

„National Health Plan (NHP) 2009–2020“ Performance Report for 2013–2014

Summary

In general, the following positive trends of goals and sub-goals (strategic objectives) can be highlighted:

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

The most important challenges to be addressed are the following:

- restoring the growth of life expectancy and disability-free life expectancy;
- the share of individuals suffering from chronic diseases and restricted everyday activities among the population increases;
- social stratification is increasing;
- there are major gender, regional and socio-economic disparities in health indicators;
- suicide rates among children and adolescents do not decrease; suicidal trends among the elderly show an increase;
- new cases of diseases in mental and behavioral disorders among children and adolescents;
- mortality among children and adolescents aged 0–19, incl. injury death rate, does not show a decrease;
- morbidity and mortality from respiratory diseases demonstrates an increase;
- number of working days, lost as the consequence of occupational accidents, is increasing;
- vaccination among children under the age of 2 years shows a steady decline;
- overweight and obesity (starting already from childhood!)
- the use of alcohol, drugs and smoking;
- high share of multi-resistance forms of tuberculosis;
- the number of new cases of HIV is not decreasing;
- recourses of health care personnel (especially, nursing care personnel);
- accessibility of health care, incl. dental services;
- satisfaction with the quality of health care shows a decline.

Introduction

This Progress Report serves to provide an overview of the achievement of indicators, linked to goals and sub-goals of the second period (2013–2016) of the NHP 2009–2020. More

substantial information about the main activities of the NHP are available from the annual NHP activity reports that are published at the website of the Ministry of Social Affairs at <http://www.sm.ee/et/tervis>.

General Objective of the Plan

The disability-free life expectancy for both men and women is expected to increase, by 2020, to 60 and 65 years, respectively, for men and women while the average life expectancy will increase to 75 years for men and to 84 years for women.

Indicator	Base level	Performance	Goal	Target level	Result
	2006	2012	2016	2020	2014
Life expectancy at birth – men Source: Statistics Estonia	67.4	71.4	73	75	72.3
Life expectancy at birth – women Source: Statistics Estonia	78.5	81.2	82.5	84	81.5
Disability-free life expectancy at birth – men Source: Statistics Estonia	48.0 (2005)	53.0	57.5	60	53.1
Disability-free life expectancy at birth – women Source: Statistics Estonia	52.2 (2005)	57.0	62.5	65	57.1

Life expectancy at birth grew in the period of 2006–2014, on the average, by **0.7 years per year** – for men and women, respectively, by 0.7 and 0.4 years, reaching, by 2014, respectively, the level of **72.3 and 81.5 years for men and women**. For men, life expectancy made a leap in 2013, but dropped by 0.4 years in 2014 while among women steady growth towards target level was observed.

The growth of expected life expectancy in 2013 was attributable to the decrease of death rate resulting from accidents, injuries and poisoning (incl. drugs and alcohol), especially, among young men. In 2014, the decrease of death rate due to accidents, injuries and poisoning (incl. drugs) did continue, however, suicides and drowning showed an increase among young men, which resulted in decline of life expectancy among men.

For the first time, **the difference in life expectancy of men and women** dropped below ten years in 2010; by 2014 this difference had decreased to **9.2 years**.

The increase of life expectancy has been three times faster in Estonia than in the European Union (hereinafter the EU) in general. Although Estonia ranks first for its life expectancy level among the Baltic States, the respective indicator is still well beyond the respective average of majority of the EU Member States. The average EU life expectancy at birth is higher than in Estonia, for women, the difference is 1.6 and for men – 5 years.

The difference in life expectancy of Estonians and people of other nationalities has decreased over the years. While in 2006 Estonians lived, on the average, 2.5 years longer than people of other nationalities, the difference decreased by more than a third by 2014,

dropping to 1.4 years. Nationality-related differences in life expectancy at birth are bigger among men than women – for men, the difference in life expectancy at birth is 2.3 years lower for men of other nationalities while for women the respective difference is 0.65 years.

According to the census of 2011, in Estonia, major differences are present in life expectancy, depending on the education of people. **People with lower level of education** (basic education or lower) **can expect to live 11.9 years less than people with higher level of education** (higher education/university degree). The differences are more pronounced among men (the difference is 11.6 years vs. 8.8 years among women). Such differences are largely attributable to healthier life style and better health awareness of people with higher level of education.

Although life expectancy has grown over the years in all counties, considerable differences can still be detected – in 2013/2014, **the inhabitants of Tartu County lived 4 years longer than the inhabitants of Ida-Viru County**. In addition, the life expectancy was higher than the average in Estonia, apart Tartu County, also in Harju and Pärnu counties.

The disability-free life expectancy number increased very rapidly in 2006–2009 (growth above 5 years for both men and women), but again, showed a decreased in 2010–2012 (by approximately 2 years, for both men and women). In 2012–2014, the disability-free life expectancy has been relatively stable, **53 years for men and 57 years for women**, which is still lower than the respective indicators for 2009–2011. However, it is positive that the disability-free life expectancy among women ages 60 and older has shown a growth over the period observed in general: from 6.0 years in 2006 to 8.2 years in 2014. In 2006–2009 the disability-free life expectancy among men 60 years old and older grew from 5.2 years to 7.5; however, by 2014 the disability-free life expectancy had dropped to 6.7 years.

Gender differences in the disability-free life expectancy have decreased in Estonia. While in 2006, women lived, in average, 4.2 years longer than men, this had decreased to 4 years by 2014. When compared to life expectancy, gender differences in the disability-free life expectancy are somewhat smaller; however, in 2014, 70% of women lived their life healthy and the same goes for 73% of men.

As for the disability-free life expectancy at birth, the gap with the EU average is bigger than we experienced with life expectancy: in 2013, the gap with the EU average for men and women, respectively, was 7.5 and 4.4 years. Latvia is the only country where the number of disability-free life expectancy at birth is lower than in Estonia; as for women, the respective indicators are also lower for Germany and Slovakia. From 2010, the average disability-free life expectancy in the EU in general has dropped, respectively, by 0.4 years and 1.1 years for men and women; in single countries the results of 2013 show a slight incurrence of growth trend.

When observed at county level, the differences in the disability-free life expectancy are extremely large or more specifically, 17.5 years – in 2013/2014, inhabitants of Lääne County could expect 63 healthy life years whereas the respective disability-free life expectancy was only 45 for Põlva County. The number of healthy life years has grown since 2006 in all the counties, apart from Hiiu and Ida-Viru counties.

