseases (both communicable and noncommunicable);
- is aware of HIV, AIDS and how to protect themselves from contracting HIV;
- is aware that saying no is standing for their rights, and can demonstrate this skill in an exercise situation;
- understands individual differences, is conscious of gender differences and special needs.

Stage III (grades 7-9) – the student:

- understands the nature of sexuality, the individuality of sexual development and is aware of the characteristics of a safe sexual behaviour, and their responsibility in this behaviour;
- values sexual rights;
- knows the rules and norms of relationships characteristic to supportive environments, understands their importance in the society and values caring, honest, just, and responsible attitudes;
- describes the different forms of personal intimacy;
- describes the individual's responsibility in a sexual relationship;
- explains the features of safe sexual behaviour;
- explains the nature of sexuality, the individuality of sexual development and the role of emotions in this development;
- explains the responsibility of partners in a sexual relationship;
- describes effective contraceptive methods;
- values responsible behaviours in sexual relations and describes sexual rights as human rights related to sexuality;
- is capable of finding help and advice with questions related to sexual health.

b) Secondary education – grades 10-12

In the curriculum of secondary education, health education is covered in the course "family education" (covering subjects such as responsible sexual behaviour, long-term relationships, health behaviour); and in the optional psychology course.

Family education learning outcomes – the student:

- values the family and can analyse the role of personal relations in life; can define their role and responsibility in the family;
- understands the need to work towards establishing safe relations, maintaining, and developing them; the student is ready to be a part of a family and the social network surrounding a family.
- respects their and their peers' human dignity, is judgment-free and respectful of all persons, considers their special needs and individuality and values individual and cultural differences;
- understands and respects different beliefs;
- is an active and competent member of a democratic society; ready to adapt to changes in one's professional and societal life; is responsible for their life and can solve personal problems;
- values the family, understands the importance of establishing and keeping mutually fulfilling and supportive relations, and the responsibility of each member of the family in upholding values and supporting the development and children;
- understands the different roles in life in the development of the career, and the importance of balancing work and family life;

- can describe the nature of love, understands the connection between love and sexual relations, understands the characteristics of safe and mutually fulfilling sexual behaviour in human relations;
- describes the impact of society and culture on attitudes on sexuality and sexual relations.

c) Vocational education and training

In vocational education, health education is included in the curricula through the general study modules, totalling 30 credit points. Among the general study modules, health education is incorporated in the social studies module (7 credit points). The aim of the social studies module is to ensure that the student understands the causal links in societal development, makes conscious choices related to them and their social environment, bears in mind social morals and values and operates as an ethical and responsible member of the society; and is loyal to the Republic of Estonia.

With regards to the more specific aims as regards to health education, the module outcomes are the following:

a) supporting the student in developing an adequate self-esteem, and provide the student with skills, knowledge, and attitudes, that support their development as a comprehensive and health-aware individual;
b) the student understands different social phenomena, processes and conflicts, the links between them and their reciprocal effects;
c) the student understands cultural diversity, the importance of democracy and its preservation, and the necessity of sustainable development, all while accepting differences in society;
d) the student values general values such as freedom, human dignity, equality, honesty, thoughtfulness, tolerance, responsibility, justice, patriotism and respect towards themselves, others, and the environment;
e) the student is aware of threats that might endanger their life and health in different crisis situations, is aware of safe behaviours and how to help peers.

In relation to health education and awareness, the evaluation criteria of the social studies module include the following (these criteria are exclusive and includes criteria relevant to the topic of this report):

a) The student can carry out self-analysis, describe their strengths and weaknesses in the context of the different roles and duties they might have in the society;
b) the student can analyse the role of the individual, the family and different institutions in societal development;
c) the student is aware of different health hazards and injuries, and is aware of how to respond in and prevent different hazardous situations;
d) the student engages consciously and according to their capacities in sports and physical activities;
e) the student can describe the importance of people and countries to engage in sustainable behaviour;
f) the student is able to describe the nature of human rights and their importance, analyses the shift in the understanding of human rights throughout the 20th and 21st centuries, and is able to draw examples of the changes in individual rights throughout history.

These learning outcomes and evaluation criteria include health education (including knowledge on sexual and reproductive health), which are also related to prevention strategies both on the school and community levels. Vocational education institutions have also incorporated prevention-based and intervention-based programmes as described in section 3. Institutions also make actively use

of trainings, events, information days related to health education for teachers, students, parents, and staff. Student representative boards are also actively in the process of these educational and awareness-raising projects.

Prevention strategies

Estonian schools have implemented, in addition to curricular activities, several programmes oriented towards prevention. These programmes include, for example, mindfulness-based Vaikuseminutid, which focuses on decreasing self-harm conducts, including alcohol and drug use, by educating participants on stress-managing techniques, self-acceptance, respect towards the environment and peers, emotional presence and other skills.

Awareness and education

Awareness and education on different identities, including, but not limited to sexual orientation, gender identity, and cultural differences (students with different first languages, roma students, etc) has been introduced to schools through different evidence-based programmes, such as KiVa Antibullying Program (introduced in 2017, renewed and updated in 2020), VEPA (internationally known as PAX Good Behavior Game), Hooliv klass (Caring Class) and other programmes. These programmes are based on intervention and are adopted by schools individually. Such programmes reach about 70% of Estonian schools and 80% of Estonian preschools. In cooperation with student representative boards, students have been given the opportunity, by way of different calls for proposals, to suggest activities which aim to increase mutual tolerance, mutual respect regardless of individual differences, and encourage an overall supportive environment in schools and in the community.

The Ministry of Social Affairs is financially supporting the Estonian Human Rights Centre and the Estonian LGBT Association through strategic partnership project agreement (the ongoing project is for the period 01.01.2020-31.12.2021). The general aim of the partnership is to promote the implementation of the principle of equal treatment, with a focus on discrimination on grounds of age or disability and equal treatment of LGBT+ persons and the protection of their human rights. More specifically in the field of education, the activities are targeted at training pupils and students, youth workers, teachers and other education experts and school staff on LGBT+ topics. There is a regular cooperation between education professionals and organization and the Estonian LGBT Association through meetings, round tables, networking, correspondence, information sharing and other cooperation. The Association also supervises and advises students and researchers on topics related to LGBT+ issues.

b) Provide information on measures to ensure informed consent to health-related interventions or treatment and on specific measures to combat pseudoscience in respect of health issues.

All health-care services in Estonia are provided based on the informed consent of the patient. In case of vaccinating children under 18, parent´s consent is being asked. Our efforts in combatting pseudoscience are aimed at raising awareness, ensuring accessibility and visibility of evidence-based information. There are some possibilities in our legislation to sanction dissemination of false information, but it is difficult to implement in practice and it needs to be proven that spreading this information poses an actual threat to a certain individual´s life and health.

Estonian Law of Obligations Act regulates use of generally unrecognised methods upon provision of health care services (§763):

(1) A method of prevention, diagnosis or treatment which is not generally recognised may be used only if conventional methods are not likely to be as effective, if the patient is informed of the nature and possible consequences of the method and if the patient has granted his or her consent to the use of the method.

(2) The legal representative of a patient with restricted active legal capacity shall grant the consent specified in subsection (1) of this section in the place of the patient in so far as the patient is unable to consider the pros and cons responsibly. A generally unrecognised method may be used in respect of a patient without the capacity to exercise his or her will without the consent of the patient or his or her legal representative if failure to use the method would put the life of the patient at risk or would significantly damage his or her health.

c) If the previous conclusion was one of non-conformity, please explain whether and how the problem has been remedied. If the previous conclusion was deferred, please reply to the questions raised.

In 2017 conclusions, the Committee concluded that the situation in Estonia is in conformity with Article 11§2 of the Charter, pending receipt of the information requested below.

The Committee asks the next report to provide information on the specific measures and awareness raising campaigns undertaken during the reference period, including in schools, to promote health and to address some of the above mentioned challenges.

Suicide mortality has been on a downward trend since 2005, mainly due to a reduction in suicides among men. In 2019, 193 people died as a result of suicide, of whom 150 were men, 9 of them aged 10–19. Since middle age (50+), the suicide mortality rate among men is significantly higher than average (14.6 suicides per 100,000 inhabitants in 2019; 23.9 for men). This is a clear indicator that more attention needs to be paid to mental health, especially among men, in order to prevent higher risk of suicide.

Mental health promotion and problems prevention

Methodological materials and tools for specialists working with children and young people:

- for kindergartens „Supporting the mental health of children at kindergartens“ and teacher trainings organized to support the implementation of material;
- web-based assessment tool for the psychosocial environment for kindergartens;
- substance use prevention and social skills handbook and trainings for teachers „Teacher's handbook for social skills“; „Recommendations for drug prevention and solving drug-related cases at school“;
- interactive web-page for parents on different topics: www.tarkvanem.ee.

Implementation of the evidence-based interventions such as:

- Early prevention program for families with children in Estonia “The Incredible Years” for parents with 2-8 years old child;
- Universal Classroom-Based Prevention Program (Pax Good Behavior Game) for schools - PAX GBG is an environmental intervention used in the classroom to create a nurturing environment that is conducive to learning;
- „Bullying-Free School“ – KiVa antibullying program for schools.

Mental health services for children and young people:

- 4 mental health centres and 4 mental health counselling offices;
- Web-based mental health counselling for children and young people

Overweight and obesity

Various ways have been used to introduce Estonian food-based dietary recommendations (2015) to the public:

- For better understanding, these recommendations are visualised as food pyramid with proportions of food categories per one week for adults with an energy need of 2000 kcal. Various campaign activities have been organised to increase the understanding and awareness of the food pyramid which summarises the principles of healthy eating based on food recommendations. The aim of these campaigns is to make people compare their diet with the food pyramid. The latest campaign in 2019 included online banners, video clips, in-store advertising and street posters. In addition, 10 volunteers had to keep food diaries for 7 days.
- Activities aimed at the recommended consumption of certain food categories
  - Articles explaining the consumption of foods which are at the top of the pyramid (sugars, sweet and savoury snacks, sweetened beverages), as well as the ones on the lower parts of the pyramid such as fruits and vegetables and berries, cereals, meat products etc.
  - Booklets “Simple recommendations for Healthy Nutrition”, “Sugars” and “Fats”
- With reference to the published Estonian nutrition and physical activity recommendations in 2017 (adopted in 2015) a lot of presentations and articles were made to introduce the new recommendations and principles.
- Based on abovementioned recommendations the simplified book for general public was published.
- In order to better visualise the physical activity recommendations, the physical activity pyramid has been composed.

Institutional catering:

- A collection of ideas was carried out to provide inspirational menus for institutional catering (schools, kindergartens). These menus had to comply with Estonian food-based nutritional recommendations.
- In addition, information days for school caterers are organised to raise awareness of providing healthier choices and to introduce the new draft regulation of catering for children's institutions. This draft regulation is in line with the new Estonian food-based dietary recommendations.
- Methodological material has been prepared for kindergarten teachers to introduce nutrition, food and physical activity recommendations since pre-school age.

The Committee asks that the next report provide up-to-date information with regard to health checks for children at schools.

The aim of healthcare at Estonian schools is to:

- Monitor the health of students
- Support the development of a healthy life-style
- Prevent the loss of health (including by immunization) and the development of chronic diseases
- Monitor the level of study-load
- The creation of a healthy study-environment
- Offer health-related emergency aid, if needed

The health of school-aged children is monitored followingly, with 4 checks carried out by the school nurse:

Table 22. Monitoring of the health of school-aged children

Age (school grade)	Health-related checks by	Dental check-up age	Vaccinations
7-8 y (I grade)	**School nurse**; dentist	7 y	
8-9 y (II grade)	Family doctor (primary care); health check-up not carried out at school		
9-10 y (III grade)	**School nurse**	9 y	
11-12 y (V grade)	Family doctor (primary care); health check not carried out at school	12 y	At the age of 12 HepB (only students who have not been vaccinated before); HPV (girls only)
13-14 y (VII grade)	**School nurse**	14 y	MMR (at the age of 13)
15-16 y (IX)	Family doctor (primary care); health check not carried out at school	15 y	dTaP
16-17 (X grade)	**School nurse**; dentist		

Source: Ministry of Social Affairs

The health check performed by the school nurse assesses the health state of the pupil, and includes the measurements for height, weight, BMI, vision accuracy, blood pressure, posture; the assessment of skin and mucal membane condition (visually), the condition of musculoskeletal condition, sexual development, mental health.

In the first half of 2019, a scheduled health-check by the school nurse was planned for 34 068 students, but was performed on 29 880 students (87,7% from planned); during the second half of 2019, the health check by the school nurse was scheduled for 34 000 students, while it was carried out on 23 058 students (67,8% from planned). **School nurses prefer to carry out the health checks during spring semester.**

Of health checks conducted, 55,8% (spring semester) and 50% (autumn semester) (2019) no health problems were detected. More detailed overview on school health statistics is provided in the following table:

Table 23. School health statistics (2016-2019)

	2016		2017		2018		2019	
	Spring	**Autumn**	**Spring**	**Autumn**	**Spring**	**Autumn**	**Spring**	**Autumn**
% of pupils eating food served at school	94,4%	95,4%	95,0%	96,0%	94,4%	96,0%	95,4%	96,2%
% of scheduled health checks carried out	87,0%	74,7%	86,0%	69,2%	87,9%	65,7%	87,7%	67,8%
% of students with no health problems detected*	54,6%	49,1%	56,2%	51,1%	55,7%	51,8%	55,8%	50,0%
% of students with detected posture problems*	12,6%	14,3%	12,1%	12,5%	11,3%	11,9%	10,4%	13,1%
% of students with decreased vision clarity*	16,4%	19,9%	17,6%	21,0%	16,7%	20,3%	16,3%	20,3%
% of students with uncorrected decreased vision clarity*	6,9%	7,1%	7,0%	7,4%	6,5%	7,7%	6,6%	7,4%
% of overweight students*	11,8%	12,8%	12,7%	13,6%	12,2%	14,0%	12,4%	14,3%
% of underweight students*	3,5%	3,3%	4,1%	2,8%	3,9%	3,2%	4,0%	3,4%
% of students with high blood pressure*	2,1%	1,9%	1,5%	1,8%	1,5%	2,3%	1,6%	2,6%

* - From health checks carried out

Source: Estonian Health Insurance Fund

3. to prevent as far as possible epidemic, endemic and other diseases, as well as accidents.

a) Please describe the measure taken to ensure that vaccine research is promoted, adequately funded and efficiently coordinated across public and private actors.

Currently, we do not have resources to actively carry out and lead research for vaccine development and we do not have any vaccine producing companies in our country. However, we do participate in vaccine clinical trials and our scientists participate in international research projects, also in the area of vaccination. More information about clinical trials can be found on the webpage of the Agency of Medicines: https://www.ravimiamet.ee/en/node/58.

In addition, we are finalising a qualitative study in cooperation with WHO and the University of Tartu where we explored barriers and drivers of vaccination among hesitant parents and we have used the WHO TIP methodology to assess possibilities to increase immunisation coverage.

b) Please provide a general overview health care services in places of detention, in particular prisons (under whose responsibility they operate/which ministry they report to, staffing levels and other resources, practical arrangements, medical screening on arrival, access to specialist care, prevention of communicable diseases, mental health-care provision, conditions of care in community-based establishments when necessary, etc.).

Health care in prisons constitutes a part of the national health care system. Health care in prisons shall be organised pursuant to the Health Care Services Organisation Act. Provision of health care services to prisoners is financed from the state budget though the Ministry of Justice. Health care services and the acquisition of medicinal products and medical devices necessary for the provision of health care services are funded from the state budget to the extent, under the conditions and pursuant to the procedure established by a regulation of the Government of the Republic.

According to Imprisonment Act, prisoners who need treatment which cannot be provided in prison shall be referred to treatment at relevant providers of specialised medical care by the medical officer of the prison. Emergency service is therefore always provided in case of urgent need of assistance.

We have 24-hour special care service for adults placed in a care institution by court order. An adult is placed in a care institution to receive 24-hour special care without his or her consent if all of the following circumstances exist:

1) the adult person has a severe mental disorder which limits his or her ability to understand or control his or her behaviour;
2) an adult is dangerous to himself or herself or to others if he or she is not placed in a care institution to receive round-the-clock special care services;
3) the implementation of previous aid measures has not proved to be sufficient or the use of other aid measures are not possible.

If the 24-hour special care service is provided to adults placed in a court-ordered care institution, the service provider must ensure the availability of nursing care for at least 40 hours per week per adult placed in a court-ordered care institution receiving the service.

The service provider must ensure the availability of family physician and psychiatrist. The mentioned medical staff visits the care institution on site. If it is necessary to visit other medical specialists, the special care service provider must organize a secure visit.

The court order is valid for a maximum of 1 year, then the court asks for an assessment of the service provider and the psychiatrist about the circumstances which caused the need for maintenance without consent.

c) Please provide information on the availability and extent of community-based mental health services and on the transition to community-based mental health from former large-scale institutions. Please provide statistical information on outreach measures in connection with the mental health assessment of vulnerable populations, including those in a situation of poverty or exclusion, the unemployed (especially long-term unemployed). Provide also information on proactive measures adopted to ensure that persons in need of mental health care are not neglected. Please also provide information from prison health-care services on the proportion of inmates who are deemed as having mental health problems and who, according to health-care professionals, do not belong in the prison system or would have possibly been spared of such a situation should suitable mental health services been available to them in the community or in specialised establishments.

Since 2007, 1845 institutional round-the-clock special service places have been closed. Places have been reorganized into settlements with the operational infrastructure and variety of job and leisure opportunities, also with good availability of mental health and other medical services. In addition, new service units have been built there. Altogether 1372 small, family-like round-the-clock service places and 870 community-based service places were created.

In new locations, medical care (psychiatrists, dental care, other medical specialists) is more available. In these settlements the mental health nurse service is also available, which is very important for the special care services users.

Prisoners are provided psychiatric care - every prison has got a psychiatrist. In-patient psychiatric treatment is provided to prisoners in the psychiatric ward of Tartu Prison.

In case a prisoner is unable to serve a sentence due to his or her state of health (e.g. due to a mental disorder), the court may release the prisoner from serving the sentence. In general, in case of any doubts, an expert examination is ordered during the court proceeding to make sure whether a person is able to serve a prison sentence. Should any doubt occur whilst serving the sentence, the prison can turn to the court and apply for release from serving the sentence.

Estonia has solidarity health insurance system, that means someone's health insurance payments or contribution to the system or access to the necessary assistance does not depend on age, income or health risks. All the medically insured people in Estonia are entitled to the same quality health care, regardless of whether or not they pay the health insurance tax. And children are covered with health insurance. The insurance cover is valid until the day of their 19th birthday (included).

d) Please also provide information about drug-related deaths and transmission of infectious diseases among people who use or inject psychoactive substances both in the community and in custodial settings. Provide an overview of the national policy designed to respond to substance use and related disorders (dissuasion, education, and public health-based harm reduction approaches, including use or availability of WHO listed essential medicines for opioid agonist treatment) while ensuring that the "available, accessible, acceptable and sufficient quality" criteria (WHO's 3AQ) are respected, subject always to the exigency of informed consent, which rules out, on the one hand, consent by constraint (such as in the case of acceptance of detox and other mandatory treatment

in lieu of deprivation of liberty as punishment) and, on the other hand, consent based on insufficient, inaccurate or misleading information (i.e. not based on state of the art scientific evidence).

Table 24. Direct drug-related deaths by sex (all ages, 2010-2019)

	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019
Men and women	101	123	170	111	98	88	114	110	39	27
Men	89	108	152	93	86	76	92	96	29	20
Women	12	15	18	18	12	12	22	14	10	7

Source: National Institute for Health Development

Between 1999 and 2019 a total of 1,705 people have died from drug overdoses in Estonia. Over the years, the average age of those who died from drug overdoses has steadily increased. While in 2002, the average person who died from a drug overdose was 24 years old, in 2018 it was 37 years old. Deaths related to drug overdoses have decreased sharply in recent years from 110 in 2017 to 39 in 2018 and 27 in 2019. Most deaths in the last 15 years have been related to the use of fentanyl and its more potent analogues (over 80% of all deaths) (EKEI 2019).

In 2019 there were a total of 27 drug overdose related deaths - nearly six times less than in 2012 (the year with highest drug related mortality). It can be mainly attributed to decrease in the availability of fentanyl on the Estonian drug market, wider implementation of the take-home naloxone programme and the launch of new treatment and harm reduction services including support person service (SÜTIK – a programme for people with long-term drug use experience). The decline in fentanyl availability was the result of a successful police work and dismantling of several major criminal networks in the end of 2017.

Based on data from 2015, there are an estimated 8,600 (95% UV 7700-9700) people who inject drugs (PWID) in the 15-44 age group in Estonia (Raag et al., 2019). Studies regularly conducted in different Estonian cities provide an overview of the risk behaviour of PWID and prevalence of infectious diseases. Studies show that the average age of people who inject drugs has increased from year to year. The main injectable drug has been either fentanyl and its analogues or amphetamine depending on the region. In recent years, the availability of fentanyl has deteriorated and amphetamines are the main substance in both Tallinn and Ida-Virumaa. The deficiency of fentanyl has also led to the use of cathinones (3D bath salts, alpha-PVP). More than half of PWID have HIV-positive status, with 60-90% depending on the region. Although the prevalence of HIV among PWID has been high, it is positive that people's awareness of their HIV-positive status has increased over the years. Most people know their correct HIV serostatus.

Table 25. The results of a survey monitoring the prevalence of HIV and risk behaviour among injecting drug users between 2012−2018

	2012	2013	2014	2016	2017	2018
Region	Kohtla-Järve	Tallinn	Narva	Kohtla-Järve	Tallinn	Narva
Average age	30 y	32 y	34 y	35 y	36 y	36 y
% of men	73%	77%	65%	71%	78%	74%
The average injecting duration	11 y	12 y	14 y	16 y	15 y	16 y
Main injected drug during the last 4 weeks	fentanyl (64%), amphetamine (34%)	fentanyl (78%), amphetamine (20%)	amphetamine (63%), fentanyl (27%)	fentanyl (65%), amphetamine (30%)	Amphetamine (51%), fentanyl (48 %)	Amphetamine (68%), fentanyl (18 %)
The use of an already used needle/syringe during the last 4 weeks	6%	23%	10%	1%	11%	3%
The use of an already used syringe/needle at any time	65%	67%	66%	60%	68%	57%
% of HIV-positive users (blood test)	62%	58%	48%	66%	54%	51%
% of users positive for HepC (blood test)	75%	90%	61%	81%	92%	80%

Source: National Institute for Health Development

Several approaches and services exist to address drug disorder. In Estonia, the most available treatment is substitution treatment of opioid addiction, the provision of which is based on the clinical protocol for opioid addiction. The primary treatment for opioid addiction is pharmacologically assisted psychosocial help, which is based on the daily administration of a methadone. The

treatment can have various objectives, which can include the termination or reduction of opioid abuse, the reduction of the harm caused by the use of opioids, and the improvement of the quality of life and wellbeing of the people addicted to opioids. Most of the substitution treatment for opioid addiction is financed from the national budget through the National Institute of Health Development (NIHD) and is free for patients. However, patients also have option of private health care. Short-term inpatient detoxification treatment, long-term inpatient treatment and rehabilitation services for adults (with special unit for women who use drugs) as well as follow-up services are also provided. In addition to specialised drug treatment services people with addiction problems can also seek help from the outpatient departments of the psychiatric clinics.

Harm reduction services include various social support services for people who use drugs, the dissemination of information as well as the distribution of the necessary equipment for safer injection and sexual life. In Estonia, the following services are provided at harm reduction centres: counselling (peer counselling, social counselling, legal aid); health-related counselling on how to more safely use drugs and avoid overdosing; provision of life-saving medication (naloxone) for people injecting opioids and their families along with the relevant training; distribution of clean syringes and needles; collection and utilization of used syringes and needles; distribution of condoms and counselling on sexual health; facilitation of washing facilities and clothing; prevention of infections, early discovery of infections (e.g. HIV testing) and referral to treatment; motivating and referral to drug treatment and rehabilitation services. Harm reduction is provided also as an outreach work and since the end of 2018 in mobile units (specially equipped busses). In the end of 2019 syringe exchange was piloted in one pharmacy. Positive experience from the pilot encouraged national plans for expanding pharmacy-based activities in 2021.

