REDUCING THE BURDEN
OF CARE IN ESTONIA

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Reducing the Burden of Care in Estonia
Interim Report

June 2017

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EXECUTIVE SUMMARY

Population ageing and the associated rise in disability rates are expected to drive up the demand for long-term care (LTC) in Estonia. In the context of limited and inequitable formal coverage, the bulk of LTC is currently provided by informal caregivers with significant economic and social costs. Looking ahead, as Estonia converges to EU norms of living standards and coverage, the state will face pressure to increase LTC spending making fiscal sustainability of LTC a challenge. Although population ageing is largely exogenously determined, the rise in morbidity, frailty and consequently, severity of LTC needs among the population can be mitigated through effective public policies in LTC.

The objective of this report is to provide an assessment of the current situation of LTC in Estonia and provide a set of policy options for the Government of Estonia to consider in strengthening LTC policy. The report was commissioned by the Government Task Force on Reducing the Burden of Care in Estonia. It contains an assessment of the current situation of LTC in Estonia and projected needs and spending, which is then used to develop policy recommendations and scenarios.

These policy recommendations and scenarios chart a course from the current system of LTC to an “ideal system”. From the users’ perspective, the “ideal system” is one which is person-centered, users are offered support in proportion to their needs and financial protection is ensured. From the policymakers’ perspective, the “ideal system” is one in which services are delivered efficiently and equitably, thus ensuring good value for money and fiscal sustainability. LTC system development is inevitably about maximizing coverage and financial protection subject to resource constraints and financial sustainability goals. The policy scenarios in this report distinguish between urgent priorities that must be addressed even in the context of current low spending on the one hand, and investment in the building blocks needed to achieve the “ideal system” on the other.

Taking stock

The demand for LTC is expected to increase significantly in future years not just because the Estonian population is ageing rapidly, but because it is ageing rapidly and less healthily, predisposing people to more severe disabilities in old age. Amongst EU countries for which comparative data are available, Estonia ranks 26th in the percentage of healthy years as a share of remaining life expectancy at 50 years old, at 47.4 percent. Estonians aged over 65 are more likely than their average EU peer to require assistance with activities of daily living, face mobility limitations, and have higher BMI. Notably, across all age groups including young adults and children, Estonians performed slightly worse than the average EU peer in terms of the proportion of individuals reporting one or more difficulties in performing daily activities. In addition, cognitive scores among the elderly in Estonia are low compared to the average EU peer.
Moreover, poverty is often correlated with unmet need for LTC. Given that wealth is limited for much of the population aged 50 years and over, lack of adequate LTC coverage places many elderly Estonians at an increased risk for poverty and social exclusion. As it is, the elderly have the highest rates of at-risk poverty in the country when pensions and social assistance incomes are excluded. The rural and less-educated are more likely to have limitations in their daily activities and consequently, higher demands for care.

Public spending on LTC in Estonia is lower than in other EU member states, leaving most LTC to be financed out-of-pocket (OOP). Estonia spent approximately 0.6 percentage points of GDP on LTC in 2013. By comparison, LTC spending as a share of GDP was about 1.5 percentage points in Germany, Austria and Luxembourg, 2.5 percentage points in Denmark and Finland and over 3.5 percentage points in Sweden, the Netherlands and Norway. Meanwhile, OOP spending has grown rapidly. Although the current absolute level of OOP payments is relatively low (given low volume of care use), it comprises a relatively large share of household income and asset wealth.

With public funding for LTC at a low level, coverage of formal LTC is inadequate, inequitable and provides little financial protection. On the health side of LTC, there is a shortage of nursing care beds. Regional accessibility to inpatient nursing care services is uneven, in part a consequences of shortages in home nurses. On the social side of LTC, the local governments’ capacity to provide social benefits and services depends to a large extent on the budgetary resources available. Although local governments have to follow legal obligations in providing LTC services, they have broad power and autonomy to define their policies, and their capacities to fund and provide services are highly unequal. As a result, access to LTC services depends largely on the residence of the beneficiary. In recent years, the coverage of home-based services for the elderly has barely expanded even though unit costs of home-based services are relatively low. The limited supply of home-based services for the elderly has led to a growing demand for general care homes. Most elderly finance social services from their state-provided pension, which is often not sufficient to cover the costs of even the least-expensive general care home.

Wide variations in level of formal service provision relative to need are partly a consequence of the lack of standardized needs assessments. Estonia is considering adopting InterRAI, a standardized assessment framework, that would provide the basis for organizing care needs around the individual user, rationalizing care, and making sure available resources are used effectively. However, until now there has been no standardized needs assessment framework that cuts across all types of health and social care. On the service delivery side, there is no unified national monitoring framework for

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2 Social Welfare Act actually obligates municipalities to provide 11 social services (among them also some LTC services) then not all municipalities do that and secondly, service standards are very general and allows broad interpretation.
assessing service delivery capacity, actual levels of provision or quality. Social care data are largely maintained at the local government level with much of it paper-based.

In the absence of adequate publicly-financed coverage, the burden of care falls disproportionately on informal caregivers, giving rise to significant economic and social costs. The reliance on informal care is underpinned by the Constitution of the Republic of Estonia (Art. 27) that stipulates that the family is required to provide care for its members in need. The State Audit Office is of the opinion that local authorities should first make sure that the person in need of care, or his or her family, are not capable of providing care themselves before providing assistance involving taxpayers’ funds. Not surprisingly, informal care responsibilities curtail family members’ (especially women’s) ability to participate actively in the labor market. A conservative estimate of the opportunity cost of time spent providing informal care was 23.9 million EUR in 2015 (confidence interval of 16.0 – 31.7 million) or ca. 0.12 percent of GDP. Besides the economic costs, informal carer responsibility incurs social costs associated with the psycho-social impact of providing care to sick, disabled family members.

The reliance on informal care exacerbates socioeconomic inequalities amongst those in need because caregiver support, like other types of social care discussed above, is allocated at the discretion of local governments. Poorer, less-educated people with disabilities are more likely to rely on informal care. Local authorities are not obliged to pay a caregivers’ allowance, and there are no minimum standards required for its provision. As a result, this allowance is allocated at the discretion of local self-governments on an ad-hoc basis, with large regional disparities in payment levels. Total spending on the caregivers’ allowance per capita (as a proxy for the level of spending) fluctuated between 0.86 EUR in Saare county to 9.86 EUR in Võru county in 2016 (a tenfold increase, but still very low), which.

The fragmentation between health and social care results in inefficiencies in the provision of LTC. The fragmentation is multidimensional, existing at financial, organizational, professional and policy levels. At present, the separation of funding streams between the state and local government levels for health and social care, mean that there is little motivation for coordinating care across the two sectors. In addition, misaligned financial incentives for providers between the different levels and sectors of care lead to the constant shuttling of patients between different health and social care settings. The organizational and professional separation of health and social care means services are fragmented both within the community (e.g. home nursing care and home help with daily activities) as well as within institutional settings (e.g. hospital-based nursing care and care delivered by social welfare institutions). The primary health care system does not yet play a central role in coordinating patients between health and

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3 The opportunity cost, also known as alternative cost, is defined as “the loss of potential gain from other alternatives when one alternative is chosen” (Source: New Oxford American Dictionary). In this case, it refers to the gains that could be achieved if informal caregivers did not have their current care obligations and could undertake different activities instead.
social care. The complete lack of integration of health and social care data exacerbates these fragmentation problems.

Factoring in future needs and costs

Rising LTC needs and costs fueled by rapid and unhealthy ageing will exert significant pressure on the public budget in the next couple of decades. The EC Aging Report (European Commission, 2015) estimates that public spending on LTC in Estonia will increase from 0.6 to 1.3 percent of GDP in the period 2013-2060 if only the pure demographic effect is taken into account. However, convergence in living standards and coverage rates towards EU averages could raise long-term care spending in Estonia to as high as 4 percent of GDP by 2060.

From an equity and efficiency perspective, there is limited room for additional public financing for LTC to come from social security and payroll taxes. Social security and payroll taxes already make up a substantial share of government revenues. While these have diminished in recent years, there is a concern that the labor tax wedge is relatively high. A further concern is the rising inequality in incomes in Estonia. Means-tested benefits and social insurance contributions have proved much less equalizing in Estonia compared to many EU countries. Increasing social taxes through the introduction of contributory public LTC insurance to finance long-term care is then not advisable under the current tax structure. Financing for the expansion of public LTC provision should come from other general revenue sources.

Developing policy options

Given the medium-term outlook for fiscal space and the fragmented structure of the current LTC system, the “ideal system” with comprehensive LTC coverage and a high degree of coordination between health and social care may not be immediately achievable. First, building up the ideal system is likely to require significant additional public spending on LTC. Secondly, dramatically changing the way in which LTC is delivered (from a largely, informally provided service to one which involves a high degree of coordination between health and social care, with emphasis on formal home and community care provision) implies a system transformation that would require time and investment in capacity at different levels of the government.

The policy scenarios in this report are intended to chart a potential course from the current situation to an “ideal system”. The objective is to maximize coverage and financial protection subject to resource constraints and the need to ensure financial sustainability. The resource commitments and system characteristics under any one scenario are not pre-determined and would ultimately depend on the political and social choices of the Estonian people. The three scenarios proposed here are simply three points on a continuum from low to high coverage. Ultimately, decisions about where on the policy continuum the country settles and associated reforms are undertaken would depend largely on society’s preferences and the political economy of those reforms.
These policy scenarios highlight two types of interventions necessary for developing Estonia’s LTC system: addressing urgent policy priorities as well as the strengthening the building blocks for moving towards the “ideal system”.

The urgent policy priorities, particularly in the context of low spending are to: address inequalities in services provision by redistribution of funding to those local governments with weaker funding capacity; and increase financial and social support to informal carers. The latter is important because informal carers will continue to be the backbone of the LTC system for the immediate future.

The building blocks comprise the stewardship function of the state as well as the legislative basis, institutions and mechanisms needed to ensure coordination of care. This report assumes that local governments would continue to deliver social care services as at present. The central state would therefore need to play an important stewardship role in ensuring horizontal equity (equal level of services for equal need), efficiency and quality in service provision. Uniform national frameworks and mechanisms to assess care needs, monitor service provision and reward good performance need to be developed and implemented by the central state. Better coordination of health and social care starts with establishing the relevant legislative and regulatory bases, including the regulatory basis for integration of health and social care data. Only once these are in place can mechanisms to promote coordination of care (such as the introduction of case managers, new payment methods and revised benefits packages) be developed. A better-coordinated, more comprehensive system of LTC would require additional resources. Human resource and infrastructure needs would need to be assessed and strategies developed for meeting these input needs over time as more financial resources become available. Implicit in the policy scenarios is the idea that in order to achieve an ideal system in the future, the building blocks need to be put in place now.

The report contains three policy scenarios, which allow for a phased development of a LTC system based on resources available. The policy scenarios are summarized in Table 1.

In Scenario 1, while public spending remains at current levels the emphasis is on redistribution of resources towards priority needs and strengthening the stewardship function of the central government to deliver better care in the future. Moving from the status quo to Scenario 1 involves re-distributing the limited public sector resources so that they are targeted at areas with greater need and the informal caregivers who provide the most support with least compensation at present. Second, it involves putting in place vital systems/frameworks for assessing need as well as monitoring performance and quality of service delivery at the local government. Third, it involves introducing regulatory and legislative changes needed to coordinate health and social care including integration of health and social information systems. Finally, it involves planning for future LTC human resource needs.
In Scenario 2, public spending is modestly increased, which makes it possible to increase coverage of formal health services, reduce the reliance on informal care and introduce elements of care coordination in health and social LTC. Under Scenario 2 the needs assessment and service delivery monitoring frameworks initiated under Scenario 1 will be fully utilized as the LTC system starts coordinating care more effectively, linking spending with performance and quality. Efforts will be made to pool financing for health and social care to improve coordination of care.

In Scenario 3, public spending is increased significantly, leading to considerable improvements in coverage, financial protection and quality of care. Under Scenario 3, the system moves closer to ideal system, especially the high levels of coverage seen in Nordic and selected Western European countries.

Table 1. Policy Scenarios for LTC Development

<table>
<thead>
<tr>
<th>Policy Scenarios</th>
<th>Scenario 0</th>
<th>Scenario 1</th>
<th>Scenario 2</th>
<th>Scenario 3</th>
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<tr>
<td>Coverage, quality, equity</td>
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<td>slightly improved</td>
<td>moderate</td>
<td>high</td>
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<td>Financial protection</td>
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<td>moderate</td>
<td>high</td>
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<td>moderate</td>
<td>low</td>
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<tr>
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<td>0.5% of GDP</td>
<td>0.6-0.8% of GDP</td>
<td>2% - 2.5% of GDP</td>
<td>3.5% - 4% of GDP</td>
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<tr>
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<td>mostly OOP</td>
<td>OOP, gov. revenue</td>
<td>mostly gov. revenue</td>
</tr>
<tr>
<td>Financing mechanisms</td>
<td>separate streams</td>
<td>separate streams</td>
<td>pooling pilots</td>
<td>pooled</td>
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<tr>
<td>Formal services</td>
<td>limited</td>
<td>still limited</td>
<td>expanded</td>
<td>dominant</td>
</tr>
<tr>
<td>Local govt. services</td>
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<td>min. standards</td>
<td>expanded M&amp;E</td>
<td>universal M&amp;E</td>
</tr>
<tr>
<td>HR needs</td>
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<td>still low</td>
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<td>high</td>
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<td>Information flows</td>
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<td>integrated vision</td>
<td>integration pilots</td>
<td>integrated</td>
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<tr>
<td>Benefit package</td>
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<td>still limited</td>
<td>expanded</td>
<td>generous</td>
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<tr>
<td>Targeting</td>
<td>poor</td>
<td>means-testing</td>
<td>expanded eligibility</td>
<td>universal, need-based</td>
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<tr>
<td>Care integration</td>
<td>fragmented</td>
<td>integrated vision</td>
<td>integration pilots</td>
<td>multi-level</td>
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<td>Social Insurance Board</td>
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<td>Director General</td>
</tr>
<tr>
<td>The Estonian Chamber of Disabled People</td>
<td>Anneli Habicht</td>
<td>CEO</td>
</tr>
<tr>
<td>NGO Estonian Carers</td>
<td>Ivar Paimre</td>
<td>Member of the board;</td>
</tr>
<tr>
<td>Association of Directors of Estonian Care Homes</td>
<td>Merike Siht</td>
<td>Vice-Chairman;</td>
</tr>
<tr>
<td></td>
<td>Mare Pariis</td>
<td>Vice-Chairman</td>
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<tr>
<td>Association of Estonian Cities</td>
<td>Jüri Võigemast</td>
<td>Director of the Bureau; Head of Social Welfare and Health Care Department (Tallinn City Government)</td>
</tr>
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<td></td>
<td>Uku Torjus</td>
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<tr>
<td>Association of Municipalities of Estonia</td>
<td>Mailis Kaljula</td>
<td>Adviser</td>
</tr>
<tr>
<td>Tartu City Government</td>
<td>Sirje Kree</td>
<td>Head of Social Welfare and Health Care Department (Tartu City Government)</td>
</tr>
<tr>
<td>Estonian Social Enterprise Network</td>
<td>Kaie Kotov</td>
<td>In charge of development programs and service design</td>
</tr>
<tr>
<td>Estonia Doctors Association</td>
<td>Maire Raidvere</td>
<td>Head, Nursing Care Department (Järva County Hospital); CEO</td>
</tr>
<tr>
<td></td>
<td>Linda Jürisson</td>
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<tr>
<td>University of Tartu/University of Tallinn</td>
<td>Reeli Sirotkina</td>
<td>Lecturer of social work</td>
</tr>
<tr>
<td>Estonian Society of Family Doctors</td>
<td>Hepp Nigol</td>
<td>Member of the Board;</td>
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<tr>
<td></td>
<td>Mari Soots</td>
<td>Member of the Board</td>
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<tr>
<td>Parliament of Estonia</td>
<td>Tiina Kangro</td>
<td>Member of the Parliament of Estonia Member of the Board of the Estonian Caregivers' Union</td>
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# Abbreviations and Acronyms

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Full Form</th>
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<tbody>
<tr>
<td>ACOs</td>
<td>Accountable Care Organizations</td>
</tr>
<tr>
<td>ADDR</td>
<td>Adult Disability Dependency Ratio</td>
</tr>
<tr>
<td>ADL</td>
<td>Activities of daily living</td>
</tr>
<tr>
<td>BMI</td>
<td>Body mass index</td>
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<tr>
<td>CCOs</td>
<td>Coordinated care organizations</td>
</tr>
<tr>
<td>CG</td>
<td>Caregiver</td>
</tr>
<tr>
<td>EC</td>
<td>European Commission</td>
</tr>
<tr>
<td>DRG</td>
<td>Diagnosis-Related Group</td>
</tr>
<tr>
<td>EEA</td>
<td>European Economic Area</td>
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<tr>
<td>EFTA</td>
<td>European Free Trade Association</td>
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<tr>
<td>EHIF</td>
<td>Estonian Health Insurance Fund (Eesti Haigekassa)</td>
</tr>
<tr>
<td>EU</td>
<td>European Union</td>
</tr>
<tr>
<td>FFS</td>
<td>Fee-for-service</td>
</tr>
<tr>
<td>GDP</td>
<td>Gross Domestic Product</td>
</tr>
<tr>
<td>GP</td>
<td>General physician</td>
</tr>
<tr>
<td>IADL</td>
<td>Instrumental activities of daily living</td>
</tr>
<tr>
<td>InterRAI</td>
<td>International Resident Assessment Instrument</td>
</tr>
<tr>
<td>IT</td>
<td>Information technology</td>
</tr>
<tr>
<td>LTC</td>
<td>Long-term care</td>
</tr>
<tr>
<td>LSG</td>
<td>Local self-government</td>
</tr>
<tr>
<td>MOSA</td>
<td>Ministry of Social Affairs (Sotsiaalministeerium)</td>
</tr>
<tr>
<td>MTÜ</td>
<td>Mittetulunduslik ühing (non-profit organization)</td>
</tr>
<tr>
<td>NHS</td>
<td>National Health Service</td>
</tr>
<tr>
<td>OECD</td>
<td>Organization for Economic Cooperation and Development</td>
</tr>
<tr>
<td>OOP</td>
<td>Out-of-pocket</td>
</tr>
<tr>
<td>PIT</td>
<td>Personal income tax</td>
</tr>
<tr>
<td>PMPM</td>
<td>Per-member per-month</td>
</tr>
<tr>
<td>SHARE</td>
<td>Survey of Health, Ageing and Retirement in Europe</td>
</tr>
<tr>
<td>SIB</td>
<td>Social Insurance Board (Sotsiaalkindlustusamet)</td>
</tr>
<tr>
<td>UIF</td>
<td>Unemployment Insurance Fund (Töötukassa)</td>
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INTRODUCTION

1. Why is LTC a policy priority?

Ensuring and improving the quality of long term care (LTC) services has become an important policy priority across European Union (EU) countries and Estonia is no exception. Dependency on LTC is a significant health-related economic and social risk for individuals and their families. Inadequate social protection against risk of dependency (through benefits in cash or in-kind for the elderly, chronically ill adults and the non-elderly disabled, including disabled children) exposes many Europeans to an increased risk of poverty and social exclusion. This number could grow as Europe's population ages. Indeed, increased longevity and associated disability are expected to substantially drive up the demand for LTC services in the context of constrained fiscal space, shrinking working-age populations, and growing care dependency ratios. Given that wealth is limited for much of the population aged 50 years and over (World Bank, 2015a), the question is: to what extent will those in need of care rely on family support or state support in the coming years?

At present, public spending on LTC in Estonia is lower than in most other European Union (EU) member states and future spending projections in the EU aging report (European Commission, 2015) envisage continued low spending. Estonia spent approximately 0.6 percentage points of GDP on LTC in 2013. By comparison, LTC spending as a share of GDP was about 1.5 percentage points in Germany, Austria and Luxembourg, 2.5 percentage points in Denmark and Finland and over 3.5 percentage points in Sweden, the Netherlands and Norway. In most of these countries, spending on LTC is projected to double by 2060 (based on national government projections), leaving Estonia still lagging behind at about 1.3 percentage points of GDP (European Commission, 2015).

Given that privately-provided care outside of the family is also low, much of LTC care is provided informally by the family, largely, although not exclusively, by older women (European Commission, 2015). Recent time use data for Estonia show that although men and women are equally likely to participate in paid work before midday, as the day progresses, women are less likely to return to paid work, focusing more on household production and care activities (Levin et al. 2015). Such care activities peak in the evening hours. This is consistent with other countries in the Europe and Central Asia region where the burden of providing care for the elderly falls disproportionately on women. As younger entrants to the labor market diminish, keeping older women full-time in the labor force—if that is their wish—will become ever more important. There are large opportunity costs to losing these older women to informal care duties. At the same time, if informal care is not provided, how else will care needs be addressed? These are the kinds of critical trade-offs that are the focus of this study.
2. What is Long-Term Care?

Long-term care (LTC) consists of a range of medical, personal care and assistance services that are provided with the primary goals of:

- alleviating pain and reducing or managing the deterioration in health status for people with a degree of long-term dependency;
- assisting these individuals with their personal care through help for activities of daily living (ADLs) such as eating, washing and dressing; and
- assisting them to live independently through help for instrumental activities of daily living (IADLs), such as cooking, shopping and managing finances (OECD, 2011).

The provision of LTC services represents a key challenge in many countries, particularly those with a rapidly ageing population. LTC services can be provided by either the health or social care sector, in institutions (e.g. hospitals, social welfare institutions) or in the home (e.g. home nursing care, home help with ADLs), and by formal carers (e.g., nurses, social workers) or informal carers (e.g. spouses, children or parents). With projections of large increases in the population needing LTC in the next decades, the challenge of meeting these needs while ensuring the sustainability of public spending is a key concern for many countries.

3. What does LTC system development entail?

LTC system development entails moving towards a LTC system that guarantees a maximum and equitable response as well as financial protection in meeting the needs of potential services users and their carers. From the users’ perspective, the “ideal system” is one which is person-centered so that the interests and needs of the users are on the forefront and users are offered support in proportion to their needs. Such a system would impose minimal burden on family and informal carers, although the family would remain a first point of call for meeting a minimum level of LTC needs. Those seeking LTC would have access to publicly financed formal care services at home and in the community, and residential care when home/community care are no longer feasible. From the policymakers’ perspective, the “ideal system” is one in which services are delivered efficiently and equitably, thus ensuring good value for money and fiscal sustainability. LTC system development entails maximizing these different objectives subject to resource constraints. In many cases, building up the “ideal system” would require significant upfront resource commitments and investments.

LTC system development also entails a focus on sustainability. The continued growth of health care costs as health systems have expanded to meet the growing health needs of populations in Europe and around the world has highlighted the importance of early investment in systems that deliver good value for money. Countries that undertook reforms to strengthen primary care and coordination of care and introduce more efficient provider payment and purchasing mechanisms have been more successful at
containing health care costs than others who did not undertake such reforms. The same is true of LTC systems and costs. Investing now in more cost-effective and good quality home and community care services would pay off in the long-run in terms of cost savings than continued reliance on more expensive institutional solutions to long-term care.

Emphasis on healthy ageing is critical for the sustainability of LTC systems. As noted above, LTC needs and expenditures will continue to grow as the population gets older. While demographic change is largely exogenously determined, the level of morbidity and frailty and rate of increase in the severity of LTC needs among the older population are amenable to change through public policy. Health care interventions to prevent and postpone the onset of morbidities associated with chronic diseases such as diabetes and cardiovascular disease need to start early in life, potentially as early as conception. Screening for chronic diseases and introducing secondary prevention and treatment for non-communicable diseases has been shown to be highly cost-effective in reducing the severity of disease later on. Changes to the living environment (e.g. ramps, parks and public spaces) that make it easier for older people to exercise and or simply move around have been shown to greatly improve the mobility of older people. Policies to encourage employers to improve the employability of older workers can ensure that older people have longer productive lives. In short, policies to promote healthy ageing, which includes the health sector and beyond, would be critical for ensuring the sustainability of LTC systems.

4. Structure of the report

The objective of this report is to provide an assessment of the current situation of LTC in Estonia and provide a set of policy options for the Government of Estonia to consider in strengthening LTC policy. The assessment and policy options will draw on the European and international experience in the area of LTC.

The report is structured as follows. Part I provides an assessment of the current situation of LTC in Estonia in two sections. Section 1 takes stock of the current situation by analyzing who needs LTC, how LTC is organized and provided, who uses LTC and what it costs. Section 2 presents need and expenditure projections. Part II takes a closer look at three topics that are of special interest to the reform of LTC in Estonia: integrating health and social care, financing models for LTC and support for informal caregivers. Part III outlines policy scenarios and offers a range of policy recommendations to address the challenges identified in Part I.
PART I: ASSESSMENT

1. Taking Stock

1.1. Who needs LTC?

The recipients of LTC typically consist of the frail elderly plus non-elderly disabled individuals, including disabled children, people with special needs and/or people with health deterioration. The following section discusses the characteristics of these population groups in Estonia based on available population and health data.

Long-Term Care Needs for the Frail Elderly Population

Estonia is facing an ever-expanding older generation, and a key challenge will be to develop the country’s long-term care system to match this population group’s increasing needs. Low fertility and high out-migration have resulted in rapidly shrinking younger generations in Estonia (Figure 1). The population of Estonia is set to decline from approximately 1.3 million in 2016 to approximately 1.2 million in 2030 and 1.1 million by 2060. With the median age rising from 34.4 in 1990 to a projected 44.9 in 2030, the proportion of the “oldest old” (80 years old and over) is set to rise substantially from 5.1 percent to 7.1 percent of the population between 2016 and 2030 (Table 2, Figure 2). The old-age dependency ratio will increase from 29.3 percent in 2016 to 39.6 percent in 2030 and to 54.9 percent in 2060. Notably, the population of elderly aged 65 and over will reach just under a quarter of the population in 2030 and 30 percent by 2060 (compared to 19.0 percent in 2016).

![Figure 1. Estonia: Age Distribution of Population, 2015 and 2030, in percent](image)

Source: World Bank staff calculations based on Eurostat data.

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Currenty, there are more women than men in the population, particularly in older age groups. However, over time as the life expectancy of men and women is expected to converge, the size of the older male and female populations is expected to become more equal.
Table 2. Indicators of population change in Estonia, in percent (unless otherwise noted), 1990, 2012, 2030 and 2060

<table>
<thead>
<tr>
<th>Age</th>
<th>1990</th>
<th>2016</th>
<th>2030</th>
<th>2060</th>
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<tbody>
<tr>
<td>0-14</td>
<td>22.2</td>
<td>16.1</td>
<td>14.7</td>
<td>15.2</td>
</tr>
<tr>
<td>15-29</td>
<td>21.1</td>
<td>17.7</td>
<td>16.6</td>
<td>16.2</td>
</tr>
<tr>
<td>30-49</td>
<td>27.3</td>
<td>27.4</td>
<td>24.6</td>
<td>23.1</td>
</tr>
<tr>
<td>50-64</td>
<td>17.8</td>
<td>19.7</td>
<td>19.9</td>
<td>15.4</td>
</tr>
<tr>
<td>65-79</td>
<td>9.1</td>
<td>13.9</td>
<td>17.1</td>
<td>18.3</td>
</tr>
<tr>
<td>80+</td>
<td>2.6</td>
<td>5.1</td>
<td>7.1</td>
<td>11.7</td>
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<tr>
<td>Working age (aged 15-64)</td>
<td>66.2</td>
<td>64.9</td>
<td>61.1</td>
<td>54.7</td>
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<tr>
<td>Old-age dependency ratio</td>
<td>17.6</td>
<td>29.3</td>
<td>39.6</td>
<td>54.9</td>
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<td>Median age (years)</td>
<td>34.4</td>
<td>41.7</td>
<td>44.9</td>
<td>46.6</td>
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<tr>
<td>50+ share of working age</td>
<td>26.9</td>
<td>30.4</td>
<td>32.6</td>
<td>28.2</td>
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<tr>
<td>50+</td>
<td>29.5</td>
<td>38.7</td>
<td>44.1</td>
<td>45.5</td>
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<tr>
<td>65+</td>
<td>11.7</td>
<td>19.0</td>
<td>24.2</td>
<td>30.0</td>
</tr>
<tr>
<td>80+</td>
<td>2.6</td>
<td>5.1</td>
<td>7.1</td>
<td>11.7</td>
</tr>
<tr>
<td>Population (thousands)</td>
<td>1,565</td>
<td>1,316</td>
<td>1,208</td>
<td>1,093</td>
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<tr>
<td>Population change</td>
<td>-15.9</td>
<td>-8.2</td>
<td>-9.5</td>
<td></td>
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</table>

Notes: * Median age in 2015 (based on the medium variant of the United Nations’ Population Projections)  
** Based on the medium variant of the United Nations’ Population Projections.  
Eurostat (2016).  
United Nations, Department of Economic and Social Affairs, Population Division (2016).
Future demand for LTC services among the elderly in Estonia will not only be driven by the size of older age groups in the population, but also by how healthily the population ages and the levels of disability among older age groups. According to 2014 data, in Estonia, 25 percent of population aged 65+ reported having severe limitations in usual activities due to health problems, deeming them “dependent on care” (Figure 3). Estonia performs below EU average in terms healthy life expectancy, particularly for women. Estonia ranks 26th in the percentage of healthy years as a share of remaining life expectancy at 50 years old, at 47.4 percent. By comparison, this share is 58.6 percent for the EU28 on average, 79.7 percent for the best-performing country, Sweden, and 54.8 percent in Finland in 2012 (Eurostat). The higher life expectancy of women compared to men in Estonia is a well-known fact, but in terms of activity limitations, women perform substantially less well than in other EU countries. Women rank second last in the EU in terms of the share of healthy life expectancy at 50 years: 40.5 percent of remaining life expectancy for a 50-year old women is disability-free in Estonia, compared to the 51.9 percent in the EU28 (average), 74.8 percent in Sweden (the best-performing country) and 49.7 percent in Finland.
In Estonia, individuals aged over 65 are more likely to require assistance with ADLs/IADLs, to have mobility limitations, and to have a higher BMI than the EU average. A reliable measure of disability and associated demand for health care and LTC is the percentage of older people who require assistance with ADLs as well as IADLs. Analyses carried out for this study using the 2013 SHARE dataset reveal that, despite improvements in life expectancy, activity limitations for the population aged 65 years and older are more common in Estonia than the EU average. Among the 15 European countries surveyed by SHARE, elderly Estonians are the most likely to have at least one limitation to ADLs at 23.2 percent and are in the top 3 most likely to have at least one limitation to IADLs at 33.2 percent (Figure 4). Elderly Estonians also have the highest prevalence of mobility limitations, including difficulty with arm function and limitations to fine motor functions (Figure 5). In general, the percentages of the population with activity and mobility limitations as well as those with general limitations increases with age (Figure 6). Worryingly, the group of 65 year olds and over in Estonia had the second...
highest BMI (Figure 7) in the EU, in itself a predictor of many chronic conditions that lead to greater demand for LTC in older ages.

Figure 4. Activity Limitations

Source: World Bank Staff, calculations using the SHARE data.

Figure 5. Mobility Limitations

Source: World Bank Staff, calculations using the SHARE data.
The SHARE data also reveal emerging issues in mental health as well as cognitive abilities. In comparison to other countries for which there is data, Estonian respondents are the most likely to report having been sad or depressed in the last month, and the most likely to report other mental health indicators such as trouble sleeping, irritability, feeling a lack of companionship, and fatigue. In addition, cognitive scores among the elderly in Estonia are low compared to other countries included in the SHARE data. In tests of word learning, date orientation, and numeracy, Estonia elderly scored below the countries’ median (Figure 8).
The number of officially disabled people in Estonia has increased slightly in recent years, despite the modest decrease in total population. In 2016, there were a total of 146,343 officially disabled persons in Estonia, representing about 11 percent of the total population. Of these, 80,989 or 55 percent of the total population with disabilities, were over the age of 63 — a slight increase from 77,617 in 2013. This represents about 29 percent of the population 63 years and older (Table 3). In this age group (63+) women are twice as likely as men to have official disability status.

Source: World Bank Staff, calculations using the SHARE data.  