From 2008, the disability-free life expectancy for Estonians is longer than the respective outcome for non-Estonians. In **2014, Estonians lived healthily 3.5 years longer when compared to non-Estonians**, the respective difference for men and women was 1.9 and 4.8 years, respectively.

According to the census of 2011, **people with lower level of education** (basic education or lower) **could expect a 13-years' shorter healthy life than the respective period enjoyed by people with higher level of education** (higher education/university degree).

The disability-free life expectancy is a complex indicator that demonstrates the average number of years that an individual can probably enjoy without daily restrictions that result from long-term illnesses. The share of people aged 16 years and older, suffering from long-term diseases, grew from 38.5% to 43.5% in 2006–2014. One of the components, used to calculate the disability-free life expectancy, is the subjective opinion of people, regarding daily restrictions that result from long-term illnesses. Until 2009, the share of people without daily restrictions, aged 16 years and older, went up to 28.4%, but has shown a steady growth since 2010, reaching the level of 2006 (34.1%) again in 2014. Therefore, though mortality rates have dropped, the growth of period of healthy life has been hindered, especially, by the fact that more and more people stay alive and suffer from chronic illnesses, which means that the share of people with chronic illnesses, incl. those facing daily restrictions, has grown.

Strategic Area I – Social Cohesion and Equal Opportunities

SO 1. Social inclusion in Estonia has significantly increased and health inequality has been reduced

Indicator	Base level	Performance	Goal	Target level	Result
	2006	2012	2016	2020	2014
Percentage of population covered by health insurance Source: Estonian Health Insurance Fund, Statistics Estonia	95.2% m: 93.3% w: 96.8%	93,7 m: 90.3% w: 96.7%	99%	100%	93.9% m: 90.9% w: 96.5%
*Relative poverty level (percentage of persons whose equivalent income is lower than the median annual equivalent net income of 60% of household members) Source: Statistics Estonia	18.3% m: 16.3% w: 20.0% (2005)	20.7% m: 19.8% w: 21.4%	16.5%	15%	22.1% m: 20.6% w: 23.5% (2013)
* Child poverty risk (percentage of children aged 15 and younger and living below the poverty line) Source: Statistics Estonia	19.8% m: 20.8% w: 18.8% (2005)	18.4% m: 19.3% w: 17.4%	18%	17%	19.8% m: 20.7% w: 18.9% (2013)
Percentage of long-term unemployed (over 12 months) Source: Statistics Estonia	2.3% m: 2.9% w: 1.7% (2007)	5.5% m: 6.1% w: 4.9%	3.7%	2.5%	3.3% m: 3.9% w: 2.7%
Suicide deaths rate per 100,000 inhabitants	18.4 m: 30.9	17.8 m: 30.8	12.5	10	18 m: 30.6

Source: Statistics Estonia, NIHD	w: 7.7	w: 6.4			w: 6.9
*From 2012 onwards, changes in methodology must be considered in comparison to earlier years; starting from 2012, information about income has been derived, in part, from registers; earlier only survey results were used.					

Target level of 2016 was achieved with long-term unemployed indicator in the sphere of social cohesion and equal opportunities. Compared to 2012, percentage of population covered by health insurance demonstrates certain positive dynamics while suicide death rate and poverty-related indicators (relative poverty level, child poverty risk) demonstrate a certain negative trend instead.

The proportion of people covered with health insurance dropped during the recession. Since 2011, this indicator has steadily remained around 94%. In 2014, **93.9% of the population was covered by health insurance**; 90.9% of men and 96.5% of women were covered by health insurance. In 2014, the number of employed insured persons increased and this is attributable to improved employment situation. Over the years, the share of people covered by insurance has been higher among women by 4–7% than among men. Population not covered by health insurance mostly consists of young men aged 20–34-years. Long-term unemployed, who remain registered at the Estonian Unemployment Insurance Fund, will maintain their health insurance. The persons without valid health insurance mostly include the discouraged, people receiving irregular income, free-lancers, people getting income from abroad and people paid under the table. People without valid health insurance can get free accident and emergency health care; some local governments support primary health care to those with no valid health insurance albeit this is not the legal obligation of local governments. Absence of valid health insurance will postpone seeing doctor in case of health problems, but the earlier we start to deal with a sickness, the cheaper it will be and the lower will be the risk of developing chronic illnesses.

The indicators that reflect social stratification have taken a slightly negative trend in recent years. Relative poverty rate has shown an increase since 2009. In **2013, 22.1% of the population of Estonia** or approximately 288,600 people **and 19.8% of children aged 0–15 lived in relative poverty**. The growth of this indicator has been caused by increase of income of population, belonging to higher income quintile whereas the income of population belonging to the first quintile has remained the same. The difference in income of poorer and wealthier fifth of the population differed 6.6 times. Like in majority countries, the relative poverty of women is higher than the relative poverty of men in Estonia. The relative poverty rate is the highest among single women aged 65 and older and in households with only one female member (respectively, 2.9 and 2.3 times higher than the respective Estonian average). The relative poverty rate of children is higher than the respective national average in Ida-Viru and Valga County.

The influence of financial and economic crisis on labor market was most pronounced in 2010, when the unemployment rate went up 16.7% and the long-term unemployment rate, respectively, to 7.6%; after that, unemployment rate has dropped. In **2014 the long-term unemployment rate went down as low as 3.3%, which** reached the NHP target level for 2016. The Ministry of Social Affairs has adjusted the long-term unemployment goal for 2016 to make it more ambitious (2.9%). Among men, the proportion of people, having looked for a job for a year or longer is higher (3.9%) than among women (2.7%). The number of non-Estonians among the long-term unemployed is 2.6 times higher than among the Estonians. This number is strongly influenced by high long-term unemployment rate of Ida-Viru County,

which was 8.4% in 2014. In Estonia, the long-term unemployment rate has been lower than the respective EU average since 2013. In 2014, the average long-term unemployment rate for the EU was 5.1%. Unemployment, especially, in long term, will influence the income, living conditions, and healthy choices of people and may exhaust natural defense mechanisms of people. As the consequence, both mental and physical health problems may express themselves. Therefore, it's important to contribute to prevention of long-term unemployment and integrate the unemployed into labor market as soon as possible.

