

Estonia



Care Work and Nursing at Hospitals and Health Centres

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Introduction

Dear Student

Welcome to Estonia! We are delighted that you have chosen to consider Estonia for your practical study placement and we hope your time here will exceed your expectations.

Using this handbook will help you prepare for your foreign study placement. It will provide you with useful background information on the nursing care of adults within the hospitals of Estonia. It is important to remember that like many things in life, the healthcare system is constantly subjected to change at both national and local level. The Estonian Ministry of Social Affairs is responsible for legislation and policy development within the healthcare system of Estonia. As a result of this many new initiatives are constantly being developed and implemented in an attempt to improve the system and facilities for users and employees of the healthcare services. Whilst every effort has been made to reflect up to date information at the time of writing this handbook you may be introduced to new initiatives whilst undertaking your placement with us in Estonia. Staff in your placement area will be happy to guide you to any new relevant information.

There is a lot of information contained within this handbook. The contents page will give you an idea of the different chapters which can be used preparatory reading for your exchange placement or as a reference guide during your time with us.

We hope you enjoy your visit to Estonia and trust that this handbook will assist you in your learning experience.



1. Typical Day of a Registered Nurse at a Hospital

1.1. Case no 1 (stroke)

◆ Linda is 75 years old. She lived independently until she suffered a stroke two months ago. She lives together with her daughter. Daughter's need to work prevents her from bringing mother to home for care. The stroke left Linda with right-sided weakness (she is also right-handed), difficulties in walking and a little inability to make her understood. Linda is slightly overweight and smokes 15 cigarettes per day.

Linda has physical therapy three times a week, and speech and occupational therapy once a week in a rehabilitation ward.

1.1.1. Typical Day of the Registered Nurse in the Rehabilitation Ward

The length of the working shift in Estonian hospitals may vary: there can be 8, 10- or 12-hours shifts. The morning shift usually starts at 08:00 and the night shift 19:00 or 20:00.

Anne is a nurse in a rehabilitation ward. She lives near the hospital, so it is easy to for a work. Today is Monday and Anne's working day starts at 08:00 a.m. She has 5 patients to take care for today.



Pictures 1 - 3. Rehabilitation ward.

08:00 Anne is listening to the nurse who had been working in the night shift, who is giving an overview of the night, patients' problems and new patients. This time there was only one new patient (Linda with the stroke).

08:30 Anne is going to visit the patients with the physician. She is documenting all the problems to the daybook.

09:00 Anne is doing ordinary morning procedures: blood tests, injections, pills, ECG. She also has to measure blood pressure and pulse. She is documenting the data to the nursing plan. Anne is assisting Linda to the toilet.

11:00 Anne is having a smoking session with Linda.

12: 00 Anne is calling a dietitian for nutrition advice for Linda. Anne is assisting Linda to the toilet.

13: 00 Anne is measuring Linda's blood pressure and pulse.

14:00 Anne is walking with Linda in the ward.

14:50 Anne is calling physical therapist to come to the ward and agree time for physical exercises with Linda.

15:00 Anne is discussing urinating problems with Linda and measuring the urinary output for the past 24 hours. She is documenting the data to the nursing plan. Anne is assisting Linda to the toilet.

16:00 Anne is measuring patients' temperature and documenting the data to the nursing plan.

17:00 Anne is measuring patients' blood pressure and pulse rates. Two

patients are having elevated blood pressure and Anne is discussing the problem with physician, who prescribes a medicine. Anne is filling in the nursing documentation.

18:00 Anne is assisting Linda to the toilet. Anne is discussing the problems of the patients with the nurse working at night shift.

18:15 Anne is leaving for home.

1.2. Case no 2 (fractura colli femori/ coxarthrosis)

◆ Linda Mägi, 65 years old, was brought to emergency room by ambulance. She had fallen down on the street while going shopping. She was admitted to the orthopaedic ward due to fractura colli femoris. When she got to the emergency room, an X-ray, ECG and blood test were done. Illness history showed that she had been suffering from coxarthrosis for about two years. The X-ray indicated that Linda had a hip fracture (fractura colli femori) and she was admitted to the orthopaedic ward for treatment and observation.