Official disability status is granted to individuals in Estonia for the receipt of social benefits (e.g. disability allowance, pension for incapacity to work, etc.). Until mid-2016, official disability status was granted following an assessment conducted by the Social Insurance Board (Sotsiaalkindlustusamet) with the help of medical experts whose task was to determine the degree of incapacity for work, and the category and cause of disability. In July, 2016, the Unemployment Insurance Fund launched the working ability assessment of people with decreased working ability, and the payment of working ability allowance. As of January 2017, working ability will solely be assessed by the Unemployment Insurance Fund. Between July 2016 and March, 2017, 8,087 individuals were assessed as having partial work ability, and 1,480 individuals as having no work ability.6

The number of old-age pensioners, one-fifth of whom need care, has grown slightly, from 296,000 in 2011 to 301,000 by the beginning of 2016. The number of persons receiving pension for incapacity for work has increased at a noticeably faster rate, especially the number of persons with 40–70 percent loss of capacity for work. Since 2011, their number has grown by 15,000, reaching 97,000 people at the beginning of 2016. Almost one in four people aged 65+ who describe their own health status as “poor” report that they do not receive any regular care (neither from a household member nor from someone outside the household) (Figure 9).

### Table 3. Disabled Persons7, Old-age Pensioners, and Persons Receiving Pension for Incapacity for Work (at the beginning of the year)

<table>
<thead>
<tr>
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</tr>
</thead>
<tbody>
<tr>
<td>Disabled persons</td>
<td>128,129</td>
<td>133,847</td>
<td>137,710</td>
<td>141,026</td>
<td>143,623</td>
<td>146,343</td>
</tr>
<tr>
<td>Old-age pensioners</td>
<td>296,199</td>
<td>297,985</td>
<td>297,413</td>
<td>300,047</td>
<td>300,151</td>
<td>300,884</td>
</tr>
<tr>
<td>Persons receiving pension for incapacity for work8</td>
<td>82,590</td>
<td>90,093</td>
<td>94,418</td>
<td>94,325</td>
<td>95,480</td>
<td>97,459</td>
</tr>
<tr>
<td>100% loss of capacity for work</td>
<td>9,661</td>
<td>9,941</td>
<td>9,724</td>
<td>9,280</td>
<td>9,199</td>
<td>9,011</td>
</tr>
<tr>
<td>80-90% loss of capacity for work</td>
<td>28,425</td>
<td>29,604</td>
<td>29,835</td>
<td>28,960</td>
<td>29,186</td>
<td>29,386</td>
</tr>
<tr>
<td>40-70% loss of capacity for work</td>
<td>44,504</td>
<td>50,548</td>
<td>54,859</td>
<td>56,085</td>
<td>57,095</td>
<td>59,062</td>
</tr>
</tbody>
</table>


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6 [https://www.tootukassa.ee/eng/content/work-ability-reforms/principles-and-methodology](https://www.tootukassa.ee/eng/content/work-ability-reforms/principles-and-methodology)

7 With official disability status

8 Of the able-bodied, working-age population
The elderly have the highest rates of at-risk poverty in Estonia when pensions and social assistance incomes are excluded, and these rates have more than doubled since 2010. In 2010, poverty rates among the population aged 65+ began to increase and by 2015 this age group had the highest at-risk poverty rates (Table 11). Protecting the pension system will be crucial for elderly welfare since pensions are extremely important sources of income for the elderly. If social assistance and pension income are excluded, at-risk-of-poverty rates among those aged 65+ are about 84 percent (though this is driven mostly by pensions rather than social assistance).

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9 The national poverty rate in Estonia is based on income. Two levels of poverty are reported: absolute and at-risk. People in absolute poverty have equalized disposable income below the estimated subsistence minimum. Total household income is divided by a sum of equivalence scales of all household members. The at-risk poverty threshold is 60 percent of the median adult equivalence disposable income.
Table 4. Poverty and material deprivation rate in Estonia by age group, 2010-2015

<table>
<thead>
<tr>
<th></th>
<th>18-64</th>
<th></th>
<th>65 and older</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2010</td>
<td>2015</td>
<td>2010</td>
<td>2015</td>
</tr>
<tr>
<td>At-risk-of-poverty rate, %</td>
<td>18.0</td>
<td>16.5</td>
<td>13.1</td>
<td>40.2</td>
</tr>
<tr>
<td>At-risk-of-poverty rate before social transfers, incl. pensions, %</td>
<td>31.8</td>
<td>28.0</td>
<td>86.4</td>
<td>83.9</td>
</tr>
<tr>
<td>At-risk-of-poverty rate before social transfers, excl. pensions, %</td>
<td>25.8</td>
<td>23.5</td>
<td>15.6</td>
<td>42.7</td>
</tr>
<tr>
<td>Absolute poverty rate, %</td>
<td>9.9</td>
<td>4.5</td>
<td>1.1</td>
<td>1.5</td>
</tr>
<tr>
<td>Absolute poverty rate before social transfers, incl. pensions, %</td>
<td>24.3</td>
<td>14.1</td>
<td>80.2</td>
<td>72.5</td>
</tr>
<tr>
<td>Absolute poverty rate before social transfers, excl. pensions, %</td>
<td>17.5</td>
<td>10.0</td>
<td>2.4</td>
<td>2.6</td>
</tr>
<tr>
<td>Material deprivation rate, %</td>
<td>22.9</td>
<td>12.1</td>
<td>17.3</td>
<td>14.7</td>
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</tbody>
</table>

Source: Statistics Estonia

Note: At-risk-of-poverty rate – proportion of persons with an equalized yearly disposable income lower than the at-risk-of-poverty threshold. At-risk-of-poverty threshold – 60% of the median equalized yearly disposable income of household members. At-risk-of-poverty rate before social transfers – the at-risk-of-poverty rate when social benefits paid by the state and local governments are not counted in the household’s income. Material deprivation rate – the share of persons, who cannot afford at least 3 items of 9 items: 1) to pay rent or utility bills, 2) keep home adequately warm, 3) face unexpected expenses, 4) eat meat, fish or a protein equivalent every second day, 5) a week holiday away from home, 6) a car, 7) a washing machine, 8) a color TV or 9) a telephone.

Note: a change data sources that took place in 2012 may affect comparability between 2010 and 2015 data.

The rural and less-educated are more likely to have limitations in daily activities and consequently, higher demands for care. Using data collected from 2004-5 and focusing on the population aged 20-79 years, the age-adjusted prevalence rate of daily activity limitations was 29.3 percent among individuals with primary education, 16.5 percent among individuals with secondary, and 11.1 percent among individuals with higher education (Almets et al., 2010). While less than 15 percent of 65+ individuals with higher education receive regular care from a household member, the proportion reaches 25 percent among those with a lower education level (Figure 10).
Rural areas, where the proportion of elderly is higher, tend to be poorer and have higher limitation rates than urban areas. The proportion of the elderly population is higher in peripheral/lagging and rural municipalities, due to the out-migration of populations into urban areas.
Figure 11). However, there is a higher concentration of elderly people in urban areas, such as Tallinn and Tartu. Older peripheral municipalities, where often almost a third of the population is 65 and above, are also generally poorer. Overall, there is a 22.3 percent prevalence rate of daily activity limitations in rural areas compared to 16.4 in urban areas (Almets et al., 2010).
Figure 11. Spatial Distribution of the Elderly

Proportion of the population over 65 in each municipality

Counties sized by number of people over 65 and shaded by Poverty Rate
Long-Term Care Needs for the Under-65 Population

The focus of this study is not limited to the elderly. Access to services for the disabled non-elderly, including disabled children, and other groups of population will also be examined. Unlike the elderly, this is not a group for whom the volume of services is expected to increase dramatically over time. The analysis will examine existing care arrangements and provide background on the options in terms of the care assistance provided by the government. Throughout the report, the analysis of long-term care spending and the future projections will be based on the entire population of disabled individuals, including the non-elderly, as well as people with special needs and health deterioration.

Across all age groups, Estonia performed slightly worse than the EU average in terms of proportion of people reporting one or more difficulties in daily activities. This was true even among the non-elderly population (Figure 12). In 2011, among 15-24 year-olds, the rate was 7.2 percent in Estonia and 4.6 percent in the EU as a whole. The size of the gap between Estonia and the EU also tended to increase with age: while 40.6 percent of Estonians aged from 55 to 64 reported having difficulties in daily activities, this applied to only 29.2 percent of Europeans on average. An overview of current rates of limitations to activities of daily life across different age groups, including youth, is presented in Figure 13. In line with these figures, the Adult Disability Dependency Ratio\textsuperscript{10} (ADDR) for adults 20 years or older is also higher in Estonia than in a number of EU15 countries\textsuperscript{11} (Bussolo et al., 2015).

![Figure 12. Rates of Difficulty in Basic Activities in Estonia, 2011, by age group\textsuperscript{12}](image-url)

Source: Eurostat (2016)

\textsuperscript{10} The ADDR is defined as the number of adults aged 20+ with disabilities, divided by the number of adults aged 20+ without disabilities (Sanderson and Scherbov, 2010).

\textsuperscript{11} Disability here is measured as self-identified activity limitations from the EU-SILC household survey and is a reliable lead indicator of disability and the associated demand for health and social LTC services.

\textsuperscript{12} A basic activity difficulty included difficulty in seeing, hearing, walking or communicating.
Figure 13. Rates of Limitations to Activities of Daily Living in Estonia, by age in 2011

Note: The rates of limitation to activities of daily living are calculated using the EU-SILC 2013, whose reference year is 2012. Responses are based on a self-assessment question of whether or not they have “Limitation in activities people usually do because of health problems for at least the last 6 months”. Responses of: 1) “yes, strongly limited” is coded as a severe limitation; 2) “yes, limited” is coded as a non-severe limitation; 3) “no, not limited” is coded as no limitation. A person is labeled to have a limitation if they have either a non-severe or a severe limitation.

Source: European Union Statistics on Income and Living Conditions (EU-SILC), 2013

Gender Gap in Long-Term Care Needs

Estonia has one of the largest disability gender gaps in the EU. In all EU member states for which gender-disaggregated data is available, women tend to display higher rates of disability than men. In 2012, the difference between the share of disabled females and disabled males was equal to about 9 percentage points in Estonia, as shown in Figure 14. This was significantly higher the European average of about 5 percentage points.
Employment Status of Disabled Individuals

While the majority of disabled people in Estonia are not currently employed, about one in three of those who are not working would be willing to work\textsuperscript{13}. In 2010, the employment rate among officially disabled individuals in Estonia was as low as 18 percent, or almost 4-fold lower than for those without disability (aged 16-64). By 2015, the employment rate of disabled people has increased to 31 percent (Table 5).

\textsuperscript{13} Saar Poll OÜ, Tartu Ülikool (Kadri Soo, RAKE; 2009). Puuetega inimeste ja nende pereliikmete hoolduskoormuse uuring Täiendanud ja toimetanud Sotsiaalministeeriumi sotsiaalpoliitika info ja analüüsi osakond.
Table 5. Labor status of working-age population (20-64) in Estonia, 2010-2015

<table>
<thead>
<tr>
<th></th>
<th>Labor force participation rate, %</th>
<th>Employment rate, %</th>
<th>Unemployment rate, %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Persons without disability</td>
<td>83    84.8</td>
<td>69.4  79.7</td>
<td>16.3   6</td>
</tr>
<tr>
<td>Officially disabled persons</td>
<td>27.2  34.7</td>
<td>18.2  31.2</td>
<td>33.1   10.1</td>
</tr>
<tr>
<td>Persons without incapacity for work</td>
<td>83.2  85</td>
<td>70.2  80.3</td>
<td>15.6   5.6</td>
</tr>
<tr>
<td>Persons with 40-100% incapacity for work</td>
<td>49.2  55.2</td>
<td>33.1  49</td>
<td>32.8   11.1</td>
</tr>
<tr>
<td>Persons with activity limitations</td>
<td>-   56.5</td>
<td>-     49.4</td>
<td>-     12.6</td>
</tr>
</tbody>
</table>

Source: Statistics Estonia

Most disabled people in Estonia are not actively seeking a job; the lack of information about available opportunities is often cited as an obstacle. About 79 percent have not searched for employment in the past four weeks, and 51 percent have not searched in the past year. Lack of information about job opportunities is cited by 38 percent of respondents as a major difficulty associated with finding employment; lack of adjustment of the workplace to accommodate people’s disabilities is cited by 33 percent, and lack of counseling about suitable jobs by 29 percent. Lastly, 18 percent of respondents cite lack of retraining opportunities as an obstacle to finding employment.

Disabled individuals who are employed tend to work full-time, but many would prefer to work part-time. In Estonia, only 18 percent of all employed disabled individuals works less than 20 hours per week; however, almost half would prefer to have a shortened work-week. In general, part-time work opportunities are limited in Estonia, partly because of taxation rules (such as the social contribution floor) which increase the tax burden of those in low-paying, part-time jobs considerably, as well as costs associated with organization of part-time jobs (these rules are described in greater detail in Annex 1).

1.2. How is LTC organized and provided?

Provision of LTC can be either formal or informal. Both types of care co-exist, either complementing or substituting for each other, depending on the type of dependency. Formal care is provided in either the public or private sector, by care assistants who are paid under some form of employment contract, and who are mainly lower-skilled caregivers or nurses. In contrast, to be considered informal, provision of care cannot be paid as if purchasing a service, though an informal caregiver may receive income transfers and, possibly, some informal payments from the person receiving care. Informal caregivers usually have an existing social tie to the care recipient.
Formal LTC services are provided by both the health and social welfare systems. The goal of long-term healthcare services is for the person to improve, maintain or regain health, or to adjust to a health condition. The goal of social LTC services is to maintain, regain or improve capabilities in day-to-day life, while either living at home independently, at home with domestic care or in institutional care (Paat and Merilain 2010). In Estonia, health care services are organized at the state level by the Estonian Health Insurance Fund (EHIF), whereas social welfare services are organized at both the state and local municipality level. This fragmentation in service organization often leads to a lack of coordination between the two sectors, despite the overlap in target populations. The specific LTC services provided by the health and social welfare systems are stipulated in the following legislative acts, which provide the legal framework governing formal LTC provision:

- General Part of the Social Code Act of 2015 (Sotsiaalseadustiku üldosa seadus), which establishes the principles and organization of social protection, rights, obligations, and liabilities of a person in applying social protection, organization of social protection financing, and the basis for managing the social protection information system
- The Social Welfare Act of 2015 (Sotsiaalhoolekande seadus), which regulates matters related to social care
- The Act on Amendments to the Social Welfare Act and Amendments to Other Associated Acts (Sotsiaalhoolekande seaduse muutmise ja sellega seonduvalt teiste seaduste muutmise seadus) of 2016
- The Social Benefits for Disabled Persons Act (Puuetega inimeste sotsiaaltoetuste seadus) of 1999 which regulates matters related to social benefits for disabled persons (procedure of establishing the degree of disability, and entitlement and amounts of the benefits)
- The Health Services Organization Act (Tervishoiuteenuste korraldamise seadus) of 2001 which provides the organization of and the requirements for the provision of health services, and the procedure for the management, financing and supervision of health care
- Health Insurance Act (Ravikindlustuse seadus) of 2002 which regulates solidarity-based health insurance

Health care services

LTC services provided through the healthcare system include geriatric assessment, institutional nursing care, and home nursing care (Box 1). Geriatric assessment is conducted to evaluate nursing care need and develop corresponding care plans. It is
typically conducted in geriatric departments of hospitals and is currently offered by 7 hospitals (Paat and Merilain, 2010). Nursing care can be provided in health care institutions (e.g. hospitals), and in patients’ homes. Patient stays in institutional nursing care are usually limited to a 60-day period; however, patients can apply for extended stays if there is space available. While medical rehabilitation is not a LTC service in Estonia by definition, it is a related support service which is utilized by patients with physical impairments or disabilities. Inpatient medical rehabilitation is provided in hospital departments while outpatient medical rehabilitation is provided in hospitals or outpatient health care centers. 

Nursing care services can also be added as necessary to the service package in social welfare institutions. For example, general (residential) care homes combine nursing, supervisory, and other types of care, as required by residents. In these establishments, a significant part of the care provided is a mix of nursing care and personal care services. The medical components of care are, however, much less intensive than those provided in hospitals (OECD, 2016). All providers of nursing care must be licensed by the Health Board.  

**Box 1. LTC and related support services provided through the health care system**

**Geriatric assessment:** an assessment of nursing care needs in elderly populations available since 2004. An interdisciplinary team performs the assessment of a client and devises individual nursing care plans. The team typically includes a physician (geriatrician or internist trained in geriatrics) a nurse, a social worker and other specialists if necessary.

**Institutional nursing care:** 24-hour nursing care provided in nursing care hospitals, nursing departments of acute care hospitals, and general care homes.

**Home nursing care:** nursing care provided in patients’ homes (mostly for patients who are immobile or have restricted ability to move).

**Medical rehabilitation:** part of specialized medical care for the restoration of impaired functions, preservation of restored functions or adjustment to a disability. Includes care and procedures that are carried out by a physiotherapist and other specialist(s) according to the patient’s condition.

The prevalence of nursing care institutions in Estonia increased during the healthcare reforms in the 1990s and early 2000s. These reforms sought to reduce the number of acute care beds and average length of stay in acute inpatient departments (i.e. by referring patients to nursing care hospitals once acute care needs are resolved, thereby freeing space for new acute care patients). In 2001, the Ministry of Social Affairs prepared the Nursing Care Master Plan 2015 in order to provide nursing care targets to

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14 The Health Board is an agency of the MOSA which is responsible for supervising healthcare providers, ensuring communicable disease surveillance and enforcement of health protection legislation (Lai et al. 2013).
match the hospital targets set out in the Hospital Master Plan 2015. The main changes recommended by the Hospital Master Plan 2015 were to turn small hospitals (mainly owned by local governments) into nursing care homes or hospitals, and to develop non-institutional nursing care services that provide home nursing and day-care nursing.

In 2013, hospitals that provided only in-patient LTC services (LTC hospitals) were reorganized as nursing care hospitals. As a result, the number of long-term nursing care facilities increased (Table 6). There was also a corresponding shift in the number of LTC beds between former LTC hospitals and nursing care facilities. By the end of 2013 there was a total of 10,375 LTC beds (former LTC hospitals had 725 beds, and nursing care facilities 9,650 beds). By the end of 2014, LTC beds had increased to 10,902 (former LTC hospitals had 698 beds and nursing care facilities 10,204 beds) (OECD, 2016). Despite the increase in nursing care facilities, the care provided by these facilities is often of insufficient quality and does not meet current needs due to inadequate premises and lack of medical personnel. There is also a shortage of nursing care beds in both nursing hospitals and social care institutions.

Table 6. Current stock of long-term nursing care providers

<table>
<thead>
<tr>
<th>Year</th>
<th>Long-term nursing care providers (inpatient and outpatient)</th>
</tr>
</thead>
<tbody>
<tr>
<td>2013</td>
<td>41</td>
</tr>
<tr>
<td>2014</td>
<td>45</td>
</tr>
<tr>
<td>2015</td>
<td>50</td>
</tr>
</tbody>
</table>

Source: National Institute for Health Development (2016)

Provision of health LTC services has grown over the past several years. The number of inpatient nursing care cases has grown by 32.6 percent between 2009 and 2015, while outpatient nursing care cases (including home nursing and geriatric assessment cases) grew by 86.9 percent in the same period (Table 7). Inpatient rehabilitation cases have grown by 11.8 percent, while outpatient rehabilitation cases have grown by 28 percent.

Table 7. Number of cases of using health LTC services, 2009-2015

<table>
<thead>
<tr>
<th></th>
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<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient Nursing Care</td>
<td>13,631</td>
<td>14,753</td>
<td>14,831</td>
<td>16,848</td>
<td>18,647</td>
<td>19,055</td>
<td>18,078</td>
</tr>
<tr>
<td>Outpatient Nursing Care</td>
<td>19,764</td>
<td>23,907</td>
<td>28,359</td>
<td>32,146</td>
<td>35,540</td>
<td>38,244</td>
<td>36,945</td>
</tr>
<tr>
<td>Home Nursing Care</td>
<td>18,599</td>
<td>22,528</td>
<td>27,017</td>
<td>30,719</td>
<td>34,101</td>
<td>36,844</td>
<td>n/a</td>
</tr>
<tr>
<td>Geriatric Assessment*</td>
<td>1,165</td>
<td>1,379</td>
<td>1,342</td>
<td>1,427</td>
<td>1,439</td>
<td>1,400</td>
<td>n/a</td>
</tr>
<tr>
<td>Inpatient Rehabilitation</td>
<td>6,713</td>
<td>6,552</td>
<td>6,531</td>
<td>6,625</td>
<td>7,191</td>
<td>7,299</td>
<td>7,502</td>
</tr>
<tr>
<td>Outpatient Rehabilitation</td>
<td>58,617</td>
<td>60,962</td>
<td>67,122</td>
<td>70,318</td>
<td>67,748</td>
<td>78,770</td>
<td>75,010</td>
</tr>
</tbody>
</table>

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15 A nursing hospital is an economic unit formed in order to provide independent outpatient and inpatient nursing services.
Note: *Since 2015, geriatric assessment is no longer planned and monitored as a separate component - as a collaboration of the Estonian Society of Geriatrics and the Estonian Health Insurance Fund, this service has been integrated into the specialized inpatient treatment.

Although the volume of home nursing care has risen every year, it is still not sufficient to meet the demand (Lai et al. 2013). Provision of home nursing services is limited by the location of service providers whom the EHIF selects via a public procurement process. As a result, not all areas in the country are equally covered.

Estonia has the 5th highest number of long term care beds in hospitals among the EU countries for which the data are available, at about 98 beds per 100,000 inhabitants in 2014 (Figure 15). Only Hungary, the Czech Republic, Finland, and Romania had higher numbers of LTC beds in hospitals. In general, the number of hospital beds in the EU-28 is decreasing. Between 2008 and 2014, the number of hospital beds in the EU has decreased by 5.9 percent; in Estonia this reduction was considerably greater at 12.6 percent. In 2014, more than three quarters (76 percent) of all beds in EU-28 hospitals were for curative care, 14 percent for psychiatric care, and the remaining 10 percent for LTC and other purposes (Box 2).

**Figure 15. Long-term care beds in hospitals, 2008 and 2014 (per 100,000 inhabitants)**

*Note: *2012 instead of 2008, **2013 instead of 2014

*Source: Eurostat*
Box 2. Classification of hospital beds by type of care

- **Curative** care beds in hospitals are for patients where the principal clinical intent is to do one or more of the following: manage labor (obstetric), perform surgery, cure or treat (including relieving symptoms, reducing severity, or protecting against exacerbation and/or complication) of non-mental illness or injury, and/or perform diagnostic or therapeutic procedures. They include beds for psychiatric and non-psychiatric curative (acute) care, from general hospitals, mental health hospitals and other specialised hospitals. Beds for palliative and long-term nursing care are recorded under long-term care.

- **Rehabilitative** care beds in hospitals are beds accommodating patients with the principal intent to stabilise, improve or restore impaired body functions and/or structures, compensate for the absence or loss of body functions and/or structures, improve activities and participation and prevent impairments, medical complications and risks. They include beds for psychiatric and non-psychiatric curative (acute) care, from general hospitals, mental health hospitals and other specialised hospitals.

- **Psychiatric** care beds in hospitals are for patients with mental health problems. Included are all beds in mental health and substance abuse hospitals, as well as beds in psychiatric departments of general and specialty hospitals. Methodological changes in the classification of hospital beds have included psychiatric beds among the various categories of beds, however, in most countries they are also accounted for separately.

- **Long-term care beds** in hospitals are for patients requiring long-term care due to chronic impairments and a reduced degree of independence in activities of daily living, including palliative care. They include beds for psychiatric and non-psychiatric curative (acute) care, from general hospitals, mental health hospitals and other specialized hospitals.

- **Other** beds include all other beds in hospitals not elsewhere classified.


In turn, Estonia ranks somewhere in the middle among EU countries in terms of the number of LTC beds in nursing and residential facilities per 100,000 inhabitants. In 2014, there were 3.7 million LTC beds in nursing and residential care facilities in the EU Member States for which data was available (Figure 16). Relative to population size, the highest numbers of LTC beds in such facilities were recorded in Sweden and Belgium (using 2011 data), with 1.3 thousand and 1.2 thousand per 100,000 inhabitants respectively. Estonia was somewhere in the middle with over 800 LTC beds per 100,000 inhabitants in 2014. In total, 19 EU Member States reported at least 600 LTC beds in nursing and residential care facilities for every 100,000 inhabitants. By contrast, the remaining six Member States for which data are available reported fewer than 400 such beds per 100,000 inhabitants, with Romania (140 per 100,000) and Bulgaria (44 per 100,000) reporting the lowest ratios.

Despite the high number of LTC beds in hospitals, regional accessibility to inpatient nursing care services is uneven. The Estonian Nursing Care Network Development Plan 2004-2015 specifies that each county should have 10 beds per 1000 people aged 65 and older. However, the average is lower (at about 8.4) because some counties such as Jõgeva, Pärnu, Viljandi and Valga counties have considerably more beds than planned, while the number of beds in Järva and Saare counties is just 57 percent of that plan.

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16 Nursing and residential care facilities refer to long-term care institutions which provide accommodation and long-term care as a package. Beds in nursing and residential care facilities are recorded separately from hospital beds.

17 2011 data was available for Belgium and Denmark; 2012 data for Luxembourg and the Netherlands; and 2013 data for France, Germany, Italy, and Spain.
Moreover, this situation is aggravated since, for historical reasons, the EHIF does not finance services in accordance with the number of people aged 65 and over living in a region. For example, the contract between service providers and the EHIF covers 40 percent of the estimated need for services in Lääne-Viru County, but 73 percent and 77 percent, respectively, in Lääne and Põlva counties (Olgo 2015).

Figure 16. Long-term care beds in nursing and residential care facilities, 2008 and 2014 (per 100,000 inhabitants)


Source: Eurostat

The number of nurses per capita is still relatively low, but progress is being made. In 2013, there were 33 doctors and 66 nurses and midwives per 10,000 inhabitants in Estonia. The 2016 goal, set in the National Health Plan for 2009–2020, was to raise the number of physicians and nurses to 83 per 10,000 inhabitants (in line with the European Union average of 84)\(^1^8\). In 2016, the Ministry of Social Affairs signed an agreement in cooperation with the Associations of Nurses, the Association of Hospitals, Health Care colleges and other parties to increase reception of nurses. The number of new nurses employed is set to rise to 517 per year until 2020. For example, about 501 nurses will be added in 2018; a substantial increase with respect to the previous average of 450 nurses per year. For the past two years, the Ministry of Social Affairs has also

\(^{18}\) Statistics Estonia
been implementing a project targeted to individuals with nursing degrees who are employed in other sectors than health care. Since it was launched, about 20 nurses per year have come back to the health care system, and the project is being scaled up.

Social LTC services and benefits

Provision of formal social LTC services includes both in-kind social services and cash benefits. These services are provided as needs-based social assistance to individuals requiring assistance with basic activities of everyday life as well as those with special care needs.

LTC in-kind services provided by the social welfare system are provided by either the local municipality or by the state. Since 2005, most social services have been the responsibility of local self-government, e.g., municipalities and cities, because they are best acquainted with local life. LTC services provided by the local municipalities include domestic service (or home care), general care services provided outside the home, support person services, and personal assistant services (Box 3). Related support services provided at the municipality level include social counselling, curatorship, social transport service, and provision of a dwelling for disabled individuals. Related support services organized at the state level include social rehabilitation services (organized by the Social Insurance Board) and vocational rehabilitation services (organized by the Unemployment Insurance Fund).

The responsibility of providing care for children with disabilities was recently transferred to local governments. According to the Act on Amendments to the Social Welfare Act and Amendments to Other Associated Acts (2016), the childcare service for children with official severe or profound disability status provided for in the Social Welfare Act has been changed into a social service organised by local government. As such, the funds for state-funded childcare services for children with a severe or profound disability will be distributed to local governments according to the number of children who need the service. Funding will be ensured through each local government’s support fund.

According to the Act, an additional 1 million Euros will be allocated from the state budget to support the parents of children with a profound disability. At present, the state funds the partial support of children with a severe or profound disability through county governments. After the amendment, only local governments will engage in the organisation of childcare service, as they are deemed to best understand the needs of the children and families in their community. In the future, the childcare service organised by local governments will also include children with a severe or profound disability with the specification that the state will partially cover an additional funding need arising from the disability.
### LTC services organized by local municipalities

**Domestic service (home care):** assistance provided to a person in activities which the person is unable to perform without personal assistance due to reasons relating to state of health, operational capacity or physical and social environment, which are essential for living at home, such as heating, cooking, cleaning, washing clothes, buying food, and running other errands outside the dwelling. The service can include personal care procedures as well i.e. helping in hygiene procedures etc.), therefore domestic service can be divided into home care (cleaning rooms, buying food etc.) and personal care (helping with personal cleaning and other hygiene procedures; feeding, etc.).

**General care service provided outside the home:** assistance provided to adults temporarily or permanently unable to cope independently at home due to reasons relating to state of health, operational capacity or physical and social environment, ensuring a safe environment.

**Support person service:** support to cope independently in situations where a person needs significant personal assistance in performing his or her obligations and exercising his or her rights due to social, financial, psychological or health problems. Upon provision of the support person service to a person raising a child, an additional objective is to ensure that the child is cared for and raised in a safe and supportive environment. The objective of providing the support person service to a child is to support the development of the child, in co-operation with the person raising the child, including performance of care procedures in the case of a disabled child, if necessary.

**Personal assistant service:** assistance to increase the independent coping ability and participation in all areas of life of an adult who needs physical assistance due to a disability, and to reduce the care burden of that adult’s legal curators.

**Curatorship:** assistance for adults who due to mental or physical disability needs cannot exercise his or her rights and the performance of his or her obligations. The duties of a curator shall be determined upon establishment of the curatorship.

**Social transport service:** transportation service to enable a person who suffers from a disability that hinders the use of a personal or public transport vehicle to get to work or an educational institution, or use public services.

**Housing for disabled persons:** Dwelling adaptations or support to obtain a more suitable dwelling for persons who have difficulties moving about, caring for themselves or communicating in a dwelling as a result of a disability.

**Childcare service:** support for a person who has legal custody or is a caregiver for a child with severe or profound disability or in need of care services according to his/her rehabilitation plan.

### LTC services organized by the state

**Special care services:** support/assistance for persons with severe, profound or permanent mental disorder and persons with severe or profound disability including:

- **Everyday life support service:** support for independent coping and development through psychosocial coping, the development of everyday life coping skills and working skills and counseling of people who are close to the person, including those living with them.
- **Supported living service:** support for social coping and integration, as well as supervision in the organization of household and everyday life to maximise a person’s independent coping when living independently.
- **Community living service:** provision of a family-like environment for the satisfaction of basic needs and accommodation and catering support to help increase the person’s ability to cope independently and to develop the skills of the organization of everyday life activities through participation in joint activities.
- **24-hour special care service:** 24-hour care, plus accommodation and catering, to ensure preservation and increase of the person’s ability to cope independently, including a safe living environment.
- **Employment support service:** supervising and advising a person in order to support their ability to cope independently and improve their quality of life, both while search for a job corresponding to that person’s particular abilities, and during employment.

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19 A detailed list of services and benefits according to the Social Welfare Act are presented in Annex 2.
**Social rehabilitation:** support for children and adults to achieve independent coping, social integration and employment or commencement of employment, according to a six months to five years-long rehabilitation plan.

**Vocational rehabilitation:** support for working-age adults to be prepared to start or maintain working life. Vocational rehabilitation may be needed to improve mobility skills or speech, learn to use assistive equipment and to address psychological problems. May include activities such as physiotherapy, occupational therapy and counselling, creative art therapy, speech therapy, help of a special needs educator, peer support, provision of psychological advice, etc.

Sources: Social Welfare Act 2017; OECD 2011a; OECD 2011b; Unemployment Insurance Fund website: https://www.tootukassa.ee/eng/content/work-ability-reforms/work-rehabilitation

**Social LTC services can be provided either in the home or in social welfare institutions.** Social welfare institutions include: day care centers, general care homes, special care homes, youth homes, residential educational institutions, and social rehabilitation centers (Social Welfare Act 2015). Municipalities sometimes manage the provision of some services (more characteristic for small rural municipalities), but most purchase them from private or public sector providers. Currently, there are 213 local self-governments in Estonia, including 183 rural municipality governments and 30 city governments. Every second municipality has fewer than 2,000 inhabitants; the smallest has around 100 inhabitants. An ongoing subnational reform in Estonia will reduce the number of local governments and increase the population size of municipalities.