The number of suicides went up during the recession, hitting the ceiling in 2009. After that, in 2010–2011, the suicide rate decreased, compared to the pre-crisis level, but went up to pre-crisis level again in 2012. Suicide is more common among men, in 2006–2014 the respective indicator was approximately 4.2 times higher among men than among women. Large share of suicides is committed by the age group of the elderly – in 2014, 25% of those committing suicides were 65 years old or older. The elderly persons represent a considerable risk group and their respective suicide mortality rate has grown over the years. County-wise, the number of suicides per 100,000 inhabitants is the largest in Põlva County, as much as 2.2 times higher than the respective Estonian average. Estonia still has some space for improvement regarding suicides. In Estonia, suicide mortality rate is almost 1.4 times as high as the respective EU average whereas among persons 65 years old and older the difference was 1.6 times as high as the average.

Strategic Area II. Safe and Healthy Development of Children and Adolescents

SO 2. Decreasing the mortality and new cases of mental and behavioral disorders among children and adolescents, and an increasingly more positive assessment given by children and adolescents to their health

Indicator	Base level	Performance	Goal	Target level	Result
	2006	2012	2016	2020	2014
Infant death rate (number of infant deaths during the first year of life per 1,000 live births) Source: Statistics Estonia	4.4 m: 5.7 w: 3.1	3.6 m: 3.1 w: 4.1	2.2	1.7	2.7 m: 2.7 w: 2.6
Child and adolescent (age group 0– 19) death rate per 100,000 people Source: Statistics Estonia	61.2 m: 82.2 w: 39.1	38.5 m: 42.1 w: 34.7	34	31	37.9 m: 44.8 w: 30.5
Child and adolescent (age group 0– 19) accident, poisoning and injury deaths rate per 100,000 people Source: Statistics Estonia	30.1 m: 42.1 w: 17.5	11.7 m: 15.0 w: 8.3	12	7	13.7 m: 22.4 w: 4.6
New cases of mental and behavioral disorders among	2251 m: 2 597 w: 1 886	2110 m: 2 583 w: 1 610	1929	1801	2287 m: 2 851 w: 1 690

children and adolescents (age group 0–19) per 100,000 people Source: NHID					(2013)
Percentage of children aged 11, 13 and 15 years reporting very good self-perceived health Source: NHID, HBSC	31.5% m: 34.2% w: 28.5% (2005/2006)	29.3% m: 32.1 w: 26.6 (2009/ 2010)	33.8%	34.7%	33.2% m: 38% w: 28.3% (2013/ 2014)
Percentage of infants who are completely or in part breast-fed up to the age of 6 months Source: NHID	55.3% (2011)	55.3%	66%	75%	55.3% (2012)

Compared to 2012, two indicators (infant death rate and percentage of children reporting very good self-perceived health) show positive dynamics. Child and adolescent death rate (age group 0-19) has remained at the same level and there are problems with reaching the target levels with two remaining indicators (child and adolescent injury death rate and the rate of new cases of mental and behavioral disorders among children and adolescents). In 2012, a new indicator, percentage of breast-fed infants was added; however, the dynamics of this indicator can't be assessed yet. In the spheres where the target level for 2016 was reached it must be maintained and progress has to be made towards the target level for 2020.

The target level for infant death rate for 2016 was already achieved by 2013; however, it was not maintained in 2014. In 2014, there were 2.7 infant deaths during the first year of life per 1,000 live births. While in 2012 50 infants died, the respective numbers for 2013 and 2014 were 28 and 36. The main reasons for infant deaths were pathologies of perinatal period and congenital abnormalities. While in 2006 the respective indicator for boys was 1.8 times higher than for girls, the gender differences are almost non-existent today. Place of living of mothers (either urban or rural settlement) plays no role for the purposes of infant deaths. However, mothers' education level does have some effect – an infant death rate was 2.2 times higher among mothers with basic or lower level of education in 2014 than among infants of mothers with higher education. At county level, infant death rate was much higher than the respective Estonian average in 2006–2013 in Ida-Viru, Jõgeva and Lääne counties. In Estonia, the infant death rate in 2012 was below the respective EU average by 1.1 times.

The target level established for child and adolescent death rate (age group 0-19) for 2016 was also achieved in 2013, but the level was not maintained in 2014 as the consequence of increased death rate among boys. However, in 2014 the given indicator for 2014 was lower than in 2012, totaling to 37.9 incidents for 100,000 children. It is important to mention that while in 2006 the death rate among boys was almost twice as high as the same indicator for girls, it was only 1.4 times higher in 2014 and this was mostly attributable to decrease of death rate of boys. The main reasons for child and adolescent deaths are injuries, perinatal pathologies and congenital abnormalities. Child and adolescent death rate has dropped the most on the account of injury deaths (by 2.2 times) and death caused by congenital abnormalities (by 2.1 times).

Child and adolescent (age group 0– 19) accident, poisoning and injury death rate per 100,000 people showed a rapid decrease in 2006–2012. In 2013 and 2014 the child and adolescent injury death rate did show certain increase, compared to 2012, but still remained below the level of earlier years. In absolute figures, this means 37 incidents of child and adolescent injury deaths in 2014 compared to 32 injury deaths in 2012. In 2006, boys' injury death rate was 2.4 times higher than the respective indicator for girls but in 2014 the difference was 4.9 times, due to faster decrease of the respective indicator for girls and growth of the indicator among boys since 2011. While in 2006 the main causes for child and adolescent injury deaths had the following ranking – accidents involving vehicles, drowning and suicides, the main causes for injury deaths had remained the same in 2014, yet the importance of suicides shows a growth trend and has become the largest, as the consequence of decrease among the other causes of death. Despite consistent decline of the indicator the child and adolescent injury death rate in Estonia still remains more than twice as high as the respective EU indicator.

New cases of mental and behavioral disorders among children and adolescents (age group 0–19) per 100,000 people demonstrated a steady decline until 2009, **but the respective indicator had a relapse, starting in 2010, and in 2013 the morbidity rate dropped to the level of 2006.** Increase in new cases of mental and behavioral disorders is **largely attributable to young men.** While in 2006 the rate of new cases of diseases among boys was 1.4 higher than among girls, 1.7 times difference was identified in 2013. By age groups, new cases of mental and behavioral disorders among the age group 1–4 (1.7 times); the respective rate has remained relatively stable among other age groups. The main mental and behavioral disorders of children, both in 2006 and 2013, were psychological development disorders, behavioral and emotional disorders and neurotic, stress-related and somatoform disorders. Over the period observed, the growth of morbidity rate is most pronounced in the group of psychological development disorders (36.4%) and behavioral and emotional disorders with the onset during infancy (15.8%). However, the morbidity rate for other mental and behavioral disorders has dropped (with the exception of mental and behavioral disorders characterized by physiological dysfunction and mental retardation; these morbidity rates have remained relatively stable).