Yesterday Linda had a total hip joint replacement surgery. She is living together with her husband and daughter, who promised to visit her as soon as possible. Currently she is experiencing thigh pain in her hip. She is also overweight (body mass ratio 27).



1.2.1. Typical Day of the Registered Nurse in the Orthopaedic Ward

Malle is a nurse in orthopaedic ward. She lives in the countryside, which is 35 kilometres from hospital. She has to take a bus to get to work and the trip takes about 1,5 hours.

Today it's Wednesday and Malle's night shift starts at 19:00 p.m. She has 10 patients to nurse.



18:45 Malle arrives at the ward. She is listening to the day shift nurse describing the patients and their problems. She is reading nursing care plans to find out the care needs of patients.

19:30 Malle is visiting patients. She is carefully listening to their problems and is documenting them to daybook.

20:00 Malle is measuring patients' temperature, pulse and blood pressure. She is also monitoring pulse oximetry. She is documenting the data to nursing plan.

20:30 Malle is giving injection for pain relief to Linda. For Linda the morphine injection has been prescribed as the best medication for her to relieve pain.

21:00 Malle is assessing Linda's pain severity after morphine injection. The pain severity was 1 according to Visual Analogue Scale (VAS). Malle knows that pain severity 1 is very low and there is no need for additional medication. She is documenting the data to the nursing plan.



Pictures 4 – 6. Operating theatre and nurses' room.

- 21:15 Malle is giving injections (antibiotics, pain killers) for patients. She is also giving the evening tablets. She is filling in the nursing documentation.
- 00:30 Malle is giving the injection for pain relief to Linda.
- 01:00 Malle is assessing Linda's pain severity after morphine injection. The pain severity was 1 according to VAS. She is documenting the data to the nursing plan.
- 04:30 Malle is giving the injection for pain relief to Linda. She is also measuring the temperature for another patient, who has shivers. The temperature was very high and malle is deciding to give paracetamol. She is documenting the data to the nursing plan.
- 05:00 Malle is assessing Linda's pain severity after morphine injection. The pain severity was 1 according to VAS. She is documenting the data to the nursing plan.
- 07:45 Malle is describing patients' problems to the nurse who came to work at day shift. They are also looking at nursing care plans and observations.
- 08:05 Malle is leaving for home.

2. How to Nurse and Care in Estonia?

◆ The needs of clients/patients must form the basis of the nursing care. The problems/needs of the client/patient may differ and therefore it is essential to find out the individual problems of every client/patient. Compilation of nursing care plan should include the following steps: defining client/patient needs, setting up the aims of nursing care, planning the activities and assessing the fulfilment of aims. Care plan goals are all measurable and time limited. Good cooperation between a patient and close relatives is essential in this process.

2.1. Principles and Values

◆ The key role of nursing care in the society is the provision of care and assistance to people at different ages in case they are not able to take care of their health. A nurse is a health care professional who, in cooperation with the other members of health care team, applies personal professional knowledge and skills to the service and help of a person, family and the whole community. The main functions of nursing are the provision of nursing care aimed at the preservation and promotion of community health, prevention of diseases, rehabilitation of health and work ability and to relieve

pain and tension; management and organisation of nursing care; pedagogical work aimed at teaching a patient, family and population groups as well as the members of health care team; development of the field of nursing and integration of nursing science into the nursing practice. A nurse respects the life, dignity and rights of a person and follows The Code of Nursing Ethics in all his/her activities.

Caring: A culture of caring, as a fundamental part of the nursing profession, characterizes our concern and consideration for the whole person, our commitment to the common good, and our outreach to those who are vulnerable. All organizational activities are managed in a participative and person-centered way, demonstrating an ability to understand the needs of others and a commitment to act always in the best interests of all stakeholders.

Integrity: A culture of integrity is evident when organizational principles of open communication, ethical decision-making, and humility are encouraged, expected, and demonstrated consistently. Not only is doing the right thing simply how we do business, but our actions reveal our commitment to truth telling and to how we always see ourselves from the perspective of others in a larger community.