**The assessment of need for these services is typically conducted by social workers employed by the municipality but also by specialist doctors in the SIB.** In case of LTC and related support services organized by the state (such as special care services; social rehabilitation, vocational rehabilitation), the needs assessment is conducted by psychiatrist or rehabilitation team. Need for childcare is also assessed by the educational system. The assessment of care needs has been part of the social welfare system’s case management process since 2004. The assessment examines physical capabilities (e.g. eating, maintaining hygiene, doing chores etc.) as well as psychological and social aspects (e.g. ability to work, communicate, etc.). The assessment involves a questionnaire, an interview and observation by a specialist, as needed. Most municipalities use the assessment tools (questionnaires) suggested by the MoSA and adapt them to their own needs. Based on this assessment, local government representatives make a decision regarding the appropriate service package and a personal care plan is developed (Paat and Merilain 2010). The same assessment tools may be used for various social LTC services provided by a municipality.

**While many users of these services are disabled, eligibility for services is defined based on the results of the assessment and does not necessarily require official disability status (depending on the policy of each municipality).** This is based on the assumption that the provision of LTC should not be linked with the official disability only, but that special needs and health deterioration must be taken into account. For example, in some municipalities a caregiver’s allowance may be provided to a carer of an elderly person without official disability status. If a caregiver’s reports signal a serious
disability, municipalities may assist that person in obtaining official disability status. However, such an individual approach is more characteristic of small municipalities.

Based on a survey of respondents aged 50 and over, the services with the highest demand included domestic service, social transport service and personal assistant service. Provision of a dwelling, care in a day care center, and rehabilitation service were lower in demand among respondents (Figure 17).

Figure 17. Demand for social services in 2015 (population aged 50+), % of respondents

Availability of social services in municipalities varies. According to the Social Welfare Act 2015, thirteen types of assistance and services should be available to disabled individuals in every local authority. However, the survey on accessibility of social services

---


21 The 13 kinds of assistance and services include: Domestic Service; General Care Provided Outside Home; Support Person; Curatorship of Adults; Personal Assistant; Shelter; Safe House; Social Transport; Provision of Dwelling; Provision of Dwelling to Disabled Persons; Debt Counseling; Everyday Life Support;
services found that on average, municipalities provided only six services, ranging from 14 to 74 percent of services. The least available services were support person service for mentally disabled adults (14 percent of municipalities/cities), and community living service for individuals with a severe, profound, or permanent mental disorder (28 percent). The most accessible services were social transport (74 percent) and domestic service (68 percent) (Uri, 2012).

In addition to in-kind social services, cash benefits are also provided by local governments and by the state. Local governments may provide caregiver allowances to informal caregivers, based on eligibility criteria determined by each local government. The state, in turn pays fees for the purchase or lease of technical aids; fees for social rehabilitation services; disability allowances for children, disabled parents, persons of working age and persons of retirement age; as well as education, work and in-service training allowances for disabled individuals. The state also provides incentives for employers employing disabled individuals (e.g. social tax incentive, compensations for workplace adaptation or provision of special equipment, and compensation for training costs) and pays eligible caregivers’ national insurance contributions and social tax. The county administration is responsible for monitoring the care system (e.g., care services, benefits, etc.) and ensuring quality of care services.

Informal care

Most informal LTC is delivered by families and friends (mainly spouses, daughters, and stepdaughters) (Lipszyc et al., 2012). Indeed, Estonian legislation considers that the primary responsibility to provide assistance to family members in need lies with the family network. The Constitution of the Republic of Estonia (Art. 27) stipulates that the family is required to provide care for its members in need. In addition, according to the Family Law Act passed in 2009, family members required to provide care are defined very broadly and include adult ascendants and descendants related in the first and second degree. Persons entitled to receive care are 1) a minor child; 2) a child who is acquiring basic, secondary, higher education, or formal vocational education as an adult until he or she attains 21 years of age; and, 3) other descendant or ascendant who needs assistance and is unable to maintain him or herself (see Art. 96-99 of the Act for details).

Families in Estonia tend to have close contacts with their older family members. Around 40 percent of the elderly interact with other family members on a daily basis, and only around 3-5 percent biweekly or about once a month (Table 8).

Employment Support; Supported Living; Community Living; 24-hour Special Care; Childcare; Substitute Home; Foster Care of Child.

Note: More detailed information on employment incentives and benefits for disabled individuals provided in Annex 1.

See also General Part of the Social Code Act Art. 11.
The State Audit Office is of the opinion that local authorities should first assess that the person himself, or his or her family, are not capable of providing care before providing assistance involving taxpayers’ funds (Riigikontroll, 2014). Similar views are shared by the Supreme Court of Estonia (Riigikohus). Individuals in need are not denied assistance if the service or vacancy is available locally (e.g., in a nursing/general care home), and the local self-government has a budget for services. However, when local self-governments are constrained by a lack of funds in budgets or lack of social workers, they often reference the Family Law Act, arguing that it is the primary responsibility of the family to provide support to a person with disability, elderly, or other dependents.

Due to the composition and characteristics of informal caregivers and their dependents, the care burden costs are high and quality is threatened. Most informal caregivers are of older age and have their own health problems. Moreover, many may lack the means and knowledge to provide the assistance necessary. Combining paid work and caring activities may prove difficult for working-age informal caregivers, particularly if they also care for children. To address care needs, they may decide on part-time work, or to drop out of the labor market. The lack of training and support for informal caregivers increases the risk of admission into institutional care (Polluste et al. 2016).

Several meta-analyses have revealed the following impacts of informal care on caregivers (Bauer and Sousa-Poza, 2015):

- Intense caregiving is related to lower working hours and lower levels of labor force participation. Results suggest that caregiving reduces labor force participation by around 12 percent for men and women.
• 75 percent of caregivers experience problems combining work and caregiving, mostly in accommodating irregular work hours and participating in training and meetings.

• Employed caregivers earn about 6 percent less than non-caregivers.

• Full-time caregivers have more absences for sickness and lower health than non-caregivers.

• One fourth of dementia caregivers reported clinically significant anxiety levels, higher than the noncaregiver controls.

A comparison of caregivers with non-caregivers shows significantly lower mental health but only small differences in physical health. Caregiving for individuals with dementia is associated with substantially higher levels of depression (Bauer and Sousa-Poza, 2015).

In Estonia, a sample survey of 1,130 respondents revealed the following characteristics of informal caregivers and their dependents24:

• Around half of dependents are a husband, wife, or partner (47 percent); other dependents include parents (23 percent); other relative or non-relative (14 percent); adult child (8 percent); or underage child (3 percent);

• 62 percent of caregivers are women, and most are aged 50-74;

• Average age of a caregiver is 60;

• 51 percent of caregivers are old-age retirees, 29 percent are working, and 2 percent are students;

• One in seven caregivers has higher education;

• 21 percent of caregivers have been officially assigned to care;

• 17 percent of caregivers have to assist more than one family member, usually underage child(ren);

• 59 percent of caregivers are the only assistant to the disabled family member;

• Almost 60 percent of caregivers provide assistance at least three hours per day, or 20 hours per week;

• 77 percent of caregivers aged 16-64 have not reduced their workload at a main job or interrupted studies, while over 18 percent have;

• 74 percent of caregivers work full time in their main job (e.g., 40 hours per week), 16 percent work less than 40 hours per week, and 10 percent work more than 40 hours per week;

• 55 percent of caregivers have flexible work/study arrangements, but 32 percent cannot change their work/study arrangements;

• 37 percent of caregivers have taken leave specifically to care for the disabled family member; 23 percent have taken unpaid leave, and 20 percent have taken special leave;

• More than half of caregivers (56 percent) have medical problems themselves, and 17 percent have severe restrictions due to their own medical issues.

• Only four percent of caregivers have received training, and 23 percent have educated themselves by reading literature.

A vast majority of caregivers have received no training but many are looking for information on how to provide care. Informal caregivers say their greatest need (38 percent of respondents) is to reduce their daily workload and have time off when caring duties could be delivered by a personal assistant. Many caregivers would also like to have better access to social transport (18 percent of respondents); financial support (13 percent); access to medical services (7 percent), and counseling services (5 percent).

As the survey data reveals, informal caregiving for disabled relatives is characterized by large gender disparities and a relatively greater care burden among the 50+ population, many of whom have health problems of their own. In 2010, 6.3 percent of 15-64 year old females reported regularly taking care of an elderly, sick or disabled relative or friend aged 15 or more; for men, this proportion was considerably lower, at 3.9 percent (Table 9). The 50-64 year old population are twice as likely as 35-49 year old adults to be providing care, at 11.3 percent for females and 7.5 percent for males.

### Table 9. The number and proportion of men and women with and without care obligations for an elderly, sick or disabled relative or friend aged 15 or more, by age group, 2010

<table>
<thead>
<tr>
<th></th>
<th>Number of persons, thousands</th>
<th>Proportion of persons (total=100), %</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Total</td>
<td>With care obligations</td>
</tr>
<tr>
<td>Males</td>
<td></td>
<td></td>
</tr>
<tr>
<td>15-64</td>
<td>437.7</td>
<td>16.9</td>
</tr>
<tr>
<td>15-24</td>
<td>96.2</td>
<td>1.4</td>
</tr>
<tr>
<td>25-49</td>
<td>230.4</td>
<td>7.2</td>
</tr>
<tr>
<td>50-64</td>
<td>111.1</td>
<td>8.3</td>
</tr>
<tr>
<td>Females</td>
<td></td>
<td></td>
</tr>
<tr>
<td>15-64</td>
<td>470.8</td>
<td>29.4</td>
</tr>
</tbody>
</table>

34
While the need for informal care is growing quickly due to the increase in life expectancy, the supply of informal caregivers is decreasing. Due to low birthrates, the size of younger generations is shrinking. In addition, because many children have migrated to cities or emigrated to other countries, they tend to live further away from their parents. Moreover, as wages increase, the labor market productivity foregone is also increasing.

1.3. Who receives LTC?

During recent years, just one third of the dependent population in Estonia received LTC (including institutional care, formal and informal home care, and cash benefits) – low compared to most other EU countries (Figure 18). This is about three and a half times lower than in Finland, three times lower than in Lithuania and Czech Republic, and twice as low as Poland. Higher coverage in these countries is explained by not only greater public spending on the LTC, but also by the distribution of funds between the types of services and benefits – all of these countries reach high coverage rates using cash benefits.

Figure 18. Country-specific coverage rates of LTC recipients, as % of dependent population; median coverage rates between 2009-2013
Note: Median coverage rates between 2009-2013 in the EU and Norway; Coverage estimated as ration between recipients and potentially dependent population. Coverage may be above 100%, as the same recipients may receive cash benefits and in-kind benefits at the same time, which is not corrected in this graph. Population of potentially dependent based on EU-SILC data on “self-perceived longstanding limitation in activities because of health problems [for at least 6 months]” is used.


However, the share of the population that accesses some kind of long-term care service is relatively high, given that public spending and coverage is low, implying that there may be room to further focus long-term care services. In 2014, about 68 thousand people or 6.1 percent of the population aged 15 years and over in Estonia received some in-kind social LTC service (Figure 19). This compares to an average of 4.2 percent in the EU (European Commission, 2016). While the data on unique social LTC service users is not available, the coverage indicators used for this analysis were calculated based on the number of users of each LTC service; hence if a person used more than one LTC service during the year 2014, he or she was included in the sample of beneficiaries more than once. Therefore the coverage indicators presented in Figure 19 are overestimated to a certain degree and should be used as indicative.

Figure 19. The distribution of social LTC users by type of service, 2014

Note: Each beneficiary of each service is counted separately, i.e. if the same person used two types of social LTC services during 2014, he or she is included into the number of beneficiaries twice. The number of users of the social rehabilitation service is unique, starting from 2012. Before that, due to application procedures, the same person could be accounted for more than once during the same year. The number of caregivers is used as a proxy for the number of service recipients. Precise numbers can be obtained from the STAR database which was not available to the World Bank team during this project. The data on caregiver’s allowances are available starting from 2011.


About 60 percent of social LTC services users are of retirement age (Figure 20). The estimated share of the group of retirement-age people who accessed at least some
long-term care services is relatively high. About 11 percent of the total retirement age population used at least one social LTC service during 2014 (Figure 21). When narrowing down to the disabled elderly population (with official disability status)\(^{25}\), the coverage of social LTC is estimated at 39 percent. Among the severely or profoundly disabled elderly\(^ {26}\), the coverage is estimated at 52 percent. According to MoSA data\(^ {27}\), 78,767 persons aged 65 and above (or 27.6 percent of this age group) had the official disability status in 2014. Of these individuals, three quarters (or 21.0 percent of the 65+ population) were severely or profoundly disabled.

**It should be noted that a substantial share of the elderly with ADL limitations and serious health deteriorations do not have official disability status, but still receive municipal assistance.** For example, as discussed in Section 1.3, some municipalities provide support to informal carers of the elderly who did not apply for or were not assigned official disability status, but who have obvious ADL limitations (the World Bank’s survey of municipalities, 2016).

**LTC coverage among officially disabled working-age adults is 12 percentage points lower than among the disabled elderly** (Figure 21). However, among the severely and profoundly disabled\(^ {28}\), estimated coverage among the working-age population is at 58 percent, which is 6 percentage points greater than that for the elderly.

**As is to be expected, children with moderate (official) disabilities receive lower coverage by social LTC services compared to children with more serious mental and physical health problems** (MoSA data, 2014). However, children with moderate disabilities access some LTC services at a noticeably higher relative frequency than adults with moderate disabilities. For example, the number of municipalities providing support to informal carers of moderately disabled children is several times greater than for working-age adults with the same disability level\(^ {29}\).

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\(^{25}\) We use different proxy indicators for the target group since identifying the exact target population given the data available is not possible.

\(^{26}\) Excluding those with moderate disabilities

\(^{27}\) Starstatistika.sm.ee, Statistics on disabled persons type of disability, age and sex, 2015.

\(^{28}\) Again, official disability status is used here.

\(^{29}\) WB’s conducted Municipality survey data, 2016
Almost a half of those who access long-term care are users of institutional care, and another 23 percent received so-called semi-institutional services provided by day care centers. Only slightly more than one out of 10 beneficiaries of in-kind social LTC and/or cash benefits received home-based services. Indeed, coverage of home-based services is estimated at only 15 percent of total need (Paat and Merilain 2010).

Retirement-age adults account for the largest proportion of general care home use while working-age adults use special care homes more frequently (Figure 22). This is because a large share of working-age adults who receive social LTC services have mental health issues and thus are clients of special care homes (about 29 percent of the group or more than five thousand people in total) (Figure 22). At the same time, retirement-age persons diagnosed with dementia and without any other serious mental illness diagnosis are not entitled to use special care services, according to the Social Welfare Act. The distribution of funds would change if one of the main areas of unmet need in the Estonian LTC systems, the care of older people who have dementia, was covered. General care homes are unable to provide specific services to those with dementia as there is an absence of specialized staff to provide the greater care they need. In addition, general care homes often have open doors, while some older people with dementia require a more secure space.
A lower proportion of the elderly population with ADL limitations receive professional care in Estonia compared to other EU/EFTA countries (for which data is available). Despite the relatively high proportion of officially disabled elderly population accessing some social LTC services, the reported proportion of older age persons with ADL limitations (and not necessarily with official disability status) who received professional help in Estonia is considerably lower than in most other countries analyzed using SHARE (Figure 23) and coverage does not differ much with increasing age.
Indeed, in the last year of life (the period of most people’s highest need) Estonia has one of the lowest uses of professional caregivers (9 percent) across all the EU countries for which information is available from the Survey of Health and Retirement in Europe (SHARE). This is particularly low in comparison to Estonia’s Scandinavian neighbors, where professional caregivers provide assistance to 62 percent of people in Denmark and 60 percent in Sweden in their last year of life. Instead, in Estonia, these people rely on receiving assistance from their relatives: in their last year of life, 37 percent of people with ADL limitations in Estonia received help from their children or grandchildren, and a half from at least one of his or her relatives. However, 43 percent of persons with ADL limitations had to cope by themselves (without any help from other people). This self-reliance is greater than found in any other SHARE country analyzed (Figure 24).

**Figure 24. Who Has Helped with ADL in the last 12 months of life?**

<table>
<thead>
<tr>
<th>Country</th>
<th>Children or grandchildren</th>
<th>One of relatives</th>
<th>Professional helper</th>
<th>Other</th>
<th>No one or person oneself</th>
</tr>
</thead>
<tbody>
<tr>
<td>Estonia</td>
<td>37</td>
<td>49</td>
<td>9</td>
<td>7</td>
<td>43</td>
</tr>
<tr>
<td>Slovenia</td>
<td>37</td>
<td>47</td>
<td>12</td>
<td>7</td>
<td>40</td>
</tr>
<tr>
<td>Czech...</td>
<td>39</td>
<td>57</td>
<td>18</td>
<td>7</td>
<td>27</td>
</tr>
<tr>
<td>Israel</td>
<td>31</td>
<td>40</td>
<td>61</td>
<td>11</td>
<td>18</td>
</tr>
<tr>
<td>Belgium</td>
<td>34</td>
<td>44</td>
<td>66</td>
<td>8</td>
<td>16</td>
</tr>
<tr>
<td>Switzerland</td>
<td>18</td>
<td>29</td>
<td>57</td>
<td>3</td>
<td>35</td>
</tr>
<tr>
<td>Denmark</td>
<td>24</td>
<td>35</td>
<td>62</td>
<td>9</td>
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</tr>
<tr>
<td>France</td>
<td>40</td>
<td>47</td>
<td>53</td>
<td>15</td>
<td>12</td>
</tr>
<tr>
<td>Italy</td>
<td>53</td>
<td>59</td>
<td>6</td>
<td>3</td>
<td>38</td>
</tr>
<tr>
<td>Spain</td>
<td>52</td>
<td>58</td>
<td>24</td>
<td>12</td>
<td>25</td>
</tr>
<tr>
<td>Netherlands</td>
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<td>30</td>
<td>58</td>
<td>14</td>
<td>27</td>
</tr>
<tr>
<td>Sweden</td>
<td>23</td>
<td>29</td>
<td>60</td>
<td>9</td>
<td>25</td>
</tr>
<tr>
<td>Germany</td>
<td>15</td>
<td>35</td>
<td>40</td>
<td>20</td>
<td>30</td>
</tr>
<tr>
<td>Austria</td>
<td>21</td>
<td>35</td>
<td>43</td>
<td>12</td>
<td>31</td>
</tr>
</tbody>
</table>

*Source:* World Bank staff calculations based on SHARE 5th wave data  
*Note:* Who has helped with ADL in the last 12 months of life? Multiple answers were possible. The categories ‘children or grandchildren’ and ‘one of relatives’ overlap. The category ‘no one or person oneself’ doesn’t overlap with any other category. Basis: All deceased people with ADLs.
In terms of medical care received in the last year of life, Estonia ranks close to the median among EU countries for several services. This includes the receipt of hospice care, home care or help due to disability, hospital stays, and medication (Figure 25). However, Estonia ranks on the lower end for receiving care in a nursing home, care from specialist physicians, care from a general practitioner, and receiving aids and appliances.

The elderly may receive informal care from caregivers either within or outside the household. About 9 percent of all people aged 65 and above receive informal care from a household member, and this proportion increases with need: 20 percent among those who also have mobility difficulties (Figure 26), and about 30 percent of those with one or two IADL limitations receive informal care from someone outside the household, and the proportion rises to 46 percent among those with three or more IADL limitations (Figure 27).
Estonians at the bottom of the income distribution are more likely to rely on informal care, particularly from household members, than those at the top of the income distribution. Those aged 65 and above who experience “some difficulties” or “great difficulties” in making ends meet are about twice as likely as those who do not experience such difficulties to receive regular care from a household member (Figure 28). In particular, among people aged 65+ with mobility limitations, 21 percent of those in the bottom income decile receive regular care from a household member, as opposed
to only 9 percent of their counterparts in the top income decile (Figure 29). Lower income is also associated with higher use of informal care from someone outside of the household (Figure 30).

**Figure 28. Proportion of people aged 65+ receiving regular care from household member, by ability to make ends meet**

**Source:** World Bank staff calculations using SHARE data

**Figure 29. Proportion of people aged 65+ with mobility limitations receiving regular care from HH member, by income decile**

**Source:** World Bank staff calculations using SHARE data
Figure 30. Proportion of people aged 65+ receiving any informal care from someone outside HH by ability to make ends meet

1.4. What are the costs of LTC?

The costs of LTC include both direct costs from public spending on health and social care services, and indirect costs, which mainly result from the caring burden’s impact on labor supply and employment. These costs are described in more detail below.

Direct costs of LTC

Overall spending

Public spending on LTC in Estonia is lower than in most other EU member states and future spending projections envisage continued low spending (Figure 31 and Figure 32). Estonia spent approximately 0.6 percentage points of GDP on LTC in 2013. By comparison, LTC spending as a share of GDP was about 1.5 percentage points in Germany, Austria and Luxembourg, 2.5 percentage points in Denmark and Finland and over 3.5 percentage points in Sweden, the Netherlands and Norway. In most of these countries, spending on LTC is projected to double by 2060, leaving Estonia still lagging behind at about 1.3 percentage points of GDP (European Commission, 2015). The large differences in public LTC spending across OECD countries may reflect a number of factors, starting with differing demographic and economic situations and ending with reliance on informal LTC.

Note: Projections are based on expenditures for medical and social LTC services as reported in the Eurostat system of health accounts (SHA) and European system of integrated social protection statistics (ESSPROS) databases. However, many countries using SHA accounting do not report expenditures on social services of LTC which may lead to underreporting of expenditures.
Higher public spending on LTC is associated with higher estimated coverage of the target group for LTC services (Figure 33). Due to high spending on in-kind and cash benefits in countries such as the Netherlands, Belgium and Finland, the estimated share of the target population that is not covered is virtually non-existent. In turn, due to low public spending on LTC in countries like Estonia, a large estimated share (about 2/3) of the target group for LTC is left receiving either non-publicly funded informal care or no care at all.

A large variation in approaches to LTC spending is apparent even among countries with comparable spending levels. For example, while “big spenders” such as Sweden, Belgium and Netherlands (as measured by the share of GDP devoted to public spending on LTC) rely more on in-kind LTC services, Finland puts more weight on cash benefits. In addition, Denmark seems to spend more on average on each case than other “big spenders” keeping some share of the target group uncovered. In contrast, Poland (a “low spender”) retains relatively high coverage via wide cash benefits, although the share of in-kind services is particularly low. “Low-spenders” such as Romania, Bulgaria and Estonia reach about the same estimated coverage levels as Ireland and Slovenia, which have twice the level of LTC expenditure (as share of GDP). However, this may reflect a trade-off between a willingness to cover greater share of the target group on the one hand, and a relatively large service package and high quality of care for those who need it most on the other.

Figure 33. Public spending and estimated non-coverage, share of total LTC coverage by provider, 2010

Source: Commission services (DG ECFIN); Lipszyc et al, 2012

Note: The "non-formal" category covers very different country-specific situations. Those under the category “informal care or no care” are severely disabled people who received only – not publicly funded – informal care or no care at all. Overlaps between types of care are possible, therefore the estimated coverage may exceed 100%.
Estonia spends a relatively low proportion of total public spending on LTC\textsuperscript{31} on in-kind benefits compared to other EU countries, but a relatively large share of its in-kind benefits are for institutional care. Estonia spends only 39 percent of its total public spending on in-kind LTC services (Figure 36). However, about 90 percent of Estonia’s formal in-kind spending on LTC services is on institutional care, surpassed only by Latvia among other EU countries (Figure 34).

**Figure 34.** Proportion of spending on institutional care as part of formal in-kind spending, in percent

<table>
<thead>
<tr>
<th>Country</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Latvia</td>
<td>93</td>
</tr>
<tr>
<td>Estonia</td>
<td>90</td>
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<tr>
<td>Netherlands</td>
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<td>Czech Republic</td>
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<td>Poland</td>
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<td>Spain</td>
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<td>Romania</td>
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<tr>
<td>Cyprus</td>
<td>9</td>
</tr>
</tbody>
</table>

**Figure 35.** Proportion of formal in-kind spending as part of total public spending on LTC, in percent

<table>
<thead>
<tr>
<th>Country</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Latvia</td>
<td>85</td>
</tr>
<tr>
<td>Estonia</td>
<td>39</td>
</tr>
<tr>
<td>Netherlands</td>
<td>100</td>
</tr>
<tr>
<td>Czech Republic</td>
<td>56</td>
</tr>
<tr>
<td>Poland</td>
<td>82</td>
</tr>
<tr>
<td>Malta</td>
<td>68</td>
</tr>
<tr>
<td>Spain</td>
<td>90</td>
</tr>
<tr>
<td>Austria</td>
<td>65</td>
</tr>
<tr>
<td>France</td>
<td>89</td>
</tr>
<tr>
<td>Slovenia</td>
<td>98</td>
</tr>
<tr>
<td>Croatia</td>
<td>93</td>
</tr>
<tr>
<td>Belgium</td>
<td>69</td>
</tr>
<tr>
<td>Luxembourg</td>
<td>65</td>
</tr>
<tr>
<td>Germany</td>
<td>96</td>
</tr>
<tr>
<td>Lithuania</td>
<td>96</td>
</tr>
<tr>
<td>Hungary</td>
<td>95</td>
</tr>
<tr>
<td>Sweden</td>
<td>53</td>
</tr>
<tr>
<td>UK</td>
<td>77</td>
</tr>
<tr>
<td>Denmark</td>
<td>100</td>
</tr>
<tr>
<td>Italy</td>
<td>86</td>
</tr>
<tr>
<td>Slovakia</td>
<td>99</td>
</tr>
<tr>
<td>Ireland</td>
<td>100</td>
</tr>
<tr>
<td>Finland</td>
<td>86</td>
</tr>
<tr>
<td>Portugal</td>
<td>99</td>
</tr>
<tr>
<td>Bulgaria</td>
<td>100</td>
</tr>
<tr>
<td>Israel</td>
<td>8</td>
</tr>
<tr>
<td>Romania</td>
<td>39</td>
</tr>
<tr>
<td>Cyprus</td>
<td>80</td>
</tr>
</tbody>
</table>

Note: The EC does not include long-term nursing care into these calculations which may partly explain the discrepancy between EC results and the results obtained by the World Bank team using the MoSA provided data. According to the MoSA data, the share of institutional care within the in-kind LTC care doesn’t exceed 80% even if all the so-called semi-institutional services as well as housing service is included.

Source: Joint Report on Health Care and Long-Term Care Systems & Fiscal Sustainability, 2016

\textsuperscript{31} Including health and social LTC spending.
Although a large proportion of total public spending on LTC is for institutional care in Estonia, the corresponding share of GDP devoted to institutional care (at about 0.34 percent) is not high compared to other EU countries. Given that the total expenditure on LTC services in Estonia is not high, the room to reduce resources devoted to institutional care is low since a major part of these funds goes to look after vulnerable disabled working-age adults in special care institutions and hospitals, and also individuals who have physical or mental disorders. For the elderly, however, the expected growth of expenditure for care homes may be balanced with a wider offer of home-based services (home care and support to informal carers).

**Expenditure assignments for LTC**

**Following the organization of LTC services in Estonia, financing for LTC is divided between the health and social care systems.** Spending on social LTC comprises the largest share (about 60 percent) of total spending on LTC (Figure 36).

**Figure 36. Long-term care public expenditure (health and social components), as a proportion of GDP, 2013 (or nearest year)**

![Figure 36. Long-term care public expenditure (health and social components), as a proportion of GDP, 2013 (or nearest year)](image)

Note: The OECD average only includes the thirteen countries that reported health and social LTC. The indicator for Estonia is based on the MoSA provided data and in contrast to the figure included into the OECD report contains also the social LTC component.

Source: OECD Health Statistics, the MoSa and EHIF data.

**Health LTC services are funded at the state level through the EHIF (Eesti Haigekassa).** The EHIF covers the majority of the cost of health LTC services (geriatric assessment, institutional nursing, home nursing and medical rehabilitation) for its insured population, which is currently about 96 percent of the total population.

**Insured patients are required to pay a copayment of 15 percent for these health LTC services, with the exception of the geriatric assessment which is fully funded by EHIF.** For institutional nursing care, the 15 percent copayment applies for a 60 day stay in a nursing care hospital, for
Social services are paid for either by local municipalities or the state. Local municipality governments distribute their LTC budgets among non-institutional services (e.g., domestic care, personal assistant service, etc.), institutional services (e.g., general care homes) and housing services (e.g., dwelling adaptations, provision of housing). Municipalities have a large degree of freedom in defining the service packages, prices, and volumes of services provided. In turn, the state is responsible for funding special care, which includes institutional and non-institutional services, as well as childcare, social rehabilitation and vocational rehabilitation. Specifically, special care, childcare and social rehabilitation are financed through the budget of the Social Insurance Board (Sotsiaalkindlustusamet), while vocational rehabilitation is financed through the budget of the Unemployment Insurance Fund (Töötukassa). Expenditure on childcare services is mainly covered from the state budget (82.9 percent of public spending in 2014, MoSA data), but most (not all) municipalities provide caregiver allowances to the parents/carers of disabled children (as well as for carers of disabled adults and elderly persons). In addition, while the state is mainly responsible for special care services, municipalities covered 7.8 percent of the total public expenditure on this service in 2014.

Service user out-of-pocket payments are also required for many social LTC services. For example, a person referred to receive 24-hour special care has to pay a contribution for catering and accommodation. In 2014 out-of-pocket (OOP) expenditure comprised 25.3 percent of the total budget for this service (Table 10). The most common services for which fees are charged by the local government are general care homes, followed by housing services, adjustments in housing, and childcare services (Pihor et al., 2011). In 2013, OOP expenditures made up 68.3 percent of the total service budget for general care homes (MoSA data). The share of out-of-pocket payments for these services has also been increasing. For example, the percentage of the copayment for general care homes in 2002 was just 39 percent of total costs. General care homes and special care homes are also the most expensive social services in terms of both private and public expenditure, amounting to Eur 41.4 million and 25.8 million in 2013, respectively.

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32 Has been introduced as a separate service block in January of 2016 and covers working age population.
Table 10. Expenditures on social care services by financier in 2013, in thousands of Euros, unless otherwise stated

<table>
<thead>
<tr>
<th>Financier</th>
<th>Housing service</th>
<th>Personal assistance service</th>
<th>Domestic service</th>
<th>Daily care centers</th>
<th>Support person service</th>
<th>Special care service</th>
<th>General (social) care homes</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Total costs</strong></td>
<td>1565.9</td>
<td>621.5</td>
<td>4988.7</td>
<td>5441.8</td>
<td>678.1</td>
<td>25794.4</td>
<td>41439.6</td>
</tr>
<tr>
<td>State</td>
<td>40.1</td>
<td>41.8</td>
<td>11.3</td>
<td>77.7</td>
<td>78.6</td>
<td>17284.3</td>
<td>177.5</td>
</tr>
<tr>
<td>Local self-government</td>
<td>1525.6</td>
<td>520.6</td>
<td>4764.5</td>
<td>++++449</td>
<td>441.4</td>
<td>1817.5</td>
<td>12839.3</td>
</tr>
<tr>
<td>Recipient of the service, his/her family, or guardian</td>
<td>-</td>
<td>30.9</td>
<td>212.5</td>
<td>574.5</td>
<td>43.3</td>
<td>6531.6</td>
<td>28305.8</td>
</tr>
<tr>
<td>Other</td>
<td>0.03</td>
<td>28.3</td>
<td>0.5</td>
<td>290.1</td>
<td>114.8</td>
<td>161.0</td>
<td>117.0</td>
</tr>
</tbody>
</table>

**Structure of expenditures, %**

<table>
<thead>
<tr>
<th>Financier</th>
<th>State</th>
<th>Local self-government</th>
<th>Recipient of the service, his/her family, or guardian</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>State</td>
<td>2.6</td>
<td>6.7</td>
<td>0.2</td>
<td>1.4</td>
</tr>
<tr>
<td>Local self-government</td>
<td>97.4</td>
<td>83.8</td>
<td>95.5</td>
<td>82.7</td>
</tr>
<tr>
<td>Recipient of the service, his/her family, or guardian</td>
<td>-</td>
<td>5.0</td>
<td>4.3</td>
<td>10.6</td>
</tr>
<tr>
<td>Other</td>
<td>0.002</td>
<td>4.5</td>
<td>0.009</td>
<td>5.3</td>
</tr>
</tbody>
</table>

*Source: Sotsiaalministeerium, 2015*

Most elderly people finance their fees for social services from their state-provided pensions; however, most pensions are not sufficient to cover costs of even the least expensive general care home. Prices in most general care homes (*hooldekodud*) vary between Eur 500 and 600 per month. The highest service fee was in the private care home ‘Benita Kodu’, Eur 1260, and in Merivälja Pansionaat, Eur 1224 for a single room, and the lowest, Eur 380 in Tabivere Social Center. In 2015, the average old-age pension was Eur 366 per month.