Since 2018 support services for people who use drugs are also implemented to encourage law enforcement arrest diversion. The program enables police officers to refer people who use drugs who have committed a drug-related offence to a support person, as an alternative to punishment. The program provides peer counselling, support and voluntary referrals to health and social programs as needed in order to improve coping skills, health outcomes, opportunities for finding and retaining employment, and the overall quality of life of people who use drugs. The findings to date indicate that women are more likely to stay actively engaged with the program than men. Promising results from the pilot project have led to the program's expansion. Description of the programme can be found here: http://fileserver.idpc.net/library/16_SUTIK_Estonia_EN.pdf

e) Please provide information on measures taken to prevent exposure to air, water or other forms of environmental pollution, including proximity to active or decommissioned (but not properly isolated or decontaminated) industrial sites with contaminant or toxic emissions, leakages or outflows, including slow releases or transfers to the neighbouring environment, nuclear sites, mines, as well as measures taken to address health problems of the populations affected. Please provide also information about measures taken to inform the public, including pupils and students, about general and local environmental problems.

Oil shale study

In 2014-2015 „Study of the Health Impact of Oil Shale Sector" was conducted by the Health Board of Estonia in cooperation with Tartu University. The results of the study on the health effects of the oil shale sector indicate that the health status of residents of Ida-Viru County is worse in many respects than elsewhere in Estonia, with environmental pollution originating from the oil shale sector being one of the potential reasons. However, this region is characterised by complex problems (such as other forms of industrial pollution, legacy pollution, difficult socio-economic situation, lifestyle, etc.), which also have an impact on the health of the residents. Although the

state of the environment has improved significantly in Ida-Viru County over the years, the data of Statistics Estonia show that the life expectancy of a child born in Ida-Viru County is still nearly five years shorter compared to that of a child born in Tartu or Tallinn. Also, the rates of disorders of the respiratory system diagnosed in children living in Ida-Viru County and mortality from disorders of the circulatory system are higher in Ida-Viru County than elsewhere in Estonia. On the other hand, mortality from accidents, poisonings and trauma is also significantly higher, which points to high risk behaviour among the residents of the region.

The study involved an analysis of pollution permits and monitoring data, followed by the modelling of pollutant levels in order to better quantify the exposure of the population to pollution across the region. Extensive clinical surveys of the respiratory tract-related ailments were conducted among more than 1000 children living in Ida-Viru and Lääne-Viru Counties and the results were compared with the data on children living in Tartu. In addition, more than 3000 adults living in Ida-Viru and Lääne-Viru Counties and Tartu were surveyed.

The results of this study show that we need to pay more attention to the state of the environment and the health of residents in the region and to carry out even more accurate and comprehensive health surveys. Long-term improvement of the health of people living in Ida-Viru County depends on cooperation between decision-makers, scientists, local governments, businesses, health systems and local residents.

Therefor the following new projects were agreed on and are ongoing from 2016-2021:

1. Biomonitoring among the population exposed to the oil shale sector (employees and residents), preliminary study - identification of biomarkers;
2. Survey of children's birth register data (comparison of birth rates of children born in different regions of Ida-Virumaa with the data of children born in other Estonian regions) and survey of their parents on exposure to oil shale sector pollution;
3. “Development and implementation of a methodology for finding the links between ambient air quality and childhood asthma and other allergic diseases in the areas affected by the oil shale industry” (METRAK);
4. "Study of drinking water of public water supply systems extracting water from Ordovician and Quaternary groundwater bodies for possible chemicals from the oil shale industry".

After the projects are ready, conclusions will be made, if and what mitigation measures will be needed to take in the oil shale sector to further improve the environment and protect the health of the people. At the moment, possibilities are being discussed to start with biomonitoring among workers and residents of the region (preliminary study has been completed).

Developments and activities in the field of radiation

1. Environmental Board shall ensure the operation of the radiation hazard early notification system. Estonian on-line system for automatic monitoring of radioactivity is in service 24 hours a day. The system consists of gamma monitoring stations, placed strategically in the country. There are 15 automated air radiation monitoring stations and 3 air filter facilities. In addition to early warning system, Environmental Board also conducts general monitoring of ionizing radiation in the environment (surface water, drinking water, milk, food (incl. forest products), soil, also seawater, biota and sediments). The requirements for conducting radiation monitoring are described in the Radiation Act, the Environmental Monitoring Act, and their regulations. The monitoring results are made publicly available on the website of the Environmental Board.

2. There is also monitoring requirements for radiation practice licence holders to ensure monitoring of control and surveillance areas. Depending on the specifics of the practice,

monitoring shall include monitoring of dose rates and monitoring of levels of radioactive contaminants in the air or on surfaces together with determining the properties of the radioactive emissions and their physical and chemical state. A holder of a radiation practice licence shall register the monitoring results and submit the results to the Environmental Board.

There are no nuclear power plants or facilities operating with nuclear fuel cycle in Estonia, neither are any activities related to nuclear fuel cycle performed. There is a former Soviet military facility with two shut-down nuclear submarine reactor compartments in safe long-term storage in Paldiski. Spent nuclear fuel was sent back to Russia in 1994. There is also a centralized facility for interim storage for the low and intermediate radioactive waste in the same location as reactor compartments in Paldiski and facilities for treatment and conditioning of radioactive waste (A.L.A.R.A Ltd). In the A.L.A.R.A Ltd license are described requirements for environmental monitoring (groundwater, effluent, soil, grass) and all monitoring data are publicly available in A.L.A.R.A Ltd. website.

3. Currently Estonia is in the process of mapping increased radon risk areas. Measurements are made by the Estonian Geological Service (GSE). Currently, the territory of Estonia can be conditionally divided into three: administrative units with increased radon risk, administrative units with low or average radon risk, and administrative units with additional research needs. Additional research is planned to be completed in the end of 2022. Although a number of indoor radon surveys have been conducted in Estonia over the years, a national indoor radon survey is planned to obtain new and more comprehensive data. In 2021, in cooperation with the Ministry of the Environment and the Environmental Board, it is planned to develop a methodology for conducting a national survey of indoor radon levels in residential buildings. The project should begin in 2022.

Developments and activities in the field of air quality

1) National air quality monitoring system - continuous monitoring stations (both national and of companies) form a network which enables to monitor air quality and model its distribution. 13 pollutants regulated by EU and some area-specific pollutants are measured (further information can be found here: http://www.ohuseire.ee/en);
2) Air quality measurement campaigns with mobile monitoring stations (most important ones are in Kiviõli, Sillamäe, Kehra, Kohtla-Järve where potential pollution may be present);
3) Aerobiological monitoring - Estonian Environmental Research Centre has been carrying out pollen monitoring in ambient air since 2011. The aim of the study is to assess the composition and concentrations of pollen particles and mold spores of allergenic plants in five Estonian cities;
4) In 2019, a guidance document on the prevention and reduction of ammonia emissions from agricultural sources was developed;
5) In 2019 a framework for good agricultural practice to reduce ammonia emissions was developed;
6) In 2017 a new concept for limit values for non-essential pollutants in ambient air was developed;
7) The renovation of heating systems of apartment- and public buildings has been supported by the atmospheric air protection sub-program of the Environmental Investment Centre: 2016 – 4, 2019 – 18 and in 2020 – 11 buildings accordingly.

Developments and activities in the field of water

Legal provisions for water protection and management are set in Water Act and in decrees of responsible ministers or government. Legal provisions include planning and organising water use

and protection; water protection objectives and exceptions to achievement thereof; conception of river basin management plans and detailed programme of measures under them to achieve water management goals; status of water; hazardous substances, groundwater pollutants and quality standards of water and soil; requirements for drinking water, natural mineral waters and bathing areas; organisation of wastewater collection and treatment; assessment and management of flood risks; environmental requirements for agricultural activities etc.

In order to achieve the sustainable water management, the River Basin Management Plans (RBMPs) have been composed according to the Water Framework Directive. There are 3 river basin districts in Estonia. Currently the RBMPs for the period 2015-2021 are implemented and new plans for the period 2021-2027 are in preparation. Preparation and implementation of the RBMPs is a public process and therefore the public is systematically involved. The Environmental Board composes the Implementation Plan of each RBMPs and annually prepares an overview on the results of implementation of water management plans. All these documents are publicly available. By the end of 2019 in the implementation phase there were 69% of surface water measures and 73% of groundwater measures that were foreseen in the Programmes of Measures of the RBMPs for the period 2015-2021. Mostly they were administrative measures that were implemented by the Environmental Board, the Environmental Inspectorate and local municipalities. By the end of 2019 the general goal of the RBMPs – to achieve and maintain a good quality of bodies of water – was achieved 54% in bodies of surface water and 79% in bodies of groundwater. The main reasons for not achieving a good status of surface water and groundwater were degradation of rivers by dams, inputs of nutrients and hazardous substances into waters. The state has worked out grants for investments of sustainable water management developments, such as investments of water management infrastructure, remediation of residually polluted sites and recovery from the fish migration barriers in rivers. Both EU structural funds and national funds have been used for these grants, with the applicant's own contribution being increased over the years.

f) In the context of the COVID-19 crisis, please evaluate the adequacy of measures taken to limit the spread of virus in the population (testing and tracing, physical distancing and self-isolation, provision of surgical masks, disinfectant, etc.) as well as the measures taken to treat the ill (sufficient number of hospital beds, including intensive care units and equipment, and rapid deployment of sufficient numbers of medical personnel while ensuring that their working conditions are healthy and safe – an issue addressed under Article 3 above). Please indicate the measures taken or foreseen as a result of this evaluation.

Measures taken to limit the spread of the virus are described here: https://www.covid19healthsystem.org/countries/estonia/countrypage.aspx

There has not yet been established a country level evaluation system to evaluate the effects of all the measures adopted.

g) If the previous conclusion was one of non-conformity, please explain whether and how the problem has been remedied. If the previous conclusion was deferred, please reply to the questions raised.

In 2017 conclusions, the Committee concluded that the situation in Estonia is in conformity with Article 11§3 of the Charter, pending receipt of the information requested below.

The Committee asks to be kept informed on the trends of food poisoning in the next report.

The following epidemiological trends characterised the spread of the diarrheal infection (often also connected with food poisoning) diseases in Estonia in 2014-2018:

- Viral diarrheal infections prevailed in the etiology of all diarrheal infections; representing 45-65% of the annual total with tendency to reduce; the incidence of rotaviral enteritis is constantly decreasing;
- as always, the majority of diarrheal infections cases were notified in children; the proportion of age group 0-4 decreased from 61% to 47%;
- notification of campylobacter-enteritis and E. coli infection increased; in 2018, the maximum number of cases was notified; the proportion of other bacterial diarrheal infections remained at the same level or decreased;
- the number of typhoid/paratyphoid chronic carriers did not differ markedly from the previous years; no new cases of chronic carriers were identified.

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

Estonia's reported waste generation per capita has increased during recent years. In 2018 Estonia produced 405 kg of municipal waste per capita that is still below the EU average of 492 kg/capita, but nevertheless waste prevention has to be a top priority. According to the previous report Estonia's municipal waste recycling rate was 32% (II method). In 2018 the recycling rate according to II method had decreased to 31% (according to IV method 28%). Landfilling of municipal waste has been increasing during recent years and it was already 22% in 2018. Separate collection of municipal waste and recycling still needs to be improved.

During the recent years Ministry of the Environment has been dedicated to enhancing separate collection of municipal waste and recycling in order to change the trends in the waste management. The Ministry of Environment advises local municipalities, guidance materials are prepared in co-operation with the Environmental Board (for example guidance material for municipalities regarding organised waste transport tenders) and financial support has prioritized separate collection and recycling. Amendments to Waste Act and to Packaging Act to implement amended EU Directives and new obligations (i.e. "Waste Package") have been prepared, implementation of Directive (EU) 2019/904 of the European Parliament and of the Council of 5 June 2019 on the reduction of the impact of certain plastic products on the environment is currently ongoing.

Civic amenity sites, collection of agricultural plastic, recycling of bio-waste and production of foam glass gravel have been supported during recent years. During the summer of 2020 an application round for the support for improving separate collection and recycling of bio-waste was open. Currently the applications are evaluated, but 43 municipalities applied for a support in the sum of 4.4 million €. A new project application round for recycling of biodegradable waste was opened in November 2020.

Estonia continuously needs to tackle reducing the amount of waste from the oil shale industry. On average, 88% of waste is generated in the manufacturing industry, energy companies and wastewater treatment, the main part of which is waste related to the oil shale industry. During the last five years, oil shale industry share of total waste generation has been 81%.

The Committee asks that the next report provide information on the concrete effects of the implementation of the above mentioned measures on the prevention/reduction of consumption of tobacco, alcohol and drugs and the trends in consumption.

Since 2014 comprehensive strategies are adopted to fight the harms caused by tobacco, alcohol and illegal drugs (green papers on alcohol policy, tobacco policy and white paper on drug policy). Due to the contingent implementation of evidence-based measures by different sectors the harms have been significantly reduced.

Smoking and passive smoking is decreasing – in 2018 17,2% of population reported regular smoking (compared to the 21,3% in 2016 and 39% in 2008), 4% of population reported being exposed to the tobacco use at work (compared to 13% in 2008). The new challenge for the health sector comes from the field of novel tobacco and nicotine products with aggressive marketing and misleading messages for the consumer.

In 2019, 10,4 litres of pure alcohol per adult was consumed. In the longer perspective, alcohol consumption has decreased significantly (in 2008 14,2 litres of pure alcohol per adult was consumed) and so have the harms, the mortality of alcohol-related diseases has decreased by a third over a decade. Yet, since 2016 the decrease has stalled and in 2019 the consumption and harms rose slightly due to the reduction of alcohol excise.

The reported illegal drug use has decreased slightly both among adults and minors, cannabis continues to be the most used drug. The deaths from overdose have decreased from 110 in 2017 to 27 in 2019 due to the successful police work and harm reduction program.

The Committee asks to be kept informed on the immunisation coverage levels.

In Estonia we are seeing a slowly declining trend in childhood immunisation coverage. Rotavirus coverage is lower than others as this vaccination was added to the national immunization programme in 2014.

Table 26. Immunisation coverage in Estonia by year, vaccination and age group.

Vaccination (age-group)	2011	2012	2013	2014	2015	2016	2017	2018	2019
Diphtheria-tetanus (7 months – 14 years)	97,1	97	96,7	96,4	96,2	95,9	95,5	95,2	94,8
Pertussis (7 months – 14 years)	96,3	96,3	96	95,7	95,4	95,2	94,7	95,2	94,8
Hib (2 years)	95,3	95,1	95,1	95	94,1	93,8	94	93,3	92,1
MMR1 (1 – 14 years)	96,6	96,3	96	95,7	95,5	95,4	95	94,7	94,4
HepB (7 months – 14 years)	95	94,7	94,7	94,1	93,4	95,1	94,6	94,4	93,5
Polio (7 months – 14 years)	97,1	97	96,7	96,4	96,2	95,9	95,5	95,2	94,8
BCG (0 – 11 months)	97	97,9	95,9	95,1	95,5	95,2	94,5	92,1	92,6
Rotavirus (1-year-olds)	-	-	-	-	65,6	86,8	88,7	87,1	83,1

Source: Health Board

In 2018, HPV vaccination to 12-year-old-girls was added to the national immunisation programme. In 2019, the coverage with HPV vaccination had increased compared to the first year – in 2018 the coverage with the 1st dose was 56,1% and in 2019 it was 61,6%.

Coverage with seasonal influenza vaccination, which has historically been low in Estonia, has also increased during the last years. In 2019, the coverage among general population was 10,2%, whereas in 2017/2018 season it was only 4%. Still, the coverage is very low and we are working on finding solutions of increasing awareness about influenza vaccination and improving the coverage.

The report further indicates that a task force led by the Government Office was established to examine the causes of injury deaths and propose measures to prevent them more efficiently. 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 Committee wishes to be kept updated on the implementation and effects of the task force recommendations.

Recommendations of injury prevention task force led by the Government Office have been reflected in sectorial development plans e.g. National Health Plan, Transportation Development Plan, Internal Security Development Plan, Violence Prevention Strategy and in policy books e.g. Estonian drug use reduction policy white paper, and green paper on Alcohol Policy. Programs of sectorial development plans are used to implement, monitor and evaluate injury prevention recommendations. Mental Health Policy green book, which also covers suicide prevention is currently under development and a suicide prevention action plan is going to be put together in 2021. The task force report helped to identify several fields not covered by systematic activities e.g. fall prevention and injury prevention in home environment. Norway EEA grants are used to start developing methods and practices to prevent injuries due to falls and injuries in home environment. In 2016 there were 868 fatal injuries and in 2019 there were 785 fatal injuries. Main causes of deaths were suicide, alcohol abuse, drug abuse and accidental falling.

Part I – 12. RESC All workers and their dependants have the right to social security

Article 12 – The right to social security

With a view to ensuring the effective exercise of the right to social security, the Parties undertake:

1. to establish or maintain a system of social security;

No information requested, except where there was a conclusion of non-conformity or a deferral in the previous conclusion for your country. For conclusions of non-conformity, please explain whether and how the problem has been remedied and for deferrals, please reply to the questions raised.

In 2017 conclusions, the Committee concluded that the situation in Estonia is not in conformity with Article 12§1 of the Charter on the following grounds:

- the minimum level of sickness benefit is inadequate;
- the minimum levels of unemployment allowance and unemployment insurance benefit are inadequate;
- the minimum level of national invalidity pension is inadequate.

Below is the explanation to the non-conformity and answers to Committee's questions.

Sickness benefit is a financial compensation paid by the Health Insurance Fund to an insured person (an employee, a civil servant, a person receiving remuneration or service fees on the basis of a contract under the law of obligations, a member of the management or controlling body of a legal person, a self-employed person, a spouse participating in the activities of a self-employed person) on the basis of a certificate for sick leave. Non-insured persons are not entitled to sickness benefit.

Based on this certificate, the employer and the Health Insurance Fund will pay to the person the benefit for temporary incapacity to work. The employer calculates the amount of the sickness benefit on the basis of the average wage in the last six months. The Health Insurance Fund calculates the benefits for incapacity to work based on the data of social tax (received from the Tax and Customs Board) calculated or paid for the beneficiary in the calendar year preceding the start date of the incapacity to work indicated in the incapacity certificate.

If the person has not worked in the calendar year preceding her or his illness and no social tax was paid or calculated for her or him, her or his average income is deemed to be equal to the minimum monthly wage established by the Government of the Republic. Which means that in case of sickness the insured person is an employee or a civil servant, she or he is also entitled to receive sickness benefit in the minimum amount of minimum salary (but not for the first three sickness days and 70% of the minimum salary).

If no social tax was paid for the worker during the preceding calendar year, but their monthly wage is above the minimum wage rate, then the minimum wage will be taken into account when calculating the sickness benefit. However, if in this case the worker's monthly wage is below the minimum wage rate, then the worker's monthly wage will be taken to account when calculating the sickness benefit. If the monthly wage of a worker is less than the minimum wage, they can turn to the local government and apply for subsistence benefit.

Table 27. Minimum amounts of sickness benefit 2016-2019, euros

Minimum level of sickness benefit 31 day on sickness leave*	2016	2017	2018	2019
I – Employed	230,71	252,29	268,39	289,80
II – Self-employed	209,30	230,71	252,29	268,39

*- 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.
Source: Health Insurance Fund

According to Estonian Health Insurance Fund, in 2019, 133,451 persons received sickness benefits with total duration of 28,5 days and on average compensated by a benefit 21 euros per day. In 2020, the number of persons has increased (even if the data is incomplete) up to 135,866, each person receiving the sickness benefits on average 25.8 days in total with an average benefit being 23 euros. The average benefit has increased from 15,5 euros in 2014.

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 negotiated between Estonian Trade Union Confederation and Estonian Employers' Confederation. The amount negotiated is approved by the Government based on subsection 29 (5) of the Employment Contracts Act.

Example:

As in 2019 the minimum wage was 540€ a month, minimum unemployment allowance daily rates and minimum unemployment insurance benefit in 2020 amount for:

Unemployment allowance daily rate in 2020: 540€/31 day*0,35 or 6,10€;

As in 2019 the minimum wage was 540€ a month, minimum unemployment insurance benefit daily rates in 2020 amount for:

Minimum unemployment insurance benefit daily rate: 540€/30 day * 0,5 or 9 €.

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 (see the information provided in this report under article 13).

In order to better address the poverty prevention issue, in June 2020 Parliament adopted amendment to the Labour Market Services and Benefits Act and Unemployment Insurance Act and from the beginning of 2021 the 31-fold daily rate of unemployment allowance shall not be less than *50 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. From 1 August 2020 the replacement rate of unemployment insurance benefit for the period of 1 to 100 calendar days increased from the 50 per cent level to 60 per cent (paragraph 9 (4) of Unemployment Insurance Act)

The following table gives an overview of changes in minimum amounts of unemployment allowance and unemployment insurance benefit and minimum wage in 2016-2019.

Table 28. Overview of changes in minimum amounts of unemployment allowance and unemployment insurance benefit and minimum wage in 2016-2019, in euros

	2016	2017	2018	2019
Minimum monthly wage	430	470	500	540
Unemployment allowance daily rate	4,41	4,80	5,31	5,65
Unemployment allowance 31-fold daily rate	136,71	150,66	164,61	175,15
Minimum unemployment insurance benefit daily rate	6,5	7,17	7,83	8,33
Minimum unemployment insurance benefit 31-fold daily rate	201,5	222,27	242,73	258,23

Source: Ministry of Social Affairs

In 2016, a new system (Work Ability reform) was set up for supporting working ability, which renewed the way of assessing working ability, also the subsidies' system.

Work ability allowance is indexed every year and due to that have increased significantly. At 2016 the sum of work ability allowance for a person with no work ability was 337,5 EUR, this year the sum of allowance is 446,7 EUR.

The new work ability support system has had a significantly positive effect on the labour market participation. Initially when the system was developed, a goal was set that by the year 2022 the number of persons with reduced working ability in employment would be increased by over 50% - that goal was established already in 2017. According to the estimates of the Ministry of Finance, by the year 2022 there will be 19 100 more persons in employment and 16 400 more persons actively looking for work due to the working ability reform, compared to how many there would be with the old system.

In the case of family and maternity benefits, the Committee refers to its conclusions on, respectively, articles 16 and 8§1 (Conclusions 2015).

The purpose of family allowances in Estonia is to ensure for families with children the partial reimbursement of expenses relating to the care, raising and education of children (Chapter 2 of the Family Benefits Act).

There are different types of family allowances and they are divided into two groups – monthly family allowances and single family allowances (paid only once).

Monthly family allowances are the following: child allowance, single parent's child allowance, guardianship allowance, allowance for a family with many children, allowance of a multiple birth of three or more children, conscript's (or person in alternative service) child allowance.

Single family allowances are the following: childbirth allowance and adoption allowance.

All the aforementioned allowances are paid through the Social Insurance Board.

1) **Child allowance** (section 17 of the FBA) is a monthly allowance paid from the birth of the child until he or she attains 16 years of age. A child who is enrolled in a basic school or upper secondary school, or a child without secondary education enrolled in formal vocational education has the right to receive child allowance until he or she attains 19 years of age. When the child attains 19 years of age, payment of the allowance shall continue until the end of the current academic year.

   The amount of family allowances has raised three times in the years 2014-2019. The child allowance for the first and second child of a family was:
   - 19.18 euros in 2014;
   - 45 euros in 2015;
   - 50 euros in 2016 and 2017;
   - 55 euros in 2018;
   - 60 euros in 2019.

   In 2014 the child allowance for the third and each subsequent child was 76.72 euros from year 2015 and onwards, the child allowance for the third and subsequent child was 100 euros.

2) **Allowance for a family with many children** (section 21 of the FBA) is paid to a parent who has three or more children for whom child allowance is paid in their family.

   The amount of allowance for a family with many children is 300 euros for a family with three to six children; for a family with seven or more children the allowance amount is 400 euros.