The percentage of children reporting very good self-perceived health is growing. According to a health behavior study of school students, the percentage of students reporting very good self-perceived health did decrease in 2009/2010; however, in 2013/2014 the number of students reporting very good self-perceived health was higher than ever. Boys assess their health as very good more often than girls (respectively, 38% and 28.3%). Compared to the base level, the percentage of boys reporting a very good self-perceived health had grown, by 2014, by 1.9% among boys while among girls the respective indicator had dropped by 0.2%. Based on home language, children from families with other home language compared to Estonian home language reported a very good self-perceived health more often (the respective indicators were 34.8% and 32.7%). There is also a link of positive assessment of health by children and economic situation of families. In 2014, children from families with a good economic situation reported their health as very good 1.3 times as often as children from families in average and 1.1 times as often as the children from families in a bad economic situation.

In 2011–2012, 55.3% of 6 months old infants were breastfed on either fully or partially. Regional differences in breast-feeding are outstanding – in 2012, 70.7% of 6 months old infants in Saare County were breast fed while in Valga County the respective indicator was only 39.7%. In 2013, only 44.7% of 6 months old infants were only breast fed.

Strategic Area III. Healthy Living, Working and Learning Environment

SO 3. Health risks from the living, working and learning environment are reduced

Indicator	Base level	Performance	Goal	Target level	Result
	2006	2012	2016	2020	2014
Respiratory disease mortality rate per 100,000 inhabitants Source: Statistics Estonia	36.9 m: 57.2 w: 19.6	33.9 m: 48.9 w: 20.7	31	31	41.4 m: 59.6 w: 25.4
Number of fatal occupational accidents per 100,000 employed persons Source: Labour Inspectorate, Statistics Estonia	4.5	2.4	2.7	2.4	2.6
Number of working days lost due to occupational accidents per 100 employed persons Source: Estonian Health Insurance Fund, Statistics Estonia	20	17.5	16	15	20
Health impact of work: percentage of employed persons who believe that their work deteriorates their health Source: European Working Conditions Survey	59.2% (2005)	43.5% (2010)	40%	30%	43.5% (2010)
* New cases of food-related infectious diseases per 100,000 inhabitants Source: Health Board	303	305.1	200	200	209.2 m: 225.2 w: 194.5
Percentage of population supplied with drinking water conforming to requirements Source: Health Board	73% (2006)	88.3%	88%	90%	97.7%
Percentage of persons	2.1%	2.7%	1.7%	1.5%	3%

diagnosed with or treated for asthma among the age group 16–64 Source: NIHD of Estonia, health behavior study	m: 1.8% w: 2.4%	m: 2.0% w: 3.3%			m: 1.7% w: 3.9%
Annual average concentration of fine particles (PM10) in the air in Estonian cities (µg/m ³) Source: EEIC	20.7% (2005)	12.6%	14%	14%	16.0%
Involvement of 2 years old and younger children with measles-mumps-rubella (MMR) immunization Source: Health Board	93.9% (2011)	93.6%	≥95%	≥95%	93.4%
*Since 2013 the list does not include unspecified intestinal bacterial and viral infections and ascariasis, as these are no longer subject for registration since 01.04.2013 and ameobiasis is to be registered from the same date (regulation of the Government of the Republic of 23.07.2009 no. 134). Therefore, these data are not comparable to earlier years.					

As for the nine goals of the strategic area, the target level for 2016 has been achieved for two indicators (number of fatal occupational accidents and percentage of population supplied with drinking water conforming to requirements). The indicator „the rate of new cases of food-related infectious diseases“ cannot be assessed, as the indicator was adjusted in 2013; the same applies for indicator „health impact of work“, as the respective surveys are carried out a 5 year interval and the survey of 2015 is not completed yet. Compared to 2012, the dynamics have been negative for five indicators (respiratory disease mortality rate, prevalence of asthma, annual average concentration of fine particles, number of working days lost due to occupational accidents and involvement of children with immunization).

Respiratory disease mortality rate did show a decrease until 2011; **but since 2012 we’ve witnessed a steady growth** and by 2014 the respective rate was **41.4 deaths per 100,000 inhabitants. The growth is mostly attributable to women.** The indicators of both men and women have increased and in 2014 the indicator of men was 2.3 times higher than the respective indicator of women. Respiratory disease mortality rate increases with age. Compared to the base level of 2014, we can observe decrease of mortality rate among population of working age, yet growth is visible among age group 65 and above. In 2014, the main causes of death for respiratory diseases were pneumonia and chronic respiratory diseases in lower respiratory organs. **Over the years, the mortality rate resulting from pneumonia has shown the highest growth.** By counties, respiratory disease mortality rate was the highest in 2013/2014 in Võru, Rapla and Ida-Viru counties (respectively, 1.7, 1.5 and 1.5 times higher than the respective Estonian average) and the lowest in Tartu and Harju counties (1.6 and 1.2 times lower than the respective Estonian average). In Estonia, the respiratory disease mortality rate is much lower than the EU average. In 2011, the respective indicator for Estonia was 1.9 times lower than the EU average, the difference for men and women was, respectively, 1.4 and 2.6 times.

The incidence of chronic lung diseases is showing a growth trend. This is demonstrated by the number of people diagnosed with/treated for asthma among age group 16–64. Contrary to the goal established, the incidence of the disease is growing. The number of people suffering from asthma among the age group 16–64 has grown from 2.1% in 2008 to 3% in 2014. Asthma is more common among women and the gap has grown (in 2014, the respective indicator for women was 2.3 times higher than for men). In Estonia, the incidence of asthma is still lower than in the EU.

The target levels for working environment indicators that were set for 2016 were achieved. Now we need to maintain the level and move towards the target levels set for 2020. In 2014, the number of fatal occupational accidents per 100,000 employed persons was 2.6. Occupational accidents are more common among age group 18–44, contributing 62.9% of all the fatal occupational accidents. Over the years, the number of fatal occupational accidents per 100,000 employed persons has been higher among men than among women. In 2006–2014, death rate was the highest in mining industry, construction sector, transport, warehouse services and communications sector. By counties, in 2006–2014 the number of fatal occupational accidents per 100,000 employed persons was the highest in Harju, Ida-Viru and Lääne-Viru counties. The indicator for Harju and Viru counties is influenced by the fact that in these countries there are more industrial enterprises and work is more intensive, which results in higher incidence of occupational accidents, including fatal accidents. However, we should keep on mind that fatal occupational accidents are an exception, not a rule. Compared to the EU average, Estonia's indicator in 2012 was 1.3 times higher.