Local municipalities establish the amount of these fees that must be covered by the recipient for social services; however they do not share a common methodology. The determination of the fee is usually based on the cost of the service and the financial status of the applicant.

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34 See [https://infogr.am/kui_palju_maksab_koht_hooldekodus](https://infogr.am/kui_palju_maksab_koht_hooldekodus)
According to a 2014 audit conducted by the State Audit Office, local authorities have expressed a need for more detailed and universal instructions on how to assess a family’s economic situation, including what kind of information should be gathered. In most cases, if local authorities investigate the beneficiary’s economic status, they collect information about incomes (in 93 percent of cases) and real estate (54 percent of cases). Ownership of cars, deposits, or securities tends not to be investigated. According to the current law, at least 15 percent of a person’s income should remain for personal use after payment of income tax, unemployment insurance premium, contribution to funded pension, and support.

In accordance with the Family Law Act, if the applicant is not able to cover the costs of care, their family is held responsible. Thus, the more solvent the family, the smaller the share paid by the local authority (i.e., the taxpayer). According to the Social Welfare Act as well as General Part of the Social Code Act, the municipality is obliged to provide services for the person who needs it: local governments may not leave a person without assistance if a person cannot pay for the service. If the applicant is not able to cover the costs and has no close relatives or has relatives who are unable to pay, the municipality provides funds to cover the gap. If there are no general care homes in the municipality the local government must identify a place in another municipality and organize person’s transportation.

Institutional care absorbs over 50 percent of the total public budget devoted to LTC in Estonia. In 2014, spending on special care homes, inpatient nursing care and general care homes comprised the largest shares of total public spending on LTC, at 22, 19 and 13 percent respectively (Figure 37). In turn, spending on both home care and home nursing care was only 5 percent of total spending each. The data available do not allow estimating precisely the budget devoted specifically to the target group since, for example, inpatient nursing care budget (the second largest category) is spent both on the disabled and non-disabled population.

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35 In an audit conducted in 2014, 82 percent of local self-governments, out of 193 surveyed, were of the view that principles on how to assess assets of the person in need should be the same across the country.
36 The elderly person’s municipality, not the municipality where the facility is located (if different)
37 Although matching the SIB and EHIF administrative data technically allows indicating the share of health care services and health care budget devoted to the officially disabled population, this would lead to substantial underestimation since the definition of the target population used in this report is considerably broader.
Home-based care is, however, far less expensive than institutional care per beneficiary. For example, in 2012, the estimated magnitude of cost per beneficiary in general care homes was on average 519 Euros per month, while home care cost per beneficiary was 62 Euros. However, use of home care among the elderly remains low, at around 2.6 percent of the elderly population receiving the service in 2014, and there appears to be no correlation between use of home-based services and availability of residential care facilities in municipalities (the share remained the same for municipalities with and without residential care facilities).

Most municipalities (136 in 2014) devote more resources to support for informal carers than for formal home care. In 2014, 48 municipalities did not provide home care, while only nine did not provide support to informal caregivers. However, when social tax is not taken into account, the mean monthly cost of support to informal caregivers is even lower than the mean monthly cost for home care, and the total public expenditure for the two services is about the same (4.8 million Euros for home care and 4.2 million Euros for the caregiver’s allowance).

Municipalities who choose to provide support to informal caregivers are free to decide on the size and eligibility criteria for the caregiver’s allowances. In some municipalities, not only family members, but also non-relatives can act as caregivers. In others, benefits are only

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38 Including state and municipal funding
provided to caregivers who are not family members – but this mostly concerns carers of the disabled adults and elderly (not children). The average monthly allowance for caregivers of working age adults and elderly people with official severe disability status is about 21 Euros and for profoundly disabled status this is increased by 11-12 Euros (Table 11). Moreover, municipalities are obliged to pay social contributions for unemployed caregivers, which increases the annual costs of this service by 64-68 percent (STAR data, 2013-2015). Since state-provided benefits for disabled children are not very high and in some cases one of the parents has to leave the labor market in order to take care of the child (especially in cases of mental disorders), many municipalities provide further support to these parents, ranging from 12.8-200 Euros, depending on municipality and degree of disability.

Table 11. Size of monthly caregiver’s allowances in Estonian municipalities, in Euros, 2015

<table>
<thead>
<tr>
<th></th>
<th>Minimum allowance, Euro</th>
<th>Maximum allowance, Euro</th>
<th>Average allowance, Euro</th>
<th>Number of municipalities who reported providing caregiver’s allowance for this group and reported the rates</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Child</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>moderate</td>
<td>12.79</td>
<td>100.00</td>
<td>31.05</td>
<td>85</td>
</tr>
<tr>
<td>severe</td>
<td>15.00</td>
<td>100.00</td>
<td>33.33</td>
<td>126</td>
</tr>
<tr>
<td>profound</td>
<td>15.34</td>
<td>200.00</td>
<td>42.99</td>
<td>125</td>
</tr>
<tr>
<td><strong>Working-age adult</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>moderate</td>
<td>7.03</td>
<td>50.00</td>
<td>18.78</td>
<td>14</td>
</tr>
<tr>
<td>severe</td>
<td>10.00</td>
<td>100.00</td>
<td>20.93</td>
<td>140</td>
</tr>
<tr>
<td>profound</td>
<td>12.78</td>
<td>200.00</td>
<td>33.15</td>
<td>144</td>
</tr>
<tr>
<td><strong>Retirement-age person</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>moderate</td>
<td>7.03</td>
<td>51.00</td>
<td>20.71</td>
<td>14</td>
</tr>
<tr>
<td>severe</td>
<td>10.00</td>
<td>100.00</td>
<td>21.12</td>
<td>138</td>
</tr>
<tr>
<td>profound</td>
<td>12.78</td>
<td>200.00</td>
<td>32.35</td>
<td>142</td>
</tr>
<tr>
<td><strong>Retirement-age person with no official disability status</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>15.00</td>
<td>70.00</td>
<td>30.08</td>
<td>14</td>
</tr>
</tbody>
</table>

Source: World Bank staff calculations based on the WB’s conducted Municipality survey data, 2016

40 159 municipalities participated in this survey, however not all of them filled out the section on the CG allowances.
Trends in public spending on LTC

The public budget for social services has grown considerably slower than expenditure on health LTC (Table 12). The budget for social services has increased 35.1 percent since 2009 while health expenditures increased by 57.6 percent during the same period. The growth of social LTC service coverage is largely due to increasing private expenditure, which has increased by 58.7 percent since 2009.

In addition to the support of the government, the European Social Fund funding helps to develop and offer services. From 2014 to 2020, the European Social Fund contributed 37 million Euros for transportation services, childcare, and support persons for children with severe and profound disabilities. The aim of the program is to restructure the current system and ensure that children with disabilities receive the support required, including access to education and everyday activities. Furthermore, improving the quality and accessibility of social services aims to decrease the care burden of caregivers and to improve the entrance to the labor market.

Table 12. Main components of LTC expenditure in Estonia (Breakdown (a) private and public, (b) health and social care (c) state, local government etc.) per million Euros

<table>
<thead>
<tr>
<th></th>
<th>2009</th>
<th>2010</th>
<th>2011</th>
<th>2012</th>
<th>2013</th>
<th>2014</th>
<th>Increase between 2009 and 2014, %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Social LTC</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Municipal expenditure</td>
<td>25.5</td>
<td>23.0</td>
<td>30.6</td>
<td>31.6</td>
<td>33.3</td>
<td>33.7</td>
<td>32</td>
</tr>
<tr>
<td>State expenditure</td>
<td>20.9</td>
<td>20.9</td>
<td>22.8</td>
<td>21.7</td>
<td>25.5</td>
<td>29.0</td>
<td>39</td>
</tr>
<tr>
<td>Private expenditure</td>
<td>25.7</td>
<td>26.9</td>
<td>28.4</td>
<td>31.6</td>
<td>35.7</td>
<td>40.8</td>
<td>59</td>
</tr>
<tr>
<td>Health LTC</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>State expenditure (EHIF)</td>
<td>24.3</td>
<td>23.1</td>
<td>24.3</td>
<td>27.7</td>
<td>32.0</td>
<td>38.3</td>
<td>58</td>
</tr>
<tr>
<td>Private expenditure</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
</tr>
</tbody>
</table>

Source: MoSA and EHIF data

The EHIF’s budget for inpatient nursing care has increased significantly in the past 6 years, growing by 100 percent from 14.9 million Euros in 2011 to 30.2 million Euros in 2016. The price of inpatient nursing care and home nursing care services has also increased by one quarter to ensure better quality of care and use of up-to-date medical expertise.

The largest relative increase among social care services was observed for childcare (grew 3.6 times), support personnel (grew 3.5 times), special care (increased by 29.2 percent) and personal assistant (increased by 37.1 percent) (Figure 38 and Figure 39). EHIF expenditure during this period grew for all the health LTC services; for inpatient nursing, medical rehabilitation and geriatric assessment costs increased nearly by a half, while expenditure for home nursing doubled.\(^{41}\) This implies that OOP payments also went up considerably at about the same rate (except for the geriatric assessment that is covered fully by state).

\(^{41}\) In 2015, this tendency remained and public health expenditure on LTC was Eur 3.9 million greater than in 2014.
During recent years, the coverage of home care services for the elderly barely expanded. Since 2009, the number of clients who received at least a minor home-care service package during the year increased by only 7 percent and spending rose by just 9 percent in nominal terms (Table 13). Out-of-pocket payment for home-care services is generally very low; local governments admit that they maintain the copayment to encourage the client to be as active as possible and not take advantage of the social worker. For example, in Aegviidu rural municipality the copayment for the minimum package (that includes buying food once a week and paying bills) is low at 4 Euros per month. In Parnu city the prices for the services are as follows: buying food (2 Euros per episode), taking a person to the doctor (3 Euros per episode, the most expensive service), preparing food (1 Euro), and taking out trash (0.50 Euro). In 2014, the share of private expenditure within the total costs for the service was 4.1 percent.
Table 13. Home care has low coverage and has not expanded much since 2009

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of clients who used the service at least once during the year</td>
<td>6,140</td>
<td>6,225</td>
<td>6,116</td>
<td>6,157</td>
<td>6,435</td>
<td>6,545</td>
<td>7</td>
</tr>
<tr>
<td>Number of caregivers at the end of the year</td>
<td>684</td>
<td>670</td>
<td>663</td>
<td>645</td>
<td>633</td>
<td>630</td>
<td>-8</td>
</tr>
<tr>
<td>OOP, Eur</td>
<td>90,528</td>
<td>120,118</td>
<td>145,432</td>
<td>197,236</td>
<td>212,508</td>
<td>217,320</td>
<td>140</td>
</tr>
<tr>
<td>Municipality + state expenditure, Eur</td>
<td>4,653,384</td>
<td>4,248,632</td>
<td>4,398,479</td>
<td>4,345,817</td>
<td>4,775,783</td>
<td>5,088,428</td>
<td>9</td>
</tr>
</tbody>
</table>

Source: The MoSA data, 2009-2014

The limited supply for home-based services for the elderly results in growing demand for general care home services as the population ages, though unit costs of home-based services are much lower. The usage of general care home services increases year to year, and from 2009 to 2014 the number of clients grew by a third. While public expenditure on this service during the five-year period increased by only 10.9 percent, out-of-pocket (OOP) spending went up by 62.0 percent comprising 71.9 percent of the total expenditure (Figure 37). Given that the average monthly payment for the general care home service considerably exceeds the average old age pension, usage indicators are limited by income level of the elderly (and their relatives).

Support for caregivers has also fallen in recent years. From 2011 to 2015, the number of supported caregivers decreased by one fifth from 17,225 to 13,547 (Table 14). Moreover, the number of caregivers for whom social tax was paid is even smaller: in 2015, 2,600 beneficiaries compared to 3,300 individuals in 2011. The slight growth of public expenditure on caregivers during the recent years reflects the increase of social contribution that local governments pay for the unemployed caregivers (by 9.8 percent), while the volume of benefits paid directly to caregivers has slightly decreased (by 2.1 percent).

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42 According to the survey conducted by the Ministry of Social Affairs, in 2009 family carers were looking after 51,951 disabled individuals who were their family members, but only 21 percent of carers were officially assigned as carers. According to the Estonian Labor Force Survey module 2010 “Combining working and family life”, 46,400 people (i.e. 29,400 women and 16,900 men) aged15-64) had a care obligation.
Table 14. Caregivers receiving an allowance, or for whom social tax was paid in 2011-2015

<table>
<thead>
<tr>
<th></th>
<th>2011</th>
<th>2012</th>
<th>2013</th>
<th>2014</th>
<th>2015</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of caregivers receiving the allowance</td>
<td>17,225</td>
<td>15,923</td>
<td>15,126</td>
<td>14,284</td>
<td>13,547</td>
</tr>
<tr>
<td>Number of cases of payment</td>
<td>180,280</td>
<td>171,319</td>
<td>164,032</td>
<td>155,046</td>
<td>146,615</td>
</tr>
<tr>
<td>For taking care of children</td>
<td>12,817</td>
<td>13,447</td>
<td>14,398</td>
<td>15,030</td>
<td>15,885</td>
</tr>
<tr>
<td>For taking care of adults</td>
<td>167,463</td>
<td>157,872</td>
<td>149,634</td>
<td>140,016</td>
<td>130,730</td>
</tr>
<tr>
<td>Caregivers for whom social tax was paid</td>
<td>3,297</td>
<td>3,188</td>
<td>3,061</td>
<td>2,872</td>
<td>2,588</td>
</tr>
<tr>
<td>Sum of caregiver allowances, Euro</td>
<td>4,213,955</td>
<td>4,163,501</td>
<td>4,197,584</td>
<td>4,159,540</td>
<td>4,123,521</td>
</tr>
<tr>
<td>For taking care of children</td>
<td>12,817</td>
<td>13,447</td>
<td>14,398</td>
<td>15,030</td>
<td>15,885</td>
</tr>
<tr>
<td>For taking care of adults</td>
<td>167,463</td>
<td>157,872</td>
<td>149,634</td>
<td>140,016</td>
<td>130,730</td>
</tr>
<tr>
<td>Social tax paid for caregivers, Euro</td>
<td>3,297</td>
<td>3,188</td>
<td>3,061</td>
<td>2,872</td>
<td>2,588</td>
</tr>
<tr>
<td>Source: MoSA data</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

It is estimated that most informal caregivers do not receive any public financial support. For example, the approximately 13,500 caregivers who received allowances in 2015, constitute less than one fifth of the estimated 72,000 individuals who were engaged as informal caregivers in the same year (Paimre, MTÜ Eesti Omastehooldus 2016). Reliance on unremunerated informal care is central to the low budget cost of the long-term care system in Estonia.

Variation in local government spending

The ability of local governments to fulfill their social benefits and services obligations depends to a large extent on the budgetary resources available. Estonia obtains the highest share of revenues from personal income tax (PIT)\(^43\) out of total tax revenues from local budgets, at 91 percent (excluding Tallinn at 93 percent). Land tax constitutes 8 percent of tax revenues, and local taxes, one percent. In 2015, 852.5 million Euros was transferred to local budgets as a share of personal income tax (PIT). Budgets of some municipalities are so small that the sum is not sufficient to provide even essential services to the population. For example, in 2015 the PIT transfer was 37,000 Euros for Piirissaare municipality; 112,000 Euros for Ruhnu municipality; 165,000 Euros for Ōru municipality; 205,000 Euros for Tõrgu municipality; and 206,000 Euros for Tudulinna municipality. Administrative reform is essential to enhance the capacity of local self-governments to provide social services and benefits.

As a response to the recession, in 2009, the proportion of PIT that was allocated to local self-governments was reduced from 11.93 percent to 11.4 percent. In 2014, the proportion was raised to 11.6 percent. As a result, revenues at the local level diminished by 40 million Euros, significantly reducing their capacity to meet commitments anticipated in legislation. The government is discussing the proposal to gradually raise the share of income tax, starting in

\(^{43}\) Personal income tax is 20 percent of income
2019, allocated to local self-governments to 12.13 percent by 2023. This will deliver an additional 65 million Euros and a portion of this amount can be utilized to enhance social services locally.

**Local governments are free to define their own policy for social LTC service provision but their capacity to fund and provide services are highly unequal.** As a result, the access to social services that is guaranteed in legislation depends largely on where the beneficiary lives. The composition of expenditure by type of service (Figure 40), especially in smaller municipalities, depends on (a) the demand for specific services, e.g. presence of the disabled children who need childcare service, (b) priorities defined by the local governments and (c) availability of resources (human resources and facilities). However, the overall supply of services depends primarily on the limited municipality budgets: the municipalities’ representatives admit that if their services were advertised more widely they would not be able to meet the demand since they cannot overspend their planned social LTC budget.

![Figure 40. Public social LTC spending by county per one officially disabled person, in Euros](image)

**Note:** For day care and care homes the expenditure by county was calculated based on facility location and is indicative only.

**Source:** World Bank staff calculations based on MoSA and Estonia Statistics data, 2014

As local authorities are not obliged to pay the caregivers’ allowance, regional disparities in payments are large (Table 15). When taking the total spending on caregiver allowance per person aged 65 or older as a proxy for the level of spending, the total spending on caregiver’s allowance per capita (as a proxy for the level of spending) fluctuated between 0.86 Euros in Saare county to 9.86 Euros in Võru county: an 11-fold difference. In 49 municipalities and cities, the number of people with official disability status is very small in Hiiu county – only 679 people in 2014 (Estonia Statistics data). Therefore in this county, the indicators calculated per one disabled person are relatively high.
there were less than ten beneficiaries of caregiver’s allowance. On average, in 2015, annual caregiver’s benefit was 304 Euros per beneficiary (ranging by locality and physical and mental status of the dependent between 5-100 Euros per month). These disparities indicate that there are no minimum standards in provision of the benefit, which is allocated at the discretion of local self-governments on an ad-hoc basis.

<table>
<thead>
<tr>
<th>Total population</th>
<th>Aged 65+</th>
<th>Ratio of aged 65+ out of total population</th>
<th>Spending on caregiver’s allowance per capita, Eur</th>
</tr>
</thead>
<tbody>
<tr>
<td>Whole country</td>
<td>1,315,944</td>
<td>250,325</td>
<td>0.190</td>
</tr>
<tr>
<td>Harju county</td>
<td>576,265</td>
<td>98,541</td>
<td>0.171</td>
</tr>
<tr>
<td>Incl. Tallinn city</td>
<td>423,420</td>
<td>76,557</td>
<td>0.181</td>
</tr>
<tr>
<td>Hiiu county</td>
<td>9,348</td>
<td>1,852</td>
<td>0.198</td>
</tr>
<tr>
<td>Ida-Viru county</td>
<td>146,506</td>
<td>3,180</td>
<td>0.217</td>
</tr>
<tr>
<td>Jõgeva county</td>
<td>31,298</td>
<td>6,948</td>
<td>0.222</td>
</tr>
<tr>
<td>Järva county</td>
<td>30,709</td>
<td>6,591</td>
<td>0.215</td>
</tr>
<tr>
<td>Lääne county</td>
<td>24,580</td>
<td>5,351</td>
<td>0.218</td>
</tr>
<tr>
<td>Lääne-Viru county</td>
<td>59,467</td>
<td>11,919</td>
<td>0.200</td>
</tr>
<tr>
<td>Põlva county</td>
<td>28,218</td>
<td>5,878</td>
<td>0.208</td>
</tr>
<tr>
<td>Pärnu county</td>
<td>82,997</td>
<td>17,484</td>
<td>0.211</td>
</tr>
<tr>
<td>Rapla county</td>
<td>34,148</td>
<td>6,419</td>
<td>0.188</td>
</tr>
<tr>
<td>Saare county</td>
<td>33,481</td>
<td>6,966</td>
<td>0.208</td>
</tr>
<tr>
<td>Tartu county</td>
<td>145,003</td>
<td>25,894</td>
<td>0.179</td>
</tr>
<tr>
<td>Incl. Tartu city</td>
<td>93,687</td>
<td>17,251</td>
<td>0.184</td>
</tr>
<tr>
<td>Valga county</td>
<td>30,524</td>
<td>6,675</td>
<td>0.219</td>
</tr>
<tr>
<td>Viljandi county</td>
<td>47,853</td>
<td>10,469</td>
<td>0.219</td>
</tr>
<tr>
<td>Võru county</td>
<td>33,973</td>
<td>7,174</td>
<td>0.211</td>
</tr>
</tbody>
</table>

Source: MoSA and Statistics Estonia data

The large variation in the funding of social care services for the elderly across local governments seems unrelated to revenues or population size. There is no clear relationship between the level of local government per capita revenues and spending on social LTC. It seems rather that differences in spending are due to the varied preferences of local governments in terms of prioritizing social LTC policies. The level of local spending is also affected by factors such as the population composition and the proportion of people with disabilities. There does not appear to be a relationship between municipality/city population size and spending. For example, in 2014, only three municipalities (Väätsa local self-government (LSG), Ruhnu LSG, and Torgu LSG\(^{45}\)) did not provide either home care or support to informal caregivers (Figure 41).

\(^{45}\) The information provided by Torgu local self-government within the Municipality survey conducted by the World Bank team in 2016 allows a conclusion to be drawn that currently there is no or almost no need for such services in this municipality. Väätsa and Ruhnu rural municipality did not provide the requested information.
Torgu LSG and Ruhnu LSG are very small municipalities (Ruhnu is an island, Torgu is also located on an island) with only 83 residents, 16 of whom are aged 65 and above (Statistics Estonia data, 2014). Väätsa is a rural municipality with a small population (214 residents aged 65 and above), providing only one social LTC service (housing service). However, there are a number of small municipalities such as Orava LSG (a small rural municipality with fewer than seven hundred residents and just 200 over the age of 65) where coverage of home care and support for informal caregivers is relatively high (38 percent of the 65+ population). Generosity may be found not only in small municipalities, but, for example, in the second largest city of Estonia, Tartu. Not only is the proportion of the target group covered in this city relatively high at 19 percent, the local government offers generous caregiver’s allowances (for children with officially disabled status this ranges from 75-100 Euros per month, and for the officially disabled adults can reach up to 66.3 Euros, depending on care needs). These rates are about double the average in Estonia.

Figure 41. Public expenditure on caregiver allowances and home care per population 65+ compared to per capita revenue, by local governments in 2014

Despite the large variation, spending on caregiver’s allowances overall is not a priority. In 2015, 852.5 million Euros of PIT was transferred to local budgets as their share of the total PIT. As PIT in turn constitutes 91 percent out of total tax revenues of local budgets, the share of payments for caregiver’s allowance constitutes only 0.45 percent of annual revenues of

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For comparison in Tallinn this is much lower at 7 percent, and in Narva city and in Pärnu city, lower still at 4 percent.
municipalities and cities, and payments for social contributions of caregivers, 0.27 percent of revenues.

**Spending by demographic group**

In contrast with spending on health, social LTC costs per beneficiary do not increase gradually with age. In Estonia, similar to many other countries (Maisonneuve and Oliveira Martins, 2013), the highest costs per patient are observed for working-age adults (
This is explained by the fact that more than a quarter of working-age adults who receive social LTC are individuals with mental health problems who use special care services, the area of social care that is responsible for the highest public expenditure both in absolute and relative terms (on average 3,600 Euros per beneficiary per year\(^{47}\)). Adults aged between 30-39, 40-49 and 50-59 years old comprise the largest portion of service users (more than 1,100 service users within each of these three age groups, MoSA data, 2014). High out-of-pocket (OOP) payments - on average 1,200 Euros per client per year- limit the demand for this public service. Slightly less than a half of working-age adults receiving social LTC services reside in municipal dwellings or social housing, and about 14 percent attend day care centers (MoSA data, 2014).

While retirement-age people comprise almost two-thirds of all social LTC users, they consume only a half of all public funds devoted to social LTC (\(^{47}\) While data on the average number of clients is not available, the indicator is calculated based on the number of clients during the year. This implies that actual costs per client are even higher.)
Figure 42. Public social LTC expenditure per beneficiary as a % of GDP per capita, 2014

Figure 43. Distribution of social LTC beneficiaries and public expenditure by age group, 2014

The relatively lower costs per retirement-age beneficiary (compared to working-age adults) is related to the less expensive set of services used by this age group. Only 3 percent of the elderly use special care, while a large share (37 percent) attend day care centers, which have moderate public costs (less than 300 Euros per regular customer per year). About a third of retirement-age clients used general care homes in 2014, which despite very high OOP payments, also require relatively moderate public expenditure at 1241 Euros per client per year (MoSA data, 2014).

As with older-age adults, children with disabilities account for relatively low public social LTC expenditure due to the less-expensive set of services provided to and used by families of these children (Figure 43). About a half of children with official disability status attend day care centers, 28 percent are provided with childcare, and another 16 percent use support person’s services.
The social LTC services covered within these calculations account for 77 percent of the total public social LTC expenditure and include home care, nursing homes, day care centers, special care homes, housing service, childcare, personal assistant, and support person. The data on the remaining social LTC services – caregiver’s allowances and social rehabilitation – can be obtained from the administrative databases only which were not available to the World Bank team during this project. Each beneficiary of each service is counted separately, i.e. if the same person used two types of social LTC services during 2014, he or she is included into the number of beneficiaries twice.

Source: World Bank staff calculations based on MoSA data.

Indirect Costs of LTC

Despite the fact that most caregivers work without payment, informal caregiving is associated with substantial indirect costs. Due to the limited access to publicly provided home- and community-based services and high costs of institutional care, many families must resort to informal caregiving. Since caregiving is time consuming and can be mentally and physically draining, it can negatively affect the caregiver’s health and ability to participate in the labor market. Employed people many need to reduce their working hours temporarily because of their child or parent’s care needs. They may also permanently move to a part-time job or withdraw from the labor market completely. The results of an analysis of the Estonian Labor Force survey data for years 2001-2016 demonstrates the effects of caring obligations and missing care services on labor supply and employment (Vork et al., forthcoming). The results of this analysis is presented below.

The effects of the caring burden on labor supply and employment

Inadequacy of care services continues to represent an obstacle to labor market participation. In recent years, about 8,000 Estonians were inactive and not seeking for a job due to their caring obligations. In addition, more than 5,000 people were employed part-time because of caring obligations. Using the Estonian Labor Force Survey between 2001 and 2016, the effects of caring obligations and lack of care services on labor supply are quantified in this section.

There were almost as many on parental leave, but these were not the focus of this note and were thus excluded from the analysis.
Despite an increase in the number of people who work part-time, the proportion of those citing a lack of care services as the main reason was unchanged, indicating that flexibility in work arrangements has increased. The number of people employed part-time because of caring obligations has been increasing rapidly over the past 15 years (from about 1,500 people in 2001 to about 5,500 in 2016). Among those working part-time, about 20 percent indicate that they are employed part-time because they lack care services.

Over the past 15 years, the number of people who do not work because of their caring obligations has declined, but almost one in three of these people still cite inadequacy of care services as the main reason. The number of people who are inactive and not seeking work because of caring obligations dropped from about 15,000 people in 2001-2005, to fewer than 10,000 since. In 2006-2007, almost 40 percent of those not employed and not looking for employment cited the lack of care services as the main reason. This proportion has dropped since then, but has remained around 20-30 percent. This suggests that while the access to care services has improved over the years, the inadequacy of care services still represents a primary obstacle to active labor market participation for about 2000-3000 people.

Inactivity and part-time employment due to care obligations tend to persist over the years. About 88 percent of those who did not seek a job because of caring were also inactive one year ago. About 8 percent were employed a year ago, and 4 percent were unemployed a year ago (as opposed to only 1.6 percent among other inactive people), suggesting caregivers may be more likely than others to feel discouraged when considering jobseeking. Similarly, about 73 percent of those who have a part-time job because of caring duties held the same job a year ago (though any changes to their working hours are not known) and only 5 percent have changed to a new job. About 5 percent left unemployment, and as many as 17 percent of inactive caregivers started seeking a part time job.

Caring obligations are mainly a burden for women. Among women aged 30 to 40, about 4-5 percent face care obligations that cause them to remain inactive or be employed part-time. This proportion is close to zero among men in the same age group. Among the 2.0-2.5 percent of women aged 30-40 who work part-time because of caring obligations, however, only about one in five justifies it with the lack of child or adult care services (Figure 44)
Logistic regression models suggest that in addition to age effects, there are strong educational and ethnicity effects on employment status among women with care obligations. Women with higher education are more likely than other women to be employed part-time because of caring, and they are less likely to be inactive because of caring. One possible explanation is that women with higher education have more flexible work options. In general, Estonians with higher education complain statistically significantly less about the lack of care services, suggesting that more educated people have access to more flexible work arrangements or have better access to care services because they can afford private services. In addition, non-Estonian women in Estonia are less likely to look for a job because of caring and also less likely to be employed part-time, compared to Estonian women.

Overall, non-Estonians seem to lack care services more than Estonians. This result may indicate inequality in access to care services by non-Estonian speakers due to regional variation, language barriers, and/or lower income.

Caring obligations also exert regional effects on employment status. While part-time work due to caring obligations is more common in Northern Estonia (i.e.: Tallinn, Harjumaa and Lääne-maa), inactivity due to caring is more common in Southern Estonia (i.e.: Põlvamaa and Võrumaa). The larger variety of jobs in Tallinn and the nearby region likely makes it is easier to combine part-time work and caring obligations.
A conservative estimate of the opportunity cost of time spent providing informal care was 23.9 million Euros in 2015 (confidence interval 16.0 – 31.7 million) or 0.12 percent of GDP. The total maximum opportunity cost was about 130 million Euros in 2015 (confidence interval 110 - 150 million Euros) or 0.64 percent of GDP per year. The confidence intervals are large (the estimates imprecise) because of the small number of data points (observations) available. Trends over time are shown in Figure 45. Estimating the indirect costs associated with the care burden is difficult because the Labour Force Survey, the best available data source for estimating opportunity costs in Estonia, does not capture a large proportion of informal care providers. The assumptions and methods used are summarized in Box 4.

**Box 4. Assumptions and methodology for estimating the opportunity costs associated with the informal care burden**

**For people who are inactive (not employed or jobseeking)** because of caring obligations, the opportunity cost was calculated using the following steps.

For each year, 2007-2016, we estimated a linear regression model where hourly gross wage was regressed on age categories, education dummies, ethnicity dummies and gender, county dummies and working hours. The purpose of the regression model was to get better predicted average monthly earnings for inactive people.²⁹

We made assumption that inactive people would work full-time 40 hours per week or 172 hours per month if they had appropriate care services.

The total labour cost for each inactive person was calculated as 172 hours per month times

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²⁹ Note that we do not make any corrections for Heckman-type of selectivity in estimating wage equation.
predicted hourly gross wage with payroll taxes (social tax 33 percent and unemployment insurance contributions by employers).

For part-time workers, because of caring obligations, we assumed that they all would work 40 hours per week or 172 hours per month using their current hourly wage. For those who did not have wage information, we used predicted hourly wage.

The total annual amount was calculated as survey-weighted total sum of individual labour opportunity costs. The upper and lower bounds of the estimated confidence intervals reflect only variations due to sampling and not any other sources of errors (e.g. due to the estimation of hourly wages). In an alternative scenario, we consider only people who have explicitly stated that missing child or adult care was the reason of inactivity or part-time (this leads to considerably smaller numbers).

The opportunity cost is calculated as a difference between actual and predicted labour costs.

2. Future needs and expenditures

2.1. Recent trends affecting LTC

In Estonia, the population is ageing, driven by low fertility rates and increasing life expectancy. Life expectancy at birth has increased from 65.9 years in 2000 and 70.8 years in 2010 to 73.1 years in 2015 for males, and from 76.3 years in 2000 and 80.5 years in 2010 to 81.9 years in 2015 for females. However, in recent years, healthy life expectancy has declined to 53.6 years for males and 56.1 years for females in 2015. This falls short of the target set up in the National Population Health Strategy (NPHS) 2009-2020 by almost four years for males, and 6.4 years for females.