Diversity: A culture of diversity embraces acceptance and respect. We understand that each individual is unique and recognize individual differences, which can be along the dimensions of race, ethnicity, gender, sexual orientation, socio-economic status, age, physical abilities, religious beliefs, political beliefs, or other ideologies. A culture of diversity is about understanding ourselves and each other and moving beyond simple tolerance to embracing and celebrating the richness of each individual. While diversity can be about individual differences, it also encompasses institutional and system-wide behaviour patterns.

Excellence: A culture of excellence reflects a commitment to continuous growth, improvement, and understanding. It is a culture where transformation is embraced, and the status quo and mediocrity are not tolerated.

2.2. Models of Nursing

◆ A nursing model is a collection of interrelated concepts that provides direction for nursing practice, research and education. In nursing practice, nursing models approach the nursing process in a logical, systematic way; the model influences the very data the nurse collects. In nursing research, nursing models offer a milieu for critical reflection of the hypotheses of the models and the testing of these

hypotheses. Nursing models have become far more prevalent since the 1970s. Prior to this, nursing care was largely dependent on the medical model and nurses practiced largely by intuition and experience.

Most nursing models involve some method of assessing a patient's individual needs and implementing appropriate patient care. An essential portion of patient care is measurable goals in order that the process can be evaluated in order to see if the health goal has been met. Nursing models can be used to produce a document known as a care plan that is used to document a patient's treatment plan as set by nurses, doctors and other healthcare professionals and auxiliary workers. These documents are considered to be living documents - they are supposed to be changed and evaluated on a daily basis as the patient's condition and abilities change.

There are several nursing models used in nursing like Roy's Adaptation Model, Orem's Self-Care Framework, Johnson's Behavioral System Model etc. The models used vary greatly between institutions and countries. However, different branches of nursing have different „preferred” nursing models.

The Roper, Logan and Tierney model of nursing (originally published in 1980) is a model of nursing care based upon activities of living. This model incorporates a life span approach,

wherein the characteristics of the person are considered with respect to prior development, current level of development, and likely future development. In conjunction with the life span approach an independence/dependence continuum is used. The model then incorporates a set of twelve activities of living (ALs), which represent those activities engaged in by individuals whether sick or well. Together these elements are referred to as “a model of living”. When using the model of living in conjunction with the nursing process a model of nursing is utilised. The ALs are as follows:

- ◆ Maintaining a safe environment
- ◆ Breathing
- ◆ Communicating
- ◆ Mobilizing
- ◆ Eating and drinking
- ◆ Eliminating
- ◆ Personal cleansing and dressing
- ◆ Maintaining body temperature
- ◆ Working and playing
- ◆ Sleeping
- ◆ Expressing sexuality
- ◆ Dying

These should be considered within the dependence-independence continuum. The twelve activities of life are used in the initial assessment of a patient upon admission, and are reviewed as the patient’s care plan evolves. To provide effective care, all of the patient’s needs (which are set out by investigating the patient’s specific requirements relative to each activity) must be met as practicably as possible.

Lifespan continuum

The model also incorporates a life span continuum, where the individual passes from fully dependent at birth, to fully independent in the midlife, and returns to fully dependent in their old age/after death. Some researchers argue that the lifespan continuum begins at conception, others that it begins at birth.

The dependence/independence continuum

The continuum considers that the newborn individual is very dependent on adult for survival, but generally gains in independence as they grow and develop. In later life, however, the individual may depend upon others or equipment for assistance with some aspects of their life, whilst being fully independent in others. During periods of ill health the nurse will assist individualst towards independence in the ALS whilst at other times they may have to help them accept dependence.

Factors influencing activities of living

The following factors that affect ALS are identified:

- ◆ Biological factors
- ◆ Psychological factors
- ◆ Sociocultural factors
- ◆ Environmental factors
- ◆ Politicoeconomic factors

Individuality of living

Each individual is unique and will experience and perform the ALS

differently to other individuals. This individuality is influenced by their stage on the lifespan, the degree of dependence/independence and the interplay of the biological, psychological, sociocultural, environmental and politicoeconomic factors.

Modifications

Within short-stay settings such as surgery it is common for the activities “sexuality” and “death” to be combined into one named “other” and for the addition of an activity “pain”. Such modifications are common and depend upon institution.