   The allowance for a family with many children in the case of three or more children was enforced on 1 July 2017 and it replaced the parent's allowance for families with seven or more children, which was paid only to a parent raising seven or more children.
3) **Single parent's child allowance** (section 19 of the FBA) is a monthly allowance paid for a child whose birth registration or vital statistics data entered in the population register contain no entry concerning the father or whose parent has been declared to be a fugitive.

   The allowance amount is double the rate of child allowance, which is 19.18 euros.

4) **Guardianship allowance** (section 20 of the FBA) is a monthly allowance paid to a child whose parents fail to perform the obligation to raise the child and to care for the child arising from the Family Law Act and for whom guardianship has been established. Payment of the allowance shall be terminated as of the month following the termination of guardianship or, upon termination of guardianship when a child attains 18 years of age, payment of the

allowance shall continue until the end of the academic year when the child attains 19 years of age or until the student is excluded from the list of the school.

The amount of guardianship allowance shall be 240 euros for each child under guardianship.

5) **Allowance for multiple birth of three or more children** (section 211 of the FBA) is a monthly family allowance paid from the children's birth, to a parent, parent of a care family or guardian, who is raising triplets or more children born at the same time. The right to receive this allowance applied until the day that the children turn 18 months old. The allowance amount is 1,000 euros.

   The allowance for multiple birth of three or more children was stipulated in December 2017 with the amendment of the Family Benefits Act and it came to force on 1 March 2018.

   If the family situation meets the conditions provided by law, all the above-mentioned benefits are paid cumulatively.

The following tables show poverty rates of households with children and the impact of family allowances and parental benefit on relative and absolute poverty rate in 2014-2018.

Table 29. Poverty rates by type of household (%), income years 2014-2018

		At-risk-of-poverty rate, %	Absolute poverty rate, %
2014	Household with children	18,1	8,0
	Adult and child(ren)	38,8	15,6
	Couple with one child	20,2	7,6
	Couple with two children	13,7	6,2
	Couple with three or more children	26,2	15,0
	Other household with children	10,1	4,5
2015	Household with children	16,4	4,4
	Adult and child(ren)	35,8	6,7
	Couple with one child	13,9	4,1
	Couple with two children	12,3	4,5
	Couple with three or more children	28,8	7,5
	Other household with children	10,3	1,9
2016	Household with children	14,9	3,1
	Adult and child(ren)	28,9	6,4
	Couple with one child	12,8	2,6
	Couple with two children	12,1	3,2
	Couple with three or more children	19,5	2,9

	Other household with children	12,7	2,3
2017	Household with children	13,7	2,2
	Adult and child(ren)	39,0	7,8
	Couple with one child	9,9	..
	Couple with two children	11,5	2,8
	Couple with three or more children	14,7	2,3
	Other household with children	9,9	..
2018	Household with children	15,2	1,5
	Adult and child(ren)	35,1	4,6
	Couple with one child	11,6	..
	Couple with two children	15,1	1,6
	Couple with three or more children	15,0	1,6
	Other household with children	10,3	..

Value ".." means data has not been calculated; data not available; unreliable data due to small size of the sample.

Source: Statistics Estonia, Estonian Social Survey 2015–2019 (income years 2014–2018)

Table 30. Impact of family allowances and parental benefit on relative and absolute poverty rate, income years 2014–2018 (percentage points)

	Impact of family allowances and parental benefit, percentage points					Impact on family allowances, percentage points				
	2014	**2015**	**2016**	**2017**	**2018**	**2014**	**2015**	**2016**	**2017**	**2018**
Relative poverty										
Household with children	5,3	6,6	7,8	8,2	8,9	2,4	3,6	4,6	6,0	5,4
Adult and child(ren)	5,5	8,1	6,5	10,3	14,7	4,5	7,8	6,3	10,2	13,9
Couple with one child	3,2	4,2	5,0	4,6	5,8	0,5	1,7	3,0	1,5	1,9
Couple with two children	4,0	6,1	8,5	5,9	6,9	1,7	2,2	3,8	3,9	2,6
Couple with three or more children	12,2	14,0	17,8	23,5	18,8	6,6	9,1	10,3	19,1	12,2
Other household with children	5,6	5,0	3,8	4,8	5,8	2,4	3,1	3,0	3,9	5,1
Absolute poverty										
Household with children	3,4	5,0	5,0	3,3	4,3	1,4	3,1	2,6	1,9	2,4
Adult and child(ren)	2,9	9,9	6,3	9,2	9,3	2,0	6,9	4,0	5,9	4,7
Couple with one child	3,0	2,1	3,4	..	..	0,2	0,9	1,4	..	..
Couple with two children	3,0	3,4	4,8	1,9	4,2	1,7	2,4	1,4	1,2	2

Couple with three or more children	8,2	18,7	11,5	9,8	7,5	4,3	11,0	6,9	4,1	4,1
Other household with children	1,9	0,4	2,4	..	..	0,5	0,4	2,4	..	..

Value ".." means data has not been calculated; data not available; unreliable data due to small size of the sample.
Source: Statistics Estonia, Estonian Social Survey 2015–2019 (income years 2014–2018)

Pregnancy and maternity leave and benefits. So far, the terms and conditions of pregnancy and maternity leave and the payment of maternity benefit continue to be stipulated on the basis of the Health Insurance Act, the Employment Contracts Act and the Civil Service Act.

Table 31. Overview of the number of days during which maternity benefit was received and percentage of maternity benefit receivers earning less or equal to/more than minimum monthly wage (2016-2019)

	2016	2017	2018	2019
Average number of days during which maternity benefit was received	139,82	139,83	139,84	139,82
% of persons earning less than minimum monthly wage	5,8%	6,0%	5,7%	6,4%
% of persons earning equal to or more than minimum monthly wage	94,2%	94,0%	94,3%	93,6%

Source: Estonian Health Insurance Fund

In autumn 2018 the Estonian Government approved amendments to the parental leave and benefits system. The amendments, which will enter into force on 1 April 2022, included also renaming of pregnancy and maternity leave as maternity leave and the introduction of changes to the terms and conditions. Compared to pregnancy and maternity leave, the period of maternity leave will be changed from 140 to 100 days, and parents will have a longer paid parental leave period (current maternity leave). Whereas the pregnancy and maternity leave was reimbursed as maternity benefit from the Estonian Health Insurance Fund budget, the maternity leave will be paid as mother's parental leave through the Social Insurance Board from the state budget. Regarding the maternity benefit, the amount of the benefit will remain 100% of an average income of mother, but if the mother's average salary would be less than the monthly Estonian minimum wage, the benefit will be paid in the amount of Estonian minimum wage[7].

According to the Health Insurance Fund, in 2019, 10,778 mothers received maternity leave and benefit, with total leave 139,8 days (out of 140 days maximum) and with average benefit 38 euros per day. The average benefit has been increasing gradually from 27 euros in 2014. In 2020, 7 924 persons have taken up maternity leave and received maternity benefit, the average maternity leave lasted for 139,6 and the average benefit was 40 euros per day. In addition, 3,329 mothers who had no taxable income during the reference year received parental benefit instead of maternity benefit, with average monthly benefit of 491 euros, according to Social Insurance Fund data.

[7] There is a statutory national level minimum wage which is agreed among the social partners every year.

The Committee asks the next report to provide also information on the coverage rate concerning invalidity as well as work accidents and occupational diseases.

In Estonia occupational accidents and diseases are covered by the national health Insurance and work ability allowance system. In 2019 95,3% of the population was covered by the health insurance. In 2017, 5,7% of the population was not covered by the health insurance, by 2019, it was 4,7%.

In 2019 December, there was 81 757 work ability allowance receivers, which comprised 9,8% from persons aged 16-64. Also, there are persons who are not evaluated in work ability system yet and are receiving the incapacity of work pensions. According to the Social Insurance Board, the number of incapacity of work pension receivers was 16 250 at the end of 2019.

The Committee asks the next report to provide information on the estimated net pension of a single person without dependants having worked 15 years at a minimum wage.

Table 32. Estimated net pension of a single person without dependants having worked 15 years at a minimum wage, in years 2015-2020

	2015	2016	2017	2018	2019	2020
Old-age pension in euros (15 years of pension qualifying period)	222,93	236,01	248,41	267,85	291,05	322,07

Source: Ministry of Social Affairs

2. to maintain the social security system at a satisfactory level at least equal to that necessary for the ratification of the European Code of Social Security;

3. to endeavour to raise progressively the system of social security to a higher level;

a) Please provide information on social security coverage and its modalities provided to persons employed or whose work is managed through digital platforms (e.g. cycle delivery services).

In Estonia, the legal status of an individual providing service through a platform is unclear and often depends on the service provided. However out of all individuals providing service through platforms only 4% of them state that the platform is their only source of income.[8] The social security coverage for such individuals depends on whether the person is working under an employment contract, is working under the contract for services or is registered as an entrepreneur or self-employed. To be entitled to main social guarantees the income must be taxed and the minimum monthly obligation for social tax must be met.

If a person earning stable income is an employee (working under the employment contract), he or she is entitled to full social security coverage. The income derived from employment is subject to social tax. When the employee is registered in the Employment Register and the social tax for his

[8] Arenguseire Keskus. Digital Footprint: The Platformisation of Work in Europe. University of Hertfordshire 2019. Page 2. – https://www.riigikogu.ee/wpcms/wp-content/uploads/2017/09/EstonianFactsheet_2019-07-05.pdf (03.12.2020).

or her employment is paid, the social insurance coverage is automatic. Social tax is paid by employers at a rate of 33% from employee's gross salary. Social tax provides health and first pillar pension insurance (the additional unemployment insurance is paid separately and generally applies to employees only). About 6% of Estonia's population is not covered with health insurance, these are mainly persons inactive in the labour market or persons who are working but are not registered in the Employment Register.

If a person is earning stable income as a service provider (working under the contract for services), the income derived is subject to social tax. Health insurance is valid for those whose social tax is paid for at least in the minimum rate of monthly obligation for social tax. In 2020, the minimum obligation for social tax is 178.20 euros monthly (the monthly rate is tied to the minimum wage established every year). Thus, persons whose work is managed through digital platforms and work under the contract for services, their income must be stable, otherwise the insurance might be intermittent (e.g. when the person works a small number of hours a month, then the minimum obligation might not be covered).

If a person earning stable income registers as an entrepreneur (establishes a company), the income becomes the company's sales and it is up to the entrepreneur whether to become employed by the company (and pay 33% on salary and additional unemployment contributions) or take out dividends (and pay only income tax). In Estonia, an entrepreneurial income account has been developed. An entrepreneur account is an appropriate voluntary solution for new forms of entrepreneurship, such as the payments received from the provision of services from one natural person to another natural person through ride-sharing service platforms. It is an account to which a natural person can transfer their entrepreneurial income, which shall be taxed with a 20% rate. The part paid from the entrepreneurial income will be divided between social tax, including health insurance, contribution to the first and second pillars of pension and income tax.

b) If the previous conclusion was one of non-conformity, please explain whether and how the problem has been remedied. If the previous conclusion was deferred, please reply to the questions raised.

In 2017 conclusions, the Committee concluded that the situation in Estonia is in conformity with Articles 12§2 and 12§3 of the Charter. Below are answers to the Committee's questions under Articles 12§2 and 12§3.

The report refers nevertheless to developments introduced in 2016, out of the reference period, concerning respectively the duration of sickness benefits and the replacement of the incapacity for work pension system by a new support system for people with decreased work ability. It also indicates that a detailed study on minimum benefits, covering all the fields of social insurance and in-cash social aid benefits was under way and was expected to be completed by the end of 2017. The Committee asks for information in the next report on the changes made, specifying the effect of these changes on the personal scope of the system and the minimum level of income replacement benefits.

The amendments made in the Health Insurance Act in 2016 harmonised the duration of sickness benefit by removing restrictions of the total number of days per year for which health insurance could be paid. According to § 57 (1) of the Health Insurance Act, in the event of a disease or injury, an insured person has the right to receive sickness benefit until the date on which their work ability is restored as specified in the certificate for sick leave, but not for more than 240 consecutive calendar days in the event of tuberculosis or 182 consecutive calendar days in the event of any other disease.

The new Work Ability Allowance is paid since 1 July 2016 if partial work ability or no work ability is established by the new assessment system. Those receiving the incapacity for work pension can continue to do so until the end of the period of incapacity for work which has been established by the old system, at which point they will be reassessed by the new system and potentially become eligible to the Work Ability Allowance.

Work Ability Allowance is a flat rate benefit. In 2019, the daily rate of Work Ability Allowance is EUR 14.89 for those who have no ability for work. If person has partial work ability the daily rate is 57% of this rate (i.e. EUR 8.49). Those with partial work ability thus receive EUR 254.70 per month, and those with no ability for work EUR 446.70 per month.

If the income of a person with partial or no work ability during the calendar month preceding the payment of work ability allowance exceeds 90 times the daily rate in force (EUR 1340.10 in 2020), the amount of his or her allowance shall be recalculated by reducing his or her allowance for the month of payment of work ability allowance by an amount which is half of the difference between his or her income and 90 times the daily rate.

c) Please provide information on any impact of the COVID-19 crisis on social security coverage and on any specific measures taken to compensate or alleviate possible negative impact.

Benefit for temporary incapacity for work was extended during the emergency situation to alleviate negative impact of COVID-19 (came into force on 1 May 2020). The Government of the Republic of Estonia decided to reimburse the first three days of sick leave during an emergency situation, which normally is not covered. The first three days of sickness are reimbursed retrospectively to anyone whose sick leave was opened from 13 March. This difference applied to all sick leaves that were opened until the end of the emergency situation on 17 May 2020. The benefit rate was 70% of a person's average income of the previous calendar year. The employer retained the obligation to compensate the employee for 4^{th} - 8^{th} day of illness.

In addition, the Government decided on health insurance continuation during emergency situation (came into force on 1 May 2020). Health insurance continued to be available for groups of persons who are otherwise obliged to pay a monthly minimum amount of social tax in order to have health insurance.

Also, an extraordinary support for the parent of a child with special needs was introduced on 10 April 2020. The purpose of the support was to provide a replacement income for a parent who, due to an emergency situation, had to be temporarily absent from work due to raising a child with special needs. Partial compensation for the loss of income of parents of children with special needs is justified due to the closure of educational institutions and the need to ensure the daily home supervision of children with special needs, support for learning and the performance of personal care activities. Also, some children with special needs have a weakened immune system, which puts them at risk for COVID-19. Therefore, it was recommended that in a situation where homework and other solutions are not possible, parents are temporarily absent from work and guaranteed state support. The support was be paid until the date of the end of the emergency situation, but not longer than 31 May 2020.

To support employees, whose employer’s activity was significantly disrupted due to extraordinary circumstances in Estonia, a remuneration benefit was introduced on 23 March 2020. The employer could apply for the benefit only after the employer had paid remuneration to an employee.

The Estonian Unemployment Insurance Fund paid the employee compensation of 70% of the employee's average salary, it was paid directly to an employee´s bank account. The benefit was

considered as remuneration paid by the employer, which the unemployment fund paid to the employee in the name of the employer and at the expense of the Estonian Unemployment Insurance Fund. An employee was entitled to remuneration benefit for up to two months over a three-month period. In order to qualify for the benefit the employer had to meet at least two conditions out of the following three: 1) the turnover of the employer or, in the absence thereof, the income in the calendar month for which the benefit is claimed has decreased by at least 30% compared to the turnover or income of the same calendar month of the previous year; 2) the employer does not have to provide work to the agreed extent to at least 30% of the employees; 3) the employer has reduced the remuneration of at least 30% of the employees by at least 30%.

As all scheduled medical appointments had been cancelled because of the emergency situation, the duration of partial, no work ability, disabilities and the payment of the corresponding benefits and pension were extended by six months. The change concerns people whose decision on incapacity for work, permanent incapacity for work or disability expired between the establishment of the state of emergency and the end of August 2020.

All social rehabilitation service decisions that expired during the emergency situation have been extended until the end of the year.

4. to take steps, by the conclusion of appropriate bilateral and multilateral agreements or by other means, and subject to the conditions laid down in such agreements, in order to ensure:

a. equal treatment with their own nationals of the nationals of other Parties in respect of social security rights, including the retention of benefits arising out of social security legislation, whatever movements the persons protected may undertake between the territories of the Parties;

b. the granting, maintenance and resumption of social security rights by such means as the accumulation of insurance or employment periods completed under the legislation of each of the Parties.

No information requested, except where there was a conclusion of non-conformity or a deferral in the previous conclusion for your country. For conclusions of non-conformity, please explain whether and how the problem has been remedied and for deferrals, please reply to the questions raised.

In 2017 conclusions, the Committee concluded that the situation in Estonia is not in conformity with Article 12§4 of the Charter on the following grounds:

- equal treatment with regard to social security rights is not guaranteed to nationals of all other States Parties;
- it has not been established that equal treatment with regard to access to family allowances is guaranteed to nationals of all other States Parties;
- the retention of accrued benefits is not guaranteed to nationals of all other States Parties;
- the right to maintenance of accruing rights is not guaranteed to nationals of all other States Parties.

Below are answers to the questions of the Committee to explain the situation.

As regards unilateral measures undertaken by Estonia, the report indicates that the State Pension Insurance Act has been amended. However, the Committee notes that those amendments will

enter into force as from 1st of January 2018, that is say outside the reference period. It asks the next report to provide for comprehensive information on this amended Act and its impact on the principle of equal treatment.

Estonia has amended the State Pension Insurance Act, the changes entered into force on 1 January 2018. From that date, all old-age and survivors' pensions earned in Estonia are exported worldwide. This means that pensions earned in Estonia by both Estonian citizens and citizens of all other Contracting States to the Charter are also paid outside the EU, EFTA and other countries covered by pension agreements.

In 2018, 181 people received pensions outside the EU or countries with whom Estonia has bilateral agreement. This number rose to 210 in 2019.

As regards bilateral agreements concluded with other States Parties that are not members of the EU or EEA, the Committee notes that Estonia had not concluded new agreements during the reference period. … The Committee considers therefore that the principle of equal treatment is not guaranteed to nationals of other States Parties to the Charter, inter alia Albania, Armenia, Bosnia and Herzegovina, "the former Yugoslav Republic of Macedonia", Montenegro and Serbia.

In response to the questions, we explain the following.

As is well known, the national social security systems can be divided into two big groups: countries where the legislation of the place of home country (*lex loci domicilii*) applies and countries where the legislation of the place of work (*lex loci laboris*) applies. Estonia belongs to the countries which social security system is based on the principle of *lex loci domicilii*.

As European Union regulations take precedence over the Estonian laws (as in all EU Member States), Estonia must implement European Union regulations. As far as social security is concerned, EU regulations do not require for the harmonisation of social security systems, however, the coordination is based on the *lex loci laboris* principle and implementing that principle is inevitable.

The aim of the EU social security coordination is to ensure that every citizen working in European Union or EFTA countries or Switzerland is covered by (agreed) social security schemes. On the other hand, the aim is to ensure that persons do not have double coverage.

Most of the EU Member States are subjects to EU Regulation No 1231/2010, under which not only nationals of European Union are the subjects of the EU social security coordination, but also third-country nationals residing legally in those Member States.

The European Union's social security coordination system is legally and technically very complex. The exchange of data is essential for its implementation. These data are agreed by the Member States and the exchange of data follows high data security requirements.

The Administrative Commission on Social Security for Migrant Workers, composed of representatives of all Member States and meeting several times a year, has a very important role to play in informing other Member States of upcoming changes in national social security systems and resolving practical issues coming up, while implementing the regulations. In addition to the Administrative Commission on Social Security for Migrant Workers, an Advisory Committee and the Technical Committee have been established. And still, as there are many problems in the implementation of the EU social security regulations, a new institution - European Labour Agency has recently been established, activities of which must contribute, inter alia, to better coordination of social security systems.

There are no similar institutions in the Council of Europe, and there is no need for that, because the Council of Europe does not establish a common labour market.

As the Council of Europe does not form a common labour market, we do not agree that nationals of the States Parties to the Charter, who reside in the territories of the Member States other than the Member States of the European Economic Area and Switzerland, must be subjects to the principle of the *lex loci laboris*.

In 2016, the Estonian Parliament made an important decision to pay from 2018 to the persons a pension regardless of the country in which they live. This was a big change, requiring additional administration and additional pension funds. There is currently no plan for unilateral extension of the payment of other social security benefits.

Regarding bilateral social security agreements, we would like to explain, that we consider the conclusion of bilateral social security agreements necessary if there is a social necessity for that. When the number of foreign nationals living in Estonia is very small, concluding a social security agreement with their country of origin is not a priority for us; we simply do not have resources to do that.

At present, we have consultations with three counterparts to the Charter - Moldova, Russian Federation and Ukraine. The aim of these consultations is to amend the existing agreements. We need to do it, as we have made changes in our social security systems and the agreements need to reflect these changes. The new EU Data Protection Regulation 679/2016 also requires the data exchange to be more closely regulated in the agreements. Making amendments to the agreements is a slow process that requires long-term resources and by now has taken already more than five years to negotiate with each country.

For years, our consultations with Azerbaijan and Georgia have been stalled, but not because we did not want to move forward, but because social security reforms were being carried out in these countries. That is why these countries felt that it was not appropriate to continue our consultations.

In 2011, we also proposed Armenia to start consultations, but for the same reason as mentioned above, Armenia was not ready to start the process.

According to the report, amendments to the State Pension Insurance Act allow old-age pensions and survivors' pensions earned in Estonia by Estonian nationals and nationals of other States Parties covered with pension agreements, to be exported to any other States. However, the Committee recalls that such amendments will only enter into force as from 1st of January 2018. It asks the next report to provide further information on this matter. Furthermore, the Committee notes that the SAAs and the EU-Armenia Agreement do not provide sufficient guarantees as such since they do not coordinate social security systems of Albania, Bosnia and Herzegovina, "the former Yugoslav Republic of Macedonia", Montenegro and Serbia with those of the EU Member States, but rather entrusts the Stabilisation and Association Councils (SACs) with this tasks by adopting decisions. The Committee considers that, in absence of such decisions, the SAAs and the EU-Armenia Agreement do not guarantee as such the retention of accrued benefits for nationals of Albania, Armenia, Bosnia and Herzegovina, "the former Yugoslav Republic of Macedonia", Montenegro and Serbia. The Committee recalls States' obligation, under Article 12§4, to conclude multilateral or bilateral agreements, or to take unilateral measures to ensure the right to retention of accrued benefits whatever the movements of the beneficiary, and reiterates its conclusion of non-conformity on this point. The Committee notes that, in the absence of decisions adopted by SACs, the SAAs and the EU-Armenia Agreement do not guarantee as such the accumulation of

insurance or employment periods for nationals of Albania, Armenia, Bosnia and Herzegovina, "the former Yugoslav Republic of Macedonia", Montenegro and Serbia. Consequently, it reiterates its conclusion of non-conformity on this point.

As regards the references in our previous report to the agreements between the European Union and the other States Parties to the Charter, our aim was to show that the European Union has a common approach to these countries and that the opening of separate consultations or negotiations must be extremely justified. We also assume that, if social security issues would have been or are important for these countries, then these countries were/are equally able to raise this issue during the negotiations. In our mind, the aim to conclude the agreements or to amend the existing agreements with social security coordination is achievable (as for example, the agreement between the EU and Turkey).

The following table shows that there are very few citizens of Albania, Bosnia and Herzegovina, North Macedonia and Montenegro and Serbia living in Estonia, thus there is currently no significant need to enter into consultations on social security agreements with these countries. Regarding Armenia, we are currently considering whether to make a new proposal to start consultations.

Table 33. Number of citizens of Albania, Armenia, Bosnia and Herzegovina, Northern Macedonia, Montenegro and Serbia living in Estonia, as of January 1, 2016-2020

Citizenship	2016	2019	2018	2019	2020
Albania	23	35	36	36	43
Armenia	251	241	250	263	279
Bosnia and Herzegovina	..	..	..	..	..
Montenegro	..	4	4	5	6
Northern Macedonia	5	9	14	17	20
Serbia	23	28	39	46	54

Value ".." means „0-2". Due to statistical confidentiality, the values „0-2"cannot be published.
Source: Statistics Estonia

We do not agree that Estonia discriminates pensioners on the ground of nationality.