Demographic pressures will not be the only driver of the expected increase in demand for LTC and associated public spending. The increase in the number of severely disabled individuals as a result of population ageing can be mitigated by improving the quality of additional years of life. However, the income effect, changes in the demand for public LTC services, and changes in the relative costs of LTC services will also have substantial effects on LTC expenditure.

Overall, rising LTC costs are expected to exert significant pressure on Estonia’s public budget. As a result of demographic pressures only, public LTC expenditure is projected to increase from 0.6 to 1.3 percent of GDP by 2060. Healthy and active aging as a means of mitigating dependency can contribute to long-term cost containment on the margins. However, convergence in living standards and increasing coverage rates towards the EU average could raise long-term care spending in Estonia to as high as 4 percent of GDP by 2060.

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50 Healthy life expectancy is a population health measure that combines mortality data with morbidity or health status data to estimate expected years of life in good health for persons at a given age.

Investing in support for informal caregivers will be critical, given that they are likely to remain the main care providers. Given that formal care is expensive and public funding is in short supply, informal care is an appealing option to meet the increasing demand for care. Informal caregiving reduces direct costs, can delay expensive hospitalization, and matches the common preference for being cared for at home and by family. However, these savings may be offset by indirect costs such as lower labor market participation, possible loss in human capital, and higher health care expenditures for caregivers.

2.2. Projected needs and expenditures

Population ageing results in a projected increase in the demand for LTC. In Estonia, the population aged 55+ will comprise a larger share of the population (Figure 46). Despite the fact that the number of older people with limitations is projected to decline (Figure 48), in coming decades a higher absolute number of older-age people (Figure 47) will mean there is a greater number of people with severe disabilities. Since the cost profile for older-age groups is higher, this will exert a larger burden on healthcare and the social LTC systems, and on informal caregiving. The growth in the need for LTC, and therefore the need for public expenditure on these services, may be mitigated if population aging is associated with greater quality of the additional years of life. Postponing the onset of severe disabilities and therefore dependency will reduce the expected rise of demand for LTC, which would reduce the increase in public expenditure by 0.3-0.4 percentage points of GDP on average for the EU-27 (Lypszyc et al., 2012).

**Figure 46. Estonia: A larger share of the population will be aged 55+**

![Figure 46](image-url)

*Source: United Nations (2015)*
However, the demographic effect is not the main driver of the expected increase of public LTC expenditure (Maisonneuve and Oliveira Martins, 2013). Since social LTC costs per beneficiary in Estonia do not increase with age, the pure age effect will have only a moderate impact, especially if mitigated by healthy aging. By 2030, the absolute number of females aged 65 and above with serious ADL limitations is expected to grow by few thousand people, while the number of males with corresponding age and serious ADL limitations is expected to remain about the same or might even slightly decrease (Figure 48). As the population is expected to live longer healthy lives, the number of females without ADL limitations will grow at a fast pace. Since the growth rate of the number of women with non-severe limitations will be only slightly lower, this group is expected to represent a smaller proportion of LTC services users than severely disabled people (and are expected to use these services much less intensively).


Note: Projections are for the population 55+
While the number of severely disabled people is projected to increase as a result of the aging population, LTC expenditure will also be affected by the income effect, changes in the demand for public LTC services, and changes in relative costs of LTC services. (Maisonneuve and Oliveira Martins, 2013). \(^{52}\) As population income rises, so too will demand for LTC services, especially for higher quality services (Colombo et al., 2011). On the one hand, this will stimulate development of the private LTC sector, but on the other hand will put pressure on the public sector. This will inevitably result in growing unmet demand for LTC services, leading to increased rates of hospital admission. Among other factors, given that in Estonia the wage levels of employees in general care homes are low, the Baumol effect (Baumol, 1967; 1993) is expected to exert substantial pressure on public expenditures in such a labor-intensive sector as LTC. Wage level within the LTC sector in hospitals is considerably higher, and contribution of this part of the workforce into the growth of state LTC expenditure will depend primarily on the extent to which public policies will support growth of salaries within the health care sector (Table 16). At the same time, given the importance of informal family caregivers, as the economy grows richer, labor market developments will influence the supply of informal care and the demand for formal publicly-provided care.

Table 16. LTC in hospitals: average wages

<table>
<thead>
<tr>
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<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Average base wage, Euro</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nurses</td>
<td>754</td>
<td>739</td>
<td>778</td>
<td>825</td>
<td>956</td>
<td>1,042</td>
<td></td>
</tr>
<tr>
<td>Caregivers</td>
<td>418</td>
<td>411</td>
<td>446</td>
<td>465</td>
<td>556</td>
<td>616</td>
<td></td>
</tr>
<tr>
<td><strong>Average wages including bonuses and premiums, Euro</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nurses</td>
<td>875</td>
<td>906</td>
<td>1,028</td>
<td>1,945</td>
<td>1,164</td>
<td>1,290</td>
<td></td>
</tr>
<tr>
<td>Caregivers</td>
<td>479</td>
<td>498</td>
<td>596</td>
<td>583</td>
<td>674</td>
<td>772</td>
<td></td>
</tr>
<tr>
<td><strong>Average gross incomes of wage earners, Euro</strong></td>
<td>767</td>
<td>798</td>
<td>844</td>
<td>900</td>
<td>954</td>
<td>1,013</td>
<td></td>
</tr>
</tbody>
</table>


LTC costs are expected to put pressure on Estonia’s public budget over the next decades. The projections for LTC expenditure in the latest EC aging report (European Commission, 2015) are that public spending on LTC in Estonia is due to increase from 0.6 to 1.3 percent of GDP over 2013-2060 due to purely demographic effects. These projections cover in-kind public spending on health and social LTC, including: formal care in institutions and at home; informal care; and LTC-related cash benefits (an overview of the methodology for the EC projections is presented)

\(^{52}\) By the data of the Estonian Chamber of Disabled People, currently there are over 1,200 people on the waiting list for special care services. In addition to the official waiting list, it is estimated that there are approximately 12,000 working-age people needing special care services, having been informally cared by their family members. Meeting the needs of these LTC receivers needs additional financing which will drive up the costs of LTC.
in Annex 3).53 The major impact on LTC spending would be a convergence to EU norms. Were costs to grow due to a convergence in living standards (the “cost convergence scenario”), in Estonia, long-term care is projected to climb to 3.3 percent of GDP by 2060. Adding to this, a convergence in LTC formal/public coverage rates to the EU average (“coverage convergence scenario”) would bring spending in Estonia to 4 percent of GDP by 2060. While Estonia currently has comparatively low LTC expenditure, the proposed increase under the cost-pressure scenario would be large enough to catch up to the EU average level. Healthy and active aging as a means of postponing the period of ADL-dependency can contribute in keeping down long-term costs on the margin.

From an equity and efficiency perspective, there is limited room for additional public financing for LTC to come from social security and payroll taxes. Social security and payroll taxes make up a substantial share of government revenues. While these have diminished in recent years, there is a concern that the labor tax wedge is relatively high—particularly for low-income workers in light of the introduction of the lump-sum minimum social tax (OECD, 2015). Further increasing the tax burden on labor would be distortive and potentially could constrain employment, especially in the case of low-income workers. A further concern is the rising inequality in incomes in Estonia: in the EU context, Estonia is notable for having relatively high inequality and larger-than-average growth in inequality over 2008-2014 (Error! Reference source not found.). This is not only due to the flat personal income tax system; in addition, means-tested benefits and social insurance contributions are much less equalizing that in many EU countries (Leventi and Vujackov, 2016) (Error! Reference source not found.). As such, increasing social taxes (through the introduction of contributory public LTC insurance) to finance long-term care is not advisable under the current tax structure. Financing for the expansion of public LTC provision should come from other general revenue sources.

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53 The calculations for in-kind spending are based on the age and gender-specific expenditure profiles and unit costs for each country. Health LTC covers long-term nursing care (which is also called “the medical component of long-term care” in the EC report). While the data on actual unit cost of cash benefits were seldom available, they are assumed to evolve in line with GDP per capita.
3. Summary of the assessment

Due to its ageing population, Estonia faces increasing demand for long-term care. Younger generations have been shrinking as a result of low fertility and high out-migration. The elderly share of the population is increasing and will continue to rise substantially in the coming
decades. The number of elderly in need of care has been increasing accordingly. In addition, Estonians are not ageing as healthily as the EU average. A key challenge for Estonia will be to match the rising long-term care needs of its ageing population.

**The current LTC system is fairly inequitable and fragmented.** Provision of LTC can be either formal or informal, with the responsibility for delivering formal LTC services divided between the health and social care sectors. There is a shortage of nursing care beds, and care provided in nursing care facilities and social care institutions is often of insufficient quality due to inadequate premises and lack of medical personnel. Despite the high number of LTC beds in hospitals, regional accessibility to inpatient nursing care services is uneven. Local governments are free to define their own policy in social LTC service provision, but their capacity to fund and provide services is highly unequal. As a result, access to social services depends largely on the residence of the beneficiary. During recent years, the coverage of home care services for the elderly barely expanded, while support for caregivers fell, even though unit costs of home-based services are relatively low. The limited supply of home-based services for the elderly results in growing demand for general care home services as the population ages. Most elderly people finance their social services fees from their state-provided pensions, which are often not sufficient to cover costs of even the least expensive general care home.

**The current LTC system also places a disproportionately large care burden on informal caregivers and family members.** A lower share of the elderly population with ADL challenges receive professional care in Estonia compared to other EU/EFTA countries. Due to the shortage of public services, most long-term care is delivered by families and friends (often by older individuals with health problems of their own), especially among lower-income Estonians. While the need for informal care is growing rapidly as a result of gains in life expectancy, the supply of informal caregivers is decreasing.

**Public spending on LTC in Estonia is lower than in other EU member states, and future spending projections envisage continued low spending.** Accordingly, the estimated coverage for LTC recipients (including both formal and informal care) is lower in Estonia than in most other EU countries. However, the share of the population that has access to some kind of long-term care service is relatively high given that public spending and coverage are low, implying that there may be room to further focus long-term care services.

**In addition to the direct costs of providing health and social LTC services, there are significant indirect costs due to the large reliance on informal caregiving in Estonia.** The informal caring burden exerts a substantial impact on labor market supply and employment. Informal care obligations represent an obstacle to active labor market participation particularly for women, non-Estonians, and individuals with lower education levels.
Part II: LESSONS FROM INTERNATIONAL EXPERIENCE ON KEY ISSUES

The assessment in Part I highlighted three topics that require closer attention in drawing up policy actions: integration of health and social care, LTC financing models and optimal ways of supporting informal caregivers. Part II therefore examines the evidence, international experience and their relevance for Estonia for each one of these topics.

Good coordination between health and social care is critical for ensuring effective provision of LTC. The experience of several European countries shows that there is considerable scope for improving care outcomes and quality by managing the interactions between these sectors more effectively. In Estonia, long-term care is fragmented across care episodes, providers, settings and services. Section 3.2 contains a more detailed discussion of the issue of integration of health and social care and identifying key enabling factors from the experience of other countries.

In light of future needs and expenditures, Estonia may need to explore new financing models to meet future demands for LTC. Despite a great variety in approaches and coverage levels of public LTC across countries, recent developments suggest that financing models are converging and that countries are increasingly moving towards “targeted universalism”. In addition, many countries are striving to improve the sustainability of funding sources for LTC, with an eye on unburdening the working-age population. Section 3.3 highlights key features of LTC financing models across OECD countries, as well as emerging financing trends.

Supporting informal caregivers and improving their chances of participating in the labour market is equally critical in the context of Estonia, where informal caregivers will continue to form the backbone of the LTC care system in the short to medium term. Section 3.4 examines benefits for informal caregivers in selected European countries.

1. Integrating Health and Social Care

Current status of integrated care in Estonia

As demonstrated in the previous sections of this report, a large proportion of the population is currently in need of LTC services, and this proportion is expected to grow in the coming decades. Along with the rise in multi-morbidity and disability, these populations will tend to have numerous contacts with health and social care providers across care settings and will increasingly need help with everyday activities such as dressing, bathing, shopping, preparing food, etc. Ensuring that these complex populations receive high-quality, continuous care that avoids unnecessary delays, errors and costs will require the delivery of services that are integrated around their needs, irrespective of sectoral boundaries.

Because of the overlap in target populations, both health and social care impacts on patient outcomes are interdependent. For example, the absence of adequate social care services can

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54 Multimorbidity - the coexistence of multiple chronic diseases and medical conditions in the same individual (usually defined as two or more conditions)
significantly increase the need for health care, and therefore cause an increase in health care costs. Similarly, a lack of adequate health care treatment or prevention can cause an increase in the severity of patient social care needs, which may require additional social care expenses. Hence, delivering integrated care services is critical not only for the patient’s benefit but also to deliver the best outcomes from providers’ effort expenditure in each sector (Mason et al. 2015).

**Fragmented nature of LTC services**

As in other countries with far more developed LTC systems, such as the UK and the US, the reasons for poor integration in Estonia stem primarily from the fragmented nature of the LTC service system between the health and social care sectors. Indeed, the fragmentation between health and social care in Estonia is multidimensional, existing at financial, organizational, professional and policy levels (OECD 2011a).

At the financial level, fragmentation arises from the separation of funding streams between the state and local government levels. Long-term health care services, such as inpatient and home-based nursing care, are financed at the state level by the EHIF through and earmarked social payroll tax. In turn, long-term social care services, such as help with daily activities in the home or in social welfare institutions, are financed primarily through local government taxes with limited equalization payments from the state for lower-income municipalities. Other social care services such as special care services and childcare services are financed directly by the state.

Health and social LTC services are also organizationally and professionally fragmented between two separate systems, each with their own cultures and modes of operation. Thus although health and social care services coexist within the community (e.g. home nursing care and home help with daily activities) and within institutional settings (e.g. hospital-based nursing care and care social welfare institutions), they often lack adequate protocols for cooperation. The organizational separation also involves separate administrative procedures as well as IT/communication infrastructures. Similarly, at the professional level, there is fragmentation between health and social care in terms of differing professional norms and cultures, social statuses and prestige, as employment terms and conditions, and working time/shift patterns and training.

Finally at a policy level, responsibility for the management of service provision and financing differs between health and social care. Health care LTC services are managed at the state level, while in social care, this responsibility is decentralized to the municipalities. Because municipalities have a wide degree of flexibility to determine the extent of services provided and how eligibility is determined, access to social LTC services is not equal across the country. Since the beginning of 2017 the EHIF’s has incorporated a common needs assessment for social and health care services in its health service list; however the practical implementation by primary care providers is yet to be accomplished in the next few years. There is thus no common, nationally standardized needs assessment instrument currently available to accurately reveal whether the right level and type of care is being prioritized.
This fragmentation of LTC between the health and social care systems contributes to inadequate coordination and continuity of patient care, which leads to a deterioration in patient outcomes. A World Bank study published in January 2015 drawing on health insurance claims data and qualitative interviews with health sector stakeholders demonstrated that the Estonian health system has a high proportion of avoidable outpatient specialist visits, acute inpatient care admissions and extended hospital stays, exacerbating the long waiting times in these care settings. The study suggested that this may be due to financial incentives as well as a lack of adequate patient management at the primary care level, limited coordination with social care and limited access to post-acute rehabilitation, nursing and social care services (particularly in the community) (World Bank, 2015b).

Indeed, the movement of patients between the two sectors is often driven by financing and according to whether/where services are being delivered, rather than according to need. For example, the use of Diagnosis-Related Group (DRG) payments in acute inpatient care, with a fixed price per case as well as capped per-diem payments on inpatient nursing care (e.g. up to 60 days) incentivize reductions in the length of stay in acute and nursing care hospitals. Ideally, this would entail a shift of patients into home-based care or general care homes, which can then help support patient recovery. However, as discussed in the previous sections of this report, access to formal home-based health and social care services is low and general care homes are expensive in Estonia. Care is mostly delegated to family members who, in turn, lack adequate support systems to provide high quality care. As a result, patients discharged from acute and nursing care in hospitals are likely to be quickly re-admitted. To make matters worse, hospitals actually benefit from the readmission, since it generates additional revenues (i.e. payment for a new DRG case). In addition, there are no financial incentives to ensure appropriate discharge planning (e.g. linking patients with adequate post-discharge care) that would help prevent readmissions.

The effect of this fragmentation is compounded by the mismatch between present models of care and the needs of the growing elderly and complex patient population. While current models focus on the reactive, episodic treatment of acute conditions, with patients regarded as passive recipients of care, the growing elderly population with long-term health and social care needs requires proactive care management with systematic coordination across care settings and sectors. As a result, recipients of LTC services are frequently at risk of “falling through the cracks” and experiencing further deterioration in their conditions, which leads to them being constantly shuttled between different types of care.

There is also an inherent equity problem between health and social care entitlements, with similar need not receiving similar support (Barker 2014). For example, while health LTC services are largely available to all insured patients at a relatively low copayment level, access

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55 A Diagnosis-Related Group (DRG) is a statistical system of classifying any inpatient stay into groups for the purposes of payment.

56 Currently there is a lack of data to demonstrate the rate of readmission due to lack of appropriate discharge or a lack of services in the community (OECD 2011a).

57 In other countries incentives for appropriate discharge planning include withholding payments for readmissions within 30 days, payments for coordination of post-acute care, etc.
to many social services require high user fees (e.g. OOP payments comprise nearly 70 percent of general care homes costs in 2015). This is due to the legal requirement for families to take primary responsibility for the care of dependent individuals as well as increasing financial pressures on local government budgets. As a result, free access to care tends to be reserved for the most vulnerable (e.g. the sickest and the poorest) people. Moreover, while patients with debilitating health problems (e.g. cancer) receive close to full coverage through the health care system, those with equally debilitating conditions that are mostly managed by the social care sector (e.g. dementia), are largely responsible for the costs.

This mismatch in entitlements has led to an overreliance on the health care sector to compensate. The “default to doctor” phenomenon creates pressures on medical staff’s time which they are ill-equipped to handle (Dorell 2015). A 2013 national audit found that 25 percent of patients who received inpatient nursing care (equivalent to Eur 4.1 million) should actually have received a different kind of care. Of these, more than a third should have received services in a welfare institution and nearly half needed outpatient nursing care and/or social care services at home, and about 20 percent could have coped at home without any services. In addition, although the Estonian Nursing Care Network Development Plan 2004-2015 specified a trilateral financing of inpatient nursing care (local authority 49 percent, Health Insurance Fund 35 percent and patient 16 percent), the EHIF currently pays 85 percent while patients pays 15 percent (Olgo 2015).

Lessons learnt from efforts to promote health and social care in the OECD: what works?

Despite the extensive body of information on care integration for people with chronic long-term conditions, there is still a relatively weak evidence base for its impacts on health outcomes and costs. Moreover, evidence on approaches that seek to reduce the barriers between care sectors is even less common and tend to be restricted to small pilot projects or confined to a particular locality or region (Nolte, Knai and Saltman 2014). Where evidence does exist, much of the focus has been on the process of change (e.g. how individuals and partners work together) rather than the direct impacts on recipients’ outcomes and costs (Petch 2012).

However, more recent evidence has produced some promising results. For example, reviews of the Program for All-inclusive Care for the Elderly (PACE) in the US, as well as Vittorio Veneto and Rovereto projects in Italy revealed that integrated working between health and social care reduced the cumulative number of days older people stayed in institutional care (Petch 2012). The PACE program has also shown the potential to improve quality of care and quality of life for older people with complex needs (Ross et al. 2011). In England, coordination between acute care hospitals and local systems including social care, primary care and community health was shown to be associated with a significant drop in hospital admissions and emergency re-admissions, length of stay and admissions to nursing care homes post-discharge (Naylor et al. 2015).

The use of integrated care teams under the Torbay Care Trust was shown to lead to a reduction in hospital bed usage, emergency admissions for those 65 and older, and delayed transfers of care (Thistlethwaite 2011), while the replication of the US Evercare case management pilot in nine English primary care trusts showed clear improvements patient satisfaction and user
experience. Results of integrated health and social care in the rural municipality of Skævinge in Denmark has also shown a decrease in expenditure on services (despite an increase in the elderly population), a reduction of delayed discharges and hospital admissions by 30 to 40 percent (Robertson 2011). The Esther project in Jönköping county Sweden involving integrated teams of nurses, social workers and secondary care clinicians was shown to reduce hospital admissions, lengths of stay, and shorten waiting lists (Robertson 2011).

The paucity of evidence on the impacts of integrated health and social care models also stems in large part from the complex multifactorial nature of these interventions, which often evolve over time and make it extremely difficult to capture and attribute tangible impacts. A diverse range of factors can contribute to effective collaboration between sectors, but these are not easy to measure. Without a standardized approach, models can vary widely, further complicating the drawing of comparisons and generalized conclusions. Furthermore, some impacts may be difficult to quantify (e.g. patient experience) and may not be measureable in the short term (Ross et al. 2011).

Past reviews of successful integrated care programs in the US, including PACE, have noted the difficulty of scaling up smaller “boutique” initiatives toward widespread service delivery reform for vulnerable chronically ill populations – which stills hold true today. In essence, it appears that the issue of scaling-up integrated care models is not an “invention problem” but a “diffusion problem” (Master and Eng 2001). That is, many successful integrated care initiatives do not represent major system breakthroughs beyond what policymakers and clinicians have been advocating for decades. Many rely on the mission-driven spirit, perseverance and support of their founders, participating clinicians and managers in the face of obstacles, delays and financial losses, which has proven difficult to replicate in other communities. Undoubtedly, an understanding of local contexts, including the existing inefficiencies and incentives in the health and care sectors, and their impacts on the implementation and sustainability of different approaches will be crucial to overcoming continued barriers to broader change in current practices (Nolte, Knai and Saltman 2014).

**Common themes**

While there is still weak evidence overall on the impact of integrated health and social care on patient outcomes and costs, there are common themes among some of the more successful models to date. These themes, explained in more detail below, may provide some lessons for countries like Estonia, which are looking to bridge this sectoral divide and further their integrated care agendas.

**Case management**

Case management is a type of integrated service program which originated in the US aiming to improve the health outcomes and wellbeing of complex patients and reduce the need for expensive emergency and acute care. Case management programs are similar to care management programs, which focus on integrating health services for patients with complex needs, but include social care and can also extend to employment and educational needs.
Case management models are premised on the notion that targeted, proactive community-based care provided by multidisciplinary care teams is more cost-effective than downstream acute care, with many centered within or around primary care practice (Ross et al. 2011). While there is no standardized case management model, these programs typically include the following attributes:

- Case-finding methods to identify complex individuals who are at risk (e.g. of an emergency hospital admission) and would benefit most from a comprehensive case management program
- A comprehensive assessment of medical and social care needs
- Joint development of care plans with patients which are easily accessible by all health and social care professionals
- Care co-ordination by designated case managers working within multidisciplinary care teams

These programs can focus on one or more specific conditions, but more often are generic programs targeting individuals with complex care needs who are at high risk for an emergency hospital admission. These programs employ systematic case-finding methods to identify complex individuals which typically consist of a combination of predictive statistical models using historical care utilization data and clinical judgement.

Once individuals have been identified, an assessment of their health and social care needs is conducted, typically by the case-manager/care coordinator, and care plans are developed. The assessment can cover areas such as: current health status; mobility issues; needs in terms of ADLs/IADLs; cognitive functioning; and current care arrangements. The health and well-being of informal carers should also be taken into account. Following the assessment, care plans are developed jointly with patients and their informal carers, taking into account personal circumstances (housing status, receipt of social benefits etc.), needs, goals and preferences. These plans map the different service inputs needed and their frequency, and also include anticipatory action plans including relevant contacts for when a patient’s condition deteriorates. The plans are ‘live’ documents which can be modified or updated depending on changes in the patient’s condition.

Finally, the core of case management is care coordination, which involves general monitoring of a patient’s condition and continued communication with patients, their carers and the various health and social care providers with whom they come into contact. This activity is led by a case manager who works in the context of a multidisciplinary care team to help patients navigate the health and social care systems. Care coordination activities may also involve medication management, transition care support, self-management support, psychosocial support and advocacy and negotiation on behalf of the patient (Ross et al. 2011).

Evidence on the impact of case management is promising, but mixed. Some studies point to positive impacts on care experiences, care outcomes and service utilization, though for reasons stated earlier in this section it is difficult to draw firm conclusions. Nevertheless, these programs are still widely accepted as a valid approach to caring for individuals with complex, long-term conditions and have been implemented internationally. Factors associated with
successful programs relate to the roles and skills of the case manager, program design (e.g. manageable caseload, single point of access, effective use of data and communication processes) as well as wider system factors (e.g., shared vision and objectives, aligned financial flows and incentives, and stakeholder engagement) (Ross et al. 2011).

Case management models have been implemented in countries including the United States, England, the Netherlands, Sweden, Denmark and Finland. Examples include the Guided Care model from the United States where registered nurses are recruited and trained to act as case managers for primary care practices that participate in managed care programs such as Kaiser Permanente, and the Virtual Wards program in the UK where community matrons or GPs act as case managers and meet regularly with members of multidisciplinary care team to monitor each patient’s conditions and care needs (Ross et al. 2011).

While case management is usually centered on primary care practices, it can also be used in hospital settings to ensure appropriate transitions back to the community. For example, the program run by an organizationally integrated health and social care company created in the Nortalje region in Sweden uses case management for patients who have been hospitalized. Case managers (usually nurses) work with physicians to develop a care plan for patients who are about to be discharged from the hospital and coordinate with other hospital-based physicians and community-based providers to ensure a smooth transition to the patients’ homes or nursing home setting (Bäck and Calltorp 2015).

Integrated care budgets

Integration of health and social care budgets has been frequently cited as an important. Separate budgets create incentives for providers in each sector to achieve the lowest cost consistent with their own goals, without considering detrimental consequences for the other sector (Mason et al. 2015); this approach will eventually have adverse impact on both sectors and to the beneficiary of these services. As a result, the pooling of resources has been touted as an effective solution to ensure that incentives are aligned and services can be purchased around the needs of the patient, regardless of which part of the system these services come from.

Pooled budgets have been used in a number of integrated care interventions though the evidence base for the effects on actual outcomes, patient experience, utilization, costs and quality of care has been hard to establish. Examples of initiatives using integrated care budgets include PACE in the United States, which pooled funding from both Medicare and Medicaid for its case management population, and Torbay primary care trust’s integrated care program which pools budgets from both the NHS and local council (Mason et al. 2015; Thistlewaite 2011). In addition, in 2013 NHS England created the Better Care Fund, a program with a £3.8 billion budget that aims to fund ways that the NHS and local governments throughout England can work more closely together (Bennet and Humphries 2014). Various pioneer initiatives are already in place around the UK, testing new approaches to integrated care, which are starting to show some promising results (NHS England 2015).

Although pooled budgets have great potential to streamline the purchasing of health and care services to meet patient needs, the integration of funding alone cannot break down all
existing barriers to collaboration. For example, without aligning IT and communication tools, incomplete client information could create inefficiencies and incentives for gaming (i.e. if one provider has more complete information than the other). Similarly, the balance of power, budget distribution and risk sharing rules need to be established so that one provider does not have the ability to override the budget claims of the other. In summary, the importance of additional tools, structures and agreements that are required to enable effective collaboration should not be overlooked (Mason et al. 2015).

Alignment of incentives

Current provider payment mechanisms do not facilitate coordination between sectors. Payment mechanisms can be used to influence provider behavior by providing financial benefits for the provision of certain desired services or the risk of lost income for undesired services. For example, fee-for-service (FFS) payments compensate providers based on the level of activity and therefore reward delivery of greater volumes of services, while capitated payments compensate providers based on a fixed amount per patient, and therefore promote the delivery of fewer (unnecessary) services in order to achieve cost savings. Since health care providers are paid only for the services which they provide within the health sector, (i.e. they do not receive any payments for coordinating between sectors) they receive no financial benefit for connecting patients to social care, even though this may help improve patients’ outcomes. In fact some providers, such as hospitals, gain financially from the lack of adequate follow-up care in the community, because this means patients will require more hospital services.

As a result, effective payment mechanisms are necessary for the linkage of services between health and social care. Examples from other countries include lump sum coordination payments, risk-based payments and global community health capitation budgets.

Lump sum coordination payments

One method for encouraging coordination between sectors includes a lump sum per-member per-month (PMPM) payment for providers or care teams who are in charge of making these connections between care providers. These could be payments to providers specifically for linking with social services, or for a broader case management program that includes coordination with social care. While these payments do not incorporate risk, they do provide a strong foundation for building accountability in this area in the future (Crawford and Houston 2015).

Risk-based payments

A second approach for enhancing coordination and collaboration is risk-based payments, such as shared savings models, bundled payments, and quality withholds or clawbacks. By making retained or received funding contingent on patients’ health outcomes (which can be

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58 Fee-for-service payments are defined payments for every unit of care providers deliver (e.g. visits, treatments, lab tests) according to a fixed price schedule. Capitation payments are fixed, up-front payments to provide a defined set of services for each individual enrolled with a provider for a specific time period, regardless of the amount of services used.
maintained or improved by receiving social care), or on connecting patients specifically with social care services, these payments deliver a clear incentive for inter-sectoral coordination. Many of these payment models are currently being used by private as well as public purchasers (e.g. Medicaid) in the United States (Crawford and Houston 2015).

Shared savings arrangements set total cost-of-care limits for the patient population treated by a group of providers, among whom savings below the cost limit are shared. These models are currently being tested by many Accountable Care Organizations (ACOs) in the US. While providers may still be paid with usual fee-for-service (FFS) payment mechanisms, the providers agree to work together in order to maintain costs below this level, and any savings that are achieved are shared among the group. The providers can also be held accountable for any excess costs that are incurred above this limit. As a result, because social care services may help improve patient outcomes and reduce costs from, for example, unnecessary emergency readmissions, connecting patients to the services they need can be viewed as an easy way to reap shared savings. These models could also make the receipt of these shared savings dependent on the attainment of specified social care quality metrics, or incentivize community-based organizations to become involved by allocating a portion of shared savings.

Bundled payments operate in a similar manner to shared savings but are restricted to specific care episodes across providers. Again, social care services can be used as an effective way to ensure that patients who are hospitalized are adequately cared for in the community after discharge. Sweden, for example, has implemented bundled payments for orthopedic procedures such as hip, knee and spine surgery. The bundled payment could also be contingent on the achievement of social care quality metrics, or allow social care or community-based agencies to receive funds as part of the bundle.

Finally, purchasers can use quality withholds or clawbacks to tie usual payments for provider organizations to social service quality metrics. For example, a certain percentage of a primary care provider or managed care organization’s PMPM payment could be withheld or taken back if certain social care service quality metrics are not achieved. Sharing risk across primary and secondary care, between health and social care.

**Global community health capitation budgets**

The last type of payment model involves capitated community health budgets for a provider or group of providers to cover a range of services over a fixed amount of time. For example, Oregon’s coordinated care organizations (CCOs) in the Unites States receive global budgets for physical health, behavioral health and dental services for Medicaid enrollees. These global budgets can include payments for social and community-based services, which the budget holder can decide to make as needed (Crawford and Houston 2015). Similar to the risk-based payments above, these capitated budgets could set performance measures that would be tied

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59 A combined price—or bundled payment—gives patients a single price for a given treatment covering the entire episode of care, including rehab. With bundled payments, the provider is accountable for any problems patients might encounter with care because it cannot bill for extra services.
to the final capitated payment that is received. Ideally, these capitated payments should be risk-adjusted to account for higher costs associated with sicker patients in providers’ target population. The advantages of capitated budgets include an enhanced focus on prevention (primary, secondary and tertiary) as well as greater efficiency in the allocation of resources. However, without appropriate safeguards in place risks may include the budget holder “cherry picking” patients who are less complex, providing lower quality of care to reduce costs, as well as shifting care to settings which are not covered by the capitated payment (Monitor 2014).

**Other factors contributing to success**

**Experiences from emerging integrated care models point to many program design factors which are necessary for successful collaboration.** For example, ensuring that all participating organizations agree to a commonly shared vision and mission for the program. Programs should include medium to long-term financial strategies that are realistic about costs, as well as sound governance arrangements and accountability mechanisms to ensure providers are held responsible for stated goals and quality targets. Furthermore, opportunities for joint training and learning, including the development of fora to discuss and resolve problems arising from cultural differences, have been shown to be key to changing organizational norms and work processes (Robertson 2011).