2.3. Nursing Process

◆ The nursing process is a process by which nurses deliver care to patients, supported by nursing models or philosophies. The nursing process was originally an adapted form of problem-solving and is classified as a deductive theory.

Characteristics of the nursing process

The nursing process is a cyclical and ongoing process that can end at any stage if the problem is solved. The nursing process exists for every problem that the patient has, and for every element of patient care, rather than once for each patient. The nurse’s evaluation of care will lead to changes in the implementation of the care and

the patient’s needs are likely to change during their stay in hospital as their health either improves or deteriorates. The nursing process not only focuses on ways to improve the patient’s physical needs, but also on social and emotional needs as well.

- ◆ Cyclic and dynamic
- ◆ Goal directed and client-centered
- ◆ Interpersonal and collaborative
- ◆ Universally applicable
- ◆ Systematic

Skills

The nursing process involves skills a nurse should possess when he or she has to initiate the initial phase of the process. Having these skills contributes to the greater improvement of the nurse’s delivery of health care to the patient, including the patient’s level of health, or health status.

Cognitive or Intellectual skills, such as analyzing the problem, problem solving, critical thinking and making judgements regarding the patient’s needs. Included in these skills are the ability to indentify, differentiate actual and potential health problems through observation and decision making by synthesizing nursing knowledge previously acquired.

Interpersonal skills, which includes therapeutic communication, active listening, conveying knowledge and information, developing trust or rapport-building with the patient, and

ethically obtaining needed and relevant information from the patient which is then to be utilized in health problem formulation and analysis.

Technical skills, which includes knowledge and skills needed to properly and safely manipulate and handle appropriate equipment needed by the patient in performing medical or diagnostic procedures, such as vital signs, and medication administrations.

Phases of the nursing process

The following are the steps or phases of the nursing process:

- ◆ Assessment (of patient's needs)
- ◆ Diagnosis (of human response needs that nursing can assist with)
- ◆ Planning (of patient's care)
- ◆ Implementation (of care)
- ◆ Evaluation (of the success of the implemented care)

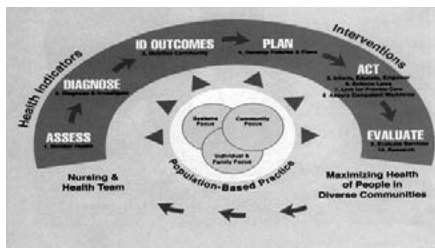


Figure 1. Phases of the nursing process.

Assessing Phase

The nurse should carry out a complete and holistic nursing assessment of every patient's needs, regardless of the reason for the encounter. Usually, an

assessment framework, based on a nursing model or Waterlow scoring, is used. These problems are expressed as either actual or potential. For example, a patient who has been rendered immobile by a road traffic accident may be assessed as having the “potential for impaired skin integrity related to immobility”.

Diagnosing Phase

Nursing diagnoses are part of a movement in nursing to standardize terminology which includes standard descriptions of diagnoses, interventions, and outcomes. Those in support of standardized terminology believe that it will help nursing become more scientific and evidence based. The purpose of this stage is to identify the patient's nursing problems.

Maslow's hierarchy of needs is used when the nurse prioritizes identified nursing health problems from the patient (see figure 2).



Figure 2. Maslow's hierarchy of needs.

Planning Phase

In agreement with the patient, the nurse addresses each of the problems identified in the planning phase. For each problem a measurable goal is set. For example, for the patient discussed above, the goal would be for the patient's skin to remain intact. The result is a nursing care plan.

Nursing orders are the actions for interventions prescribed to help achieve the stated goals and objectives. When writing nursing orders remember to include:

- ◆ What
- ◆ Where
- ◆ When
- ◆ How much
- ◆ How long

The steps in Nursing Care Planning are:

Determine priorities from the list of nursing diagnoses.

Set long-term and short-term goals to determine outcomes of care.

Develop objectives to reach the goals.

Write nursing orders to direct care to meet the goals.

Implementing Phase

The methods by which the goal will be achieved is also recorded at this stage.

The methods of implementation must be recorded in an explicit and tangible format in a way that the patient can understand should he wish to read it. Clarity is essential as it will aid communication between those tasked with carrying out patient care.