The following table shows that Estonia does not make the right to pension dependent on the nationality of the pensioner.

Table 34. Persons living in the States Parties to the Charter and receiving an Estonian pension

Country	2016			2017			2018			2019		
	Living in a foreign country	**Estonian residents**	**TOTAL**	**Living in a foreign country**	**Estonian residents**	**TOTAL**	**Living in a foreign country**	**Estonian residents**	**TOTAL**	**Living in a foreign country**	**Estonian residents**	**TOTAL**
Austria	28	0	28	27	0	27	30	0	30	31	0	31
Belgium	6	0	6	8	0	8	10	0	10	11	0	11
Bulgaria	40	0	40	49	0	49	50	0	50	56	0	56
Spain	61	0	61	65	0	65	77	0	77	74	0	74
Netherlands	10	0	10	11	0	11	8	0	8	4	0	4
Croatia	2	0	2	2	0	2	0	0	0	0	0	0
Ireland	55	0	55	60	0	60	65	0	65	60	0	60
Iceland	2	0	2	2	0	2	3	0	3	4	0	4
Italy	19	0	19	21	0	21	21	0	21	19	0	19
Greece	5	0	5	5	0	5	5	0	5	6	0	6
Cyprus	2	0	2	2	0	2	2	0	2	1	0	1
Lithuania	651	65	716	679	63	742	688	60	748	708	58	766
Luxemburg	4	0	4	4	0	4	3	0	3	3	0	3
Latvia	1 897	930	2 824	1 912	908	2 817	1 886	854	2 737	1 847	796	2 640
Moldova	1	9	10	1	12	13	4	11	15	7	11	18
Norway	57	0	57	62	0	62	67	0	67	69	0	69

Poland	9	0	9	14	0	14	14	0	14	13	0	13
Portugal	7	0	7	7	0	7	8	0	8	7	0	7
France	17	0	17	20	0	20	22	0	22	24	0	24
Sweden	298	0	298	316	0	316	329	0	329	328	0	328
Romania	1	0	1	1	0	1	2	0	2	3	0	3
Germany	1 645	0	1 645	1 747	0	1 747	1 797	0	1 797	1 799	0	1 799
Slovakia	4	0	4	5	0	5	4	0	4	5	0	5
Finland	4 674	0	4 674	4 884	0	4 884	4 738	0	4 738	4 683	0	4 683
Great Britain	157	0	157	172	0	172	178	0	178	191	0	191
Switzerland	10	0	10	9	0	9	11	0	11	12	0	12
Denmark	13	0	13	14	0	14	15	0	15	17	0	17
Czech Republic	15	0	15	15	0	15	15	0	15	17	0	17
Ukraine	925	418	1 337	1 094	415	1 503	1 278	383	1 651	1 411	358	1 763
Hungary	16	0	16	16	0	16	16	0	16	20	0	20
Russia	1 416	2 672	4 084	1 828	2 849	4 669	2 364	2 863	5 216	2 993	2 929	5 913
Azerbaijan	0	0	0	0	0	0	1	0	1	1	0	1
Georgia	0	0	0	0	0	0	2	0	2	2	0	2
Malta	0	0	0	0	0	0	1	0	1	0	0	0

Source: Social Insurance Board

We do not agree that Estonia discriminates beneficiaries on the ground of nationality.

The following table shows that Estonia does not restrict the payment of sickness benefits to nationals of Albania, Armenia, Bosnia and Herzegovina, Northern Macedonia, Montenegro and Serbia.

Table 35. Citizens of Albania, Armenia, Bosnia and Herzegovina, Northern Macedonia, Montenegro and Serbia for whom Estonia paid sickness benefits

Citizenship	2016	2017	2018	2019
Albania	1	2	2	1
Armenia	10	12	12	20
Bosnia and Herzegovina	..	..	..	..
Northern Macedonia			1	1
Montenegro	..	..	..	..
Serbia	..	..	..	..

Value ".." means „0-2". Due to statistical confidentiality, the values „0-2"cannot be published.
Source: Estonian Health Insurance Fund

The following table shows that Estonia does not restrict the payment of unemployment benefits and work ability allowances to nationals of Albania, Armenia, Bosnia and Herzegovina, Northern Macedonia, Montenegro and Serbia.

Table 36. Citizens of Albania, Armenia, Bosnia and Herzegovina, Northern Macedonia, Montenegro and Serbia, for whom Estonia paid unemployment insurance benefits, unemployment allowances and work ability allowances

Citizenship	2016	2017	2018	2019
Unemployment insurance benefits recipients				
Albania		…		
Armenia	…	5	8	6
Bosnia and Herzegovina				
Northern Macedonia				
Montenegro				
Serbia				
Unemployment allowance recipients				
Albania	…			…
Armenia	4	…	10	6
Bosnia and Herzegovina				
Northern Macedonia				

Montenegro				…
Serbia				
Recipients of work ability allowance				
Albania				
Armenia		12	19	25
Bosnia and Herzegovina				
Northern Macedonia				
Montenegro				
Serbia				

*If the number of recipients is 3 or less, then it is indicated in the table „…“.
If the box is empty, no applications have been submitted.
Source: Estonian Unemployment Insurance Fund

The following table shows that Estonia does not restrict the payment of disability benefits to citizens of Albania, Armenia, Bosnia and Herzegovina, Northern Macedonia, Montenegro and Serbia.

Table 37. Citizens of Albania, Armenia, Bosnia and Herzegovina, Northern Macedonia, Montenegro and Serbia to whom Estonia paid disability benefits

Citizenship	2016	2017	2018	2019
Armenian	2	2	2	1
Unspecified	22	25	24	19
Total (unique persons)	**24**	**27**	**26**	**20**

Source: Social Insurance Board

The following table shows that Estonia does not restrict the provision of social security cover to citizens of Albania, Armenia, Bosnia and Herzegovina, Northern Macedonia, Montenegro and Serbia.

Table 38. Citizens of Albania, Armenia, Bosnia and Herzegovina, Northern Macedonia, Montenegro and Serbia, who were issued with proof that the person is covered by the Estonian social security system while working abroad

Citizenship	2016	2017	2018	2019
Albania	3	2	3	1
Armenia		1		1

Total (unique persons)	**3**	**3**	**3**	**2**
Citizens of Bosnia and Herzegovina, Northern Macedonia, Montenegro and Serbia did not submit applications.				

Source: Social Insurance Board

The Committee notes from MISSOC that Estonia applies the rules whereby the payment of family benefits is conditional on the claimant's children being resident in Estonia. According to the report, granting family benefits to parent or guardian of the child who lives in the countries which apply a different entitlement principle, in particular where the State concerned also apply the means-test, would, in the light of the Estonian system, represent an important administrative burden to Estonia and, consequently, it does not foresee concluding any agreement covering family benefits or taking unilateral measures to provide family benefits to persons residing abroad. The Committee recalls that in the absence of an agreement, Estonia is required under Article 12§4 of the Charter to take unilateral steps to comply with the requirements of this provisions. The Committee considers therefore the situation not to be in conformity with the Charter on this point.

In Estonia, payment of state family benefits is based on the principle of *lex loci domicilii*, which means that both children for whom the allowance is paid, and their parents must live in Estonia. The only difference is that in the European Economic Area and Switzerland, Estonia applies the EU regulations.

In Estonia, the right to state family benefits does not depend on nationality and whether the parent is employed or not, studying or engaged (or not engaged) in other activities. Family benefits are paid, depending on how old the child is, whether he/she is studying or not, how many children are in the family, whether the child is raised by a single parent, whether the child is growing up in guardianship or whether it is an adoption. The amount of parental benefit is calculated by the amount of income the parent received earlier and the amount of income they receive at the time of receipt of the benefit. In addition to the above mentioned, in the European Union, it is important to know, in which country the parents work, in which country the child lives and with which parent the child lives. Double payments should be avoided.

Thus, the payment of family benefits depends on the receipt of a whole set of reliable data. For a child residing in Estonia, this data is obtained from different national databases, and in the framework of the European Economic Area and Switzerland these data are exchanged between countries; alongside the exchange of information on paper, an electronic information system between the competent national authorities is being developed.

It is not possible to pay family benefits without reliable data; if this were to be done, families and children who receive benefits based on reliable data would be put in an unfair position.

On the basis of the foregoing, we do not agree that we do not guarantee equal treatment with regard to family benefits to nationals of all other States Parties to the Charter.

The following table shows that Estonia does not restrict the payment of family allowances to citizens of Albania, Armenia, Bosnia and Herzegovina, Northern Macedonia, Montenegro and Serbia. Unfortunately, the data of the citizens of Bosnia and Herzegovina, Northern Macedonia and

Montenegro are not identified in our information system; when they have children living in Estonia, they could be classified as “unspecified” while the number is very small.

Table 39. Citizens of Albania, Armenia, Serbia and Kosovo, who received Estonian family allowances

Albanian				
Year	**2016**	**2017**	**2018**	**2019**
Recipients of family allowances	1	1	2	2
Number of children	3	3	5	5
Armenian				
Year	**2016**	**2017**	**2018**	**2019**
Recipients of family allowances	37	37	36	40
Number of children	60	60	62	74
Serbian				
Year	**2016**	**2017**	**2018**	**2019**
Recipients of family allowances	2	2	2	5
Number of children	3	3	3	9
Kosovo				
Recipients of family allowances	2	2	2	2
Number of children	3	4	4	5

Source: Social Insurance Board

Part I – 13. RESC Anyone without adequate resources has the right to social and medical assistance

Article 13 – The right to social and medical assistance With a view to ensuring the effective exercise of the right to social and medical assistance, the Parties undertake: 1. to ensure that any person who is without adequate resources and who is unable to secure such resources either by his own efforts or from other sources, in particular by benefits under a social security scheme, be granted adequate assistance, and, in case of sickness, the care necessitated by his condition;

a) *Please describe any reforms to the general legal framework. 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 minimum income in Estonia for an individual or household with lack of resources is the subsistence benefit. It consists of two parts: actual housing costs and a benefit paid at the subsistence level. The benefit is non-contributory, means-tested and not taxable. Local authorities administer the subsistence benefit and can exercise discretion within certain limits. There are no parallel minimum income schemes in Estonia.

The subsistence benefit is granted to a person living alone or with a family whose net income after the payment of housing costs (up to certain limits) is below the subsistence level. The subsistence level is intended to cover minimum expenditures on the consumption of food, clothing, footwear and other goods and services. The Parliament establishes the subsistence benefit level annually. Since 2019, subsistence level was raised to 150 euros:

- the subsistence level for a single or first family member is 150 euros,
- every subsequent family member's subsistence level is 120 euros (80% of the single level) and
- every minor's subsistence level is 180 euros (120% of the single level).

There is a supplement for lone parents of EUR 15 per month.

A major set of amendments[9] in the subsistence benefit regulation were introduced in 2018, with the aim to make the scheme more flexible and motivate beneficiaries to take up employment.

1) A new element in the scheme to motivate benefit recipients to take up work was introduced. In the event that a subsistence benefit applicant or a member of a family applying for the benefit starts receiving earned income and was granted subsistence benefit for at least two previous months, the following shall not be included in the income test:
   - 100% of earned income during the first two months;
   - 50% of earned income during the following 4 months.

[9] Amendments were adopted by the Parliament on 6.12.2017, entered into force on 01.01.2018, published RT I, 28.12.2017, 8, https://www.riigiteataja.ee/akt/128122017008

It is possible to use this exception once in 24 months per family member. The aim of this amendment is to motivate people to participate in the labour market and to improve their socio-economic situation. Prior to the amendment, a person who had received the subsistence benefit, usually lost the right to the benefit as soon as started to work.

2) Salary earned by students is not included as income of the family upon calculating the subsistence benefit. The aim of this change is to motivate young people to work legally and realise that working is a key measure against poverty.

3) The need-based family benefit, that had been in effect since July 2013 (with the latest rate 45 € in case of one child, 90 € in case of two or more children), was abolished and integrated to the subsistence benefit scheme. All family benefits were fully included to family income when calculating subsistence benefits. The subsistence level was raised, and the subsistence level of each minor child was increased to 120% of subsistence level. The needs-based family benefit did not have the expected positive effect of reducing poverty due to low take-up, as the receivers of needs-based family benefit made up only approximately a quarter of the expected number and were, at the same time also receivers of the subsistence benefit.

4) Local authorities were given more discretion to consider the person's situation, wealth and assets as well as general circumstances in the country.
   - In certain cases, local authorities have a right to establish more favourable conditions for granting the subsistence benefit. For example, upon calculating a subsistence benefit local municipalities:
     - may choose not to include grants and benefits supporting studying or working, benefits paid to cover specific expenses or loss, or monetary benefits and gifts received to improve the coping (up to a certain limit);
     - for persons or families who have been granted subsistence benefit successively during the previous six months, local authority may take into account single housing expenses which are unavoidable due to requirements of legislation or due to risk on the health or life. These expenses can be taken into account within a subsistence limit during one calendar year.
   - Local municipalities may also refuse to grant the benefit or reduce the sum of the benefit if the applicant or a member of a family applying for a benefit is a person of working age with ability to work, is not working, looking for a job, or studying full time or does not agree to accept additional help and services provided by local authority. Benefit applicants who are jobseekers have to comply with the individual action plan by the Unemployment Insurance Fund or receive services offered by local authority. It is also a matter of discretion whether to grant the benefit or not in the case of alimony not being pursued, a person or family has other means to cope (immovable or movable property) or they have not made an effort to improve their economic situation in any way.

Table 40. General data about the subsistence benefit in 2016–2019

	2016	2017	2018	2019
The number of households that received subsistence benefit	15 300	14 056	12 226	10 904
The number of persons (number of household members) that received subsistence benefit	27 990	25 360	20 931	18 719
Number of satisfied applications	99 305	88 726	75 402	65 645
The average amount of months/turns receiving the subsistence benefit per family	6,5	6,3	6,2	6,0
The proportion of beneficiaries of subsistence benefit in the population, %	2.1	1.9	1.6	1.4
The funds used for subsistence benefit, including supplementary allowance for families with one parent (in euros)	21 122 425	18 304 537	16 873 247	15 953 189

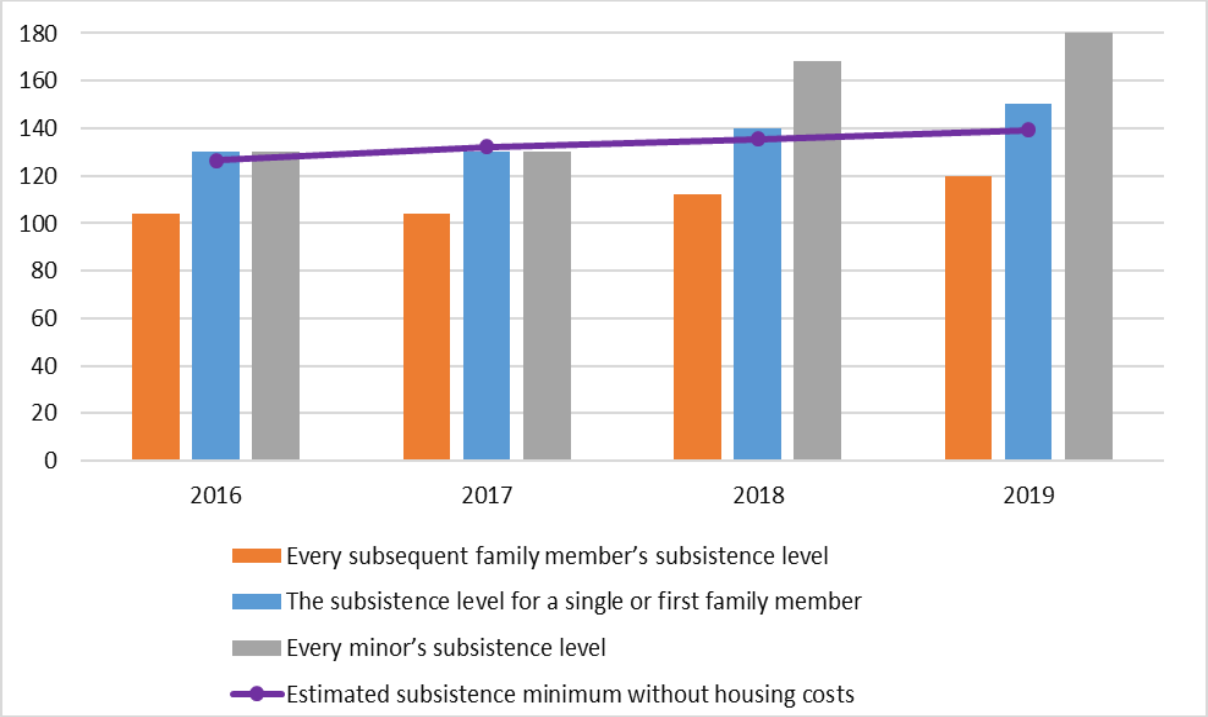
Source: Ministry of Social Affairs, Social Services and Benefits Registry

Table 41. Comparison of the subsistence level and subsistence minimum in 2016 –2019

	2016	**2017**	**2018**	**2019**
The subsistence level for a single or first family member	**130**	**130**	**140**	**150**
Every subsequent family member's subsistence level	104	104	112	120
Every minor's subsistence level	130	130	168	180
Estimated subsistence minimum per 30 days for one person	**200.12**	**207.23**	**215.44**	**221.36**
minimum estimated food basket	91.50	96.72	99.71	102.70
Housing	73.65	75.19	79.93	82.25
other expenses	34.98	35.32	35.80	36.41
Estimated subsistence minimum without housing costs	**126.48**	**132.03**	**135.51**	**139.11**

Source: Ministry of Social Affairs, Social Services and Benefits Registry, Statistics Estonia

Figure 4. Comparison of the subsistence level and subsistence minimum in 2016 –2019



Source: Ministry of Social Affairs, Social Services and Benefits Registry, Statistics Estonia

b) Please indicate any specific measures taken to ensure social and medical assistance for persons without resources in the context of a pandemic such as the COVID-19 crisis. Please also provide information on the extent and modalities in which social and medical assistance was provided to people without a residence or other status allowing them to reside lawfully in your country's territory.

The provision of social assistance, including emergency social assistance is under the competences of local authorities. During the COVID-19 crisis, local authorities continued the payment of subsistence benefit, as well as other benefits under their competences, and provision of food aid and other services. There were no centrally implemented specific social assistance measures for persons without resources. With the intention to prevent further difficulties for parents of children with special needs, the state introduced a temporary financial support. The aim of the financial benefit was to provide state supported income for parents, who have taken unpaid leave due to the closure of kindergartens and schools, in order to guarantee the everyday surveillance, study support and personal hygiene procedures of their children. Parents of children with profound, severe or moderate disability, educational special needs and lack of immunity were granted 70% of their average income of the previous calendar year for each calendar day of the unpaid leave. The measure was applicable until the end of emergency situation (17 May 2020). The budget of the measure was 10 MEUR.

The **sickness benefit scheme** was also temporarily expanded to cover the first three days of sick leave which previously has been persons own liability. The aim of that was to offer additional support to relieve the economic situation.

People without a residence or other status allowing them to reside lawfully in Estonia are provided with emergency social assistance by local authority in whose administrative territory the person is staying at the time of need. Emergency social assistance consists of at least shelter, food and clothing and is provided until needed. It is also possible to receive emergency

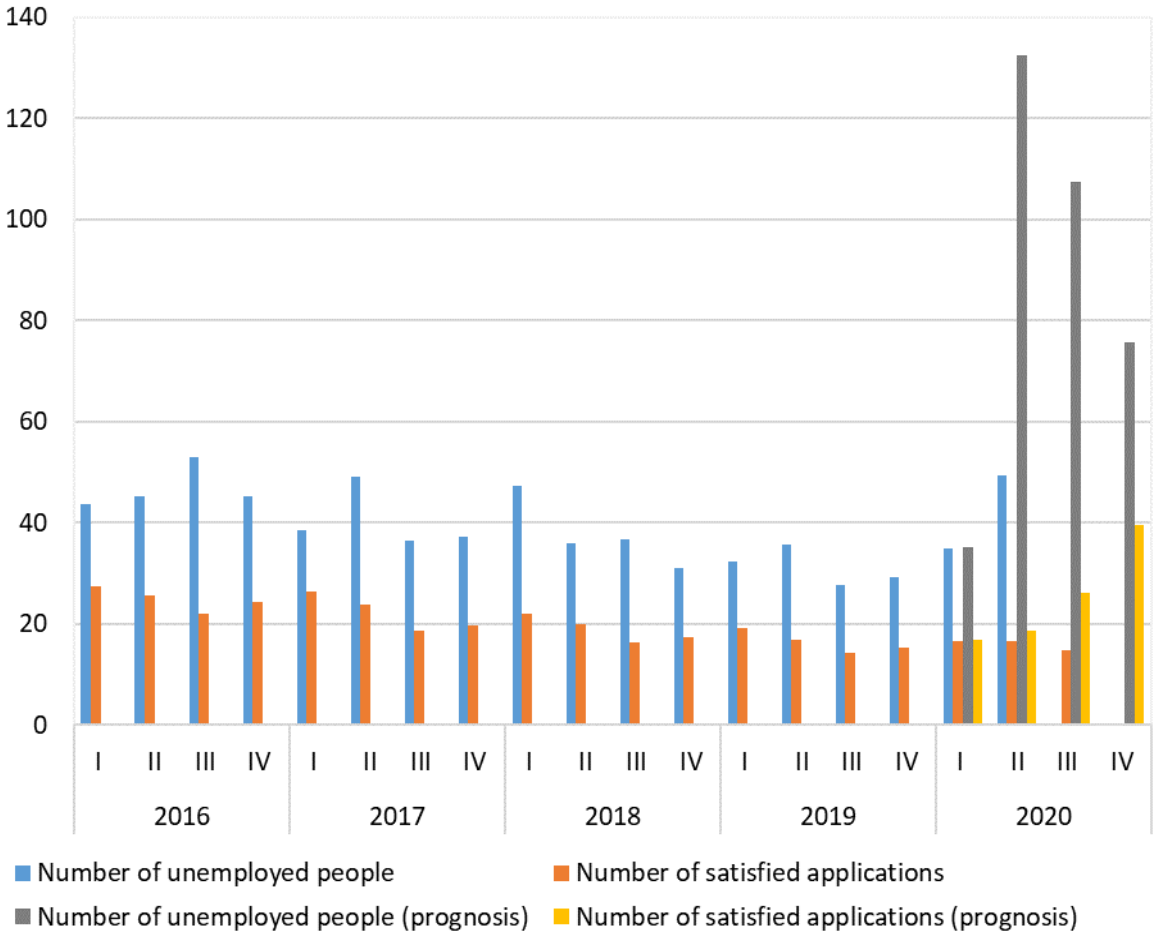
medical care. Whereas the definition of emergency medical care has not changed in the law, during the pandemic situation the list of medical services that are covered is broader than before. In the case of suspicion of COVID-19 with health insurance uncovered person all necessary services are covered – emergency ambulance care, diagnostics, treatment in the specialised care and in primary care level.

Social Welfare Act was complemented with specific regulation[10] on financial support measures to be applied in extraordinary situation for prevention of difficulties in coping arising from extraordinary situation. The amendments stipulate that during an emergency situation, a state of emergency or a state of war, the Government of the Republic may establish by a regulation additional financial support measures for relieving and preventing difficulties in coping arising from the emergency situation, state of emergency or state of war. Persons whose coping may have deteriorated to a significant extent due to the emergency situation, state of emergency or state of war are entitled to financial support measures. The one-time cost of a financial support measure shall not be less than 5 euros or more than ten times the subsistence level. The financial support measures may be applied until the need for such measures ceases to exist but not longer than 60 days after the termination of an emergency situation, a state of emergency or a state of war. The measures may be applied retroactively as of the declaration of an emergency situation, a state of emergency or a state of war.