**Importantly, many successful programs emphasize that the goals of changes in care delivery processes should be centered on addressing the needs of people who rely on them, independent of who is providing care.** The focus of new approaches should be on achieving service integration in accordance with user need rather than organizational integration. Some programs have cited the stories of fictional care users struggling to navigate fragmented systems in order to adequately convey the need and purpose of integrated care. Common examples include “Mrs. Smith” from the Torbay primary care trust’s model in England’s and “Esther” from Jonkoping county council’s program in Sweden.

**Many other contextual factors have also proven to be beneficial.** These include adequate leadership and “commitment from the top”; supportive legislative and policy frameworks to guide and sustain integrated care arrangements between health and social care providers; and sharing of data across providers to maintain transparency, ensure that incentives are aligned, and to allow for the adequate mapping and redesign of patient pathways (Pearson 2015).

**In summary, although there is no “one size fits all” approach, key features of successful models in other countries may provide lessons for Estonia on how to better integrate health and social care.** These include the use of case management, pooled budgets and aligned payment incentives between care sectors. Though the evidence on the impacts of integrated care models on health outcomes and costs is still relatively weak, some more recent approaches have started to show promising results, including reductions in hospital admissions, average lengths of stay, admissions to nursing care, and some improvements in quality of care and patient experience. A number of program design and contextual factors have also been shown to play an important role. While addressing the underlying causes of fragmentation more broadly will be a complex and long-term endeavor, implementing interventions such as those presented in this report would represent a first step to reducing the harmful effects of a system which has become increasingly out of touch with the needs of future populations.
Current reform plans of the EHIF

The EHIF is pursuing a number of reforms in the next few years which appear to be in line with many of the international experiences described above. For example, one strategic priority of the EHIF for the next few years is conducting thorough analyses of payment models and developing strategic purchasing arrangements which incentivize high quality care and effective coordination of care between different care settings, including between healthcare and the social system. Another priority for the EHIF will be to develop the availability of post-acute services including rehabilitation and nursing care in the hospital as well as home nursing care through strategic planning and contracting. In addition, the EHIF intends to support holistic reforms of long term care in Estonia, including possibilities to integrate general care homes and inpatient nursing care facilities into one integrated care unit.

In light of findings from the World Bank study regarding a lack of high-quality patient management in primary care, the EHIF together with MOSA plan to strengthen primary care through the development of multi-disciplinary teams within so-called primary care centers. The development of the infrastructure for these primary care centers is currently being financed through recently-secured European Commission funding. To support the development of primary health care centers, EHIF is developing a new purchasing model with the goal of ensuring more efficient service delivery in primary care as well as better integration within the health care system and between health care and social care systems. The new purchasing model will create prerequisites for a strong management function, flexible working conditions, expanding primary care services and establishing clear roles for administrative staff.

The multidisciplinary teams within primary care centers are expected to improve the access to and coordination of needed services across the health and social care sectors. According to the EHIF, the primary care centers should provide family doctor and family nurse services (minimum 3 doctors and 3 nurses in a center), as well as physiotherapy, midwifery and home nursing services. Providing home nursing care through primary care centers with the support of the family doctors’ professional team would allow for improved access to the service, as well as a more comprehensive and adequate needs assessment since family doctors and nurses are likely to be particularly familiar with the insured persons on their lists. Indeed, with the development of these primary health care centers, the EHIF is committed to support the implementation of a case management program within these primary care centers in order to comprehensively assess patients’ conditions/needs and adequately coordinate health and social care services accordingly.

The EHIF is currently piloting a preliminary case management model as part of a separate project with the World Bank. This program identifies eligible participants using an algorithm which draws on current administrative data on patients’ health and social statuses, as well as the family physician's intuition. After conducting a comprehensive health and social care needs assessment, family physicians and patients develop care plans together, outlining the patient’s key health and social care goals as well as contingency plans in case the patient’s health or
social situation deteriorates. Family physicians and nurses are responsible for coordinating the patient’s care as needed (providing referrals, setting up appointments, etc.) and routinely following-up on the patient’s care status, adjusting the care plan as needed. Although the social welfare system has implemented a case management model in Estonia since 2004, this appears to be exclusively focused on social care needs, and lacks systematic assessment, coordination and monitoring of care needs across the health and social care sectors.

2. Financing LTC

Key features of LTC financing models

Most OECD countries have collectively-financed schemes to cover personal and nursing care costs for reasons of both equity and efficiency. Uncertainly with respect to whether, when and for how long an individual might need LTC services means that pooling the financial risk associated with long-term care is a more equitable and efficient solution than relying on out-of-pocket payments. Although public LTC financing is still relatively low in most OECD countries (as a share of GDP), it is a sector that is evolving rapidly. Public LTC spending has shown a faster upward trend than health care spending\(^\text{60}\) (Colombo et al. 2011).

Single program universal LTC coverage systems ensure high rates of eligibility and comprehensive coverage, but at a relatively high cost. Universal coverage is provided either as part of a tax-funded social care system, as in Nordic countries, or through dedicated social insurance schemes, as in Germany (see Annex 5), Japan, Korea and Luxembourg, or by arranging for LTC coverage mostly within the health system, as in Belgium. Single program universal models have proved effective in ensuring high levels of eligibility and coverage. The separation between health and LTC budgets has also limited substitution of expensive health facilities and providers for LTC needs, or the “social hospitalization” of the frail elderly. However, the higher coverage rates in terms of eligibility, range of services covered and reimbursement rates have meant that single program universal models are relatively expensive. These systems generally cost a larger share of national income and domestic budgets than the OECD average – typically above the OECD average of 1.5 percent of GDP (Colombo et al. 2011). In the Netherlands, which had some of the most generous LTC coverage in Europe, LTC cost the public sector 4.3 percent of GDP in 2010 and was expected to rise to 7-9 percent by 2040, prompting a major reform of the LTC system (Maarse and Jeurissen, 2016).

Mixed systems that combine universal and means-tested elements in LTC coverage are less costly, but care recipients end up being responsible for a large share of the cost. In these systems LTC coverage is provided through a mix of different universal programs and benefits operating alongside, or a mix of universal and means-tested LTC entitlements (e.g. cash benefits in Austria, France, Italy; in-kind benefits in Australia, New Zealand). In countries that provide

\(^{60}\) In the past decade, the health component of total long-term care has increased, in per capita terms, at an annual average of over 7% in real terms across 22 OECD countries, compared to an average real per capita health spending growth of slightly over 4%.
income-related universal benefits, all those assessed as eligible on care-need grounds receive public benefits, but the amount is adjusted to recipient’s income, with significant variation (Colombo et al, 2011). In France for instance, the health insurance program pays for the health cost for all nursing-home stays (access is based on care need), while the Allocation personnalisée d’autonomie (APA) is an income and needs-adjusted cash benefit available to disabled people aged 60 years or older. The monthly cash allowance varies according to the assessed level of dependence between 530 and 1,235 Euros (April 2010), but depending on their income, beneficiaries are required to forgo a certain percentage of the assessed level of APA, up to a 90 percent reduction off the assessed floor. As a result, APA pays up to 1,235 Euros for high-need/low-income users, and down to 27 Euros for higher-income users (Colombo et al, 2011). Mixed systems provide coverage for at least a share of LTC cost for all people needing care, and offer a stable source of support for LTC-dependent people, but leave a significant share of LTC costs to be covered by the care recipient and their family. The fragmentation of benefits and entitlements across multiple programs also creates incentives for cost-shifting, and makes it difficult to quantify the level of care received per user.

Means-tested LTC systems are effective in controlling overall costs, but may result in elderly and/or disabled people’s impoverishment in order to become eligible for care. Countries with means-tested systems include the United Kingdom (excluding Scotland, which has a universal system) and the United States. These systems limit public benefits to people who are poor (usually a definition that takes into account both income and assets) or who become poor due to the high costs of medical and long-term care. The philosophical premise behind means-tested programs is that the primary responsibility for care of older people, and younger people with disabilities, rests with individuals and their families and that the government should act only as a payer of last resort for those unable to provide for themselves. By targeting public funds towards the poor, this approach can be effective at limiting costs, even though the cost per eligible user may be high (Colombo et al. 2011). However, these systems can result in unmet needs and leave families above the assets/income threshold vulnerable to high LTC expenditure (Fernandez et al., 2009).

Universal coverage or not, the comprehensiveness of publicly financed LTC coverage varies along three dimensions: (i) eligibility rules, (ii) range of services covered, and (iii) level of cost sharing (Colombo et al, 2011). Each one is discussed below.

To begin with, all countries have eligibility rules setting the care-dependency status based on a needs assessment. The United States (for Medicare and Medicaid), Canada (for Chronic Care Funding in Ontario), parts of Switzerland, Iceland, Spain, Italy, and Finland all employ the International Resident Assessment Instrument (InterRAI) for assessing care needs and better target care support. InterRAI consists of a range of standardized assessment instruments that apply to different care settings such as residential care (RAI-LTCF), home care (RAI-HC), palliative care (RAI-PC) and mental health (RAI-MH). This tool provides a consistent way to assess care needs along the full continuum of health and social care. Once need is assessed, the benefit amount is typically adjusted to need. Usage of InterRAI is limited due to a number of reasons, starting with the fact that introduction and maintenance of a new system demands substantial resources, and ending with the point that InterRAI is rather volumetric, medically oriented and may be found to encroach the responsibilities of particular professions. Moreover
InterRai can be potentially used as a basis for reimbursement (based on patients’ level of acuity) thus disrupting the existing reimbursement systems of the according institutions.

**An assessment of income and/or assets is another step** towards establishing eligibility (in means-tested systems) or determining user cost-sharing or the amount of public subsidy in mixed systems. Income assessment includes a share of the imputed rent of non-financial income from assets, (e.g.: secondary home). In France, a means-tested allowance for elderly individuals called the PSD (prestation spécifique dépendence) provided for recovery of expenses from elderly people’s estates after death. This proved such a deterrent for participation that the scheme was transformed into the APA, which provides universal coverage and abolished recovery of expenses from estates (Chevreul and Brigham, 2013).

The LTC benefits package varies considerably across systems, ranging from health/nursing care to domestic care, practical help and assistive devices, to board and lodging. Health/nursing care (the need for medical services typically provided by nurses) is generally covered under public health-financing arrangements. Domestic care and practical help, such as cleaning and cooking and help with so-called instrumental activities of daily living (IADL) is typically not covered by public LTC systems, with some exceptions (e.g. Nordic countries). Board and lodging are typically not covered by public schemes and eligibility for these benefits is means tested. Even in countries with very comprehensive universal LTC coverage, significant cost sharing can be required for this benefit. For example, in Norway, municipalities can ask up to 80 percent of resident income in user cost sharing (Colombo, 2011).

Publicly financed LTC coverage involves cost-sharing in all countries, but the level and manner in which it is determined varies. In some countries, public benefit is capped, rendering care recipients and households responsible for paying the cost difference between the set public amount and the actual cost of LTC services (e.g., Germany, Czech Republic, France, Italy, Austria). Other countries have flat rates of cost-sharing as in Belgium, Korea (20 percent in institutions, 15 percent at home), and Japan (10 percent co-payments), with upper ceilings on the user contributions in Belgium and Japan, but not in Korea. In some other countries, private LTC cost sharing is set according to disposable income and/or assets of the LTC user, with very diverse approaches regarding maximum amounts taken into consideration to calculate user cost sharing. For example, in Sweden, co-pays are income-relayed with a cap for home help services of Eur 180 per month, while in Ireland (from 2010) individuals contribute 80 percent of their assessable income and 5 percent of the value of any assets to nursing-home costs (Colombo, 2011).

**Emerging trends in financing LTC**

Despite the diversity in approaches and levels of coverage of public LTC coverage, recent reforms in many OECD countries suggest that LTC financing models are converging in many ways. Means-tested systems have been criticized for their lack of coverage. The use of asset testing for accessing a nursing home is being phased out in New Zealand, while Ireland introduced in 2009 a system of “tailored universalism” for coverage of institutional care (Colombo 2011). Meanwhile, in countries with comprehensive universal coverage, the range of benefits provided has been questioned, and there is greater targeting to those with the most
severe needs. Sweden has increased targeting of public services to the most sick and disabled (OECD, 2005). In the Netherlands, comprehensive LTC reforms initiated in 2015 and accompanied by large expenditure cuts has resulted in a shift from residential to non-residential care, and to greater decentralization of non-residential care. In Japan, low-need users were moved to a prevention system in 2006, with a focus on healthy ageing.

Most countries are moving towards “targeted universalism” in LTC coverage. Universality of entitlements does not mean that all LTC should be free, and as noted above, much of LTC coverage does involve some element of cost sharing. Paying higher benefits to low-income dependents, as in Austria, France and Australia, is one way to target limited public sector LTC resources more effectively towards those who need it the most. Targeting through restrictions in the benefits package is less straightforward because of challenges in defining needed services. For instance, support for domestic care and help with IADLs such as shopping, cleaning or administrative tasks may be limited on cost-control grounds but the distinction between personal and domestic help can be difficult to make. Coverage of support for some IADL activities, as in Sweden, Denmark, Germany and Luxembourg, is reported to have helped to prevent dependent people with relatively high care needs from moving to even more expensive care settings. By contrast, board and lodging is considerably more expensive than personal and nursing care, and a strong case exists for high levels of cost-sharing for this aspect of LTC. Including assets in the means test for cost-sharing and/or board and lodging benefits is a good way to target the benefits package effectively.

In addition, many countries are looking at ways of making the source of funds for LTC more sustainable, particularly to reduce the burden on current working-age cohorts. One way is tax-broadening, which means financing beyond revenues earned by the working-age population. Japan, the Netherlands, Belgium and Luxembourg complement payroll contributions with alternative revenue sources (Colombo 2011). Another way is to pool more effectively across generations. Japan’s LTC insurance premia are levied on those aged 40 and over, while in Germany retirees also contribute to LTC insurance based on their pension. A third way is to introduce innovative financing approaches such as public-private partnerships or voluntary funding schemes based on automatic enrolment with opt-out options (e.g. US, Singapore).

3. Supporting caregivers

Investing in supporting informal caregivers, including raising their competences and skills, will be critical given that they are likely to remain the primary providers of care in Estonia. The demand for informal care is likely to increase with care needs in the medium-term, unless there is a large expansion in formal long-term care provision. Undoubtedly, if dignified aging is to be ensured, the increased demand for caregiving must be met, yet formal care is expensive and public money in short supply. Fostering informal care arrangements, therefore, is appealing because it saves direct costs in professional care services, can postpone expensive hospitalization, and meets individual preferences in terms of care provision at home and by family members. Informal care can also deliver savings by sparing patients from longer/unnecessary hospital admissions; however, these savings may be offset by such indirect
costs as reduced employment, possible loss in human capital, and higher health care expenditures for caregivers.

**Different countries implement different solutions to support informal caregiving.** In particular, many countries have introduced caregivers’ allowance for selected caregivers, related to unemployment benefit, minimum wage, subsistence minimum, or a fixed amount (Box 6). In some countries, including Estonia, relevant costs are covered from local budgets. Many countries are covering costs for pension insurance, unemployment insurance, and/or medical insurance for informal caregivers with whom a contract has been signed. In many other countries (Belgium; the Czech Republic; Greece; Italy; Portugal; Spain; Switzerland; the Netherlands), informal caregivers are not entitled to any special cash benefit.

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61 Eurocarers defines a carer as a person who provides unpaid care to someone with a chronic illness, disability or other long lasting health or care need, outside a professional or formal framework. https://www.eurocarers.org/userfiles/files/factsheets/Carerspercent20inpercent20Europepercent20- percent202009.pdf

62 Additional information on benefits for caregivers in Ireland and Great Britain is provided in Annex 4.
**Box 5. Benefits for informal caregivers in selected European countries, 2016**

**Caregivers’ allowance:** Austria (equivalent to unemployment benefit); Bulgaria (statutory minimum wage); France; Iceland (provided only in special circumstances, e.g., the caring spouse has no income/pension of their own or has had to stop working to take care of the pensioner at home; the benefit can only be granted for six months at a time and is means-tested); Ireland (fixed caregiver’s benefit, caregiver’s allowance or constant attendance allowance, domiciliary care allowance, or respite care grant); Malta (fixed amount); Poland (fixed amount); Slovakia (up to 111.32 percent of the subsistence minimum per month if only one person receives home care and up to 148.42 percent of the subsistence minimum per month if two or more persons receive care, a means-tested benefit); UK (fixed amount - GBP 62.10 (Eur 84) per week).

**Coverage of costs for pension insurance, unemployment insurance, and/or medical insurance:** Austria (by the Federal Government); Croatia (state budget.); the Czech Republic (health insurance covered); Estonia (insurance provided to registered caregivers); Finland and Germany (pension and accident insurance); Lithuania and Luxembourg (pension insurance); Poland (social insurance paid from the State Budget); Spain (voluntary insurance with reduced contributions).

**Compensation during temporary incapacity for provision of care due to illness:** Croatia (caregivers are entitled to compensation during temporary incapacity for provision of care due to illness and during vacations, when they do not perform caregiving activities). Also in Estonia, working people may receive temporary work incapacity benefit (care benefit) to take care of an ill family member. This benefit is part of the Health Insurance Act: an insured person, on provision of a certificate of care leave, has the right to receive care benefit for up to seven calendar days to nurse a family member (aged over 12) at home.

**Temporary accommodation:** Croatia (temporary accommodation is provided for children in need of care while parent-caregivers take annual leave, and if children are in hospital for a period not longer than two months).

**Leave of absence:** Germany (family care leave, i.e., the caregiver has the right to a leave of absence from work of up to 24 months, with a 15 hours per week minimum working time requirement); Germany (employees working in companies with at least 15 employees have a legal right to partial or full-time leave for up to 6 months in order to take care of a relative); Hungary (unpaid leave for a maximum duration of 2 years).

**Annual leave:** Croatia (up to four weeks); Finland (statutory leave); Italy (paid leave of 3 days per month for a maximum of 6 days per month if the worker takes care of two disabled relatives); Slovakia (a maximum of 30 days per year); Denmark (the duration of care leave varies from 1 to 3 months).

**Special leave:** Germany (employees can use up to 10 working days away from work in order to organize suitable care or ensure nursing care during this time (short-term work incapability).
Box 5 (continued). Benefits for informal caregivers in selected European countries, 2016

**In-kind benefits**: Austria (a house visit is offered, on request, to the main family caregiver so that any problems arising from the nursing situation that causes the strain can be examined); Germany (care courses for family caregivers and other voluntary caregivers); Ireland (caregiver's allowance: free travel, electricity or gas allowance and television license); Romania (personal assistant is entitled to free urban and inter-urban transportation, etc.).

**Cash benefit provided by the local governments to caregivers**: Denmark (a fixed amount - DKK 21,546 (Eur 2,887), but no more than the previous earnings); Estonia (can vary between local authorities between Eur 15 and Eur 100 per calendar month); Finland (depends on the municipality, minimum Eur 384.67 per month); Latvia; Norway and Sweden (duration and amount of cash benefits depend upon the decision of the municipality); Slovenia (fixed amount – Eur 734.15).

**Partial payments for loss of income**: Slovenia (734.15 Euro; paid to a parent who has left his/her job in order to care for a child with special needs); Denmark (income replacement benefit for domiciliary care and/or training of a disabled child under the age of 18 amounts to maximum DKK 29,274 (3,923 Euro) per month).

**Caregivers not entitled to any special cash benefit**: Belgium; the Czech Republic; Greece; Italy; Portugal: Spain; Switzerland; the Netherlands.

**Allowance paid to the dependent person**: The care allowance is paid to the dependent persons and can be used to pay informal caregivers (the Czech Republic; Luxembourg; Romania; Spain)

Source: MISSOC 2016

PART III: POLICY OPTIONS

1. Policy Scenarios and Options

In LTC system development, the “ideal system” is one which guarantees a maximum and equitable response as well as financial protection in meeting the needs of potential services users and their carers and which is fiscally sustainable in the long-run. From the users’ perspective, the “ideal system” is one which is person-centered so that the interests and needs of the users are on the forefront and users are offered support in proportion to their needs. Such a system would impose minimal burden on family and informal carers, although the family would remain a first point of call for meeting a minimum level of LTC needs. Those seeking LTC would have access to publicly financed formal care services at home and in the community, and residential care when home/community care are no longer feasible. From the policymakers’ perspective, the “ideal system” is one in which services are delivered efficiently and equitably, thus ensuring good value for money and fiscal sustainability. Public policies in the health sector and beyond that promote healthy would also enhance the sustainability of the LTC system by reducing the severity of and postponing the need for LTC.

Given the medium term outlook for fiscal space and the structure of the current LTC system, the ideal system may not be immediately achievable. First, the ideal system would require significant additional public spending on LTC. As noted above, there are constraints as to potential sources of this additional public financing. Secondly, dramatically changing the way in which LTC is delivered – from a largely, informally-provided service to one which involves a high degree of coordination between health and social care, with emphasis on formal home and community care provision – implies a system transformation that would require time and effort.

The policy scenarios in this report are intended to chart a potential course from the current situation to an “ideal system”. The objective is to maximize coverage and financial protection subject to resource constraints and the need to ensure financial sustainability. The resource commitments and system characteristics under any one scenario are not pre-determined and would ultimately depend on the political and social choices of the Estonian people. The scenarios proposed here are simply different points on a continuum from low to high coverage. Ultimately, decisions about where on the policy continuum the country settles and associated reforms are undertaken would depend largely on society’s preferences and the political economy of those reforms.

In developing Estonia’s LTC system, it would be important to address urgent policy priorities as well as invest in the building blocks for moving towards the “ideal system”.

The urgent policy priorities, particularly in the context of low spending are to: address inequalities in services provision by redistribution of funding to those local governments with weaker funding capacity; and increase financial and social support to informal carers. The latter is important because informal carers will continue to be the backbone of the LTC system for the immediate future.
The building blocks comprise the stewardship function of the state as well as the legislative basis, institutions and mechanisms needed to ensure coordination of care. This report assumes that local governments would continue to deliver social care services as at present. The central state would therefore need to play an important stewardship role in ensuring horizontal equity (equal level of services for equal need), efficiency and quality in service provision. Uniform national frameworks and mechanisms to assess care needs, monitor service provision and reward good performance need to be developed and implemented by the central state. Better coordination of health and social care starts with establishing the relevant legislative and regulatory bases, including the regulatory basis for integration of health and social care data. Only once these are in place can mechanisms to promote coordination of care (such as the introduction of case managers, new payment methods and revised benefits packages) be developed. A better-coordinated, more comprehensive system of LTC would require additional resources. Human resource and infrastructure needs would need to be assessed and strategies developed for meeting these input needs over time as more financial resources become available. Implicit in the policy scenarios is the idea that in order to achieve an ideal system in the future, the building blocks need to be put in place now.

The policy levers in this process are level of public financing, the way in which services are organized and delivered, and the breadth and depth of the LTC benefits package (Figure 51). The level of public financing allocated to LTC is largely exogenously determined by economic factors. The way in which services are organized and delivered and the benefits package are partly endogenous as they are directly influenced by the level of financing. They are also influenced by the availability of human resources, information systems and the degree of coordination between providers and between the health and social sectors.

Three policy scenarios are presented here that illustrate how outcomes may be maximized subject to constraints, and with constraints being relaxed over time. They are compared against the status quo of limited coverage and financial protection. Scenario 1 involves
distributing the limited resources more equitably and laying the legal and institutional foundations for a more coordinated and better-managed system of health and social LTC. In Scenario 2, public spending is modestly increased, which makes it possible to increase coverage of formal health services, reduce the reliance on informal care and families’ care burden, and introduce elements of care coordination in health and social LTC. In Scenario 3, public spending is increased significantly, leading to considerable improvements in coverage, financial protection and quality of care.

Table 17 summarizes each of the three policy options, which are then described in detail.

<table>
<thead>
<tr>
<th>Expected outcomes</th>
<th>Status quo</th>
<th>Scenario 1</th>
<th>Scenario 2</th>
<th>Scenario 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Coverage and equity</td>
<td>Minimal for most groups</td>
<td>Low but with slight improvements</td>
<td>Moderate</td>
<td>Near-universal coverage</td>
</tr>
<tr>
<td>Financial protection</td>
<td>Minimal</td>
<td>Remains limited</td>
<td>Moderate</td>
<td>High</td>
</tr>
<tr>
<td>Quality</td>
<td>Limited</td>
<td>Slight improvements for informal caregivers, little other improvement</td>
<td>Improve as coordination of health and social care increases</td>
<td>High</td>
</tr>
<tr>
<td>Fiscal sustainability risks</td>
<td>Low System sustainable as public financing remains very low</td>
<td>Low System sustainable as public financing remains very low</td>
<td>Medium Need to ensure effective cost-containment mechanisms are built in as delivery systems expand</td>
<td>High High fiscal costs have the potential to grow unsustainably</td>
</tr>
<tr>
<td>Burden on informal carers / family</td>
<td>Very high High economic costs in terms of withdrawal from the labor market and associated opportunity costs</td>
<td>Very high High economic costs in terms of withdrawal from the labor market and associated opportunity costs</td>
<td>Modest More people able to enter into part-time or full-time employment if they wish to</td>
<td>Low More people able to enter into part-time or full-time employment if they wish to</td>
</tr>
<tr>
<td>Financing</td>
<td>Level of public financing by 2030</td>
<td>Low 0.5% of GDP</td>
<td>Low 0.6-0.8% of GDP</td>
<td>Medium 2-2.5% of GDP</td>
</tr>
<tr>
<td>Sources</td>
<td>Predominantly OOPs with limited contributions from</td>
<td>Predominantly OOPs with limited contributions from</td>
<td>Still predominantly OOPs but rising contributions from</td>
<td>Predominantly government revenues with</td>
</tr>
<tr>
<td>Mechanisms</td>
<td>government revenues</td>
<td>government revenues</td>
<td>government revenues</td>
<td>limited cost-sharing through OOPs</td>
</tr>
<tr>
<td>----------------------------------------------------------------------------</td>
<td>--------------------------------------------------------------------------------------</td>
<td>--------------------------------------------------------------------------------------</td>
<td>--------------------------------------------------------------------------------------</td>
<td>-----------------------------------</td>
</tr>
<tr>
<td>Separate streams for health and social care, central and local government</td>
<td>Separate streams for health and social care, central and local government + pilots for pooling budgets for health and social care</td>
<td>Separate streams for health and social care, central and local government + pilots for pooling budgets for health and social care</td>
<td>Pooled health and social care budgets channeled through primary care</td>
<td></td>
</tr>
<tr>
<td>Supplementary funding from state to local governments based on financial capacity</td>
<td>Supplementary funding from state to local governments based on financial capacity</td>
<td>Supplementary funding from state to local governments based on financial capacity</td>
<td>Supplementary funding from state to local governments based on financial capacity</td>
<td></td>
</tr>
</tbody>
</table>

### Delivery

<table>
<thead>
<tr>
<th>Family and informal caregivers</th>
<th>Primary responsibility for providing assistance to family members in need</th>
<th>Not expected to provide more than a minimum level of care, scope and extent of which would be defined by the state taking into account societal preferences</th>
<th>Not expected to provide more than minimum level of care</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Begin to expand support networks of informal care providers</td>
<td>Expand informal care provider networks</td>
<td>Sustain informal care provider networks so that they are available countrywide</td>
</tr>
<tr>
<td>Formal health and social services</td>
<td>Intervene if families have no other options to support family members</td>
<td>Primary care centers begin to be actively involved in care coordination role for health and social care by taking the lead in assessing needs, identifying services needed and assigning users appropriately</td>
<td>Primary care centers play central role in coordinating health and social care</td>
</tr>
<tr>
<td></td>
<td>Networks of non-state LTC providers are expanded where there is willingness and interest to do so on a voluntary basis</td>
<td>Increased supply of home- and community-based services (e.g. nursing, personal care, social transport etc.)</td>
<td>Home and community care services significantly expanded so as to prolong care at home</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Primary care centers play central role in coordinating health and social care</td>
<td>Informal care largely substituted by publicly financed formal care including at home.</td>
</tr>
<tr>
<td>Capacity and performance of local governments in service</td>
<td>Large variation in capacity and performance related to variations in local government services</td>
<td>Monitoring and evaluation and annual reporting by local governments is routinely carried out</td>
<td>Monitoring and evaluation and annual reporting by local governments is universal and</td>
</tr>
</tbody>
</table>
| provision | funding, which drive large inequalities in access to care and outcomes | MoSA establishes a national monitoring framework for LTC. Includes:
- legal and regulatory basis to require reporting;
- information systems to support this (see under health and social care data below)
- human resource analytical capacity at state and local government levels
- set of health and social care indicators

Based on framework, continuous monitoring and evaluation system is instituted for annual review of LTC provision with local government responsible for providing data to national government

Introduce review of technical capacity of local governments

Introduce pay-for-performance to reward local governments that report regularly

by most local governments | routinized
| Local governments form partnerships, overcome capacity constraints in delivery based on review of technical capacity
| Expand pay-for-performance to include outcome or output related performance (e.g. better coordination of health and social care)
| Expand pay-for-performance to include outcome or output related performance (e.g. reduced hospitalizations)

<p>| Human resource needs | As most social care providers are informal, there is Little room to expand human resources formal LTC. | Create new cadre for care coordinators and train them | Significantly expand cadre of care coordinators, home |</p>
<table>
<thead>
<tr>
<th></th>
<th>Benefits package and targeting</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Information flows</strong></td>
<td></td>
</tr>
<tr>
<td>Little training and skills development or actual planning of human resources</td>
<td>Prepare a LTC (health and social care) human resource strategy, including assessment of training needs</td>
</tr>
<tr>
<td></td>
<td>Introduce payment reforms to incentivize better integration of health and social care (pilots + scale-up)</td>
</tr>
<tr>
<td>Highly integrated within the health sector</td>
<td>Establish foundations for better integration of health and social care by: developing a shared vision, regulatory and policy framework for case management and coordination</td>
</tr>
<tr>
<td>Highly fragmented and of poor quality in social care sector.</td>
<td>Introduce professional and services integration (pilots)</td>
</tr>
</tbody>
</table>

| Benefits package                       | Caregiver allowances and in-kind services that are not sufficient to meet LTC needs. | Little room for expansion. Any additional resources allocated to increase informal caregiver support. National unified criteria for caregiver allowances are established. Provide additional home-based services such as personal care and domestic services to the extent the budget would allow. | Priority given to expanding the set of services available at home and community (home nursing, personal care and domestic services, social transport etc.) so as to prolong care at home as much as possible before institutional options are needed. Increased support to informal caregivers. Ceiling for OOPs for LTC subject to controls. | Generous package, but main principle is to prolong care at home. Package will include access to institutional care, but only if home- and community-based options are not viable (based on needs assessment). Increase access to end-of-life care at home. Ceiling for OOPs for LTC subject to controls. |
| Targeting                              | Little formal targeting; poorer local governments more likely to restrict benefits package than others | Targeting based on needs and financial vulnerability Caregiver allowances and benefits are means tested | Universal with targeting based on needs and income assessments Means-testing for caregiver allowances and benefits but eligibility criteria | Universal some targeting based on needs assessment. Coverage for severely disabled ~100% Caregiver allowances and benefits paid based on needs assessment. |
Scenario 1: Status quo with some improvements in equity and support for informal carers

Scenario 1 takes the current low level of public funding as given and focuses on getting better value for money within the existing resource envelope by: improving equity of service provision; addressing differentials in service provision and quality (particularly in those local governments with less financial capacity); and formalizing and expanding support networks of informal care providers. It also introduces policy and implementation reforms, or at the very least, the legal and institutional basis for those reforms, in order create the enabling factors to move towards an ideal system when the financial constraints are less binding. These include putting in place monitoring, reporting and needs assessment frameworks and systems. This scenario would result in some limited improvements in equity and support to informal caregivers, but does not significantly reduce the care burden on families.

Expected outcomes under Scenario 1

- Little scope to significantly increase horizontal equity in service provision.
- Financial protection and quality of care remain limited.