Evaluating Phase

The purpose of this stage is to evaluate progress toward the goals identified in the previous stages. If progress towards the goal is slow, or if regression has occurred, the nurse must change the plan of care accordingly. Conversely, if the goal has been achieved then the care can cease. New problems may be identified at this stage, and thus the process will start all over again. It is due to this stage that measurable goals must be set - failure to set measurable goals will result in poor evaluations.

The entire process is recorded or documented in an agreed format in the patient's care plan in order to allow all members of the nursing team to perform the agreed care and make additions or changes where appropriate.

3. What is the Education of Nurses Like?

◆ There are two Health Colleges in Estonia (in Tallinn and Tartu) providing nursing education. The general objective of the curriculum of basic nursing education is the provision of internationally recognised high quality applied higher education to work in health care.



Picture 7. Tallinn Health College.

The nurse, who has passed the curriculum, can plan, accomplish, assess and develop nursing care pursuant to patient's individuality. For the acquisition of special skills and knowledge it is necessary to pass additional specialised nursing education/specialisation programme in higher education institution or to acquire respective knowledge and skills through professional additional training programme.

A nurse is a health care worker who, in cooperation with the other members

of health care team, applies personal professional knowledge and skills to the service and help of a person, family and the whole community. The main functions of nursing are the provision of nursing care aimed at the preservation and promotion of community health, prevention of diseases, rehabilitation of health and work ability and to relieve pain and tension; management and organisation of nursing care; pedagogical work aimed at teaching a patient, family and population groups as well as the members of health care team; development of the field of nursing and integration of nursing science into the nursing practice. (Professional Standard NURSE, III, IV, V). A nurse respects the life, dignity and rights of a person and follows The Code of Nursing Ethics in all his/her activities.

The philosophical base of the curriculum is the conviction of human's uniqueness and caring for people is the central idea of nursing. A nurse is a member of multidisciplinary team, who shares the responsibility for the promotion of health and care of patients with other members of the team. The nursing care is informed, non- judgemental expression of care, comprising respect for the needs of an individual. The nursing care is aimed at patient's independent coping with living activities, which is a mutual process requiring systematic approach

to plan, carry out and assess the care of a patient. Such systematic approach requires the use of analytical and critical thinking, problem solving skills and interpersonal and psychomotor skills. Provision of nursing care is evidence-based, presenting continuing and developing integration of theory and practice.

3.1. Organisation of Study

◆ Basic nursing education has been organised following four different study schedules:

- ◆ basic nursing education with the nominal study period for 3,5 years;
- ◆ basic nursing education with the nominal study period for 2 years.

The persons, who have finished nursing studies earlier, have the possibility to acquire applied higher education with shortened time period with the nominal study period for 2 years, pursuant to the Accreditation of Prior and Experiential Learning (APEL).

The nominal study period is divided into courses; one course accounts for 40 CP/60ECTS.

The first course is aimed at giving knowledge about the fundamentals of nursing, nursing ethics, human anatomy and physiology and the main concepts of nursing to form appropriate

attitudes and value judgements and create conditions for the development of critical thinking and analysing skills. Teaching is concentrated on health promotion and healthy person through the whole lifespan. The acquired knowledge forms the bases for coping with further studies developing student's foreign language skills, skills to use professional scientific databases and work independently to develop student's self- management skills. Practical training in work environment takes place in different training bases providing care services for people.

During the second course the students deepen the skills of critical thinking and develop the skills to find interconnections for the acquisition of clinical knowledge and practical skills; the application of nursing process in the provision of necessary nursing care for patients and constructive feedback. Skills to analyse professional scientific literature are formed and developed. Teaching is concentrated on the pathological processes in human body. Students acquire knowledge about the nursing of a patient with internal disease, surgical patient and a sick child. Practical training in work environment takes place in stationary institutions: in the wards of internal-, surgical- and children's diseases.

The aim of the third course is to prepare readiness for the application of nursing process in case of nursing special- and complicated illnesses and



for independent organisation of nursing care considering the qualifications and competency of personnel. Readiness for the development of the speciality through research is formed and developed. Teaching is concentrated on mental health, intensive-, family- and home nursing; and also the nursing of patient with infectious disease, geriatric patient and the patient with dermatovenerological disease are treated. Study practice in work environment takes place in psychiatric and intensive care wards and in the field of family- and home nursing.