Number of working days lost due to occupational accidents decreased during the recession to 15.4 working days per 100 employed persons in 2009. Over the years that followed, recovering economy brought along **slow increase of the number of working days lost due to occupational accidents, reaching the base level of 20 working days per 100 employed persons in 2014.** Certificate of incapacity for work, taken as the consequence of occupational accident, is taken for a period longer than the respective period for regular certificate of incapacity for work. While in average, certificate of incapacity for work was taken for a period of 15.8 days in 2014, the respective period was 19.4 days in case of occupational accidents.

It should be mentioned here that the target levels for 2016 for the number of fatal occupational accidents and the number of working days lost due to occupational accidents have slightly increased in the NHP 2013–2016 action plan as the target levels for 2016 were achieved in 2010–2011. The final goals for 2020 remained the same, as the decrease in the number of working days lost due to occupational accidents is small because a decrease in the number of fatal occupational accidents will mean more occupational accidents that require a leave for temporary incapacity for work.

According to the European Working Conditions Survey, which is held at every five years, 43.5% of employees have formed an opinion that the work they do will deteriorate their health. Compared to year 2005, the number of such employees has dropped by one fourth (the level of 2005 being 59.2%). Men see the influence of their work as more negative for their health than women. Estonian employees find much often than the EU employees that their work deteriorates their health (24% of employees), which serves to demonstrate the fact that in the EU, Estonia is still among the countries where the working environment is less safe and does not support the health of employees. Employees of Latvia and Slovenia have formed even worse opinion of their working environment than the Estonians (respectively, 53% and 45% of employees).

As the content of the indicator „New cases of food-related infectious diseases per 100,000 inhabitants“ has changed since 2013, the data is no longer directly comparable to the information of earlier years. Since 2013 the list does not include unspecified intestinal bacterial and viral infections and ascariasis, as these are no longer subject for registration since 01.04.2013 and ameobiasis is to be registered from the same date (regulation of the Government of the Republic of 23.07.2009 no. 134).

In 2014, the rate of new cases of food-related infectious disease per 100,000 inhabitants was 209.2 – for men, 225.2 and for women – 194.5. Therefore, the respective indicator for men is 1.2 times higher than for women. The most common food-related infectious disease that people catch is rotavirus enteritis. Starting from 2014 the immunization of children against rotavirus began. Over the years, incidence of shigellosis (5.2 times) and salmonellosis (4.8 times) has dropped considerably. However, incidence of campylobacterial enteritis (2.5 times) and acute enteropathy, caused by Norwalk virus (2.2 times) has increased considerably. At county level, morbidity rates were the highest in 2014 in Pärnu, Lääne and Ida-Viru counties, respectively, 1.5, 1.4 and 1.3 times higher than the respective Estonian average. In Jõgeva County, however, the respective indicator was 2.7 times lower than the Estonian average.

The percentage of population supplied with drinking water conforming to requirements was 97.7% in 2014. In the given year, there was no public water supply network with microbiological indicators not matching the established limits. Chemical non-conformities are mostly linked to excess of fluorides, but there have also been cases of boron limits being exceeded. In general, chemical indicators that characterize the situation of water supply systems demonstrate stable improvement, mostly as the consequence of fitting of water treatment facilities, drilling new wells and connecting problematic water supply networks to networks that supply high-quality water.

The annual average concentration of fine particles (PM10) in the air in Estonian cities has dropped steadily. The NHP action plan for 2013–2016 included adjusted annual average concentration of fine particles (PM10) in the air in Estonian cities for 2016 to a more ambitious level as the target level for 2016 was achieved in. **Since 2013, the attempts to maintain the achieved level have failed and by 2014** average concentration of fine particles (PM10) in the air in Estonian cities had increased up to **16 µg/m³**. However, compared to the base level the indicator is still 1.3 times lower.

The coverage of measles-mumps-rubella (MMR) immunization among 2-year-olds and younger children has dropped since 2011 below the level recommended by the World Health Organization, reaching **93.4%** in 2014. The goal was not achieved in six counties: Harju (89.5%), Viljandi (93.7%), Võru (93.8%), Hiiu (93.9%), Pärnu (93.9%) and Valga (94.9%). The indicators were the best in Rapla (98.4%) and Ida-Viru (98.2%) counties. Decline in immunization level is a common trend in Europe and has resulted in outbreaks of measles among the grown-ups in many developed countries.

Strategic Area IV. Healthy Lifestyle

SO 4. Physical activity of the population has increased, nutrition is more balanced and the level of risk behavior has decreased

Indicator	Base level	Performance	Goal	Target level	Result
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	2006	2012	2016	2020	2014
Percentage of overweight persons in the age group 16–64 Source: NHID, health behavior study	30.5% m: 37.3% w: 26.1%	29.9% m: 35.9% w: 25.6%	26%	25%	32.5% m: 39% w: 28.2%
Percentage of obese persons in the age group 16–64 Source: NHID, health behavior study	15.5% m: 14.9% w: 16.5%	19.0% m: 18.6% w: 19.3%	13%	12%	19.5% m: 18.9% w: 19.9%
Percentage of overweight school students Source: Estonian Health Insurance Fund; school healthcare reports	7.8% (2006/ 2007)	10.5% (2011/ 2012)	6.5%	6%	11% (2013/ 2014)
Number of new cases of HIV infections per 100,000 inhabitants Source: Health Board	47.2 m: 60.4 w: 35.9 (2007)	23.8 m: 33.9 w: 15.0	20	15	22.1 m: 29.4 w: 15.7
Percentage of pregnant women with HIV among all pregnancies Source: Health Board	0.3%	1.05%	<1%	<1%	0.8%
Percentage of adolescents (age group 15–16) who have tried illegal drugs Source: ESPAD survey	30%* m: 37% w: 23% (2007)	32% m: 36% w: 27% (2011)	24%	21%	32% m: 36% w: 27% (2011)
Number of fatal accidents, poisonings and injuries per 100,000 inhabitants Source: Statistics Estonia	121 m: 201 w: 53	87 m: 145 w: 36	78	61	71.2 m: 117 w: 31
Number of people died in traffic accidents with participation of intoxicated drivers Source: the Estonian Road Administration	53	17	14	14	16
Coronary and vascular disease related death rate among age group below 65 per 100,000 inhabitants Source: Statistics Estonia	94 m: 150 w: 41 (2011)	98 m: 155 w: 43	73	56	93 m: 146 w: 41
Percentage of people who exercise on regular bases among age group 16–64 Source: NHID, health	36.3% m: 36.9% w: 35.8% (2010)	35.5% m: 33.9% w: 36.6%	45%	53%	36.7% m: 35.8% w: 37.3%