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<table>
<thead>
<tr>
<th>Policy and implementation reforms needed</th>
</tr>
</thead>
<tbody>
<tr>
<td>➢ Legal definition of long-term care</td>
</tr>
<tr>
<td>Current definition of LTC is very broad</td>
</tr>
<tr>
<td>Establish definition of LTC and state in law</td>
</tr>
<tr>
<td>Review LTC definitions as population structure and needs change</td>
</tr>
<tr>
<td>Review LTC definitions as population structure and needs change</td>
</tr>
<tr>
<td>➢ Introduce standardized needs assessment systems</td>
</tr>
<tr>
<td>Needs assessment is fragmented with different agencies using different needs assessment systems across social care sector, and do not effectively combine assessment of health and social care needs</td>
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<tr>
<td>Introduce a uniform, national needs assessment framework and system that combines health and social care</td>
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<tr>
<td>Building on needs assessment framework, develop guidelines for scope and extent of family provision, esp. for means testing and asset testing of family resources</td>
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<tr>
<td>Ensure that uniform national guidelines and standards are used assess needs, means and assets and family capacity to provide usual care</td>
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<tr>
<td>➢ Better integrate health and social care</td>
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<tr>
<td>Fragmented system with large incentives to cost-shift from one sector to another</td>
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<tr>
<td>Establish foundations for better integration of health and social care by: developing a shared vision, regulatory and policy framework for care coordination, the care coordinators and case management model</td>
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<tr>
<td>Introduce payment reforms to incentivize better integration of health and social care (pilots + scale-up)</td>
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<tr>
<td>Introduce professional and services integration (pilots)</td>
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<tr>
<td>Promote professional and services integration and introduce organizational integration if possible</td>
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- Large incentives for cost-shifting from social care to health care, since the latter is better funded.
- Excessive care burden on families, which apart from welfare losses also has implications for labor market participation and productivity.
- Fiscally sustainable, contains the costs of the LTC system

**Financing model**

**Low financing maintained**

This is a low spending scenario, with public expenditure on long-term care capped to grow from 0.6 percent in 2013 to 0.8 percent of GDP in 2030 (current Ministry of Finance baseline). Given that contributory LTC insurance is not a viable option as noted above, the system would continue to rely on general government revenues and out-of-pocket expenditures. The low level of public spending would require greater targeting of expenditures based on need and financial vulnerability as discussed below. A means-tested LTC financing system which involves care recipients having to deplete their assets in order to become eligible is not recommended.

**Financial capacity of local governments improved**

Given unequal local government resources and the lack of earmarking of funds for long-term care, equitable provision of long-term care (particularly social services) across geographical regions requires supplementary funding from the national government to local governments with less financial capacity. One option to address this is for the state to set nationally the eligibility criteria based on the sufficiency of local government revenues and the size/needs of eligible dependent population, and then provide as-required additional funding to local government/cities. This top-up for local governments/cities with lower financial capacity would be additional to the general top-up payment that is received from the equalizing fund (tasandusfond), which is currently not sufficient to equalize financing capacity. The top-up is expected to reduce inequalities in local governments’ capacity to fund LTC and thus improve in access to services overall as in the French government example in Error! Reference source not found.

**Box 6. Supplementing local authorities’ funding**

In 2000 France introduced the *Allocation personnalise d’autonomie (APA)*, which had a mixed system of funding comprising local authorities' contributions and a national funding source to generate additional revenue and reduce inequalities in local governments' capacity to fund long-term care.

**Note:** the subnational resource allocation formula (including the equalization fund) is being reformed and would need to take into account any changes in responsibility. Indicators of LTC social care need should inform the equalization formula).
Delivery of LTC services

Family remains at the center of the LTC system

This scenario involves retaining the strong reliance on the role of family, given low public provision. Primary responsibility for providing assistance to family members in need would remain with the family network. State institutions may intervene when a family is unable to support dependent family members, and/or the health status of the dependent requires state intervention. This Scenario places an unusually high level of obligation on the family to supply care needs, but there is little flexibility for improving on this in the low-spending Scenario.

Increased support for informal carers.

The work of informal caregivers needs to be recognized by expanding coverage of a caregiver's allowance, differentiated according to family circumstances. The state should establish a nationally unified set of criteria for caregivers’ allowances to address large local government-level differentials in criteria and consequently in payments to caregivers. A social tax for the caregiver should also be introduced, and if necessary, caregivers’ allowances could be financed from the state budget (with relevant changes in the share of personal income tax that is allocated to local self-governments). Caregivers should also have the opportunity to work under a contract that entitles them to an old-age pension and health insurance. In order to apply for this, the potential recipient or his/her dependent should meet certain criteria, such as extent of disability of the dependent, minimum hours of care per week, etc. The size of the allowance could be linked to certain benchmarks, such as the minimum wage. The size of the allowance could be a fixed amount approved annually with the state budget. If initially costs have to be contained, the caregiver's allowance and benefits could be means tested and then the beneficiary population expended over time (with eligibility criteria relaxed).

Support networks for informal carers and networks of non-state providers need to be formalized and expanded. First, better support for caregivers is critically needed, including counselling, respite care and flexible workplace regulations. Specific recommendations for action under Scenario 1 include: a country-wide free-of-charge call center on caregiving (say 07-24) so that caregivers can get immediate and first-hand information and assistance; training funds for caregivers and assistance with arranging training courses both in-person and online. Secondly, the development of support services for caregivers that enable them to remain active in paid employment and maintain a social life would improve the social inclusion of caregivers. Thirdly, caregivers would benefit from the support of non-governmental organizations, for instance people with dementia and their families receiving information, guidance, advice, help with adjusting to the situation, and peer support. Fourthly, identifying opportunities for bringing together existing household-level informal care at the community level will help lay the foundations for expanded role community-based care in the future.

Under Scenario 1, the state could support experimentation of variety of models (including different forms of Internet+) and intelligent technologies and applications for home- and community-based services to promote the matching of the supply side and the demand side and promote different forms of quality and affordable services to older people. Several good examples exist for creating supportive networks for caregivers as summarized in Error!
Finally, efforts should be made to encourage the non-state providers in the system to form networks and play a more active role in providing services.

**Box 7. Examples of caregiver networks**

**Timebanks**, which began originally in the USA and are now expanding to other countries, are networks of people and/or organizations, where members provide mutual support for a specific purpose, using time as the basic currency. Within these networks, for every hour of time that a member ‘deposits’ in a timebank for providing service to another, they are able to receive one hour of service time in return from another member. Timebanks are used for various purposes, including tutoring in school, health and wellness efforts, hospital discharge support, helping seniors to age in community, and more. The NOLA Timebank in the USA, for example, allows members who provide in-home respite care for an elderly person to receive assistance from other members, in exchange for another service. Timebanks can vary in size from as few as 20 people to tens of thousands. Most (but not all) timebanks use timebanking software to help keep track of member activity.

Norway’s **Care Plan 2020** aims to improve the framework conditions for non-profit suppliers of health and care services, simplify guidelines for funding and transfers to the volunteer sector, and increase coordination with Ministry of Culture responsible for the central government’s relationship to the non-governmental sector, while **Dementia Plan 2020** seeks to require municipalities to offer a day activity service to people with dementia.

**Greater efforts to strengthen local government service delivery**

The state, specifically MoSA, should set up compulsory minimum standards for LTC service delivery and a national monitoring framework to measure and evaluate the delivery of social services by local governments/cities. Compulsory minimum standards are needed to address large differentials in what is actually delivered by local governments across the country, and includes the nationally unified criteria for caregiver allowances noted above. Although minimum standards exist at present, the criteria are not compulsory resulting in large variations in service delivery relative to need. As a first step, the legal and regulatory basis for such reporting needs to be established. Information systems to support the framework need to be established in parallel (see section on information flow below). Given large variations in data management and analytical capacity across local governments, some investment in the human resource analytical capacity is warranted. As a two-way reporting system, state and local governments would need to agree on the set of indicators to use.

Next, an ongoing monitoring and evaluation system should be put in place, underpinned by the national monitoring framework in order to conduct a periodic (annual) review of LTC. Local governments would be responsible for providing information on service delivery to the national government, which would then analyze the quality and adequacy of provision (according to state regulations/law). Incentives could be provided for local governments/LTC providers who meet quality/quantity indicators for LTC provision. Here the LTC strategy is
dependent on the outcome of the future subnational administrative reform, which is intended to increase municipality size and provide quality public series to all residents. Sweden provides very good examples of effectively monitoring local government provision of LTC as summarized in Box 8.

**Box 8. Monitoring local government performance in Sweden**

For the Public Report on Elder Care Statistics, Sweden collects data from local governments on behalf of the National Board of Health and Welfare Evaluation (www.socialstyrelsen.se).

In addition, Sweden has developed clinical registries to measure quality in LTC, including: a) The Senior Alert Registry, which compiles individual data on falls (incidence), pressure sores and malnutrition and assists in identifying the vulnerable elderly population who should receive LTC assistance; b) The Palliative Registry, which gathers information on LTC inputs (such as institutional beds/spots, staff availability, the existence of a care plan etc.) associated with end-of-life care and information on deaths; c) The Swedish Dementia Registry, which compiles data on demographics (age and gender), health status (BMI, mental state, medical diagnosis) and treatment/services received (medical and social services). The Swedish Registry on Behaviour and Psychiatric Symptoms in Dementia also puts together individual-level data on the treatment received for the affected population; and d) National-level user satisfaction surveys which measure user satisfaction with municipal LTC services.

Sweden also introduced a pay-for-performance scheme in 2010 to provide incentives to municipalities which reach agreed performance standards (such as reduced hospitalization and meeting data reporting requirements).

The monitoring and reporting system could be the basis for a review of capacity (the availability of relevant human resources) to determine the challenges faced by local governments/cities in delivering services. Then, the state could identify and encourage (small) local governments that may need to seek partnerships with other municipalities in order to effectively deliver services.63

The monitoring and reporting system could also be the basis for introducing pay-for-performance (P4Ps) to local governments, as in the Sweden example above. Initially, the P4P’s could reward regular reporting of good quality data.

**Greater efforts improve efficiency within and between the health and social care sectors**

Other technical work (World Bank Health RAS) has already identified policy reforms to improve efficiencies in care provision through streamlining and simplifying the current models of primary care capitation and payment per case for inpatient care. These will allow for clearer behavioral signals and decreased administrative burden for family physicians and thus, help increase efficiency in the delivery of health care services. It may be worth exploring...

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63 The Estonian social enterprise Helpific is a successful example of caregiver networks. Helpific is a web-based support environment, through which people with special needs can find voluntary helpers or paid services. See https://helpific.com/en
how to incentivize hospitals / nursing homes to extend their services so that they can directly provide home- and community-based services or provide technical support for home- and community-based service facilities.

In addition, given wide variation in cost and clinical/care outcomes between facilities and municipalities, the poorest performers’ outcomes should be brought closer to those of the best through monitoring and publishing of indicators. The monitoring and reporting system described above would provide data for such analysis. In the UK, a recent Audit Commission study found that unexplained variation in the costs of provision between similar councils could lead to improved value for money equivalent to more than £450 million, if unexplained additional spending per head was reduced to the median in councils of similar type. In Italy, spending differentials appear to be associated with differences in the degree of appropriateness of the treatments, supply structure and social capital indicators. These results suggest that savings could be achieved without reducing the amount of services people receive.

**Develop a human resource strategy for LTC**

Moving towards an ideal system where LTC is largely financed by the state and provided formally would mean significantly expanding the supply and capacity of care workers, particularly those who would work in home/community settings. While there is little scope for such expansion during Scenario 1, it would be important to develop a human resource strategy now to meet such needs in the future. This would include identifying training needs and estimating the financial and other resources needed to expand and strengthen that cadre of social care workers. In many OECD countries, human resource needs for formal LTC care are increasingly met by migrant workers because the work and remuneration are not attractive enough for the local population. Japan has invested in training LTC workers in other countries (e.g. Philippines) and introduced the foreign workers into Japan under strictly controlled visa programs to meet domestic shortages in the supply of LTC workers. If foreign workers are not an option for Estonia, it is all the more important that the human resource strategy considers potential demand for work in LTC care and the types of financial incentives needed (e.g., what are other professions that LTC work would be competing with and what does the labour market look like?). The human resource strategy should also plan for the creation and training of a new cadre, the care coordinators discussed further below.

**Benefits package and targeting**

**Benefits package would remain limited.** There is little room to expand social care provision when institutional care spending is relatively low but makes up a large share of the budget (a large part of institutional spending is for the dependent non-elderly; while the spending mix could be altered, it is difficult to make savings here). The package of health-related LTC would remain the same, although addressing inequalities in the distribution of home nursing services would be beneficial. Any additional resources available to local governments should be channeled to support informal care providers and to slightly expand the home and personal-care services available to the population.
Social LTC services would be targeted to a narrow group. This would involve channeling support to the most dependent (with a focus on the most vulnerable groups: children and adults with severe long-term physical/intellectual disabilities and psychiatric disorders; elderly people with advanced dementia; and people with severe limitations toward end of life) and to those in greatest financial need. Targeting would therefore be based on (a) needs-based criteria that uses an individual's level of dependency/disability to determine the level of institutional or social care required (based on a common assessment); and (b) financial vulnerability (based on a common assessment of income and assets).

A standardized single country system for targeting social services for long-term care based on income/wealth (means test, and if appropriate, asset test) and degree of disability is critically needed. The criteria would be set by the state to ensure uniformity across the country, and the assessment carried out by local governments. This is discussed in more detail below.

Policy and implementation reforms to move towards the ideal system

A clear definition of LTC needs to be agreed on and stated in the Law. The definition of LTC proposed in this report could serve as the basis for this. The lack of a clear definition undermines effective and rational provision of services at present.

Effective coordination between health and social care services is essential for not only improving outcomes and quality of LTC, but also for ensuring value for money in both the health and LTC sectors. While the fiscal constraints under Scenario 1 would not allow for significant reforms in this direction, it would be quite feasible to lay the foundations for a better integrated system of health and social LTC.

The following reforms undertaken under Scenario 1 would be critical for introducing more substantive integrated care reforms in the future when the fiscal context is more conducive, and thus move the LTC system closer to an ideal system.

Introduce a needs-assessment framework and process that covers both health and social care

Estonia is considering adopting InterRAI, a standardized assessment framework, and this is highly recommended. This should involve bringing together all existing systems for assessing need, including rehabilitation and work-ability assessments. The adoption of such a needs-assessment framework is the basis for organizing care needs around the individual user, rationalizing care (e.g. avoiding unnecessary hospital admissions), and making sure available resources are used effectively. Combined with effective measures to assess income/wealth, this framework would also ensure that resources are allocated equitably to those in greatest need.

Error! Reference source not found. provides country examples of the use of such frameworks.

Box 9. Unified health and social care needs assessment frameworks

Canada, Belgium, Iceland and the United States have adopted the InterRAI system.
The UK’s Care Act 2014 defines local authorities’ duties in relation to assessing people’s needs and eligibility for publicly-funded care and support.

Easy Care, is a unique suite of tools for identifying threats to health, independence and well-being in old age. These tools allow front-line practitioners and voluntary workers to
undertake a brief multi-dimensional assessment of a person’s physical, mental and social functioning. It is also simple enough to be self-completed by an older person. The results can be used to mobilize information, advice and support based on the priorities of that particular person, which is the key to delivering a personal and efficient service response.

Develop shared vision and goals, and foster commitment from the highest levels of leadership for integration of health and social care.

It is important to develop early on a shared vision for integrated health and social care, with the goals of introducing care delivery processes centered on addressing the needs of people who rely on them, independently of who is providing care. As described earlier, successful programs have been centered around fictional care users struggling to navigate fragmented systems in order to adequately convey the need and purpose of integrated care, such as “Mrs. Smith” from the Torbay primary care trust’s model in England’s and “Esther” from Jonkoping county council’s program in Sweden. Ensuring commitment from the top is equally important.

Address regulatory constraints to integration of health and social care

There are four key tasks involved:

(i) Review the legal framework set by the various health and social care acts to identify any regulatory blocks to integration. Lack of detail in social care legislation (e.g. on where the responsibilities for medical treatment end and where social care begins) can lead to competing goals, with poor alignment of professionals across health and social care. Putting a roadmap in place for modifying the legislation appropriately can start now. This includes review of legislation to permit sharing of electronic data between health and social care (discussed below);

(ii) Establish detailed requirements for objectives and content of all social welfare services. Regulations should establish minimum standards in provision of relevant services to be adhered to by local self-governments;

(iii) Raise awareness of the rights of patients and their families, and the services available to them;

(iv) Develop legislative and policy frameworks to guide and sustain integrated care arrangements between health and social-care providers. Programs should include medium to long-term financial strategies that are realistic about costs, as well as sound governance arrangements and accountability mechanisms to ensure providers are held responsible for stated goals and quality targets.

Experiences from other countries show that addressing these regulatory constraints early on is critical for integration (Error! Reference source not found.).

Box 10. Addressing regulatory barriers to integration

Reforms in Norway and Sweden clearly specified social responsibilities. For instance, the 1992 Ädelreformen Elderly Reform enforced making municipalities responsible for social care of the elderly.

The Assessment of integrated care in England, Northern Ireland Scotland and Wales showed
that the most critical role of national policy-makers is to remove the barriers that inhibit progress, establish a policy context that is fully aligned with the aims of integrated care, and through their policies and actions demonstrate that integrated care is a core objective for government.

Sweden: **Norrtaelje model** (aligning the health care and social care sectors in terms of high-level organization and funding to better integrate care for older people with complex needs) also illustrates the importance of addressing regulatory issues early on.

Establish regulatory and policy framework for care coordination and case management

*The first step is to identify and establish the legal basis for the entity or provider who would play the case manager role.* The new Primary Care Centers are well placed to perform this role, as discussed elsewhere. EHIF is in the process of setting up a purchasing model for primary care centers to promote good coordination not just the within health system but also within the social care system.

*The second step is to identify the person within the entity to be the care coordinator, responsible for the task of health and social care case management.* Case managers already exist in social care. What is proposed here is the establishment of a new cadre of care coordinators who would: have a background in both health and social care; lead multidisciplinary teams in carrying out needs assessment using the tools discussed above; and manage each case where both health and social care is needed. It is particularly important that care coordinators have the authority and the mandate to make decisions across social and health sectors.

*The third step is to develop the case management model itself.* This would involve identifying and agreeing on: case-finding methods to identify complex individuals who are at risk (e.g. of an emergency hospital admission) and would benefit most from a comprehensive case management program; a comprehensive assessment of medical and social care needs (see above on assessment framework); joint development of care plans with patients which are easily accessible by all health and social care professionals; and care co-ordination by designated case managers working within multidisciplinary care teams. MoSA is already developing models of care pathways as part of the integration of care pilots in Viljandi. These could provide the basis for developing care plans. Case management models are in use several countries as shown in Box 11.

**Box 11. Case management models for health and social care**

The United States: **Guided care model** where registered nurses are recruited and trained to act as case managers for the primary care practices that participate in managed care programs, such as Kaiser Permanente.

The UK: **Virtual wards program** where community matrons or GPs act as case managers and meet regularly with members of multidisciplinary care teams to monitor patients’ condition.
and care needs.

Sweden: The Nortalje model uses case management for patients who have been hospitalized. Case managers (usually nurses) work with physicians to develop a care plan for patients who are about to be discharged from the hospital and coordinate with other hospital-based physicians and community-based providers to ensure a smooth transition to the patients’ homes or nursing home setting.

The Netherlands: Case management models for people with dementia have developed in the Netherlands over the past decade to address the need for strong collaboration between various disciplines in the care and support sectors involved in the management of dementia patients.

Denmark: Case management is provided by municipalities to all elderly persons needing support. A case manager acts as personal counsellor for older people applying for support.

Finland: Institution-based care for dementia patients is managed by nurses. Nurses assess clients’ needs, prepare plan based on the clients’ needs, evaluate and implement the plan with the help of other professional teams such as physiotherapist, occupational therapists, and social workers.

Promote integration of health and social care data

Integrating social care data with the e-health system would enormously improve information flows. The main requirements for this are already in place in Estonia: interoperable electronic health records, health information exchange, and unique ID would all allow for increased portability of data. The key next steps would be to: standardize medical and social care records; link medical care records to hospital, community and social care records; integrate the different registries to follow elderly patients and disabled non-elderly people who need LTC through their health and social care pathways; and train personnel in the social sector to track, read and interpret patients’ medical and social care records. There are many good examples of this from around the world as shown in Box 12.
Box 12. Integrating health and social care data

Australia: Records for all people aged 65+ who were assessed under the Aged Care Assessment Programmes were linked to data for six major aged care programmes and to mortality data over a four-year period. The linked data enabled examination of care pathways, including entry into residential homes vs. community care.

Torbay, UK: The Trust records users’ NHS number and links health and social care records (already links hospital inpatient, outpatient, community services and adult social care services, and is now linking with GP practice records). The information has been used to support patients at home and reduce hospital bed use, emergency bed days, delayed transfers of care and costly care home placements.

San Francisco, USA: CARE is an Internet-based care management programme that enables providers and agencies to exchange information and coordinate care management.

Scotland: Health and Social Care Data Integration and Intelligence Project has developed linked individual-level longitudinal social care dataset.

Canada, Belgium, Iceland and the United States have adopted the InterRAI system and incorporate the standardized instrument into their information platforms.

Scenario 2: Moving towards an ideal system

Scenario 2 involves relaxing the budget constraint to continue to expand the package of LTC services including personal and domestic care services, as well as enhancing support to informal caregivers. It would also involve further strengthening integration of health and social care by introducing payment reforms and promoting professional and services integration (pilots). In essence, Scenario 2 would move Estonia significantly closer to an ideal system than Scenario 1 would achieve.

Expected outcomes under Scenario 2

- Increased accessibility as the benefits package is expanded.
- Improved financial protection due to the cap on OOPs for LTC.
- Reduced informal and/or family care burden would allow more informal carers to return to the workforce on a part-time or full-time basis.
- Better coordination of health and social care would also improve quality of care and outcomes for users.
- With the increased fiscal cost, there would be a need for cost containment to ensure fiscal sustainability. But targeting a national basket of services should help keep costs under control, while improved coordination in health and social care services should lead to more rational and cost-effective patterns of service use.
Financing model

Modest increase in spending

Public spending would increase modestly in this scenario, with public expenditure on long-term care reaching up to 2-2.5 percent of GDP in 2030. The long term care system would continue to rely on financing from general revenues as described under Scenario 1. Co-payments/out-of-pocket expenditures would be moderate (with room to protect the most vulnerable groups). Top-up financing for local governments based on eligibility criteria discussed under Scenario 1 would continue. With primary care centers beginning to play a more active case management role for health and social care, it may be possible to experiment with pooling health and social care budgets at the primary care center or another appropriate entity at the local government level.

Delivery of LTC services

Diminished role of family in LTC

Family members would be expected to supply a minimum level of care, but anything more than usual care is voluntary\(^{64}\). This would allow more flexibility in families’ obligations to provide long-term care. The state would define the scope and extent of the minimum level of LTC that the family network would be expected to provide, taking into account societal preferences. If a family is found to be unable to provide this minimum level of care, society should intervene. Guidelines for the means/asset testing of family resources and needs assessment instruments recommended under Scenario 1 would be the basis for defining the scope and extent of family network provision. As emphasized earlier, principles to investigate the financial status or assess assets of the person in need (and his/her family) should be the same across the country to promote equity.

Increase support for informal caregivers

The increased fiscal space for LTC should be used to further increase support for caregivers, both through increased allowances and by formalizing support networks, as discussed under Scenario 1. Support networks should include a country-wide, free-of-charge caregivers’ call center to provide immediate, first-hand information and assistance to caregivers. A webpage should also be established as a source of information on caregiving. Additional funds should be allocated to train caregivers, with courses both in-person and online, and to expand the activities of the existing caregiver’s network, Helpific. Temporary accommodation should be provided to children in need of care while parents/caregivers take annual leave. During periods

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\(^{64}\) For example, in the Netherlands, the concept ‘usual care’ was introduced in the AWBZ-assessment (Algemene Wet Bijzondere Ziektekosten - The General Exceptional Medical Expenses Act). Usual care is care that does not involve any recourse to the AWBZ. It is the normal everyday care that partners or parents and children living together are considered to offer each other because they are jointly responsible for the functioning of that household. It is only correct to use the term ‘usual care’ in the context of a joint household. It is generally assumed at policy level that usual care will not exceed eight hours a week and will last for a period of less than three months (Struijs, 2006).
of temporary incapacity for provision of care due to illness, compensation should be provided so that a substitute caregiver can be hired.

Continue to strengthen local government capacity and performance

The monitoring and reporting system instituted under Scenario 1 would be used routinely, and the P4P initiative expanded. Local governments would be responsible for providing information on service delivery to MoSA, which would then analyze the quality and adequacy of provision (according to state regulations/law). The P4P initiative could be expanded to strengthen data quality and to reward local governments that provide services more effectively (e.g., number of cases of LTC recipients for whom post-discharge care was coordinated effectively by health and social care staff working together)

Primary care centers instrumental in coordination of care

Reforms are already underway for primary care centers to play a more central role in coordinating health care, thus avoiding unnecessary admissions and reducing lengths of stay. Scenario 2 could build on these reforms to both exploit any efficiency savings in the health sector and to better coordinate health and social LTC. Specific reforms are outlined below.

LTC workforce is expanded

Given the large resource envelope under Scenario 1, the LTC workforce could be expanded following the human resource strategy developed earlier. This would include training more home nurses and personal and domestic carers. It would also involve training and introducing the newly created cadre of care coordinators.

Benefits package and targeting

Expanded benefits package

The larger resource envelope under Scenario 2 would allow the benefits package to expand the set of formal services available at home to supplement informal care and postpone the need for residential care, including more home- or community-based services. The benefits could include more home nursing services (healthcare), as well as personal and domestic care services and social transport services (social care). Improving the availability of home-based services not only improves quality of care for the user, but also postpones the need to institutionalize care. Scenario 2 could increase caregiver allowance coverage for informal carers of the severely disabled to close to 100 percent and make other allowances more generous.

Targeting and out-of-pocket cost caps

More universal targeting is feasible, as is the introduction of a ceiling for out-of-pocket costs. Essentially, formal LTC services would increasingly be available to everyone, subject to needs being assessed and determined using the standardized needs assessment framework already established. Care allowances would also be available to more families as the income/asset eligibility criteria would be relaxed. The introduction of a ceiling on private spending would be subject to some controls but would essentially improve financial protection for families.
Policy and implementation reforms needed to move towards the ideal system

Building on the integrated care reforms initiated under Scenario 1, Scenario 2 would be able to initiate more substantive reforms to ensure better coordination of health and social care. They are as follows:

**Introduce payment reforms that would strengthen financial incentives to promote greater integration of care**

Several possible payment mechanisms could be introduced, depending on the type of organizational reform that is undertaken. With lump-sum coordination payments, a lump sum per-member per-month (PMPM) payment is made to providers or care teams responsible for linking up health and social care. These could be payments specifically for linking with social services, or for a broader case management program that includes coordination with social care. Alternatively, risk-based payments include shared savings models, bundled payments, and quality withholds or clawbacks. And global community health capitation budgets involve capitated community health budgets for a provider or group of providers to cover a range of services over a fixed amount of time. Again, there are good examples of these from around the world as shown in Box 13. Other work under the World Bank Health RAS has examined the applicability of these models for Estonia in more detail and should be examined as part of the policy development process for LTC.

**Box 13. Payment mechanisms to promote health and social care**

Austria – Lump sum Pay for coordination is used for diabetes disease management programs. GPs are paid an initial premium (€53) upon patient enrolment in DMP and a quarterly payment (€25) to supplement the traditional FFS.

US – Accountable Care Organization Shared Savings Program: The Medicare Shared Savings Program was established by the Affordable Care Act in the US to facilitate coordination and cooperation among providers to improve the quality of care for Medicare Fee-For-Service (FFS) beneficiaries and reduce unnecessary costs.

US - Oregon’s Coordinated Care Organizations (CCOs): Oregon’s CCO’s use global budgets for physical health, behavioral health, and most recently oral health services.

The Netherlands – Insurers pay bundled payments to a principal contracting entity — the care group — to cover a full range of diabetes-care services for a fixed period of 365 days.

**Promote professional and services integration**

It is also important to actively promote multi-disciplinary teams and service integration, as payment reforms alone would not achieve this. Important elements of this reform would include: regular contact between medical professionals and institutional / social care providers; joint clinical and care guidelines helping to co-ordinate care through different pathways and reduce avoidable medical and care variations; joint care coordinators, care planning systems, etc; specialized care providers to address complex health problems; and intermediate care services, coupled to appropriate quality assurance systems. Scenario 2 could
pilot and eventually scale-up reforms to promote professional and services integration. Again, there are useful examples from around the world to consider on this (Box 14).

**Box 14. Examples of professional and services integration**

<table>
<thead>
<tr>
<th>Country</th>
<th>Description</th>
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<tbody>
<tr>
<td>Denmark</td>
<td>A series of strategies to follow elderly patients once they are discharged from hospitals through preventative visits at the home for all older persons, contracts between municipalities and hospitals about discharge procedures, meetings between home nurses and hospital staff.</td>
</tr>
<tr>
<td>England</td>
<td>A new cadre of geriatric nurse practitioners (GNP) has been created to reduce fragmentation across care settings.</td>
</tr>
<tr>
<td>France</td>
<td>Service Intégré de Soins à Domicile coordinates the distribution of tasks among health and social care professionals for home care.</td>
</tr>
<tr>
<td>Sweden</td>
<td>(i) Municipalities around Lidköping started a common political board to deliver co-ordinated care for the most fragile elderly. Staff from different professional and institutional backgrounds work in networks to provide services such as: day care medical rehabilitation; geriatric day care; and occupational therapeutic and physiotherapeutic work in people’s own homes. (ii) Gävle municipality has established joint primary care/municipality elderly care teams, constituted by people from councils and municipalities, who prepare joint care plans upon discharge from hospital. (iii) Södertälje municipality succeeded in joining together health and municipality personnel to care for people with mental health problems.</td>
</tr>
<tr>
<td>Colorado, USA</td>
<td>Care Transition Coaching interventions encourage management of care transitions, self-care, and improve communication across care settings have shown encouraging reductions in rates of re-hospitalization.</td>
</tr>
</tbody>
</table>

**Scenario 3: Closer to an ideal system**

Scenario 3 is one where most of those seeking LTC have access to publicly-financed formal care services that are available at home and in the community to supplement informal care provided by the family network, and residential care services when home/community care is no longer feasible. The near-universal entitlement to publicly financed LTC services would inevitably involve considerably higher levels of public spending.

**Expected outcomes under Scenario 3**

- High levels of access and financial protection
- Negligible informal care burden and reduce negative impact on labour market participation of family members
- High fiscal cost and potential for unsustainable growth of demand (Netherlands and France experience).
Financing model

High spending.

Under Scenario 3, public expenditure on long-term care would approach 3.5 - 4 percent of GDP in 2030. Of the three sources of financing for long-term care (insurance, general revenues and out of pocket), the system would mostly rely on general revenues. Co-payments/out-of-pocket expenditures would be low.

Funding channelled through primary care

The integrated care reforms introduced under Scenarios 1 and 2 would lead to primary care centers effectively coordinating health and social care, and holding the budgets for both health and social care for the registered population. See more discussion of pooled budgets and organizational integration in the Policy Reform section below.

Delivery of LTC services

Diminished role of family in LTC with state at the center of the LTC system.

Family members would be expected to provide a minimum level of care, the scope of which would be defined by the state; anything more than this would be voluntary. Compared to Scenario 2 there is more scope to move to a universal-type of LTC system where informal care is substituted largely by publicly-provided formal care (as in Scandinavia). Care for informal caregivers would be available and sustained where needed.

Local governments deliver services more effectively

Local government capacity and performance would be monitored and reported on routinely. P4P schemes could be expanded to reward local governments that coordinate health and social care effectively and reduce hospitalizations, etc.

Emphasis on prolonging care at home and de-institutionalizing LTC

With the significantly larger resource envelope, it would be possible to expand the supply of home and community-based services, including the infrastructure and human resources to support this. This would allow for moving LTC out of hospitals and nursing homes into users’ homes and community. This is discussed in more detail below.

Benefits package and targeting

The benefits package would be comprehensive and include the full range of home-based services including home nursing services, personal and domestic care, social transport and access to day care centers, as well as any institutional care as needed. Universal targeting is made possible by high public spending; a ceiling for out-of-pocket can be set for long-term care private spending (subject to some controls).
Policy and implementation reforms to move towards the ideal system

Pool budgets and introduce organizational integration

This would involve complete integration of health and social care: merging organizational and financial boundaries through joint purchasing, pooled budgeting, single payments systems or bundling across health and social care. This is the most complex level of integration, but one that encourages continuity of care and shares financial risk across different levels of government or organizational units. Box 15 provides examples of this. However, the applicability and feasibility of these reforms are difficult to assess at this point in time, given the relative underdevelopment of health and social care integration in Estonia.