The COVID-19 outbreak did not bring along rapid growth of people in financial need, but since May, there has been a slight increase in the number of subsistence benefit receivers. The increase is expected to grow in the near future, because relieving measures offered to people who lost their jobs by the Estonian Unemployment Fund (unemployment insurance benefit, redundancy benefit, unemployment allowance), are ending and the amount of subsistence benefit receivers always grows in autumn (since seasonal jobs end and dwelling costs are higher because of heating).

[10] Amendments were adopted on 8.04.2020, implemented 10.04.2020, published RT I, 09.04.2020, 14, https://www.riigiteataja.ee/akt/109042020014

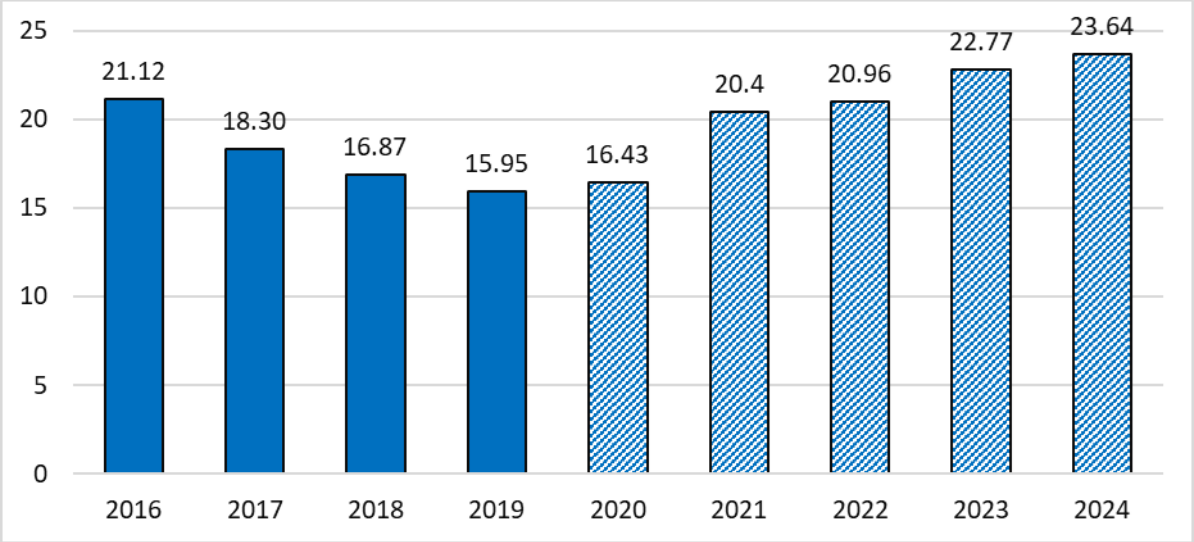
Figure 5. Number of unemployed people and satisfied subsistence benefit applications in 2016-2020, thousand



Source: Ministry of Finance, Ministry of Social Affairs, Statistics Estonia, Estonian Social Insurance Board

The consequences of the pandemic are projected to lead a significant increase in unemployment rate in autumn 2020, which in turn means, that a large proportion of people will need social assistance with some delay. It is also projected, that families needing support will need it for a longer period. In connection with this, additional funding for the subsistence benefit is foreseen from the state budget in the following years.

Figure 6. State budget allocations for subsistence benefit, 2016-2019 and prognosis for 2020-2024, million euros



Source: Ministry of Finance, state budget negotiations with local governments

c) If the previous conclusion was one of non-conformity, please explain whether and how the problem has been remedied. If the previous conclusion was deferred, please reply to the questions raised.

In 2017 conclusions, the Committee concluded that the situation in Estonia is not in conformity with Article 13§1 of the Charter on the ground that the level of social assistance paid to a single person without resources is not adequate. Below is the explanation to the non-conformity and answers to the Committee's questions.

The average amount of subsistence benefit for average households is significantly higher than for single member households. Firstly, in Estonia, families with children are seen as a priority in alleviating poverty and guaranteeing minimum income and therefore their subsistence level is higher than a single person's level (150 EUR vs 180 EUR). Secondly, there is a significant amount of single member households that have no dwelling costs (living in a shelter), which is also a reason for lower average benefit amount.

Table 42. The average amount of benefit per one application (in euros) in 2016-2019

	Single member household				Average household			
	2016	**2017**	**2018**	**2019**	**2016**	**2017**	**2018**	**2019**
The average amount of benefit per one application	152.77	153.72	169.46	183.09	212.70	206.30	223.78	243.02
of which dwelling costs make up[1]	43.80	46.39	52.11	55.92	39.66	42.42	47.36	50.00

[1] If dwelling costs covered in the subsistence benefit scheme are higher than income that is taken into account while calculating the subsistence benefit

In this connection, the Committee refers to its conclusion of 2009 where it noted that in case the benefit is refused where the person repeatedly refuses an employment offer, such persons have the right to emergency social assistance in accordance with Section 28 of the SWA, if they find themselves in a socially helpless situation due to the loss or lack of means of subsistence. The Committee asks whether emergency social assistance is always maintained even in those cases where persons are refused social assistance due to the fact that they fail to register as unemployed.

According to the §134 (3) of Social Welfare Act, local municipality has the right to refuse to grant a subsistence benefit or to reduce the sum of the granted subsistence benefit if it finds that a benefit applicant or a member of a family applying for a benefit has made no other effort to improve his or her own material situation or the material situation of his or her family. Refusal of an employment offer or not being registered as unemployed or job-seeker with the Estonian Unemployment Insurance Fund, is one of the grounds to refuse to grant a subsistence benefit.

According to the §8 of Social Welfare Act, emergency social assistance is provided to all persons who are in Estonia and find themselves in a socially helpless situation due to the loss or lack of means of subsistence which guarantees the persons at least food, clothing and temporary accommodation. Emergency social assistance is a needs-based support, that is provided for anyone in need until a person is no longer in a socially helpless situation due to the loss or lack of means of subsistence.

Food aid is distributed twice a year to recipients of subsistence benefit, people and families who according to their incomes are entitled to subsistence benefit, recipients of certain local government benefits and people in shelters. The food aid is equally accessible in all regions of Estonia. Food aid is supported by the European structural funds (FEAD) and distributed by the state's long-term partner Estonian Food Bank, in cooperation with local governments.

There are additional initiatives in distributing the food aid. For example, Estonian Food Bank is the state's strategic partner in establishing the support network to those persons and families, who are not entitled to food aid financed from FEAD, but whose income is slightly above poverty line and thus might need assistance (for example single parent families). Estonian Food Bank is active in all regions and distributes donated food.

The Committee asks whether the benefit to meet the housing costs is granted in addition to the subsistence benefit or is already included in the amount granted (€ 90 in 2015). In the former case, the Committee wishes to be informed of the average amount granted as housing benefit to a single person in receipt of subsistence benefit.

The subsistence benefit in Estonia consists of two parts: actual housing costs and a benefit paid at the subsistence level. The subsistence level is to provide for a certain minimum guaranteed income, which the person should have after payment of housing costs. Since 2019, the subsistence level for single or first family member is 150€, each subsequent adult family member 120€ (80% of single level) and each minor family member 180€ (120% of single level).

To calculate the subsistence benefit amount, housing costs are taken into account up to the limits of the specified standards for dwellings. The limit of standards for dwelling is 18m^2 per each family member and in addition 15m^2 per family. In case the number of rooms is equal to the number of persons living there, the total area of the dwelling is taken into account. There is an exception considering pensioners and persons with partial or absent work ability - the limit for them, if living alone, is 51m^2. Local authorities establish the limits for housing costs to ensure decent subsistence annually.

Upon the calculation of subsistence benefit, within the limits of socially reasonable norm established by the law and reference prices established by the local authorities, the following costs are taken into account:

- rent;
- the administration costs of the apartment building, including costs related to repairs;
- the 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 and
- the fee for the transport of municipal waste.

Table 43. The total amount of dwelling costs compensated from the subsistence benefit funds in 2016 –2019

	2016	2017	2018	2019
The funds used for subsistence benefit, including supplementary allowance for families with one parent (in euros)	21 122 425	18 304 537	16 873 247	15 953 189
of which dwelling costs make up[1]	3 938 671	3 764 077	3 570 804	3 281 948
percentage dwelling costs make up form the total fund of subsistence benefit	18.6	20.6	21.2	20.6

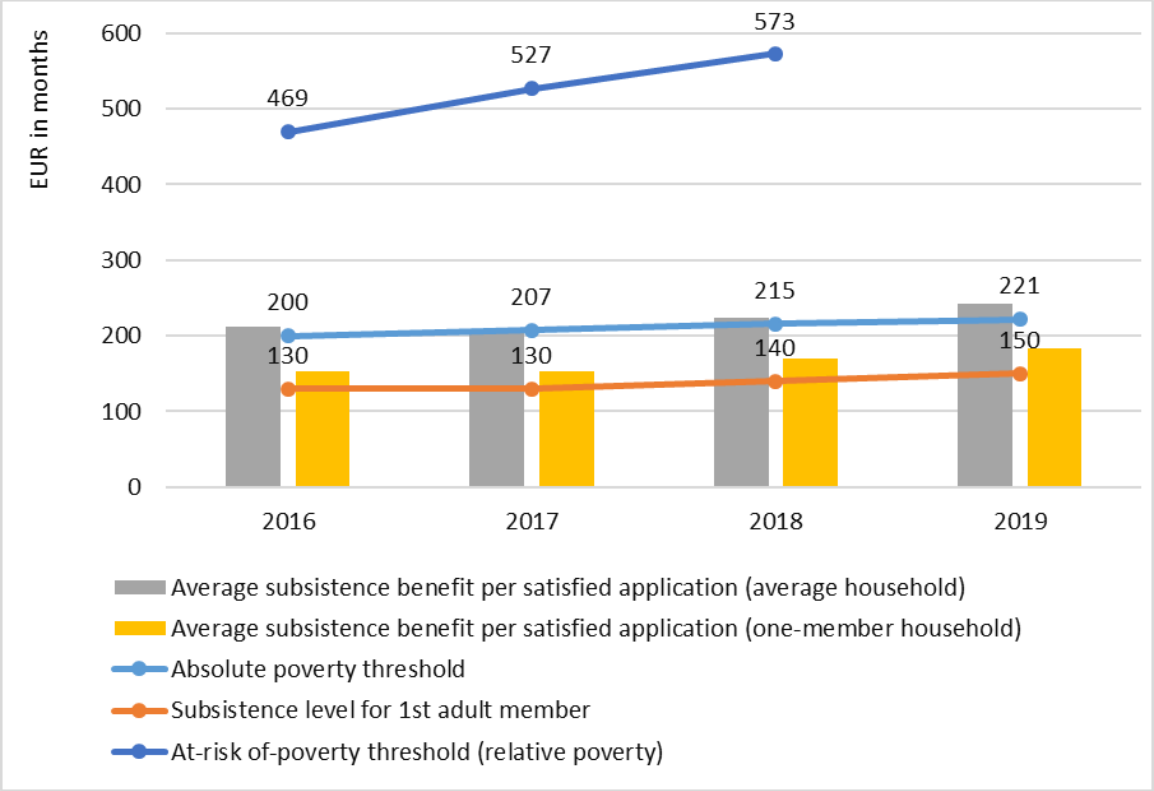
[1] If dwelling costs covered in the subsistence benefit scheme are higher than income that is taken into account while calculating the subsistence benefit

Source: Ministry of Social Affairs, Social Services and Benefits Registry

Poverty threshold, defined as 50% of median equivalised income and as calculated on the basis of the Eurostat at-risk-of-poverty threshold value was estimated at € 329 in 2015. In the light of the above data, the Committee considers that the level of social assistance for a single person is

inadequate on the basis that the minimum social assistance that can be obtained falls below the poverty threshold.

Figure 7. Poverty thresholds, subsistence level and average subsistence minimum (including dwelling costs) in 2016–2019 (income years)



Source: Ministry of Social Affairs, Social Services and Benefits Registry, Statistics Estonia

The Committee asks the next report to provide updated information regarding the right of appeal and legal aid.

Paragraph 36 of the General Part of the Social Code Act (adopted 9.12.2015, entered into force 1.01.2016) gives grounds for submitting challenge: any decisions or operations made in the organisation of social protection shall be contested to the administrative authority that has made such a decision or operation. In case of disagreement with the decision on subsistence benefit, the applicant has the right to file a challenge with the local government within 30 days as of the date of becoming aware of the decision, or to file an appeal with an administrative court within the same term.

State legal aid[11] is provided for persons, who are unable to pay or are able to pay only partially for competent legal services due to their financial situation at the time of need for legal aid, or if the person's financial situation does not allow for meeting basic subsistence needs after paying for legal services. Upon assessing the financial situation of an applicant, the applicant's assets and income and the assets and income of the family members who live together with the applicant, the number of dependants of the applicant, reasonable housing expenses and other relevant circumstances will be taken into account. It has to be noted, that state legal aid may be granted

[11] State Legal Aid Act, adopted 28.06.2004, entered into force 1.03.2005, with later amendments, published RT I 4.01.2019, 18, https://www.riigiteataja.ee/akt/R%C3%95S

without the obligation to compensate for the state legal aid fee or state legal aid expenses, but also with the obligation to partially or fully compensate the fee or state legal aid expenses in a lump sum or instalments.

State legal aid includes representing a person in administrative court proceedings, representing a person in administrative proceedings, drawing up legal documents and other legal counselling or representing of a person.

Several non-profit associations provide simpler legal aid to the people with financial needs. Such associations can often be supported by local municipalities, universities or public authorities. For example:

Eesti Juristide Liit (Estonian Association of Lawyers) together with students from law faculties provide free of charge legal advice in Tallinn and, in cooperation with local governments, free legal aid days in all Estonian regions.

HUGO.legal, in cooperation with the Ministry of Justice of Estonia, provides legal counselling for favourable conditions for all Estonian residents whose gross monthly income is up to 1700€. To receive legal aid, a client agreement must be concluded and a co-payment of 5 € must be paid. Legal aid is provided with a few exceptions in all legal matters and in all forms, both on-site consultation in all county centres and online. Clients are advised in both out-of-court and court proceedings, as well as in drafting documents and communicating with the authorities. The client who has entered into a contract has the right to receive the assistance of a lawyer for a total of 15 hours in one calendar year, of which the first 2 hours are free of charge and 13 next hours 100% of the hourly rate (i.e. 40 €).

Estonian Chamber of Disabled People and *Estonian Union of Pensioner's Associations* provide legal counselling for people with special needs and people of pensionable age, respectively. Simpler legal aid may also be found and asked on webpage: https://www.juristaitab.ee/.

The Committee recalls that under Article 13§1, foreigners who are lawfully resident in the territory of a Contracting Party and lack adequate resources must enjoy an individual right to appropriate assistance on an equal footing with nationals, i.e. beyond emergency assistance. Furthermore, they cannot be repatriated on the sole ground that they are in need of assistance. Once the validity of the residence and/or work permit has expired, the Parties have no further obligation towards foreigners covered by the Charter, even if they are in a state of need. However, this does not mean that a country's authorities are authorised to withdraw a residence permit solely on the grounds that the person concerned is without resources and unable to provide for the needs of his family. The Committee understands that the person's residence permit may not be renewed but it will not be withdrawn before its legal expiry, on the sole ground that the person concerned is in need. The Committee asks if this understanding is correct.

According to the General Part of the Social Code Act § 3(1) the subjects who have the right to receive social services, social benefits and other assistance, are:

- permanent residents of Estonia (Estonian citizen residing in Estonia, foreigners residing in Estonia on the basis of a long-term residence permit or permanent right of residence);
- foreigners residing in Estonia on the basis of residence permits or right of residence;
- persons enjoying international protection staying in Estonia.

In addition, the Aliens Act § 10 refers same abovementioned principle and stipulates that a foreigner staying in Estonia is guaranteed rights and freedoms equal to those of an Estonian citizen unless the Constitution, this Act, other legislation or a treaty binding on Estonia provides otherwise.

Therefore, all foreigners, who have a residence permit in Estonia, may apply for social services. In addition, according to the Social Code § 3(2) and Social Welfare Act § 8 every person who is in Estonia, has a right to receive emergency care and emergency social assistance regardless of their legal status in Estonia (also people who do not have a legal basis to stay in Estonia).

According to the Aliens Act § 17(1) 3), one condition for applying the residence permit is sufficient legal income which would enable an alien and the family members of an alien the subsistence in Estonia. Legal income is considered a wide range of different opportunities: lawfully earned remuneration for work (as well as possible future income from employment contract at the moment of application process), 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 are deemed to be legal income, etc. The purpose of this provision is to protect a foreigner, who arrives to the foreign country, from falling into a vulnerable situation where he/she is unable to cope himself.

The Committee understanding is correct that the person's residence permit may not be renewed but it will not be withdrawn before its legal expiry, on the sole ground that the person concerned is in need. According to the Administrative Procedure Act § 6, an administrative authority is required to establish the facts relevant to the matter and, if necessary, collect evidence on its own initiative for such purpose. The administrative act should consist of written reasoning for the issue of an administrative act as well as the considerations from which the administrative authority has proceeded upon issue of the administrative act (the Administrative Procedure Act § 56). In the period 2015 up to first 9 months of 2020 there have not been any cases for withdrawal of the residence permit for the sole reason that a foreigner has no sufficient legal income for stay in Estonia.

The Committee cannot accept the necessity of halting the provision of such basic emergency assistance as shelter, guaranteed under Article 13 as a subjective right, to individuals in a highly precarious situation. The Committee has considered that even within the framework of the current migration policy, less onerous means, namely to provide for the necessary emergency assistance while maintaining the other restrictions with regard to the position of migrants in an irregular situation, remain available to the Government with regard to the emergency treatment provided to those individuals, who have overstayed their legal entitlement to remain in the country (Complaint No. 90/2013, Conference of European Churches (CEC) v. the Netherlands, decision on the merits of 1 July 2014, §123).

The provision of emergency social assistance to irregularly present migrants staying in Estonia is organised by the local municipality in whose administrative territory the person is staying at the time he/she is in need of assistance.

Emergency social assistance is provided to persons (irregularly present migrants included) who find themselves in a socially helpless situation due to the loss or lack of means of subsistence which guarantees the persons at least food, clothing and temporary accommodation. Such help is provided to a person until he/she is no longer in a socially helpless situation due to the loss or lack of means of subsistence.

Emergency care provided by hospitals, family doctors and emergency ambulance is free for everybody in Estonia, including for irregularly present migrants.

For more detailed information about emergency assistance for irregular migrants, please see the 14th report of Estonia.

2. to ensure that persons receiving such assistance shall not, for that reason, suffer from a diminution of their political or social rights;

No information requested, except where there was a conclusion of non-conformity or a deferral in the previous conclusion for your country. For conclusions of non-conformity, please explain whether and how the problem has been remedied and for deferrals, please reply to the questions raised.

In 2017 conclusions, the Committee concluded that the situation in Estonia is in conformity with Article 13§2 of the Charter.

3. to provide that everyone may receive by appropriate public or private services such advice and personal help as may be required to prevent, to remove, or to alleviate personal or family want;

No information requested, except where there was a conclusion of non-conformity or a deferral in the previous conclusion for your country. For conclusions of non-conformity, please explain whether and how the problem has been remedied and for deferrals, please reply to the questions raised

In 2017 conclusions, the Committee concluded that the situation in Estonia is in conformity with Article 13§3 of the Charter.

4. to apply the provisions referred to in paragraphs 1, 2 and 3 of this article on an equal footing with their nationals to nationals of other Parties lawfully within their territories, in accordance with their obligations under the European Convention on Social and Medical Assistance, signed at Paris on 11 December 1953.

No information requested, except where there was a conclusion of non-conformity or a deferral in the previous conclusion for your country. For conclusions of non-conformity, please explain whether and how the problem has been remedied and for deferrals, please reply to the questions raised

In 2017 conclusions, the Committee concluded that the situation in Estonia is in conformity with Article 13§4 of the Charter.

Part I – 14. RESC Everyone has the right to benefit from social welfare services

Article 14 – The right to benefit from social welfare services With a view to ensuring the effective exercise of the right to benefit from social welfare services, the Parties undertake: 1. to promote or provide services which, by using methods of social work, would contribute to the welfare and development of both individuals and groups in the community, and to their adjustment to the social environment;

a) Please explain how and to what extent the operation of social services has been maintained during the COVID-19 crisis and whether specific measures have been taken in view of possible future such crises.

The organisation and provision of social services are under the competences of local governments and their practice during the pandemic varies.

Services in care facilities

Due to the spread of COVID-19 in residential long-term care homes the reception of new customers was suspended. Long-term care homes were able to receive new customers only when all isolation measures were taken, incl. testing new customers. One new care home was open for new customers. Due to the spread of COVID-19 within care homes the reception of visitors was refused, and customers were subject to movement restrictions. People in 24-hour special care services and in long-term care homes are not allowed to leave the territory of care home until the end of emergency.

Long-term care home customers experienced loneliness and social isolation. In Saaremaa, the first Estonian region severely hit by COVID-19, laptops were organised by the Estonian Social Insurance Board for long-term care home customers to communicate with their relatives, but the practice was not widespread in all Estonian regions.

Estonian Health Board established national social welfare task force to coordinate COVID-19 responses in long-term care homes, to support the containment, provide guidelines and monitor the situation. Estonia issued guidance, recommendations and information to support service providers in protecting care recipients and staff. Topics covered include working conditions, hygiene, quarantine, safety.

One of the tasks of the social welfare task force was to alleviate the lack of nurses in long-term care homes. It is a common practice in Estonia that nurses take up shifts in both hospitals and long-term care homes. Due to the pandemic, nurses were allowed to work only in one facility (which is often hospital) and long-term care homes reported the shortage of nurses. All problems are solved case-by case. Short time e-training courses for new carers were provided by the Estonian Unemployment Insurance Fund. Voluntary webpage www.vaab.ee gathers information on people who have completed training in medicine and are ready to help hospitals and long-term care homes during the COVID-19 pandemic.

Nursing care facilities continued to provide services to all their current clients. No one was discharged from the nursing care facility and the Estonian Health Insurance Fund extended all current service provision contracts.

Special infection expert teams work in all regions of Estonia, providing at least 2 days on spot counselling in long-term care homes, with possibility for distance counselling in a later stage.

Home-care services and other assistance

Local governments are responsible for the organisation of welfare of the elderly and other people. The majority of Estonian local governments reported that they had been in contact (mainly via phone) with the elderly in their region and reacted with services and assistance, if needed.

The provision of home services continued, and local governments reported on the increasing need for these services. Social workers often provide elderly with food and medicines. In addition, volunteers (for example www.kogukondaitab.ee) offer their assistance in delivering food and medicines. Food stores introduced a recommendation to leave morning hours for risk groups.

Food assistance is organised by local governments and therefore the practice varies. The food assistance is mainly organised in cooperation with Estonian Food Bank. A number of local governments continued to provide school meal for children during the closure of schools, but the concrete target group (for example children from families with coping difficulties etc) and other conditions for school meal are determined by local governments.

Childcare facilities are under the responsibility of local governments, who decides their closure and working arrangements. Depending on local government, parents are exempt or partially exempt from paying for the childcare. The state has not obliged to close the childcare facilities but has called on parents not to bring their children into childcare. Local governments have created possibilities for 24-hour childcare for children of medical workers, policemen, rescue, social service providers etc, but did not report any users.

Helplines, including new crisis helpline 1247, are in operation providing all kind of information about the crisis, emergency situation and related support measures, also offers psychological first aid which is provided in cooperation with the specialists of the 116 006 victim support crisis hotline of the Social Insurance Board. Many local governments established their own helplines during pandemic in spring. A phone-based dementia helpline 644 6440 advices carers of people with dementia also in the COVID-19 related questions. Dementia Competence Centre has elaborated guidelines and recommendations to carers and family members living with people with dementia[12]. Tallinn Children´s Hospital crisis hotline 678 7422 advices workers at the front line of the COVID-19, such as health workers and police, who are worried about themselves and their children.

Support to local governments

As the local governments' revenues have decreased, the Estonian government allocated additional 130 million € financial support to local governments to mitigate the effects of the crisis. 30 million will go to compensate the costs of the crisis (incl. in social sector), 70 million for new investments and 30 million for local infrastructure.