behavior study					
Consumption of absolute alcohol per capita per annum Source: Estonian Institute of Economic Research	10.2 (2011)	10.27	<8	<8	10 (2013)
Percentage of everyday smokers among age group 16–64 Source: NHID, health behavior study	26.2% m: 36.8% w: 18.7% (2010)	26.0% m: 36.2% w: 18.3%	21.5%	18.3%	22.1% m: 31.4% w: 15.8%
Number of new cases of tuberculosis per 100,000 inhabitants Source: NHID, Tuberculosis Register	19.8 m: 29.8 w: 11.2 (2011)	17.7 m: 26.9 w: 9.7	16	14	15.6 m: 22.5 w: 9.6
* Base level of 2007 was adjusted, based on the outcomes of ESPAD survey.					

The 2016 target was achieved for the following NHP indicators: number of fatal accidents, poisonings and injuries, number of new cases of tuberculosis and percentage of pregnant women with HIV among all pregnancies. In the following years, the focus should be on maintaining the achieved level. Considerable additional effort is required to move towards the target levels set for 2020 and reaching the average EU level. Most of the health behavior indicators (number of new cases of HIV infection, number of people died in traffic accidents with participation of intoxicated drivers, coronary and vascular disease related death rate among age group below 65 per 100,000 inhabitants, percentage of people exercising regularly, alcohol consumption and daily smoking) all demonstrate a slight positive trend, however, major effort will be required to reach the target level of 2016. The largest problems are linked to negative trends of three overweight-related indicators. It is not yet possible to provide an adequate assessment of percentage of adolescents (age group 15–16) who have tried illegal drugs, as the respective survey is conducted every four years and the results for the study of 2014/2015 school year will only become available in the beginning of 2016.

Coronary and vascular disease related death rate among age group below 65 per 100,000 inhabitants dropped to **93 cases** in 2014. Morbidity rate among men is 3.6 times higher than the respective rate for women. In age group below 65, the main cause of coronary and vascular disease related death is coronary ischemia. Over the years, coronary and vascular disease related death among age group below 65 has dropped in all types of diseases, apart hypertension.

The main risk factors for coronary and vascular diseases are excessive body weight, limited exercising and physical activity, consumption of alcohol and tobacco.

Excessive body weight and obesity are becoming a more and more serious problem in Estonia. **Health behavior study of adult population of Estonia shows that more than a half (52%) of adult population is overweight. The percentage of overweight people** (Body Weight Index 25–29,9 kg/m²) had increased by 2014 to **32.5%** (respectively, 39% of men and 28.2% of women) and the percentage of **obesity** (Body Weight Index 30 or above kg/m²) to **19.5%** (respectively, 18.9% of men and 19.9% of women). Excessive body weight has constantly increased and the growth is somewhat faster among men than among women. The proportion of overweight men is higher than the proportion of overweight women (in average, 1.3 times).

As the age advances, the percentage of overweight and obese persons grows both among men and women and this is common to all the developed countries. As we compare Estonians and people from other nationalities, the latter have shown higher percentage of overweight people over the recent years. As we compare Estonia to the EU, the percentage of overweight persons is among the lowest, however, the percentage of obesity is among the highest – we are surpassed only by Hungary and Malta.

Information also shows that overweight and obesity is starting to be a problem already among children, which is really worrisome. **The percentage of overweight school students shows a growth tendency and reached 11% in academic year 2013/2014.** Since 2006, the percentage of overweight students has grown by 1.4 times and even if the indicator has increased somewhat slower over the recent years, the growth trend is still there.

According to a health behavior study conducted among Estonian school students in 2009/2010, overweight indicators were higher in Estonia among age group 11 and 13 than the EU average and among age group 15, only missed the EU average by 0.5%. However, the results of a health behavior study conducted among Estonian school students in 2013/2014, show that the percentage of overweight boys and girls remained at the level of 2009/2010 (16.6% of boys and 10.7% of girls) or the growth slowed down.

The number of people who exercise more often than twice a week grew until 2010, and then dropped a bit, but there was a growth again in 2014 and therefore, in **2014 36.7% of the population exercised more often than twice a week** – respectively, 35.8% of men and 37.3% of women. Women tend to be physically more active than men. As we observe age groups, it can be seen that the percentage of exercisers has grown in all age groups but does show a certain decline as age advances (the difference between the youngest and the oldest age group is double). As we look at levels of education, population with higher education is physically more active – the indicators of men and women with higher education are, respectively, 1.4 and 1.2 times higher than among men or women with basic or lower level of education. Among Estonians, the percentage of population who exercise on regular bases is 1.2 times higher than among other nationalities. The percentage of physically active people is the highest in North-Estonia and the lowest in Central Estonia.

Based on the results of a 2013/2014 health behavior study among school students, physical activity also shows an increase among school students. According to the survey, 52% of boys and 44% of girls spend two or more hours of their free time with intense physical activity. The percentage of physically active on 5–7 days a week has dropped among children (aged groups 11, 13 and 15) (incl. among girls 1.4% and among boys 7.0%) and the percentage of those physically active on 1–4 days per week has increased. 38.3% of boys and 32,5% of girls are physically active on 5–7 days per week.

Alcohol abuse and smoking are connected with the incidence of several diseases and the Estonian mortality rate caused by alcohol and tobacco related diseases exceeds the corresponding indicator for the old EU Member States almost twice.

Consumption of absolute alcohol per capita started to decrease during the recession, starting from 2009, but shows a growth tendency again as the economy started to restore in 2011. **In 2013, Estonians consumed 10 liters of absolute alcohol per capita per year**, which is 2.6 liters less than in 2007 (the year characterized by largest consumption of alcohol).

Consumption of strong alcohol has considerably decreased. In 2013, adult population (age groups 15 and above) consumed, per capita, 87 liters of beer, 13 liters of wine, 11.2 liters of strong (incl. 6.9 l of vodka) and 20.9 liters of light alcoholic drinks (cider, mixed drinks) per year. Alcohol consumption of Estonian population is greater than in the Nordic countries. In Finland,

Denmark, Sweden and Norway the quantities of absolute alcohol, consumer per capita in 2013, were respectively 11.6, 10.5, 9.9 and 7.8 liters per adult person (Estonian Institute of Economic Research).