The aim of the fourth course is to fix and apply the acquired theoretical knowledge and practical skills in the



Pictures 8 - 12. Practical studies at school.

different fields of nursing. Studies are concentrated on the creation of interconnections and integration of theory and practice. Practical training in work environment takes place in different health care institutions.

Teaching is conducted in the forms of auditory, practical and independent work, whereas practical work is divided into the practice in teaching environment and practice in work environment. In the course of auditory work, independent work and practice in teaching environment the student acquires the necessary knowledge, comprehension and professional skills necessary for planning, provision and assessment of nursing care. In the course of the practice in work environment the students participate in these activities of social- and health care institutions that are connected with nursing, nurses' activities and learning of responsibility.

The volume of auditory work forms up to 50% of the total volume of theoretical studies and independent work not less than 50%. In case the subject comprises practice in work environment the volumes are as follows: auditory work up to 50%, independent work not less than 20% and practice in work environment not less than 30%. During the whole study period students are obliged to choose elective- and optional subjects in the volume of 240 hours, i.e. 6 CP/9ECTS.

Practical training

The volume of practical training in work environment is 58CP/87ECTS, i.e. 58 study weeks. Practical training forms an integral part of the nursing curriculum. The overall aim of the practical training is to integrate theory and practice. Students can choose the place for their practice from the list of practice placements, which meet the requirements. Practical training is supervised by nursing teachers from school and in practice placement each student has also a mentor.

Academic education (master level) is available in the Faculty of Nursing Sciences of Tartu University. Nursing education in Estonia is illustrated in figure 3.

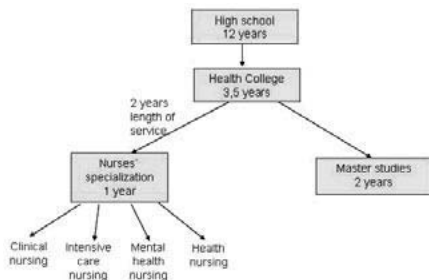


Figure 3. Nursing Education in Estonia.

3.2. Employment Situation

- ◆ The nursing qualification obtained at Health Colleges provides an opportunity to be employed as a general nurse in

all the areas of health care in a hospital or community care facilities. Currently there are about 7 nurses per 1000 people. 57% of them work in hospitals and the greatest need is in specialist areas (see table 4). The Ministry of Social Affairs has already recognized that the increasing shortage of nurses threatens the further implementation of hospital reforms, which include major increases in long-term and nursing care capacity. In 2004, it put forward a proposal to the Ministry of Education to fund training for 500 basic nurses plus 200 specialist nurses, also the extra training was needed due to the fact that 28% of nurses are 50 years or older. The proposal was based to meet the target of 8-9 nurses per 1000 people by the year 2015. However, while there is political will to increase the number of nurses being trained, according to the most optimistic prognosis and not taking into account the possible emigration we could reach a level where there are only 7,5 nurses per 1000 people by the year 2015.

Nurses' professional associations have been working to standardize the different nursing specialities. The Ministry of Education approved their standards in 2003. These standards and terms of reference are compatible with similar requirements elsewhere in the European Union, thus enabling the free movement of nursing professionals within the EU. For example in 2005, 300 nurses took the documents for working abroad.

According to the study, carried out late in 2003 among health care professionals in Estonia, only 5% had definite plans to go to work abroad and 56% had intentions to go. However, it has been stated that the migration of health care workers is not a biggest problem in the Estonian health care sector. The major problem is that 6% of registered physicians and 13% of registered nurses do not actually work in the health care sector.