5 million € funding to develop and provide social welfare services, for which need emerged during the crisis, was opened for local governments in August 2020 and will remain opened until the end of funds.

[12] https://eludementsusega.ee/covid-19/, not available in English

The Government allocated additional 550 000 € to victim support and psychosocial crisis assistance.

b) If the previous conclusion was one of non-conformity, please explain whether and how the problem has been remedied. If the previous conclusion was deferred, please reply to the questions raised.

In 2017 conclusions, the Committee concluded that the situation in Estonia is in conformity with Article 14§1 of the Charter. Below are answers to the Committee's questions under Article 14§1.

The Committee takes note of the legislative developments which have taken place outside the reference period and asks that the next report provides information on the impact of these measures in practice.

Ministry of Finance, in co-operation with other ministries, has created a service level assessment tool[13] that compares local governments based on criteria in various sectors, including social welfare. It turns out that when assessing local governments based on selected criteria, unfortunately no Estonian local government reaches the highest level in the field of social welfare. However, it must be noted, that social welfare does not only consist of criteria assessing the availability of services, but it should also consist of, for example, effectiveness, staff and infrastructure indicators.

The Committee notes that the report refers mainly to changes that have been introduced in the rehabilitation services and outside the reference period. The Committee recalls that social services include in particular counselling, advice, rehabilitation and other forms of support from social workers, home help services (assistance in the running of the home, personal hygiene, social support, delivery of meals), residential care, and social emergency care (shelters) (Conclusions 2005, Bulgaria). The Committee further recalls that Article 14§1 guarantees the right to general social welfare services and that the right to benefit from social welfare services must potentially apply to the whole population; the provision of social welfare services concerns everybody who find themselves in a situation of dependency, in particular the vulnerable groups and individuals who have a social problem, therefore, social services must be available to all categories of the population who are likely to need them. (...) (Conclusions 2009, Statement of interpretation on Article 14§1). In this respect the Committee asks that the next report provides updated information on the situation regarding all categories of social services.

The majority of social services are provided or organised by local governments. State provides services that are not reasonable to provide on local level due to their complexity. State-provided social services are for example rehabilitation, special care services and technical aids. Local governments have to provide or organise services listed in the social welfare act but may also establish services needed in their area of governance (for example food delivery, laundry service, sauna service etc).

[13] *Local government assessment tool is available here: https://minuomavalitsus.fin.ee*

Table 44. Social welfare services provided by local governments, 2019

2019	Home care	Support person	Dwelling	Social transport	Personal assistant	Debt counselling	Care of adult persons
Service users	7 274	2 951	17 702	16 886	376	1 935	10 040
Number of local governments providing services	79	75	78	76	39	48	74
% of all local governments	100	95	99	96	49	61	94

Ministry of Social Affairs does not collect data about general care service, shelter service and safe home service.
Source: Ministry of Social Affairs

The capacity of local government to provide social benefits and services depends to a large extent on available budgetary resources by local governments. Ministry of Social Affairs has initiated a number of projects and open calls to support local governments in the development and provision of welfare services.

The Committee takes note of the changes that have taken place outside the reference period and asks that the next report provides updated information on the implementation of the Welfare Plan for 2016-2023.

The Welfare Plan 2016-2023 is implemented through yearly renewable activity programmes. Each branch – employment, social security, social welfare and gender equality - has its own implementation programmes with concrete activities and budget[14]. Achievements of the Strategy are measured by special dashboard[15].

The Ministry of Social Affairs, who is responsible of the implementation of the Welfare Plan 2016-2023 has initiated the process of renewal of the plan. The first revision of targets is done by the Ministry's department of analysis and statistics. The first results of this analysis, published on the Ministry of Social Affairs website[16], emphasize that during the implementation of Welfare Plan:

- objectives of the employment sector were achieved, although the COVID-19 pandemic will have its impact on the employment in forthcoming years;
- absolute poverty rate has decreased to 2,2%, but people in relative poverty (with income less than 573 EUR per month in 2018) has stayed around 21-22%. Unemployed, single parents and elderly are more exposed to poverty. The absolute poverty rate is expected to increase as a result of the COVID-19 pandemic;

[14] Programmes are published on the Ministry of Social Affairs website: https://www.sm.ee/et/sotsiaalministeeriumi-valitsemisala-tegevuspohine-eelarve
[15] *Please see the Strategy's dashboard on Statistics Estonia website: https://juhtimislauad.stat.ee/dashboard/5*
[16] https://www.sm.ee/sites/default/files/hea_ja_lpa_eesmargid.pdf

- the objective to decrease the share of people receiving welfare services in care facilities compared to people receiving welfare services in their homes. Although, a number of activities and support measures have already been initiated (all described in the report of current chapter), Estonian social policy continues to aim at establishing conditions and supporting life in dignity, independent coping, living at home and participation in the society of people with mental special needs and elderly as long as possible.

During the elaboration od new Welfare Plan 2023-2030, special working groups will be established who will analyse the situation in detail and set objectives and activity lines for the next period.

The report indicates that the lack of social services especially in the small local governments and with low population density may hinder the employment and quality care possibilities. 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 to these challenges, the local government reform focuses on the improvement of accessibility and quality of social and other public services. In this respect the Committee asks the next report to provide a detailed information on concrete measures on effective and equal access to social services.

Despite the Estonian long-term goal to increase the provision of home services and decrease the number of institutional service users[17], the organisation of long-term care (LTC) and provision of assistance is mostly institutionalised and there is an unmet demand for services supporting independent living at home. In the absence of LTC services organised and financed by the local governments or centrally by the state (for example special care services, rehabilitation, technical aids), the burden of care falls disproportionately to informal caregivers. Informal LTC is most frequently delivered by the family and/or their friends. According to Statistics Estonia, approximately 60,000 have care responsibilities[18], this includes more than 8,100 persons who are not in paid work due to their care obligations and about 6,500[19] have been forced to take a part-time job due to the need to take care of their family member. 15% of people over 50 have been forced to reduce working hours, change the employment or exit the labour market within the past 24 months due to the need to take care of their family member or a close person[20].

It is known for policy makers, that the accessibility and quality of social services depend on the local government. Local government's capacity to provide social services depends to a large extent on the local government's budgetary resources available. Although local governments are obliged to follow legal obligations in providing LTC services, they have broad powers and a large degree of freedom in defining the service packages, prices and volumes of the services. As their capacities to fund and provide services are unequal, access to and quality of LTC services depends largely on the residence of the beneficiary. The main challenge in forthcoming years is to develop a policy framework for a long-term care organisation and to define the role of informal carers in legislation.

[17] The Estonian Welfare Development Plan 2016-2023 sets the target to increase the proportion of people who receive home based care non-institutional services, which support independent coping at home, and day-and-night institutional care services from 1,4 in 2014 to 2,2 in 2023. For additional information, please see: https://www.sm.ee/sites/default/files/content-editors/eesmargid_ja_tegevused/welfare_development_plan_2016-2023.pdf

[18] Estonian Social Survey, 2019, Statistics Estonia

[19] Estonian Labour Force Survey, 2018, Statistics Estonia

[20] Coping of Older People and the Elderly Survey, Ministry of Social Affairs, 2015, https://www.sm.ee/sites/default/files/content-editors/Ministeerium_kontaktid/Uuringu_ja_analuusid/Sotsiaalvaldkond/veu2015aruanne_tnsemorsapraxis_final.pdf

Long-term care has been on the political agenda during recent years. Number of measures have been initiated to support local governments in social services elaboration and provision.

- A special high-level task force was assembled at the Government Office from 2016 to 2017. The aims of the task force were to analyse the long-term care organisation in Estonia[21], develop general policy guidelines and propose solutions to decrease the care burden. The task force concluded that long-term care organisation in Estonia could be improved by offering high-quality integrated social and health care services at both a state and local level, according to actual needs[22].

- First proposals about reorganisation of long-term care in Estonia were approved by the Cabinet of Ministers in December 2018. The measures[23], with the total budget of 16,4 MEUR, included:
    1) flexible day and weekly care service for people with a mental disability, launched on the 1st of January, 2018;
    2) establishment of Dementia Competence Center (DCC) in September 2018 and adaptation of places in care homes according to the needs of people with dementia;
    3) person-centred coordination model with a focus on people with complex care needs, launched in 2018;
    4) introduction of carer's leave for carers of adult family member. A new leave form entered into force under the Employment Contract Act from 1st of July 2018. Employees can use additional leave (5 days per calendar year) to care for an adult family member with a profound disability. The leave allowance is compensated based on minimum wage that has been established by the ECA (minimum wage in 2019 is 540 €).

- The Ministry of Social Affairs started the preparations for elaboration of long-term care financing schemes at the beginning of 2019. The preliminary long-term care project was combined with a project to modernize policy for people with special needs. A project "Modernizing long-term care arrangements and policies for people with special needs" was developed.

- In 2019, in close cooperation with social partners and stakeholders, thematic working groups and Advisory Board were set up. The working groups developed three possible long-term care management and financing models. The Cabinet of Ministers decided between three fundamental choices: 1) a needs-based local government and state partnership model; 2) solidarity-based care insurance model; 3) state long-term care model where long-term care is organized at national level. The preference was given to continue with the development of the new needs-based local government and state partnership long-term care management and financing model. In principle, the new model will be based on the current LTC management and financing structure, reinforced by more support from the state to local governments:
    1) The state will develop LTC services that are not possible or reasonable to develop on local level and local governments shall have the opportunity to purchase these services from the state.
    2) A common voluntary standardised needs assessment tool and methodologies to assess LTC needs will be developed. Guidance materials will be elaborated and counselling and training will be made available for local governments.

[21] For additional information, please see the World Bank Group analysis on reducing the burden of care in Estonia (2017), https://www.riigikantselei.ee/sites/default/files/content-editors/Failid/hoolduskoormus/estonia_ltc_report_final.pdf

[22] For additional information, please see the Task Force's final report (only in Estonian): https://www.riigikantselei.ee/sites/default/files/content-editors/Failid/hoolduskoormus/hoolduskoormuse_rakkeruhma_lopparuanne.pdf

[23] For the description of measures and initial result, please see respective parts of the current report.

3) Additional earmarked financial incentives for the organisation of LTC will be granted to local governments through a state support fund, while local governments are expected to match LTC funding with these state allocations.

In addition, a guaranteed monthly minimum income after co-funding LTC services will be established. Local governments shall be obliged to assess the financial capacity and guarantee that out-of-pocket payments will not jeopardise that LTC needs of service users remain met. As a fundamental change, a proposal to exempt second-degree descendants and ascendants from the maintenance obligation was made.

- Necessary legislative amendments will be elaborated during 2020 to 2021 and the new LTC concept is to be implemented in 2022 at the earliest. Experts have assessed that the Estonian LTC system needs additional investments of at least 150 million euro to provide more access to LTC services, support the LTC workforce and to decrease the share of out-of-pocket payments by service users.
- Proposals to alleviate the informal care burden and support informal caregivers are currently being prepared by the Ministry of Social Affairs and will be submitted to the government for discussion and decision in the near future.

Estonian social policy aims at establishing conditions and supporting life in dignity, independent coping, living at home and participation in the society of people with mental special needs and elderly as long as possible. The precondition for independent living is the existence of high-quality social infrastructure and availability of social services that help to prevent institutionalisation.

Several measures and projects have been introduced to support local governments in the development and provision of social services.

- In 2018, Estonia introduced a new special day- and weekly care service for adults with moderate, severe or profound intellectual disability who require major care, supervision and assistance. Service's aim is to allow intellectually disabled person to live at home and the caregiver to be enrolled with employment or studies. In 2019, special funds were allocated from state budget to support local governments in establishing the service places. Altogether, 245 service places have been created by 31.10.2020. Estonia has also launched a special 24-hour care service for people with autism spectrum disorders.

- Piloting and implementation of new flexible coordination model. The first pilot project (ended in 31.07.2019) on care coordination was carried out in six Estonian regions[24]. The project has helped identify shortages and find possible solutions how to help persons with unmet needs and their families in best way possible. The project indicated the importance of care coordinator functions. However, it became clear, that not all regions in Estonia would benefit from a care coordinator role per se, but more flexible model, taking into account local circumstances might be beneficial for some local governments. From mid-2020 to the end of 2021, an improved model is implemented in 6 Estonian regions and is expected to widen to 12 regions by 2022.

- Piloting of new social transportation models. In 2018 a pilot program in five counties started to test different social transport delivery models. During the pilot program, partners will organise the logistics and operator service of social transport. As a result, the model or models of the social transport, which take into account the specificities of the regions, are cost effective, connected to public transport etc., will be elaborated. The pilot program lasts until the end of 2022.

[24] Six regions, where care coordination project was implemented, were: Tallinn (Haabersti District Government), Tartu, Saaremaa together with Ruhnu and Muhu islands, Tori, Tõrva together with Valga and Otepää and Rakvere municipalities.

- Open calls for social services for persons with disabilities and elderly. There have been three rounds of open calls for local governments, but also private and third sector service providers to develop social welfare services for persons with disabilities and the elderly. Supported activities were implementation of support person service, personal assistance service, day-care centres, interval-care and home-care service, counselling services and support groups for people with care burden and integrated welfare services. 45 projects are currently being implemented in most of the regions in Estonia.

- Empowering local municipalities with special support team in Social Insurance Board. Since 2019, the social welfare unit that contributes to the implementation of welfare policies and to the coordination of cross-sectoral cooperation was created in Social Insurance Board. The unit provides strategic, operational and case-based counselling for local governments in performing their social welfare tasks. Common workshops, trainings and information seminars are organized to raise awareness among local municipalities and service providers.

- Addressing the needs of local municipalities in North-East Estonia. Local municipalities in North-East Estonia differentiate from the local municipalities of other regions for their small contribution to the development of social services at the regional level. A special mentoring programme to the North-East Estonian local municipalities was developed in December 2019. The programme aims at strengthening the government support to municipalities in their performance of social welfare tasks; support the development of social welfare organisation at local level and harmonising and enhancing the quality of welfare measures at the local level. As the result of the mentoring programme, North-East Estonian local governments are expected to increase the participation and quality of the applications in the open calls and other state-financed measures that support the design and provision of social welfare measures and services. The mentoring programme ends in 2021 with open calls for projects in social welfare.

- Improving energy efficiency of local government long-term care homes. In 2017 and 2019 two open calls for municipalities under the measure “Energy Efficiency of Municipal Buildings and the Construction of Energy Efficient Buildings” were carried out. Local governments had a possibility to apply for financial support for adaptation of existing long-term care homes to follow energy efficiency requirements (12 grant recipients in 2017 and 9 grant recipients in 2019) or to build new nearly zero energy long-term care homes (11 grant recipients in 2019).

- Adaptation of homes of people with special needs. Local governments are financially supported in adaptation of homes of persons with special needs for improvement of mobility and access to the building or dwelling, improvement of personal hygiene or improvement of kitchen facilities. Two calls for applications have been carried out in 2018 and 2019. Adaptation of homes for 472 persons with disabilities were supported in the first round (2018); and for 1229 persons in the second round (2019). Third round on applications is currently opened. In total, 2000 homes of persons with special needs will be adapted between 2017-2022.

The report indicates that 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, elaborated service specific guidelines in 2011. Since then those guidelines have been implemented during the reference period and are going to be further developed with the elaboration of specific general social services quality guidelines that will be operational from 2017. In order to make the monitoring system effective and beneficial for the improvement of quality of social services, the Ministry of Social Affairs has initiated the concept of advisory monitoring which has started in the Centre for Quality in Social Services established in 2012 as EQUASS Competence Centre and has enlarged

its duties since then. In this respect the Committee asks to know about the impact in practice of these measures.

Social services quality surveillance and development is under the competences of Estonian Social Insurance Board, that took over the previous work done by the Astangu Vocational Rehabilitation Centre's work in social services quality development. Since 2019, the local government support unit that contributes to the implementation of welfare policies and to the coordination of cross-sectoral cooperation was created in Social Insurance Board. The unit has elaborated general social services guidelines and service-specific guidelines[25]. The unit provides strategic, operational and case-based counselling for local governments in performing their social welfare tasks. Common workshops, trainings and information seminars are organized to raise awareness among local municipalities and service providers.

Equass competence centre was closed and Equass is not centrally financed any more. However, organisations may continue to implement Equass principles on their own initiative. Estonian Association for Quality continues to be the cooperation partner for Social Insurance Board. In 2020, development social services quality will be one of the action lines for Estonian Association for Quality[26].

The report indicates that the Special Care Development Plan 2014-2020, approved by the Minister of Social Protection in September 2014, prioritise the development of supportive services, focusing on community-based development of person-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. In this respect the Committee asks to receive updated information on the result of the Special Care Development Plan 2014-2020.

Transition from institutional to community-based care is one of the priorities in Estonia. The initial plans for the process were made more than a decade ago. Gradual deinstitutionalisation of special care was set as a goal in the Reorganisation of State-Owned Special Care Institutions and Services Plan in 2006. Welfare development plan[27] is continuing a similar course of development of the field of welfare services for 2016–2023. The process includes providing services in smaller, home-like units, developing and providing community-based, supportive services for preventing the need for institutionalisation and enabling people to live independently.

We had two open application rounds for granting support for the measure "Reorganization of special care institutions", which is part of the activities of the European Regional Development Fund`s measure in Estonia "Development of welfare infrastructure, adaptation of the environment to meet the needs of people with disabilities". The aim of the reorganization is to ensure better living, studying and working conditions for people with special mental needs.

By 2023, it is planned to close 8 large special care homes and reorganize 1025 service places into small groups in the middle of communities (of which at least 322 24-hour special care service places will be replaced with community-based service places) and create an additional 525 community-based service places.

[25] Guidelines are available: https://www.sotsiaalkindlustusamet.ee/et/kvaliteet-ja-jarelevalve/kvaliteedijuhised#Eesti%20sotsiaalteenuste%20kvaliteedijuhis (only in Estonian)

[26] https://www.eaq.ee/sotsiaalteenuste-sektori-toetamine-ja-arendamine-uuel-eku-strateegiaperioodil/

[27] https://www.sm.ee/sites/default/files/content-editors/eesmargid_ja_tegevused/welfare_development_plan_2016-2023.pdf

The goal of the Special Care and Welfare Development Plan for 2014–2020[28] was that by the end of 2020, the share of people with special mental needs receiving 24-hour special care services living in accommodation units with more than 30 people needed to decrease from 65% to 30%. By 2020 the goal has been achieved.

For supporting transition from institutional to community-based care Estonia has started service design in special care service (financed by the European Social Fund). The aim of service design is to work out integrated, person-centred and flexible special care service system. In 2018, the first service design pilot project ended. The aim of the project was to analyse the special care system and design it according to the needs of the clients and principles of deinstitutionalisation. During the project, a pilot was carried out testing the possibilities of local governments to greater role in organising the services to people. Initial testing showed positive results but at the same time it brought out some issues and flaws. For more testing and solving the problems that had arisen the next pilot started at the end of 2019. Person-centred care model allows the person with mental disorder to live at home as long as possible and get different services he or she needs, from local government or organized by local government.

There are several new services developed for specific target groups in the area of special care services:

- daily- and weekly care service for adults with moderate, severe or profound intellectual disability who require major care, supervision and assistance. Services' aim is to allow intellectually disabled person to live at home and the caregiver to go to work;
- daily- and weekly care and 24-hour special care for people with autism spectrum disorders and with radically harmful behaviour.

New services significantly reduce the care load of the family members of the persons with mental disability.

To improve the access to state welfare services changes have been made to increase the budget. Overall budget (for the three state services: social rehabilitation, technical aid and special care services) was 64 M € in 2019 (in 2017 was 42 M €, in 2018 52 M €).

Beginning from the spring 2019 the Social Insurance Board case managers use a special evaluation tool for assessing the need for assistance and care of the persons with mental disability.

In its previous conclusion (Conclusions 2013) the Committee asked to know how many complaints have been lodged at local level and how many have been dealt with regarding quality control of social services. The report states that the Ministry of Social Affairs does not collect information about the complaints lodged at local level. However, in the framework of yearly monitoring, the local governments may present the number of complaints submitted during the year, but this practice is not very common. Only few local governments submit the number of complaints. Most of the complaints are on the granting and payment of subsistence and other benefits. Nevertheless, the report indicates that the low and scarce number of complaints shows 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 of 2016) and other activities such as, information articles about social services, dissemination of information via Ministry's website the Ministry of Social Affairs has planned to raise public awareness about user's rights, including enforcement and empowerment of advocacy organisations. The Committee takes note of the reply and requests that the next report provides information on the improvement following the elaboration and dissemination of service-based quality guidelines by the government,

[28] https://www.sm.ee/sites/default/files/content-editors/eesmargid_ja_tegevused/Sotsiaalhoolekanne/Puudega_inimetele/special_care_2014-2020.pdf

regarding raising public awareness about user's rights, including enforcement and empowerment of advocacy organisations.

Social services quality surveillance and development is under the competences of Estonian Social Insurance Board. Since 2019, the local government support unit that contributes to the implementation of welfare policies and to the coordination of cross-sectoral cooperation was created in Social Insurance Board. The unit has elaborated general social services guidelines and service-specific guidelines[29]. The unit provides strategic, operational and case-based counselling for local governments in performing their social welfare tasks. Common workshops, trainings and information seminars are organized to raise awareness among local municipalities and service providers.

Advocacy organisations in social welfare (for example Estonian Foundation of Disabled People, Estonian Union of Pensioners Associations etc) have been financed mainly through gambling tax on yearly basis. Project based financing has resulted in a situation where their voice in policy development and public awareness is not as strong as it would be and cooperation between organisations is not as good expected. Therefore, in 2019 amendments to the Gambling Tax Board regulation reorganised the financing of NGOs. Instead of yearly projects, strategic partnership for at least two years was established in social sector.

Regarding the request from the Committee to know about the ratio number of staff to users, the report indicates that the Ministry of Social Affairs does not monitor and publish the requested information regularly. The survey on social workers referred in the previous report, was one fold and currently no other surveys are planned. In this respect the Committee reiterates its request to know about the ratio number of staff to users in social services.

Ministry of Social Affairs does not regularly collect data about the workforce in social welfare. Recent survey on social welfare workforce education and skills was carried out in 2016[30]. The survey presented current workforce in welfare sector (please see Table 45) and predicted the need for following 5 years. The report prognosed that the increasing need is for local government social workers, social care workers due to the ageing of population and support persons. The decline in need will occur in childcare and management.

Table 45. Number of workforce in social sector, 2016

		Number of workforce
Management and high-level specialists	Managers	640
	Social workers and counsellors	2530
Intermediate specialists and personal carers	Childcarers and personnel in substitute homes	2750
	Care workers (incl. in institutions, home care and healthcare)	2060
	Activity supervisors	1350

[29] Guidelines are available: https://www.sotsiaalkindlustusamet.ee/et/kvaliteet-ja-jarelevalve/kvaliteedijuhised#Eesti%20sotsiaalteenuste%20kvaliteedijuhis (only in Estonian)

[30] Please see the report on https://oska.kutsekoda.ee/field/sotsiaaltoo/ and summary in English: https://oska.kutsekoda.ee/wp-content/uploads/2016/05/Sotsiaalt%C3%B6%C3%B6_ENG.pdf

	Support persons	475
TOTAL		9805

Source: OSKA report, 2016

Next survey on similar basis and with similar methodology is currently being prepared and will be carried out in 2021. The survey will present information on social welfare workers education, skills and needs in 5- and 10-years perspective.

2. to encourage the participation of individuals and voluntary or other organisations in the establishment and maintenance of such services.

a) Please provide information on user involvement in social services ("co-production"), in particular on how such involvement is ensured and promoted in legislation, in budget allocations and decision-making at all levels and in the design and practical realisation of services. Co-production is here understood as social services working together with persons who use the services on the basis of key principles, such as equality, diversity, access and reciprocity.

There is no general approach in user involvement in social services. There are some scarce examples of good practices, but this method is gaining continuously more attention.