Results of a health behavior study among school students show the long-expected development. More specifically, the first incidence of consumption of alcohol and the first getting drunk now happen at a later age. While in 2009/2010, 62% of school students tried alcohol first at the age of 13 years or younger, the respective indicator was 49% in 2013/2014. In 2009/2010, 24% of school students from age group 15 had first got drunk at the age of 13 and younger and by 2013/2014 the respective indicator was 19%.

The number of regular everyday smokers in age group 16–64 remained stable during the recession, while smoking among men slightly reduced, while the same indicator for women increased. **By 2014 the percentage of regular everyday smokers among age group 16–64 had dropped to 22.1%.** Men smoke twice as often as women. Everyday regular smoking habit has reduced in all age groups. Among persons with basic or lower level of education everyday regular smoking is 3.5 times as common as among Estonians with higher education. People from other nationalities smoke 1.2 times more often than Estonians. On regional bases, the respective indicator is the highest in central Estonia. Despite the decrease of smoking habit the respective Estonian indicator is still higher than the EU average. In 2012, Latvia was the only EU country with larger percentage of daily smokers (34.3%; in Estonia 26%).

The number of smoking children is alarmingly high, but this trend shows a decline. While in 2009/2010 22% of 15 year old boys smoked at least once per week or more frequently and the same goes for 16% of girls of the same age, the respective indicators were 12.7% and 10.9% in 2013/2014. People have started to postpone the onset of smoking. While in 2009/2010 63% of boys and 48% from age group 15 were 13 years old when they smoked their first cigarette, the respective indicators were 49% and 40% in 2013/2014.

Apart from traditional smoking, the use of alternative tobacco products is also widespread in Estonia; in 2014, 15.4% people of age group 16–64 had used water pipe at least some times a year; 15.7% and 2.3, respectively, had used e-cigarettes and snus. Compared to 2012, the percentage of smokers of e-cigarettes has tripled. Younger age groups are more common users of alternative tobacco products.

For Estonia, drug addiction and the spread of the HI virus (which is, by nature, concentrated epidemics) remain a problem and a great source of threat for human health and life expectancy (the spread of HIV among intravenous drug users is above 5% and below 1% among pregnant women). Current preventive measures, adopted to slow down the spread of HIV, have given positive results. Compared to year 2007, the incurrence of new cases of HIV infection has dropped by almost half (from 47.2 new cases to 21.1 per 100,000 inhabitants). However, **since 2012 there have been no considerable changes regarding this indicator.** The incidence of newly diagnosed HIV cases is still higher among men than among women. Yet the indicator drops faster among men than among women. While in 2006 the indicator among men was 2.1 times higher than among women, the difference was 1.9 times in 2014. The age of HIV-positive people (new cases) demonstrates a stable growth, both among men and women – in 2014, only 8% of new cases were diagnosed in the age group of 15–24 year-olds. The reason for increase of age is probably attributable to ageing of intravenous drug users' population (and probably also their sex partners) and decreased incidence of new HIV cases among new intravenous drug users. The percentage of people who contract the infection by means of (hetero)sexual relations demonstrates a growth. In 2014, the rate of newly diagnosed HIV cases per 100,000 inhabitants was the highest in Ida-Viru County (82 cases) and Tallinn (34 cases). In other places in Estonia, 4.1 cases were diagnosed per 100,000 inhabitants. Despite decreased number of new HIV cases, Estonia's indicator still holds the first place among the

EU Member States. In 2013, the respective coefficient in Estonia was 4.3 times higher than the respective EU average.

According to the information supplied by HIV treatment council, in 2014, there were 111 pregnant women in Estonia who has tested positive for HIV; the number of births was 13,618. This means that in 2014, the percentage of pregnant women with HIV infection was 0.8%. However, it is positive that modern medicine allows preventing the spreading of HIV infection from mother to children and the percentage of people, contracting HIV by vertical infection, still remains low – in 1988–2014, 0.5% of all cases (three cases in 2012, two cases in 2013 and three cases in 2014).

The results of a drug use survey ESPAD of 2011 allow us to conclude that drug use among school students has slowed down. While from 2003 to 2007 the number of students of age group 15–16, who have tried illegal drugs, went from 24% to 30% (30% growth), the percentage of adolescents of age group 15–16, having tried drugs, had went from 30% to 32% in 2011 (6.7% growth). Among girls, the percentage of students who have tried drugs has increased by 4%. However, boys are more apt to experiment with drugs than girls. The results for boys and girls in Estonia are, compared to the average of the countries that took part in the survey, exceed the average, respectively, by 1.5 and 1.3 times.

The incidence of tuberculosis per 100,000 inhabitants dropped in 2014 to 15.6, which matched the target level for **2016**. The incidence of tuberculosis has decreased, thanks to programme-based activities. In Estonia, mostly lung tuberculosis (93.7%) is diagnosed. Among men, the incidence of tuberculosis is much higher than among women – in 2014, the respective indicator for men was 2.3 times higher than among women. Many people who are diagnosed with tuberculosis for the first time have problems with alcohol and/or drug abuse – 46.8% of the patients registered in 2013. As for counties, the highest rates of new disease cases were in 2014 in Valga, Võru and Põlva counties and the lowest in Rapla, Tartu and Saare counties. Despite consistent decrease of incidence of tuberculosis in Estonia the number of cases per 100,000 inhabitants in 2012 was still 1.5 times higher than the respective EU average. Extremely high percentage of multi drug resistant new cases of tuberculosis is the main problem for Estonia (16.3%), this ranks us among the top there with Latvia and Romania and compared to conventional medicinal products, treatment of this form of tuberculosis requires medicinal products that are ten times more expensive.

The number of deaths as a result of accidents, poisonings and injuries per 100,000 inhabitants had decreased, by 2014, to 71 and the NHP target level for 2016 was already achieved in 2013. Decrease of deaths as a result of injuries has had positive influence on both life expectancy and disability-free life expectancy. Although the injury death rate among men has declined faster, over the years, than among women, the respective indicator still remains very high – for men, the indicator was 3.8 times higher in 2014 than the respective indicator for women and cases involving men contributed 77% of all cases of all injuries that result in death. Compared to 2012, injury death rate has decreased in almost all age groups. The injury death rate was the highest in 2014 among age group 85 and older. As for accidental poisonings, we can observe decrease of death rate, compared to 2012, but accidents involving vehicle, falling, smoke, fire and flames and suicide rates show no considerable improvement. Three leading causes for injuries that result in death were suicides, accidental poisonings and falling. Despite improved injury death rate the Estonian injury death rate was, in 2011, still 2.2 times higher than the respective EU average (for men, 2.5 and for women, 1.5 times).