Box 15. Examples of pooling budgets and organizational integration

US – **PACE** (comprehensive delivery system for health and social services: good consumer satisfaction, reduction in use of institutional care, controlled utilization of medical services, and cost savings to public and private payers of care)

US – **S/HMOs**, i.e.: Social Health Maintenance Organizations (**increase likelihood of successful discharge**),

Belgium – coordination of care through **SISD** (**Service Intégré de Soins à Domicile**) within **INAMI** (**Institut National d’Assurance Maladie-Invalidité**)

France – integrated **SPASAD** (**Services Polyvalents d’Aide et de Soins A Domicile**), which integrate social assistance and home-care nursing services. The latter were previously provided separately through the **SSIAD**: **Service de Soins Infirmiers à Domicile**

Expand formal home- and community-based services

With the significantly-expanded resource envelope, it would be important to expand the supply of home and community-based services, an important pre-condition for de-institutionalizing LTC. A first step would be to pilot a range of respite and support services (such as mobile on-call day and night care, home nursing, etc.) in order to identify which services are most useful for both patient and caregiver. Also important for providing care at home is the expansion of the formal care workforce, including building up a team of aged care and nursing practitioners to strengthen the training of professional service providers, enhance the attractiveness of the aged nursing profession and improve the overall quality of aged care and nursing practitioners. Community-based services should also be expanded, including developing a supportive social network for patients and their caregivers, at home, in the community, and in special care homes. Increased support for non-governmental organizations in providing people with dementia and their families with information, guidance, advice, help with adjusting to the situation, and peer support is also recommended. The examples in Box 16 help illustrate how different countries expanded supply. Again, specific policies would need to be developed for Estonia when the timing and fiscal resources are conducive for such a supply expansion.
Box 16. Examples of how countries expanded LTC supply

<table>
<thead>
<tr>
<th>Country</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Canada, Ireland, New Zealand, Sweden</td>
<td>Direct investment to support expansion of home care supply.</td>
</tr>
<tr>
<td>US</td>
<td>The Home and Community-Based Services Plan Option under the Affordable Care Act (ACA) 2010 gives states the flexibility to expand home and community-based services benefits. Under the “Community First Choice Option,” states providing supports and services for home caregivers can receive higher federal funding; Enhanced Home Care Pilot Program (additional training for home care providers resulted in better health results as well as lower overall health care costs, leading to cost reductions.</td>
</tr>
<tr>
<td>Italy</td>
<td>Community-based pro-Active Monitoring Program (CAMP) (phone monitoring and home visits reduced hospital admission rates and use of LTC) (Marazzi et al., 2015).</td>
</tr>
<tr>
<td>Netherlands</td>
<td>Long-term Care Act (Wet Langdurige Zorg, WLZ) in 2015: substantial shift of from residential care to non-residential care, call for greater individual responsibility in LTC. Responsibility for providing all non-residential care also transferred to insurers/municipalities, with discretion regarding the type and extent of assistance to be delivered. “Green Care Farms”, facilities that provide day-care activities in small-scale, home-like care environments. Nursing staff have integrated tasks.</td>
</tr>
<tr>
<td>Singapore</td>
<td>TGC (TOUCH Caregivers Support), a national grant for caregivers who want to undertake training.</td>
</tr>
</tbody>
</table>

Introduce regulatory measures and financial incentives to move LTC out of hospitals and nursing homes

Once the supply of home and community-based services have been sufficiently expanded (as described above), it would be feasible to introduce regulatory measures to move LTC out of hospitals and nursing homes. Reforms could include: making municipalities responsible for arranging care for dependents after discharge from hospital or upon assessment of need; and introduction of financial incentives to limit admissions and hospital stays based on need and other criteria. Introducing such reforms without adequate home and community LTC supply would lead to gaps in coverage and put users at risk for large OOPs. Examples in Box 17 illustrate how other countries managed these reforms.
Box 17. Reforms to move LTC out of hospitals and nursing homes to home and community

<table>
<thead>
<tr>
<th>Country</th>
<th>Reform Measures</th>
</tr>
</thead>
<tbody>
<tr>
<td>Austria, Netherlands, Sweden, United States, and United Kingdom</td>
<td>Cash benefits are directed either at users or providers to enhance user choice and stimulate a rebalancing of services and resources toward home and community-based care.</td>
</tr>
<tr>
<td>Finland and the Czech Republic</td>
<td>Developed guidelines to promote home care and enforce admission of those with high care needs only.</td>
</tr>
<tr>
<td>Hungary</td>
<td>Restricted budgets and imposes stricter criteria for admission to nursing homes.</td>
</tr>
<tr>
<td>Japan</td>
<td>Payment for LTC services for those with the lowest level of care needs—accounting for more than half of all patients in long-term care beds—has been set below the care production cost since 2006.</td>
</tr>
<tr>
<td>Sweden</td>
<td>Makes significant use of financial incentives to steer change. Since 1992, municipalities in Sweden have been required to arrange care for dependents after treatment in acute and geriatric hospitals, in an effort to reduce utilisation of health services. By making local governments financially responsible for the cost of patients whose acute care treatment has been completed, municipalities have strong incentives to take care of elderly people upon discharge from hospitals (e.g. through expanding housing for the elderly, special housing, round the clock care services, home-care service, etc.). The Act on Support and Service for Persons with Certain Functional Impairments (1995) moved a large number of people with functional impairments from hospitals into their own flats in the municipalities.</td>
</tr>
<tr>
<td>Norway</td>
<td>The <a href="#">2012 Coordination Reform</a> introduced a fee for bed-blocking, with large effect (Kverndokk and Melberg, 2016).</td>
</tr>
<tr>
<td>US</td>
<td>States receive additional funding for each Medicaid beneficiary transitioned from an institution to the community under the “Money Follows the Person” initiative. Started in 2005, these programs have increased federal funding for states to assist programs that stimulate service provision at the place where people needing care want it delivered, e.g. own homes. In addition, through increased federal financial aid, the “State Balancing Incentive Program” incentivizes states to increase the proportion of Medicaid spending on home and community care.</td>
</tr>
</tbody>
</table>

Increase end-of-life care at home

**End-of-life care is increasingly a major policy concern** not least because it is expensive, but also because patients’ preferences to be at home are often in conflict with the ability / availability of carers to look after them. Introducing optimized palliative care services outside hospital will have a cost but could reduce the number of deaths in hospital and improve quality of care and patient satisfaction. There are good examples from other countries (Box 18) that Estonia could examine under Scenario 3.
Box 18. Experiences with palliative care

Palliative care pilots in the UK (PCFP) and Croatia (CEPAMET)

Australia: Palliative Care Extended Packages at Home (PEACH) pilot (potential as a cost-effective end-of-life care model relative to usual care) [2013]

Sweden: Palliative Advanced Home Care and Heart Failure Care (cost-effective: costs for staffing are higher than usual care, but offset by the reduced need for hospital-based care) [2015]
PART IV: CONCLUSIONS

This review was carried out in response to a request from the Government of Estonia to the World Bank to provide evidence and guidance on strengthening the provision of LTC in Estonia. The Government of Estonia's Task Force on Reducing the Burden of Care was the primary counterpart for this study. Following this review, the Task Force will develop policy and strategy guidelines to submit to the Government of Estonia for developing and reshaping the necessary laws and regulations.

Whatever the social and political choices that shape the evolution of LTC policy in Estonia, this study highlights two types of policy interventions that are essential for moving away from the status quo and towards the “ideal system”: urgent policy priorities and the building blocks. Any additional investment in LTC, particularly in the short to medium term should be directed towards addressing urgent priorities and putting in place the building blocks.

The urgent policy priorities, particularly in the context of low spending are to: (i) address inequalities in services provision by redistributing funding to those local governments with weaker funding capacity; and (ii) increase financial and social support to informal carers. The latter is important because informal carers will continue to be the backbone of the system for the immediate future.

The building blocks comprise the stewardship function of the state as well as the legislative basis, institutions and mechanisms needed to ensure coordination of care. This report assumes that local governments would continue to deliver social care services as at present. The central state would therefore need to play an important stewardship role in ensuring horizontal equity (equal level of services for equal need), efficiency and quality in service provision. Uniform national frameworks and mechanisms to assess care needs, monitor service provision and reward good performance need to be developed and implemented by the central state. Better coordination of health and social care starts with establishing their legislative and regulatory bases, including the regulatory basis for integration of health and social care data. Only once these are in place can mechanisms to promote coordination of care such as the introduction of case managers, new payment methods and revised benefits packages be developed. A better-coordinated more comprehensive system of LTC would require additional resources. Human resource and infrastructure needs would have to be assessed and strategies developed for meeting these input needs over time as more financial resources become available. Implicit in the policy scenarios is the idea that in order to achieve an ideal system in the future, the building blocks need to be put in place now.

Ultimately, the resource commitments and system characteristics under any one policy scenario depend on the political and social choices of the Estonian people. The three scenarios proposed here are simply three points on a continuum from low to high coverage. Decisions about where on the policy continuum Estonia wants to be and which reforms are undertaken would depend largely on society’s preferences and the political economy of those reforms.
1. Limitations of this review

There are several limitations to this review, all of which are linked to data availability.

To begin with, individual level data on social care provision at the local government level are largely incomplete. Most municipalities maintain paper-based data on LTC recipients only for contracts signed. Aggregate, not individual-level data on costs for each type of service are recorded electronically, which meant it was possible only to calculate average monthly costs per client. With regard to home care, there are no electronic data on the services provided. Even those local governments that do enter their data into the STAR (local government social care database) were not able to provide the full list of clients in general care homes. This is partly because they record information on those elderly for whom at least some part of the service payment is compensated by the local government.

Secondly, it was not possible to analyze transitions of care between health and social sectors. In principle, the databases of the Estonian Health Insurance Fund, Social Insurance Board, Unemployment Insurance Board and STAR could be merged using the unique national identification number. This combined administrative database could be used to look at duplication or gaps in coverage as various care users negotiate their way through the different systems of health and social care. In practice, it took well over a year to agree on the data sharing and confidentiality protocols for the World Bank to gain access to the data. This work is on-going and an empirical analysis of transitions of care may be produced at a future data.

Third, this review provides much less comprehensive coverage of the non-elderly users of care than the elderly. The definition of LTC adopted for this review covers both the elderly and non-elderly who are in need of LTC. However, the survey data on the elderly are much more widely available. Surveys such as SHARE provide rich time-series data on the LTC needs, utilization and costs of those over 65 years of age. Similar data on the non-elderly disabled are lacking.

2. Knowledge gaps

Looking ahead, there are few pieces of analysis that should be undertaken as part of developing LTC policies to ensure that the design of the future system is based on sound evidence. A full assessment of the current stock and quality of human resources for LTC is needed. Such an assessment would encompass workers in the health and social care sectors, differences in skills and career expectations and remuneration. It would also carry out a qualitative assessment of the challenges of bringing health and social care under one sphere, potentially with pooled financing. A fiscal space analysis for LTC should be carried out to assess potential sources of revenue for LTC against projected expenditures. This would allow for a clearer assessment of the fiscal sustainability of the various policy scenarios. Private provision of LTC needs to be explored further. There is a tendency to equate the private sector with informal care and public sector with formal care. In many countries with more developed LTC systems such as the USA, public financing with private (formal care) provision is increasingly the norm. The market for private LTC services is growing rapidly worldwide. The extent to which the private sector may fill gaps in service provision merits closer attention.
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Annex 1: Long-term care and supporting social services and benefits in Estonia

Domestic service is a social care service organized by local authorities, the objective of which is to ensure adults are able to be independent and cope safely in their homes, maintaining and improving their quality of life.

General care service provided outside an adult’s home is a social service organized by local authorities, the objective of which is to ensure that when that adult is temporarily or permanently unable to cope independently at home due to reasons relating to state of health, operational capacity or physical and social environment, they are able to cope in a safe environment.

Support person service is a social care service organized by local authorities, the objective of which is to support adults to cope independently in situations where they need significant personal assistance in performing their obligations and exercising their rights due to social, financial, psychological or health problems. Personal assistance includes guidance, motivation and development of greater independence and responsibility.

Curatorship is established by local authorities for an adult who due to mental or physical disability needs assistance in the exercise of his or her rights and the performance of his or her obligations on the basis of an application by the person. The specific duties of a curator are determined upon establishment of the curatorship.

Personal assistant service is a social care service organized by local authorities, the objective of which is to increase the independent coping ability and participation in all areas of life of an adult who needs physical assistance due to a disability within the meaning of subsection 2 (1) of the Social Benefits for Disabled Persons Act and reduce the care burden of the legal curators of the person receiving the service.

Shelter service is a social service organized by local authorities, the objective of which is to provide a place of temporary overnight stay, including beds, washing facilities and a safe environment, to an adult who is unable to find a place of overnight stay.

Safe house service is a social service organized by local authorities, the objective of which is to ensure temporary housing, a safe environment and basic assistance to the persons specified in subsection (2) of this section. This includes crisis assistance where necessary, to help restore the person’s mental balance and operational capacity in everyday life, care based on age and needs, and information regarding other avenues of assistance.

Social transport service is a social service organized by local authorities, the objective of which is to enable a person who has a disability within the meaning of subsection 2 (1) of the Social Benefits for Disabled Persons Act and whose disability hinders the use of a personal or public transport vehicle, to use a means of transport which corresponds to his or her needs in order to get to work or an educational institution, or use public services.

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Provision of dwelling is a social service organized by local authorities, the objective of which is to ensure access to a dwelling for a person who, due to their socio-economic situation, is unable to provide a dwelling which corresponds to the needs of their needs, and those of their family. Disabled people who have difficulties moving about, caring for themselves or communicating in a dwelling as a result of a disability within the meaning of subsection 2 (1) of the Social Benefits for Disabled Persons Act shall be assisted by a local authority in adapting their dwelling or in obtaining a more suitable dwelling.

Debt counseling service is a social service organized by local authorities, the objective of which is to assist a person in identifying his or her financial situation, conducting negotiations with creditors, satisfying claims, and avoiding the creation of new debts through enhancing the ability to cope and resolve other problems related to debt.

The objective of the everyday life support service is a person’s best possible independent coping and development by supporting psychosocial coping, the development of everyday life coping skills and working skills and counseling of those close and/or living together with the person.

The objective of the employment support service is to supervise and advise a person in order to support their ability to cope independently and improve their quality of life both during the search for a job corresponding to that person’s abilities and during employment.

The supported living service means supporting social coping and integration of a person, together with supervision in the organization of household and everyday life to ensure that person can cope as independently as possible when living independently.

The community living service means the creation of a mode of life similar to a family that satisfies a person’s basic needs and development, together with accommodation and catering in order to increase their ability to cope independently and to develop the skills of organizing everyday activities through participation in joint activities.

The 24-hour special care service means a person’s 24-hour care and development, together with accommodation and catering to ensure preservation and increase of that person’s independent coping and safe living environment in the territory of the service provider.

Childcare service means a service supporting the ability of a person who has the right of custody over a child, or that child’s caregiver to cope or work, during which the care, development and safety of the child is guaranteed by a provider of childcare service instead of the persons specified above.

Substitute home service means ensuring family-like living conditions that meets a child’s basic needs and prepares them for coping as an adult, including the creation of a secure physical and social environment promoting his or her development.

Social benefits:

The objective of subsistence benefit is to alleviate material deprivation of people and families in need of assistance as a temporary measure, supporting their ability to cope independently by
providing minimum funds to satisfy their primary needs. A person living alone or a family whose monthly net income, after the deduction of housing expenses, is below the subsistence level has the right to receive a subsistence benefit. The Riigikogu establishes the subsistence level for a person living alone or to the first member of a family for each budgetary year by the state budget. Subsistence level is established based on minimum expenses (consumption of foodstuffs, clothing, footwear and other goods and services which satisfy primary needs).

Emergency social assistance is provided to people who find themselves unable to cope due to the loss or lack of means of subsistence, guaranteeing these people a minimum of food, clothing and temporary accommodation.

Needs-based family benefit: if at least one member of a family is a child receiving child allowance on the basis of the State Family Benefits Act, the family has the right to receive a needs-based family benefit, provided that: 1) the family’s average monthly net income is below the income threshold of needs-based family benefit or 2) a subsistence benefit was granted to the family for the month preceding the application for a needs-based family benefit.
Annex 2: European Commission projections of public LTC expenditure for the EU28 Member States, 2013-2060

Short methodology overview

The macro-simulation models developed capture the effect of demographic and non-demographic factors on future public expenditure on LTC. The methodology aims at analyzing the impact of changes in the assumptions made about:

- the future relative numbers of elderly people, reflecting changes in the population projections;
- the future numbers of dependent elderly people, by applying changes to the prevalence rates of dependency;
- the balance between formal and informal care provision;
- the balance between home care and institutional care within the formal care system;
- the unit costs of care.

The projections also take into account the budgetary effects of the recent policy reforms in each country. The impact of these reforms was modeled as a percentage change of LTC expenditure relative to the base year of projections (2013), differentiated for the various LTC areas. In case of Estonia, the reported wage adjustments were taken into account.

The projections, distinct to forecasts, do not aim to estimate the changes in future LTC expenditures capturing the effects of all the main underlying factors at once. The estimates are provided given the according set of assumptions under each scenario, leaving aside the impact of other factors.

Projection scenarios and assumptions

The latest EC Aging report (European Commission, 2015) introduces 11 different scenarios and provides estimates of changes in LTC expenditure for each of them. The aim of each scenario as well as the key assumptions are provided in the table below.

<table>
<thead>
<tr>
<th>Scenario</th>
<th>Aim</th>
<th>Key assumptions</th>
</tr>
</thead>
</table>
| Demographic scenario    | Isolates the size effect of an ageing population on public expenditure on LTC. | Proportion of the older disabled population who receive LTC is constant over the projection period.  
All gains in life expectancy are spent in bad health/with disability.  
For all types of LTC, expenditure per user grows in line with GDP per capita. |
| Base case scenario      | Reflects the highly labor-intensive characteristic of the LTC services. | For in-kind services, LTC unit costs are related to GDP per hours worked.  
Unit cost of cash benefits evolve in line with GDP per capita growth. |
| High life expectancy    | Assumes further demographic                                          | Life expectancy in 2060 is higher by one year than the "base                     |

66 This characteristic is assumed in all the scenarios except for the demographic one.
<table>
<thead>
<tr>
<th>Scenario</th>
<th>Development</th>
<th>Case* projected life expectancy.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Constant disability scenario</td>
<td>Assumes improvements in the health status.</td>
<td>The profile of age-specific disability rates shifts in line with changes in life expectancy.</td>
</tr>
<tr>
<td>Shift to formal care scenario</td>
<td>Policy-change scenario that assumes an increase in the public provision of formal care replacing informal care.</td>
<td>A 10-year\textsuperscript{67} progressive shift into the formal LTC sector of 1% per year of dependent population who have so far received only informal care or cash benefits.</td>
</tr>
<tr>
<td>Coverage convergence scenario</td>
<td>Policy-change scenario that assumes an extension of the public coverage.</td>
<td>Upward coverage convergence to the EU28 average by 2060 (for the countries below the corresponding EU28 average). &quot;Formal coverage&quot; includes institutional care, formal home care, and cash benefits.</td>
</tr>
<tr>
<td>Cost convergence scenario</td>
<td>Captures the potential impact of a convergence in real living standards on LTC spending.</td>
<td>Upward convergence of the relative age-gender specific per beneficiary expenditure profiles (as percent of GDP per capita) to the EU28 average by 2060 for the countries below it.</td>
</tr>
<tr>
<td>Cost and coverage convergence scenario</td>
<td>Combines the &quot;coverage convergence&quot; and the &quot;cost convergence&quot; scenarios.</td>
<td>Upward convergence of unit costs and coverage to the EU28 average for the countries below it.</td>
</tr>
<tr>
<td>AWG reference scenario</td>
<td>Intermediate scenario between the &quot;demographic&quot; and the &quot;constant disability&quot; scenarios.</td>
<td>Half of the projected gains in life expectancy are spent without care-demanding disability.</td>
</tr>
<tr>
<td>AWG risk scenario</td>
<td>Combines the &quot;AWG reference&quot; and the &quot;cost and coverage convergence&quot; scenarios.</td>
<td>Half of the projected gains in life expectancy are spent without care-demanding disability.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Upward convergence of both total average cost and coverage to the EU28 average for the countries below it.</td>
</tr>
<tr>
<td>Total factor productivity risk scenario</td>
<td>Assumes lower Total Factor Productivity (TFP) growth.</td>
<td>Country-specific TFP growth rates converge to 0.8%.</td>
</tr>
</tbody>
</table>

Source: European Commission, 2012\textsuperscript{68}; European Commission, 2015

\textsuperscript{67} The first 10 years of the projection period

Annex 3: Caregiver support in Ireland and the U.K.

Carer’s benefits in Ireland

Carer's Allowance is a payment to people on low incomes who look after a person who needs support because of age, disability or illness (including mental illness). If a person qualifies for a Carer's Allowance, they may also qualify for free household benefit (if they live with the person for whom they care) and a Free Travel Pass.

To be entitled to a Carer's Allowance, the carer must be living with, or in a position to provide full-time care and attention to a person in need of care who does not normally live in an institution; the carer must not be engaged in employment, self-employment, training or education courses outside the home for more than 15 hours per week. The person receiving care must require full-time care and attention, being so incapacitated as to require continuous supervision in order to avoid danger to himself or herself or continual supervision and frequent assistance throughout the day in connection with normal bodily functions, and is likely to require this full-time care and attention for a period of at least 12 months.

Carer's Allowance is means tested. Any payment made by the Department of Social Protection is not taken into account in the means test for Carer's Allowance. The actual income from investments and money in a savings account is not taken as means. Instead, investment items such as, money in a savings account, cash-in-hand or money in a current account and the cash value of investments and property are added together and a special formula is used to work out weekly means. The means test for the Carer's Allowance involves assessing the carer’s income (excluding their home): Eur 332.50 of their gross weekly income is not taken into account (or disregarded). If the carer is married, in a civil partnership or cohabiting, the first Eur 665 of their combined gross weekly income is disregarded.

If the carer provides care to more than one person, they may be entitled to an additional 50 percent of the maximum rate of Carer's Allowance each week. Two carers who are providing care on a part-time basis in an established pattern can also share a single Carer’s Allowance payment and the annual Respite Care Grant. A non-taxable Carer’s Support Grant of Eur 1,700 (June 2016) per person cared for is paid once per year. The carer may also be eligible for carer’s leave.

Table 18. Carer’s allowance rates in Ireland in 2016

<table>
<thead>
<tr>
<th>Carer</th>
<th>Maximum weekly rate</th>
</tr>
</thead>
</table>


70 Carer allowance in Australia see: https://www.humanservices.gov.au/customer/services/centrelink/carer-allowance
<table>
<thead>
<tr>
<th>Carer</th>
<th>Maximum weekly rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aged under 66, caring for 1 person</td>
<td>Eur 204</td>
</tr>
<tr>
<td>Aged under 66, caring for 2 or more people</td>
<td>Eur 306</td>
</tr>
<tr>
<td>Aged 66 or over and caring for 1 person</td>
<td>Eur 242</td>
</tr>
<tr>
<td>Aged 66+, caring for 2 people</td>
<td>Eur 363</td>
</tr>
<tr>
<td>Increase for a Qualified Child</td>
<td>Eur 29.80 (full-rate) Eur 14.90 (half-rate)</td>
</tr>
</tbody>
</table>

**Carer’s benefits in Great Britain in 2016**

A person who cares for someone for at least 35 hours per week could receive GBP 62.10 per week. There is no obligation to be related to, or live with, the person you care for to be eligible. Carer’s Allowance is taxable. However, Carer’s Allowance on its own is below the threshold for paying tax, and carers will only have to pay tax if they have other sources of taxable income, such as an occupational pension or earnings.

For eligibility, carers must meet all the following conditions:

- Look after someone who gets a qualifying disability benefit;
- Look after that person for at least 35 hours a week;
- Aged 16 or over;
- Not in full-time education;
- Earn GBP 110 a week (after deductions) or less; and
- Satisfy UK residence and presence conditions.

The 35 hours can include:

- Time spent physically helping the person
- Time spent ‘keeping an eye’ on the person the carer looks after, e.g., preventing them coming to harm by walking out of the house
- Time spent doing practical tasks for them, e.g., cooking

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• Time taken doing practical tasks, even if not done in the presence of the looked-after person, may also count (for instance, if a carer looks after someone who visits them regularly for the care they need, time spent preparing for the visit or cleaning up afterwards should count).

If the carer is in paid work (including self-employment) and earns more than GBP 100 per week (after deductions), they are not eligible for Carer’s Allowance. Carer’s Allowance counts as income in calculating means-tested benefits.

A person cannot usually be paid Carer’s Allowance if they receive one or more of the following benefits:

• State Retirement Pension
• Contributory Employment and Support Allowance
• Incapacity Benefit
• Maternity Allowance
• Bereavement or widow’s benefits
• Severe Disablement Allowance
• Contribution-based Jobseeker’s Allowance

Conclusions and best practices. In most countries with caregivers’ allowance, the benefit is paid out from the state budget, based on unified criteria, as a state-provided social guarantee. In order to apply for the benefit, the potential recipient or his/her dependent should meet certain criteria, such as the dependent person’s extent of disability, minimum hours of care provided per week, etc.

On some occasions, the size of the allowance is linked to certain benchmarks, such as the minimum wage or subsistence minimum. Often, the size of the allowance is a fixed amount approved annually with the state budget.

Caregiver’s allowance is much higher in other countries (e.g., Ireland and UK), than in Estonia, and every person who meets the criteria is eligible to receive the allowance. In the UK and Ireland, allowances are targeted to low-income carers, or carers who provide hours of care above a minimum threshold. The cost of providing such benefits is still much lower than the cost of keeping dependents at residential care facilities.

In addition to caregivers’ allowance, a person who provides care may qualify for further benefits, such as pension insurance, unemployment insurance, and/or medical insurance; compensation during temporary incapacity for provision of care due to illness; household benefit; or a caregiver’s support grant (in Ireland). Allowance is often means tested, and in some countries, the recipient’s assets are also evaluated. Caregivers can apply for special leave, either from work or from taking care of dependents. Care allowance can be paid directly to dependent people who can use it to pay informal caregivers.
Annex 4: Long-term care insurance in Germany

Most OECD governments have set up collectively-financed schemes for personal and nursing-care costs. One third of the countries have universal coverage either as part of a tax-funded social-care system, as in Nordic countries, or through dedicated social insurance schemes, as in Germany, Japan, Korea, Netherlands and Luxembourg, or by arranging coverage mostly within the health system, as in Belgium. While not having a dedicated “LTC system”, several countries have universal personal-care benefits, whether in cash (e.g., Austria, France, Italy) or in kind (e.g., Australia, New Zealand). Finally, two countries have ‘safety-net’ or means-tested schemes for LTC costs: the United Kingdom (excluding Scotland, which has a universal system) and the United States.\(^\text{72}\)

Private LTC insurance has a potential role to play in some countries, but unless made compulsory will likely remain a niche market. In the United States and France, the largest markets in the OECD, 5 percent and 15 percent respectively of those aged over 40 have an LTC policy.

Germany passed its long-term care insurance legislation in 1994 and has two different kinds of care insurance: mandatory care insurance and voluntary, private care insurance. Basic care insurance is one of Germany’s five mandatory insurances (the others are health, accident, unemployment and pension insurance).\(^\text{73}\)

Contributions to the mandatory scheme are paid equally by employers and employees (1.175 percent by an employee, and 1.175 percent by an employer - 2.35 percent in total), and are calculated from gross income up to a social security contribution ceiling which is fixed every year (in 2016, €50,850). Legislation provides for a pre-insurance period of 2 years. The pre-insurance period for children is fulfilled if one of the parents has carried it out. Compulsorily insured pensioners pay 2.35 percent of their pension. Insured persons born after 1940 without children pay a supplement of 0.25 percentage points of all contributory earnings from the age of 23 years.

Germany’s long-term care insurance is funded on a pay-as-you-go basis whereby contributions are distributed immediately to fund care – which means that premiums have to be raised as the ratio of recipients to non-recipients increases.

The condition for granting the care service is the classification of the person in need of long-term care into a category by the medical service of the sickness insurance. To reach category I there has to be at least a daily need for support with at least two activities laid down by law in the areas of personal hygiene, feeding or mobility.

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\(^{73}\) MISSOC database – Mutual Information System on Social Protection, The 2016 release, see: http://ec.europa.eu/employment_social/missoc/db/public/compareTables.do
The levels of care are organized as follows:

*Care level I*: a need for assistance for at least 90 minutes per day with basic care needs of at least 45 minutes per day.

*Care level II*: a need for assistance must be at least 180 minutes per day with basic care needs of at least 120 minutes per day.

*Care level III*: a need for assistance is required for at least 300 minutes per day with basic care needs of at least 240 minutes per day.

*Hardship provision*: If the conditions for category III are fulfilled and an extraordinary level of care is present, these people may qualify for the hardship provision, which provides for higher benefits. In order to establish such an extraordinary level of care within the meaning of the hardship provision, basic care provision (personal hygiene, feeding and mobility) should be required for at least six hours per day, of which at least three care episodes should occur during the night.

Monthly benefits in kind (provision of basic care, domestic help and care by outpatient care centers or individual carers) correspond to:

- Care category I: up to €468
- Care category II: up to €1,144
- Care category III: up to €1,612
- In special hard cases - up to €1,995

People with a considerable limitation of daily living skills classified in the so-called category 0 receive benefits in kind corresponding to up €231 per month. In category I, the value of the benefits in kind is increased by €221 to reach €689 per month, and in category II it is increased by €154 to €1,298 per month.

Lump-sum payment of the costs for care, medical care treatment and social care expenses as a monthly benefit in kind in the following categories:

- Category I: €1,064
- Category II: €1,330
- Category III: €1,612
- In cases of particular hardship: €1,995

Moreover, the long-term care insurance pays additional care benefits to the care facility for people with an extensive general need of care, so that in general for every 20 residents one care person can be employed. With the new Care Support Act that came into force in 1 January 2015, this does not only apply for people with a limitation of daily living skills, but also for people in need of care in full and partial in-patient care facilities. Respite care envisages payment of up to €1,612 for up to 6 weeks per calendar year for the substitution of a carer, if he/she is on holiday or ill. Half of the care allowance continues to be
paid for up to six weeks per calendar year. In addition to the amount of benefit for the preventive care, up to 50 percent of short-term care amount (i.e. up to €806 per calendar year) can be used as domestic preventive care.

If a person in need of care provides for the care him-/herself, he/she can get care allowance in order to ensure necessary basic care and household assistance in an adequate way. For this benefit the monthly amount is:

- Category I: €244
- Category II: €458
- Category III: €728

People with a considerable limitation of daily living skills classified in the so-called category 0 receive a monthly care allowance of €123; in category I, care allowance increases by €72 to reach €316 per month, and in category II by €87 to €545 per month.

Cash benefits and benefits in kind may be combined: if the person in need of care only partly claims the benefits-in-kind, s/he is entitled to receive proportionate care allowance. The care allowance is reduced by the percentage corresponding to the claimed benefits-in-kind. The person in need of care is bound by the decision relating to ratio between cash benefits and benefits-in-kind for a period of six months.

Benefits of long-term care insurance are tax-free; furthermore, expenses relating to care may be deducted from taxes.

When a close relative develops a need for acute care, employees can can take up to 10 working days away from work in order to organize suitable care or ensure nursing care (short-term work incapability). During this time, the patient's long-term care insurance fund grants care assistance money which is limited to a maximum of 10 working days as wage replacement benefits.

Moreover, if a family member provides at least fourteen hours of care per week, long-term care insurance covers their social security premiums and respite care for a vacation. One aim is to make the “job” of primary caregiver more attractive relative to regular employment. There are no regulations on how cash is used, and some hire a paid helper.

Germany’s long-term care insurance system seeks to recognize and encourage family caregiving. Beneficiaries may choose to receive direct services or a cash allowance. Although the cash allowance is half or less the value of home and community-based services for a given level of need, about 72 percent of beneficiaries living at home choose this option. (Another 15 percent choose a combination of cash and services).