1) Garage 48 on Estonian wellbeing[31] was initiated in 2017 to find innovative ideas for the development of Estonian people's wellbeing.
2) „Vunki mano" is a series of social hackathons where everyone is welcome to participate in developing innovative services and working on solutions that promote life in Võru county[32].
3) Person centred service design pilot project in special care to increase the involvement of local governments in the service provision of this target group[33].
4) A green paper on technological innovations in social welfare[34] (approved by the Government in June 2020) proposes possibilities to implement new technological solutions, service models, and increase awareness and skills in the provision of high-quality LTC services. Technological (including digital and distance-spanning) solutions could support living at home by increasing wellbeing and quality of life. However, the use of these solutions has not been very active in Estonia, capacity needs to be improved and implementation actively supported in the forthcoming years. Support for the use of innovative solutions includes enabling a wider use of different assistive technologies both at home and in the provision of different services outside the person's home. Also, activities that promote the quality, availability and effective (remote) monitoring must be supported.

[31] https://garage48.org/events/idea-garage48-wellbeing
[32] https://vunkimano.ee/
[33] https://www.sotsiaalkindlustusamet.ee/et/puue-ja-hoolekanne/erihoolekandeteenused/isikukeskse-erihoolekande-teenusmudeli-rakendamine
[34] https://www.sm.ee/sites/default/files/news-related-files/roheline_raamat_tehnoloogiakasutuse_suurendamine_inimese_igapaevase_toimetuleku_ja_heaolu_toetamiseks_kodus.pdf

b) If the previous conclusion was one of non-conformity, please explain whether and how the problem has been remedied. If the previous conclusion was deferred, please reply to the questions raised

In 2017 conclusions, the Committee concluded that the situation in Estonia is in conformity with Article 14§2 of the Charter pending receipt of the information requested below.

The report indicates that 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. In this respect the Committee asks to know what are the quality criteria that service providers must meet.

Quality criteria for social services were introduced in the new Social Welfare Act[35] in 2016. The act regulates purpose of the services, description of the content of the services and concrete requirements for service providers and, in certain cases, for persons who provide services directly to clients. Government of the Republic or Minister may establish additional quality requirements for services listed in the Social Welfare Act, however, this possibility has not been used.

For all services regulated by the Social Welfare Act, objective and content of the service, obligations of local authorities, requirements for service providers, and if necessary, for persons directly providing services are established. For example, many services are not allowed to provide by person whose criminal record for an intentionally committed criminal offence may endanger the life, health and property of the person entitled to receive the service. For support person service, the direct ascendants or descendants are not allowed to provide service. For some services for example childcare, debt counselling), additional education and training requirements are established.

Since 2018, general social services quality criteria are established in the law[36]: provider of social services must proceed from generally accepted quality principles: person-centeredness, empowering nature of the service, orientation towards outcome, needs-based approach, integral approach, protection of a person's rights, involvement, competence and ethics of the employee and the good work organisation and high-quality management of the organisation.

Quality unit in the Estonian Social Insurance Board monitors the fulfilment of quality criteria established by the Social Welfare Act, and issues activity licences for general care homes. Other Agencies, for example Health Board, Veterinary and Food Board, Labour Inspectorate, State Agency of Medicines and Rescue Board perform monitoring according to their competences. Chancellor of Justice monitors the fulfilment of human rights.

Local Government Counselling Unit of the Estonian Social Insurance Board has elaborated general social services guideline and specific guidelines for social services, altogether for 18 services in 2020[37].

The Committee notes that the report provides information outside the reference period and asks that the next report provides updated information and developments following the adoption of the

[35] Social Welfare Act, adopted 9.12.2015, entered into force 01.01.2016 (with some paragraphs enforced later), published RT I, 30.12.2015, 5, https://www.riigiteataja.ee/akt/121042020038

[36] Amendments to the Social Welfare Act, adopted 15.11.2017, entered into force 01.01.2018, published RT I, 28.11.2017, 2, https://www.riigiteataja.ee/akt/128112017002

[37] Please see social services giudelines on Social Insurance Board website: https://www.sotsiaalkindlustusamet.ee/et

new Welfare Development Plan 2016-2023, in particular on activities for raising public awareness about the rights and provision of social services and empowerment of people and representative organisations of different user's groups.

In 2019, local government advisory unit that supports local governments and contributes to the implementation of welfare policies and to the coordination of cross-sectoral cooperation was created in Social Insurance Board. The unit provides strategic, operational and case-based counselling for local governments in performing their social welfare tasks. Common workshops, trainings and information seminars are organized to raise awareness among local municipalities and service providers. Local government advisory unit regularly publishes information materials, data, guidelines etc on its website[38] and advices both single persons and local governments.

Organisations of advocacy organisations in social welfare (for example Estonian Foundation of Disabled People, Estonian Union of Pensioners Associations etc) have been financed mainly through gambling tax on yearly basis. In 2019, an analysis about the financing of disability organisations was carried out in order the find possibilities for better organisation, sustainability and clarity in the provision of financial support. Since 2019, amendments to Gambling Tax Board regulation reorganised the financing of NGOs. Instead of yearly projects, the at least two years strategic partnership was established. In December 2019, the Estonian Foundation of People with Disabilities, Estonian Food Bank, Estonian Union of Pensioners Association and NGO "Kuldne Liiga" were chosen as strategic partners in social welfare.

In case of elderly, for example, cooperation between different organisations is not as good as expected and the elderly's voice in policy development and public awareness is not as strong as it should be. Therefore, the Ministry of Social Affairs initiated a two-year strategic partnership with elderly organisations. Two leading partners are tasked with development of training programmes for elderly advocacy organisation to raise their competences in cooperation and networking, policy development, advocacy and media relations. As the result, it is expected that elderly organisations themselves are ready to lead the cooperation networks and represent the opinion of the elderly more strongly and in a better-coordinated manner.

During 2014-2015, the Gambling Tax Board and National Foundation of Civil Society have financed a development programme on social entrepreneurship and programme on increasing the potential of public services in the social sphere through inclusion of volunteers. The selected projects aimed to give practical professional counselling and training in the establishment and development of social enterprises and inclusion of volunteers in their activities. In this respect, the Committee asks to know whether and how the government ensures that services managed by the private sector are properly and effectively supervised and that private services are accessible on an equal footing to all.

Social Welfare Act establishes certain quality requirements for service providers, for example educational requirements and/or activity licence. The latest quality requirement is for general care homes – since 2020, all general care homes must have activity licence. Activity licences are issued by Estonian Social Insurance Board. Social Insurance Board is also responsible for quality monitoring of social services.

Pilot project for testing volunteering in welfare system was carried out in 2018-2020. The aim of the project was to increase awareness of local municipalities about the possibilities of involving

[38] For more information please see: https://www.sotsiaalkindlustusamet.ee/et/kvaliteet-jarelevalve/kohaliku-omavalitsuse-noustamisuksus

volunteers in helping people with special needs and the elderly, and develop a suitable model for engaging volunteers in Estonia. The project addressed loneliness of elderly and improvement of social inclusion of older people. Volunteers provided company (conversation, reading, handicraft), accompanied people (in shopping, visiting doctor, social events), helped with homework (cleaning, gardening) and assistance in storing memories. Project was carried out in 43 municipalities in 12 regions of Estonia.

Within the project volunteers provided company or assisted elderly and people with special needs wherever they were staying (home, residential care, hospital etc). Altogether, 237 volunteers participated in the project (50% of them were 55 years and older) who provided help and company to 70 persons. The results show that voluntary support improved participants livelihood (77%), independency and coping with daily activities (42%), allowed to continue living at home (23%) instead of moving to institutional care, etc. As a result, in 2021 it is planned to implement the developed volunteering model all over Estonia. The Cabinet of Ministers approved respective proposal in December 2020.

Part I – 30. RESC Everyone has the right to protection against poverty and social exclusion

Article 30 – The right to protection against poverty and social exclusion

With a view to ensuring the effective exercise of the right to protection against poverty and social exclusion, the Parties undertake:

a. to take measures within the framework of an overall and co-ordinated approach to promote the effective access of persons who live or risk living in a situation of social exclusion or poverty, as well as their families, to, in particular, employment, housing, training, education, culture and social and medical assistance;

b. to review these measures with a view to their adaptation if necessary.

a) Please provide detailed information on measures (legal, practical and proactive, including as regards supervision and inspection) taken to ensure that no person drops under the poverty threshold, and provide also information on the impact of the measures taken. Please indicate how many people in your country are at risk of poverty, how many in a situation of poverty, and how many in extreme poverty, including specific data for children.

Support for active labour market participation as well as for activating, adequate, and sustainable social protection help to increase the economic coping of people. Information on specific measures for preventing and alleviating poverty are provided under the questions below.

In 2018, 21.7% or 284 300 people of the Estonian population lived in relative poverty or below the relative poverty line. 2.2% of the Estonian population lived below the absolute poverty line or with less than the estimated minimum means of subsistence. Both – absolute poverty and at-risk-of poverty have decreased slightly during last year, as in 2017, 21.9% of Estonia's population lived in relative poverty and 2.7% in absolute poverty. The following table describes recent changes in absolute poverty and at-risk-of-poverty rate during 2015-2018.

Table 46. At-risk-of-poverty rate and absolute poverty rate by sex and age group, 2015-2018, %

		At-risk-of-poverty rate, %			Absolute poverty rate, %		
		Total	**Males**	**Females**	**Total**	**Males**	**Females**
2015	Total	21.7	19.2	24.0	4.3	5.0	3.7
	0-17	18.6	19.1	18.2	5.1	4.8	5.5
	18-64	17.1	17.8	16.5	4.9	5.7	4.1
	65 and older	40.2	26.1	47.4	1.3	..	1.1
2016	Total	21.0	18.4	23.3	3.2	4.0	2.6
	0-17	16.5	16.6	16.3	3.5	4.0	2.9
	18-64	16.2	16.9	15.6	3.9	4.6	3.3
	65 and older	41.2	28.4	47.8	0.8	..	..

2017	Total	21.9	19.3	24.2	2.7	3.6	1.9
	0-17	15.2	14.6	15.8	2.5	2.2	2.8
	18-64	16.4	17.4	15.3	3.5	4.6	2.4
	65 and older	46.4	35.0	52.3	..	..	..
2018	Total	21.7	19.3	23.7	2.2	2.7	1.7
	0-17	17.2	16.9	17.4	1.6	0.9	2.3
	18-64	16.1	17.4	14.9	3.0	3.8	2.2
	65 and older	43.7	31.9	49.9	..	..	..

.. data have not been calculated; data not available; unreliable data due to small size of the sample.
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 2018, the median equalised disposable income stood at 11 461 euros per household member per year. The at-risk-of-poverty threshold (i.e. 60% of the median income) was 6 877 euros per consumer per year. In 2018, people with a monthly equalised disposable income below 573 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 2018, the absolute poverty threshold was 215 euros per consumer per month. The following table shows the recent changes in yearly disposable income and poverty threshold.

Table 47. Equalised yearly disposable income and poverty threshold, 2015–2018 (in euros)

	2015	2016	2017	2018
Mean equalised yearly disposable income	10 102.21	10 697.88	11 750.4	12 779.98
Median equalised yearly disposable income	8644.68	9384.24	10 530.89	11 460.92
Yearly at-risk-of-poverty threshold	5186.81	5630.54	6318.53	6876.55
Monthly absolute poverty threshold	201.41	200.12	207.23	215.44

Source: Statistics Estonia

The depth of relative poverty can characterise by the poverty rate upon different poverty thresholds: 40%, 50% or 70% of median equalised income. The threshold at 40% of median equalised income distinguish the persons with the lowest resources living in relative poverty (see the following table).

Table 48. Poverty rate by poverty threshold and age group (%) in 2015-2018

		Total	**0-17**	**18-64**	**65 and older**
2015	40% of median income	6.5	6.3	7.3	4.0
	50% of median income	13.1	12.3	12.3	16.5
	60% of median income	21.7	18.6	17.1	40.2

	70% of median income	29.3	24.5	22.8	56.0
2016	40% of median income	6.5	5.9	7.4	3.9
	50% of median income	13.0	10.4	11.4	20.8
	60% of median income	21.0	16.5	16.2	41.2
	70% of median income	28.9	23.0	21.6	58.9
2017	40% of median income	6.6	5.3	7.5	5.1
	50% of median income	13.9	9.2	10.9	28.2
	60% of median income	21.9	15.2	16.4	46.4
	70% of median income	30.1	23.4	22.0	62.9
2018	40% of median income	6.3	5.3	7.0	5.2
	50% of median income	13.9	10.0	11.2	26.2
	60% of median income	21.7	17.2	16.1	43.7
	70% of median income	29.6	24.4	22.0	59.1

Source: Statistics Estonia

A comparison of the population groups reveals that in Estonia, relative poverty threatens women, disabled people, and the unemployed the most. In 2018, the at-risk-of-poverty rate was 23.7% for women and 19.3% for men. Men's poverty, on the other hand, is deeper. For women, the absolute poverty rate was 1.7% and the relative median at-risk-of-poverty gap was 20.9%, whereas for men these indicators stood at 2.7% and 26.6%, respectively.

In 2018, the relative poverty rate for disabled people was 43.5% and the absolute poverty rate was 1.2%. The relative poverty rate of disabled people has increased during the reference period, in contrast to absolute poverty.

Among unemployed, retired and other inactive persons, 43.9% lived below the at-risk-of poverty threshold in 2018 and 3.8% lived below the absolute poverty threshold. In 2018, the relative poverty rate of persons not at work was more than 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 52.6% of them living in relative poverty and 16.4% in absolute poverty. Among the employed population, 10% of wage employees lived in relative poverty and 1.5% in absolute poverty in 2018. 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 2018, 28.4% of entrepreneurs lived in relative poverty and 9.3% in absolute poverty. The changes in poverty rates according to main labour status are listed in the following table.

Table 49. At-risk-of-poverty rate and absolute poverty rate by main labour status and sex, 2015–2018, %

		At-risk-of-poverty rate, %			Absolute poverty rate, %		
		Total	Males	Females	Total	Males	Females
2015	Employed	9,6	9,9	9,3	2,3	3,0	1,7
	..wage employee	7,7	7,0	8,3	1,1	1,4	0,9

	..self-employed	26,1	27,6	23,1	12,6	12,8	11,9
	Not at work	40,5	36,6	42,9	6,6	8,9	5,1
	..unemployed	54,8	62,1	44,0	28,1	30,6	24,4
	..retired	45,0	31,2	52,0	1,9	2,4	1,7
	..other inactive	30,8	35,5	27,6	8,7	10,2	7,7
2016	Employed	9,3	9,7	9,0	2,1	2,5	1,6
	..wage employee	7,7	7,6	7,8	1,0	1,0	1,0
	..self-employed	23,5	22,9	25,0	11,1	11,9	9,4
	Not at work	41,2	37,1	43,7	4,9	6,8	3,7
	..unemployed	50,1	52,3	46,2	20,0	21,0	18,4
	..retired	46,1	33,6	52,6	1,0	..	0,9
	..other inactive	31,8	37,2	28,2	8,2	9,9	7,0
2017	Employed	9,3	9,5	9,0	1,6	1,9	1,2
	..wage employee	8,5	8,7	8,3	1,1	1,4	0,7
	..self-employed	16,6	15,4	19,0	6,3	5,6	..
	Not at work	46,1	43,1	47,9	4,7	7,9	2,6
	..unemployed	51,9	60,9	39,5	18,7	24,9	..
	..retired	53,7	43,2	59,1	0,7	..	..
	..other inactive	33,3	38,9	29,2	7,9	11,4	5,4
2018	Employed	10,0	11,0	9,0	1,5	2,1	0,8
	..wage employee	8,0	8,5	7,6	0,6	..	..
	..self-employed	28,4	27,4	30,7	9,3	10,6	..
	Not at work	43,9	39,3	46,8	3,8	5,6	2,6
	..unemployed	52,6	57,8	46,0	16,4	19,9	..
	..retired	51,0	39,4	56,9	..	..	..
	..other inactive	31,0	35,1	28,0	6,6	8,1	5,4

.. data have not been calculated; data not available; unreliable data due to small size of the sample.

Source: Statistics Estonia

The relative poverty of children decreased from year 2015 (18.6%) until 2017 (15.2%). In 2018, the indicator increased by two percentage points, that means, 17.2% of children lived below the relative poverty line. The absolute poverty rate of children has decreased since 2013 and was 1.6% in 2018 (see table 1). Social transfers have an important impact on reducing the child poverty, but lower absolute poverty rate for children is also in relation to better household employment situation. Due to recession, the share of children (aged 0–17) living in unemployed household increased to 12.9% in 2010, but it has decreased to 7.3% by 2019. Also, the poverty of families with children has decreased during the reference period, especially the poverty of families with at least three

dependent children. In 2018, the relative poverty rate of these families was 15% (for comparison, in 2015 the relative poverty was 28.8%). The absolute poverty rate of these families was 1.6% in 2018 (in 2015, 7.5%). Also, the absolute poverty rate of single-parent families has decreased to 4.6% (in 2015, 6.7%).

Traditionally, social transfers help significant number of people out of poverty. In 2018, social transfers (including pensions) reduced relative poverty of the population by 45% (before social transfers 39.3% of the population lived in relative poverty, while after social transfers – 21.7%). Social transfers (including pensions) reduced absolute poverty of the population by 90% (before social transfers 22.7% of the population lived in absolute poverty, while after social transfers – 2.2%).

b) Please provide information on measures taken to assist persons affected by poverty, social exclusion and homelessness during the COVID-19 crisis, or after the crisis to mitigate its effects.

The responsibility of assisting people affected by poverty, social exclusion and homelessness is in the competences of local governments.

During the COVID-19 crisis, local governments continued the provision of social services and payment of benefits and allowances. COVID-19 outbreak did not bring along rapid growth of people in financial need as we expected. Local authorities, who are responsible of granting and paying out the subsistence benefit, have discretion to take into account the person's situation, wealth and assets as well as general circumstances in the country. In certain conditions (as COVID-19 crisis), local governments were given a right to establish more favourable conditions for granting the subsistence benefit.

Since May we have noticed a slight increase in the number of subsistence benefit receivers (please see data from report on Article 13). The consequences of the pandemic are projected to lead a significant increase in unemployment rate in autumn 2020, which in turn means, that a large proportion of people will need social assistance with some delay. It is also projected, that families needing support will need it for a longer period of time. In connection with this, additional funding for the subsistence benefit is foreseen from the state budget in the following years.

Due to the COVID-19 pandemic, the provision of some services (for example day care) had to be cancelled while the need for other services (for example home care) has emerged. Local governments reacted to the changed need and nobody was left helpless. For example, local government reported they have been in contact (mainly via phone) with the elderly in their region and reacted with services and assistance, if needed.

The provision of home services continued, and local governments reported on the increasing need for these services. Social workers often provided elderly with food and medicines. In addition, volunteers (for example www.kogukondaitab.ee) offered their assistance in delivering food and medicines. Food stores introduced a recommendation to leave morning hours for risk groups.

Food assistance is organised by local governments and therefore the practice varied during the crisis. The food assistance is mainly organised in cooperation with Estonian Food Bank. A number of local governments continued to provide school meal for children, but the concrete target group (for example children from families with coping difficulties etc) and other conditions for school meal were determined by local governments.

Childcare facilities are under the responsibility of local governments, who decide their closure and working arrangements. Depending on local government, parents were exempt or partially exempt from paying for the childcare during the COVID-19 crisis. Local governments were obliged to guarantee childcare if parents needed to go to work, i.e. for parents who work e.g. in healthcare,

police, rescue, social services, transport, food production, grocery stores etc. Local governments also created possibilities for 24-hour childcare.

All schools were closed, and schoolchildren studied from distance from mid-March to the end on school year. Local governments guaranteed internet connection for teachers and schoolchildren, it has been needed for carrying out studies. Local governments and schools with the help of private sector and volunteers organised laptops and computers for schoolchildren who reported the need for assistance.

Helplines were open. Special crisis hotline 1247 of the Emergency Response Centre, providing all kind of information about the crisis, emergency situation and related support measures, also offers psychological first aid which is provided in cooperation with the specialists of the 116 006 victim support crisis hotline of the Social Insurance Board. Dementia helpline 644 6440 advices carers of people with dementia also in the COVID-19 related questions. Dementia Competence Center has elaborated guidelines and recommendations to carers and family members living with people with dementia. Tallinn Children´s Hospital crisis hotline 678 7422 advices workers at the front line of the COVID-19, such as health workers and police, who are worried about themselves and their children. Some women`s support centres have been practising and communicating (especially through social media) through web-based solutions and chat options, as a possibility to get help if making a phone-call is not possible.

To protect incomes of certain risk groups, Estonia introduced following temporary measures

1. On 19 March 2020, the Government approved temporary subsidy programme of 250 million euros to compensate for the drop in labour earnings[39]. The subsidy grants an income for the employees and helps the employers to surpass temporary difficulties without need to lay off staff or call bankruptcy. It is paid up to two months during March till May (extended until June) for the employees whose employers are impacted by the extraordinary circumstances caused by COVID-19. The amount of the subsidy was 70% of the average monthly wage of the employee with the maximum amount of €1000 per employee per month. Altogether 137 683 employees from 17 563 institutions benefited from the measure.
2. Temporary financial support to parents of children with special needs. The aim of the financial benefit was to provide state supported income for parent, who temporarily had to leave the labour market (i.e. whose employment contract was suspended or who is on holiday without pay) due to the closure of kindergartens and schools, in order to guarantee the everyday surveillance, study support and personal hygiene procedures of their children. Parents of children with profound, severe or moderate disability, educational special needs and lack of immunity were granted 70% of their average income of the previous calendar year for each calendar day, whereas the minimum amount of allowance per month was 540 EUR and the maximum amount 1050 EUR[40]. The measure was applicable until the end of emergency, with the last payments made in June 2020. The budget of the measure was 10 MEUR, of which 1,3 MEUR was used. The allowance was paid to 1304 persons.
3. Sickness benefit scheme was temporarily expanded to also cover the first three days of sick leave which previously has been persons own liability. This possibility was used in 101 321 cases during COVID-19 crisis.

[39] Up-to-date information on temporary subsidy programme, including the conditions of eligibility is available in Estonian, Russian and English at the homepage of the Estonian Unemployment Insurance Fund.

[40] More information is available on the Social Insurance Board website (not available in English): https://www.sotsiaalkindlustusamet.ee/et/puue-ja-hoolekanne/erivajadusega-lapse-vanema-erakorraline-toetus

4. Due to an emergency situation it was temporarily possible for an employee to apply for a sick leave online. The case may be opened by a person who is ill, has a child who is ill, needs to care for a close family member, or has been exposed to COVID-19.

Support to local governments.

As the local governments' revenues have decreased, the Estonian government allocated additional 130 million € financial support to local governments to mitigate the effects of the crisis. 30 million will go to compensate the costs of the crisis (incl. in social sector), 70 million for new investments and 30 million for local infrastructure. Additional 5 million € funding to develop and provide social welfare services, for which need emerged during the crisis (for example home care services, day care centre services, debt counselling, psychological counselling etc), was opened for local governments in August 2020. In addition, the Government has allocated additional 550 000 € to victim support and psychosocial crisis assistance.

c) If the previous conclusion was one of non-conformity, please explain whether and how the problem has been remedied. If the previous conclusion was deferred, please reply to the questions raised.

In 2017 conclusions, the Committee deferred its conclusion for Article 30 of the Charter pending receipt of the information requested below.

The Committee takes note of the policy measures taken to implement the legal framework. For example, the strategic vision 'Sustainable Estonia 21' aims to increase welfare and social inclusion by 2030. To reach this goal, specific active labour market measures will be developed, a system of life-long learning will be created as well as a system of support measures meant to endorse the participation of excluded groups in the labour market. The Committee asks the next report to provide information on the results achieved. It also asks whether specific measures are foreseen for the elderly in view of the very high poverty rate of this group.

For active labour market measures, please see information provided under the next question.

Measures for elderly

The best way to alleviate poverty is to bring people back into employment. Access to labour market services has been improved for the elderly (more information on labour market measures is provided under the next question).