In 2014, traffic accidents, caused by intoxicated drivers, were fatal for 16 people. The

number of fatalities decreased fast in 2007–2010 (from 81 cases to 16 cases); then the indicator started to grow and decline every other year and has remained around 16–23 fatalities per year. In 2014, there were 16 fatalities and a year before – 23. The majority of traffic accidents caused by intoxicated drivers happened in Valga County in 2014; however, the incidence was also higher than average in Pärnu, Rapla and Viljandi counties.

Strategic Area V. Development of the Healthcare System

SO 5. All people have access to high-quality healthcare services.

Indicator	Base level	Performance	Goal	Target level	Result
	2006	2012	2016	2020	2014
* Number of physicians per 100,000 inhabitants Source: NHID	322	329	320	320	343
* Number of nursing care personnel per 100,000 inhabitants Source: NHID	680	645	830	900	645
Percentage of people who are fairly or very satisfied with the quality of health care Source: SoM, survey “Satisfaction of Residents with Healthcare Services”	69% (2007)	78.5%	76%	80%	69.7%
Percentage of people who believe that accessibility of health care is good or very good. Source: SoM, survey “Satisfaction of Residents with Healthcare Services”	60% (2007)	55%	65%	68%	42.6%
** Percentage of household expenditures as a share of total healthcare expenditures Source: NHID	24%	17.8%	<25% %	<25%	22.3% (2013)
* New methodology has been applicable for the collection of data about health care personnel since 2013, which means that certain differences can be observed, compared to previous years.					
**In 2013, the methodology for total healthcare expenditures was adjusted. 2011 version of the ISHA classification was introduced; in addition, household expenditures will be calculated on the bases of economic activities and service provision reports; earlier this was done on the bases of household surveys. Therefore, from 2013 onwards, household expenditures can't be directly compared to reports from previous years.					

Total health care system profit and the percentage of the population, covered with valid health insurance, decreased during the economic recession. Two of the NHP goals have been maintained at the desired level (number of physicians and percentage of household expenditures as a share of total healthcare expenditures); no progress has been made in the desired direction regarding the remaining three indicators (number of nursing care personnel, quality and accessibility of health care).

As for the number of physicians, the aim is to keep the number as close to the base level as possible. In 2014, Estonia had 343 physicians per 100,000 inhabitants. The number of physicians per 100,000 inhabitants increased until 2008, then dropped a bit in 2009, and then started to grow again. In 2013, approximately 75.3% of Estonian physicians were women. The average age of physicians is approximately 51 years and almost half of them were 40–59 years old. Therefore, ageing is one of the problems with doctors. 68.6% of all physicians work at hospitals. As for specialties, family physicians, anesthesiologists and intensive care doctors and gynecologists are most strongly represented among physicians. One fifth of all physicians work for more than one employer. The largest number of physicians per 100,000 inhabitants is in Tartu County where the number is 2.3 times higher than in Estonia in general. Compared to the EU average, the number of physicians per 100,000 inhabitants in Estonia in 2011 was slightly below the EU average (3.3 physicians in Estonia vs. 3.4 physicians per 1,000 inhabitants in the EU).

In 2013, Estonia had 645 nursing care personnel per 100,000 inhabitants. 98.3% of nursing care personnel was female, their average age was approximately 45 years and most of them were 40–59-years old. 74.5% of all nursing care personnel worked at hospitals and specialty-wise, the percentage of general practice, family, anesthesiology and intensive care personnel was the largest. 10.9% of nursing care personnel worked for more than one employer. Compared to the EU average in 2011, Estonia had 1.3 times less nursing care personnel per 100,000 inhabitants. The ratio of nursing care personnel/ physicians is also 1.9 in Estonia, which is much lower than the respective EU average (2.3). This shows we still have potential for further optimization of the organization of work of nursing care personnel and physicians.

In 2014, 69.7% of population were fairly or very satisfied with the quality of health care in Estonia and 42.6% believe that accessibility of health care is good or very good. While satisfaction with the quality of health care has remained relatively stable since 2006 (moderate increase until 2012, followed by a decline to base level), the percentage of population who believe that accessibility of health care is good or very good has decreased by 2014, compared to base level, by 17.3%; the decline mostly took place after year 2012 (by 12.4%). Elderly Estonians and inhabitants of rural areas tend to believe more that the quality and accessibility of health care is good in Estonia. Over the last year, 81% of population have attended to physicians appointment, most often, their family physician (68%). 51% have attended specialists and specialists' attendance has increased somewhat over the last years, reaching the level of 2009. 41% of the population have used dental services and this is the highest level for 2012–2014. As for accessibility of health care, the largest problems are due from accessibility of special health care; about one fifth of all those who have attended medical specialist over the last year have experienced problems in this respective sphere. 87% of the population were admitted to family doctor centers within 4–5 working days or faster (incl. 28% on the same day). 53% of patients had access to medical specialist within one month; 20% had to wait longer than two months.

Households' health care expenditures as a share of total health care expenditures have consistently decreased until 2012. In 2013, households' health care expenditures as a share of total health care expenditures totaled 22.3% and this indicator remains around the target level. Decrease in households' health care expenditures as a share of total health care expenditures was due, during the earlier years, mostly to increased consumption of generic medicinal products and reduced used of dental services. In average, total health care expenditures per one household member went from 9.7 euros in 2006 to 10.4 euros in 2012. The absolute total did increase, however, the ration to total households' health care expenditures decreased – in 2006 the respective indicator was 4.3% and in 2012 – 3.7%. In

2000–2012, medicinal products consumed largest share of patients' total health care expenditures (50–60%), followed by outpatient services 22–34% (incl. dental services, 19%–27%). However, it can be shown, by income groups, that the expenditures on medicinal products total to 70% of patients' total health care expenditures among the quintile with the lowest income and the quintile of population with higher income spend more of their total health care expenditures on dental services. Dental services' and medicinal products expenditures have remained basically at the same level in households' budget while expenditures on outpatient services have grown. Though expenditures on medicinal products have started to drop, in recent years, one third of patients will still not buy their medicinal products for economic reasons. Compared to the EU average, in 2012 the percentage of household expenditures on the total healthcare expenditures was 1.1 times higher (the EU average was 16.3%).