Table 50. Employment rate of 63-74 year old persons (2016-2019)

	2016	2017	2018	2019
Employment rate of 63-74 year olds, %	29,8	29,8	30,5	32,6

Source: Ministry of Social Affairs

Also, Estonian old-age pension and national pension is paid in case of employment. One of the goals of the Estonian Government's action plan for the 2019 – 2023 is to increase the well-being of the elderly through supplementary pension increases. In 2021, in addition to the annual indexation, an additional increase of the national pension is planned. The increase of the national pension by 30 euros in 2021 will affect more than 3,000 pensioners and raises old - age pensioners out of absolute poverty (estimated at the subsistence minimum in 2019 was 221.36 euros, new national pension will be 251.63 euros).

In 2017, pensioner's living alone allowance, a lump sum support of 115 € per year[41] was introduced[42] for old-age pensioners living alone according to population register and with pension lower than 1.2 times the amount of average old-age pension (582€ in 2020). Salary from employment, other social allowances or income are not taken into account while granting the allowance. The allowance is not subject to income tax and not included in income when calculating the subsistence benefit. The aim of the pensioner's living alone allowance is to improve financial independence and reduce poverty of pensioners' living alone.

Table 51. Recipients of allowance for pensioners living alone in 2017-2020

	2017	2018	2019	2020
Recipients of allowance for pensioners living alone	85 375	79 898	87 599	90 047

Source: Social Insurance Board

In 2020, an extraordinary pension increase of 7€ was introduced[43]. Raising the basic part of the pension in 2020 will affect nearly 330 000 people, while helping relatively more non-working retirees with lower pensions. It is evaluated that extraordinary pension increase of 7 € decreases the at-risk-of-poverty rate of 65+ years old persons by 0,6pp.

The 'National Reform Programme 'Estonia 2020' aims to reduce the at-risk-of-poverty rate to 15% by 2020. To reach this goal, measures are taken to increase the employment of disadvantaged groups in the labour market (elderly, disabled people, etc.). The Committee asks the next report to provide information on the results. Information should also be provided on the existence of coordination mechanisms for these measures, including at delivery level (that is, how coordination is ensured in relation to the individual beneficiaries of assistance and services).

General economic measures and the improvement of economic performance affected the employment of disadvantaged groups. In addition to that, several significant policy changes focused on increasing the employment of disadvantaged groups in the labour market.

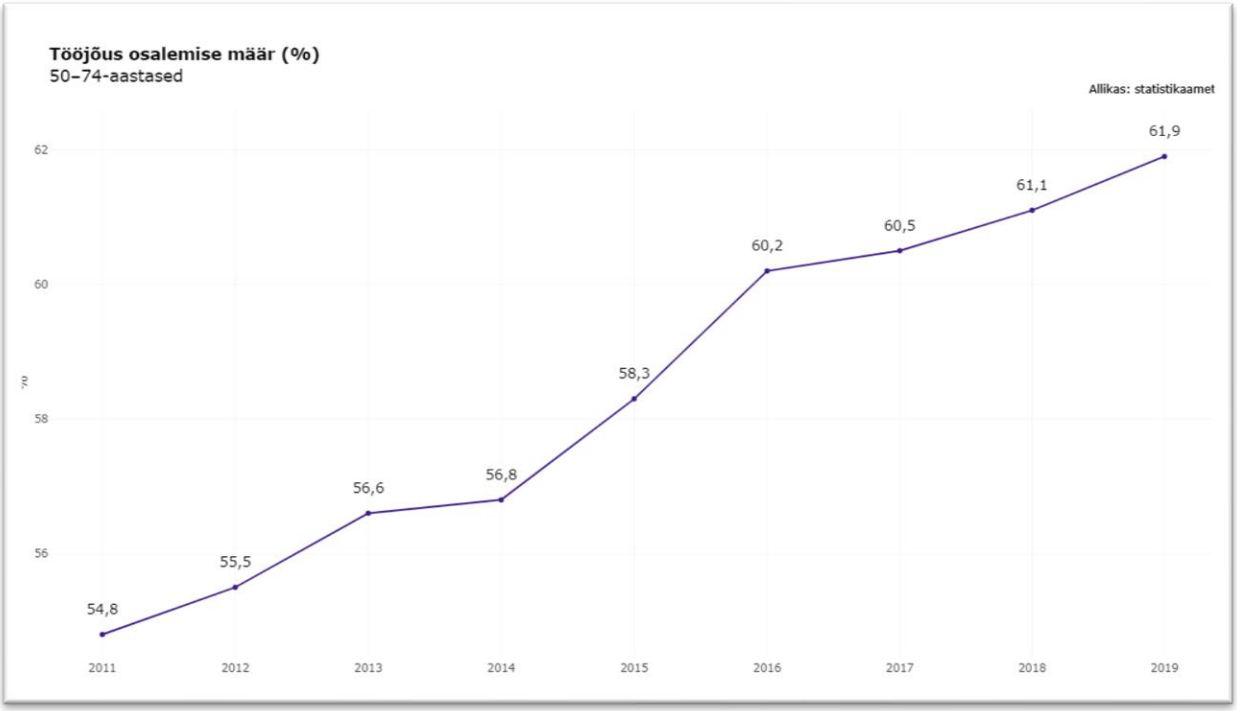
Job-seeking pensioners continued to receive active labour market policies similarly to other groups. From 2017, a comprehensive policy measure, the Employment programme for 2017-20 was launched with the aim to prevent unemployment and support structural changes in the economy. Workers in the highest risk of unemployment—people with health problems, people with outdated or without professional education, people with insufficient language skills and people aged over 50 were eligible for measures supporting short- and long-term upskilling in informal and formal education. Employers were supported by covering training costs for new hires or to support adjustment with economic changes. The support rate was higher for workers in risk of unemployment.

[41] For more information, please see Estonian Social Insurance Board website: https://www.sotsiaalkindlustusamet.ee/et/uksi-elava-pensionari-toetus-0

[42] Amendments to the Social Welfare Act, adopted 23.11.2016, entered into force on 1.01.2017, published RT I 6.12.2016, 1 https://www.riigiteataja.ee/akt/106122016001

[43] Amendments to the §61 of the State Pension Insurance Act, adopted 20.11.2019, entered into force 01.01.2020, published RT I, 28.11.2019, 1 https://www.riigiteataja.ee/akt/128112019001

Figure 8. Participation in the employment, 50-74 aged people in years 2011-2019



Source: Statistics Estonia

The Committee notes that according to the European Semester Country Report Estonia 2017 the effect of social transfers has declined and is limited, going from over 36% in 2010 to just 22% in 2015. The Committee asks whether and what measures are taken or foreseen to ensure that social transfers effectively reduce poverty.

A major set of amendments[44] in the subsistence benefit regulation were introduced in 2018, with the aim to make the scheme more flexible and motivate beneficiaries to take up employment (for detailed information, please see report on Article 13).

Since 2019:

- the subsistence level for a single or first family member is 150 euros;
- every subsequent family adult member's subsistence level is 120 euros (80% of the single level) and;
- every minor's subsistence level is 180 euros (since 2018 120% of the single level);
- there is a supplement for lone parents of EUR 15 per month.

Abovementioned amendments are prognosed to decrease the share of people living in absolute poverty up to 2,8 percentage points. In 2018, the share of people living in absolute poverty was 2,2%[45].

Children with disabilities and their families face higher poverty risk (20,7% in 2018) than children and families in general (17,2%)[46]. Households with disabled children estimate their standard of living lower than all Estonian households with children on average. Higher expenditure arises from severe or profound disabilities. Expenditure of 50% of households with profoundly disabled children

[44] Amendments were adopted by the Parliament on 6.12.2017, entered into force on 01.01.2018, published RT I, 28.12.2017, 8, https://www.riigiteataja.ee/akt/128122017008

[45] Source: Statistics Estonia

[46] Source: Statistics Estonia.

range from 119 to 339 € per month but may rise to 600 €. Families with severely disabled children spend 60–219 € and with moderately disabled children 48–159 € per month on the child's special needs. In the majority of cases, the disabled child allowance (69.04 euros per month for a moderate disability and 80.55 euros per month for a severe or profound disability before 2020), was not enough to cover families' extra costs arising from the child's disability. Since 2020, social allowances for children with disabilities increased[47]. Allowances were doubled in case of moderate and severe disability and tripled in case of profound disability. New amounts of the allowances are provided in the table below.

Table 52. Amounts of allowances for children with disabilities before and since 2020

	Before 2020	Since 2020
To a child with moderate disability	69,04 €	138.08 €
To a child with severe disability	80,55 €	161,09 €
To a child with profound disability	80,55 €	241,64 €

Source: Ministry of Social Affairs

For information on family allowances, please see the information provided under Article 12 in this report.

Annual indexations have constantly raised Estonia's old-age pension. For example, the old-age pension with 44 years of service (the average pensionable service in Estonia is 44 years) has increased from 395 euros to 528 euros.

Table 53. Overview of increased old-age pension due to annual indexations, 2016-2020

	01.04.2016	01.04.2017	01.04.2018	01.04.2019	01.04.2020
Pension amount (with 44 years length of service)	395,25 EUR	415,64 EUR	446,52 EUR	483,24 EUR	528 EUR

Source: Ministry of Social Affairs

On 1 April 2020, the base amount of pension was additionally increased after indexation by 7 euros. Following indexation, the base amount of pension totals €208.5 and the value of one year of pensionable service amounts to €7.104. Additionally, the value of base amount was increased from €208.5 to €215.5 as a result of an extraordinary increase of €7.

This step was meant to reduce the risk of poverty of old-age pensioners and improve their wellbeing. The additional increase in the base amount increased the pensions of all old-age pensioners as well as those receiving pensions for incapacity for work or survivor's pension. Pensioners not active in the labour force benefited most from this.

On 1 April 2021, the additional increase in the base amount of the pension planned as a solidarity component will increase the pensions of all old-age pensioners. The increase in the base amount of the pension will affect almost 320,000 people, will reduce the relative poverty rate of pensioners by an estimated 1.2 percentage points. There will be also an increase in the supplementary child benefit, which provides additional income for pensioners who have raised one or more children for at least eight years and whose child was born before 2013.

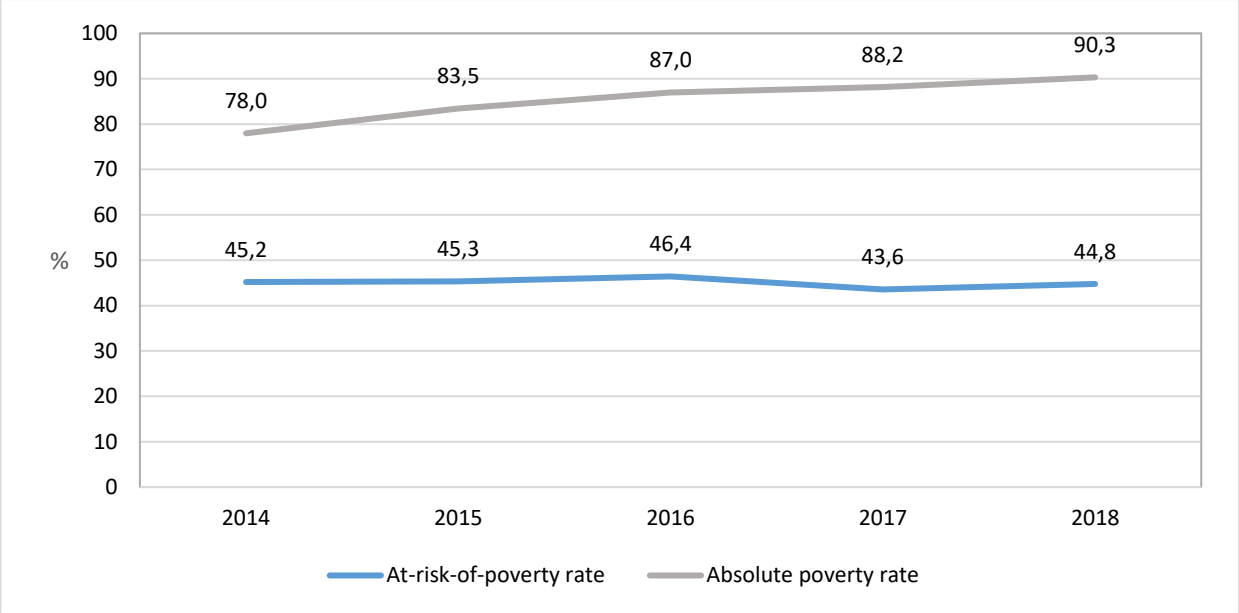
[47] Amendments to the Social Benefits for Disabled Persons Act were adopted on 13.02.2019, enforced starting from 01.01.2020, published RT I, 27.02.2029, 11 https://www.riigiteataja.ee/akt/127022019011

On 1 April 2021, it is also planned to increase the national pension. The national pension provides income in old age for people who have not fulfilled the length of service requirement for receiving an old-age pension and who have lived in Estonia for at least five years directly before applying for the pension. An extraordinary increase in the national pension rate will help to ensure a minimum subsistence level for the recipients of the national pension.

The Committee further observes that total Government expenditure on social protection fluctuated around 12% of GDP during the reference period while increasing slightly in 2015 to 12.9%. The Committee notes that this is significantly below the EU average of 19.2% in 2015 and asks that the next report contain detailed data demonstrating that the budgetary resources allocated to combating poverty and social exclusion are sufficient in view of the scale of the problem at hand.

Social transfers have an important part in reducing poverty. In 2018, various state allowances, benefits and pensions reduced relative poverty of the population by 45% (before social transfers 39.3% of the population lived in relative poverty, while after social transfers – 21.7%). Social transfers (including pensions) reduced absolute poverty of the population by 90% (before social transfers 22.7% of the population lived in absolute poverty, while after social transfers – 2.2%).

Figure 9. Proportion[1] of poverty rate with and without social transfers, 2014–2018

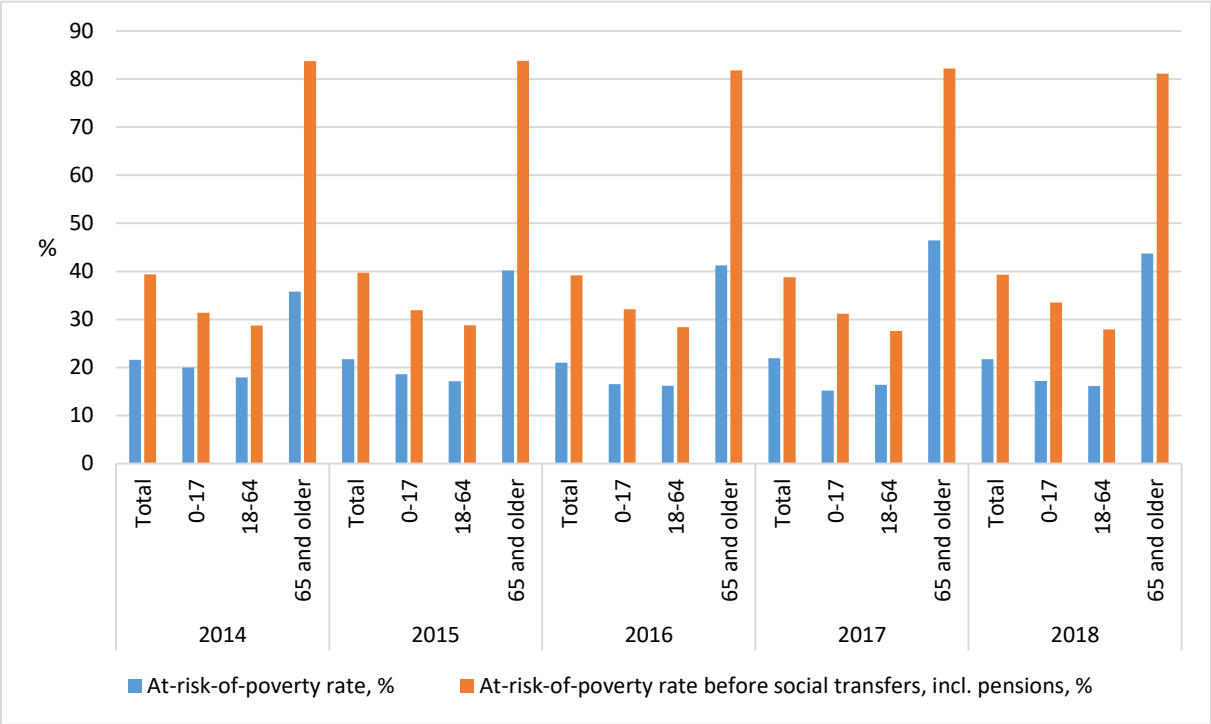


[1] Showing decrease in poverty rate of the population, resulting from social transfers, as a percentage.
Source: Statistics Estonia

Social transfers have the strongest influence on relative poverty among population 65 years old and older. Without the social transfers (including pensions), in 2018, 81.1% of population 65 years old and older, would have lived in relative poverty.

In 2018, the social transfers (including pensions and family benefits) reduced the at-risk-of-poverty rate for children by 16.3 percentage points, thus by 49% (from 33.5% to 17.2%).

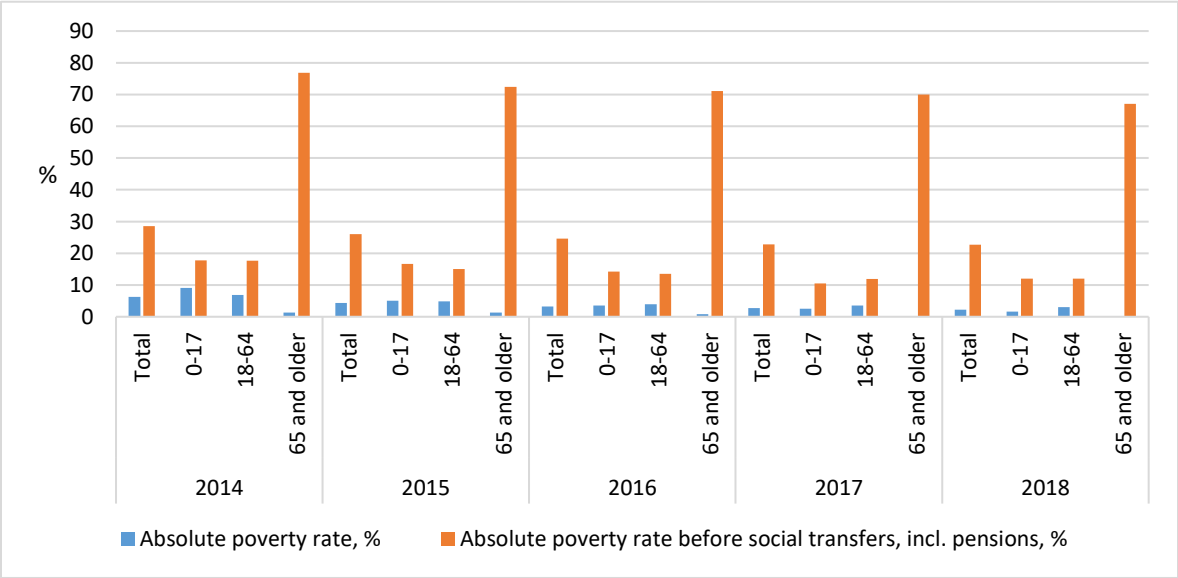
Figure 10. At-risk-of-poverty rate with and without social transfers by age group, 2014-2018



Source: Statistics Estonia

In 2018, without the social transfers (including pensions) 12% of children would have lived below absolute poverty threshold. Hence, social transfers (including pension, family benefits) reduced the absolute poverty for children by 10.4 percentage points (approximately 87%).

Figure 11. Absolute poverty rate with and without social transfers by age group, 2014-2018



* Data on the absolute poverty rate of older people are not available due to small size of the sample in 2017-2018.

Source: Statistics Estonia

Finally, the Committee refers to its conclusions of non-conformity under other provisions of the Charter which are relevant to its assessment of compliance with Article 30 (see Conclusions 2013, Statement of interpretation on Article 30). It refers in particular to Article 12§1 and its conclusion that the minimum level of several social security benefits (sickness, unemployment, old age and invalidity pensions) are manifestly inadequate (Conclusions 2017), to Article 13§1 and its conclusion that the level of social assistance paid to a single person without resources is not adequate (Conclusions 2017) and to Article 16 and its conclusion that family benefits are not of an adequate level for a significant number of families (Conclusions 2015).

For the minimum level of sickness benefit, unemployment allowance, unemployment insurance benefit, work ability allowance, and family allowances, please see the information provided in this report under article 12.

Since 2020, Estonia introduced new rates of allowances for children with disabilities[48]. Children with disabilities and their families face higher poverty risk (20,9% in 2017) than children and families in general (15,2%). The benefits for children with disabilities were not increased since 2006. The objective was to bring the level of monthly disability allowances[49] into accordance with real additional costs borne by the families of children with disabilities. Allowances in case of moderate and severe disability were doubled and tripled in case of profound disability. New amounts of the allowances are provided in the table below.

Table 54. Amounts of allowances for children with disabilities before and since 2020

	Before 2020	Since 2020
To a child with moderate disability	69,04 €	138.08 €
To a child with severe disability	80,55 €	161,09 €
To a child with profound disability	80,55 €	241,64 €

Source: Ministry of Social Affairs

The Committee notes from the report that statistical data concerning poverty and social exclusion are published yearly by Statistics Estonia. This information is then analyzed in various studies, for example on subsistence allowance, children, people with disabilities and elderly. These analyses evaluate the impact of social benefits to the social protection systems and the at-risk-of-poverty rates. However, the Committee recalls that Article 30 of the Charter requires the existence of monitoring mechanisms for reviewing and adapting the efforts in all areas and sectors, at all levels, national, regional, local, to combat poverty and social exclusion; mechanisms which should involve all relevant actors, including civil society and persons directly affected by poverty and exclusion (see Conclusions 2003, France, Article 30). It therefore asks that the next report contain comprehensive information on such mechanisms covering all sectors and areas of the combat against poverty and social exclusion. In this respect, the Committee also wishes to know how

[48] Amendments to the Social Benefits for Disabled Persons Act were adopted on 13.02.2019, enforced starting from 01.01.2020, published RT I, 27.02.2029, 11 https://www.riigiteataja.ee/akt/127022019011

[49] The allowance of children with disabilities is calculated as a percentage of monthly social benefit rate (25,57 EUR). Starting from 2020, the allowance to a child with a moderate disability is 540% of the social benefit rate, to a child with a severe disability 630% of the social benefit rate and to a child with a profound disability 945% of the social benefit rate.

individuals, research institutions and voluntary associations take part in assessing measures to combat poverty (see also Conclusions 2013, Statement of interpretation on Article 30).

Welfare development plan 2016-2023[50], that forms the basic approach for combatting poverty and social exclusion, was adopted by the Government in 2016. Welfare Development Plan Committee[51], consisting of representatives of social partners, NGOs active in social sector and other ministries, was established to lead the elaboration and implementation of the development plan, including approve the development goals, measures, activity plans and yearly reports. The Committee also acts as an advisory body to the Structural Funds priority axes in the fields of social inclusion (priority axe No 2) and access to labour market (priority axe No 3). Members of the Committee are, for example, representatives of Estonian Association of Cities and Municipalities, EAPN Estonia, Estonian Union for Child Welfare, Estonian Chamber of Disabled People, Estonian Union of Pensioners Associations, Estonian Social Work Association etc. The Committee will continue with the same tasks for the next Welfare Development Plan 2023-2030.

Statistics Estonia has created dashboards for different sectors, including for social sector, to simplify the finding and use of statistics. It is also possible to use personalised dashboard with the most relevant data for user. Social Welfare Development Plan indicators form one of the central government dashboards[52].

[50] https://www.sm.ee/sites/default/files/content-editors/eesmargid_ja_tegevused/welfare_development_plan_2016-2023.pdf

[51] Please see full list of tasks and members of the Welfare Development Plan Committee (only in Estonian): https://www.sm.ee/sites/default/files/content-editors/eesmargid_ja_tegevused/Sotsiaalse_turvalisuse_kaasatuse_ja_vordsete_voimaluste_arengukava_2016_2023/heaolu_2016-2023_juhtkomitee.pdf

[52] Please consult the dashboard on Statistics Estonia website: https://juhtimislauad.stat.ee/dashboard/2