Table 1. *Employment situation of practising nursing and caring professionals.*

<i>Name/Description</i>	<i>2000</i>	<i>2001</i>	<i>2002</i>	<i>2003</i>	<i>2004</i>	<i>2005</i>	<i>2006</i>
Midwives	507	453	422	403	406	424	444
Qualified nurses	8010	7951	8294	8412	8270	8421	8359
Qualified nurses for general care	5854	5613	5331	5242	5235	5100	5137
Qualified nurses for specialised care (branch nurses)	2156	2338	2963	3170	3035	3321	3222
Total number of qualified nurses and midwives	8517	8404	8716	8815	8676	8845	8803
Total number of nursing professionals	8517	8404	8716	8815	8676	8845	8803
Caring personnel (e.g. nursing aids, assistants)	704	719	680	841	760	689	864
Total number of nursing and caring professionals	9221	9123	9396	9656	9436	9534	9667

4. How Are the Health Care Services Organized in Estonia?

4.1. Description of the Organisation

◆ The main bodies responsible for planning, administration, regulation and financing in Estonia are the Ministry of Social Affairs, the Health Care Board, the State Agency of Medicines (SAM), the Health Protection Inspectorate and the Estonian Health Insurance Fund (EHIF).

Ministry of Social Affairs

According to the Statute of the Ministry of Social Affairs, one of the objectives of the activities of the Ministry is to ensure a balanced availability of health services and medicinal products; the main function of the Healthcare Department is to plan the health policy and organise its implementation with the aim of ensuring the availability of health services and medicinal products, their quality and safety; the main function of the Health Information and Analysis Department is to plan the policy of health information and organise its implementation with the aim of ensuring necessary information with safe and user-friendly access to it for providing substantiated health services.

The Health Care Board

According to its Statutes, the Health Care Board is a government agency which operates within the area of government of the Ministry of Social Affairs, has a directing function within the scope of its authority, exercises state supervision and applies enforcement powers of the state to the extent and pursuant to the procedure prescribed by law.

The main function of the Health Care Board is quality assurance and supervision of the structure:

- ◆ issue of activity licenses for providers of specialised medical care, emergency medical care and nursing care;
- ◆ registration of healthcare professionals and healthcare providers;
- ◆ supervision over compliance with the quality requirements for the structure set in its activity licence,
- ◆ coordination and organisation of the activities of the competency board of healthcare professionals.

In addition to structural quality assurance, the Health Care Board organises the work of the expert committee on the quality of healthcare. The function of the committee is review of complaints from patients or their representatives and provision of expert appraisal of the quality of health services.

The Estonian Health Insurance Fund

According to the Estonian Health Insurance Fund Act and the Statutes of the Estonian Health Insurance Fund, the Estonian Health Insurance Fund has a right and obligation to check the expediency of the use of health insurance resources and the correctness of certificates of incapacity for work and discount prescriptions issued. One of the responsibilities of the Estonian Health Insurance Fund is to establish quality criteria for health insurance benefits.

Being the main financer of health services, the Estonian Health Insurance Fund has established certain requirements for healthcare providers on the accessibility and quality of health services in the contracts concluded with them. The Estonian Health Insurance Fund has a right to check the compliance of the information on certificates for sick leave, prescriptions, invoices submitted to the Health Insurance Fund, case histories, and health cards, and thus check the expediency of the use of resources related to the provision of health services included in the invoices. Since 1999, surveys on the population's satisfaction with the accessibility and quality of health services have been carried out each year upon the request of the Estonian Health Insurance Fund.

In 1997, The Estonian Health Insurance Fund started checking treatment quality

and since 2002, periodical checks on treatment quality have been carried out in various fields, e.g internal diseases, surgery, intensive care, obstetrics and gynecology. Treatment quality is assessed by renowned specialists in the field.

County Governments

According to the Health Services Organisation Act, it is the responsibility of county governors to organise the provision of general medical care in the county and to ensure supervision over that. According to the act, county governors assess the volume of the activities and the economic activities of the providers of general medical care.

4.1.1. Primary, Secondary and Tertiary Health Care

Health care in Estonia is divided into primary (family physician or practitioner, ambulance, pharmacies, public health services), secondary (medical specialist in health centers or hospitals, long term care, nursing homes, rehabilitation centres) and tertiary (high-specialized care in hospitals) (see figure 4). Health care can be either private (primary care and part of out-patient specialist care) or public.

All persons insured with the Health Insurance Fund have a family practitioner. Family practitioner is the key position in the system since he/she is the first medical personnel an individual meets with. The family

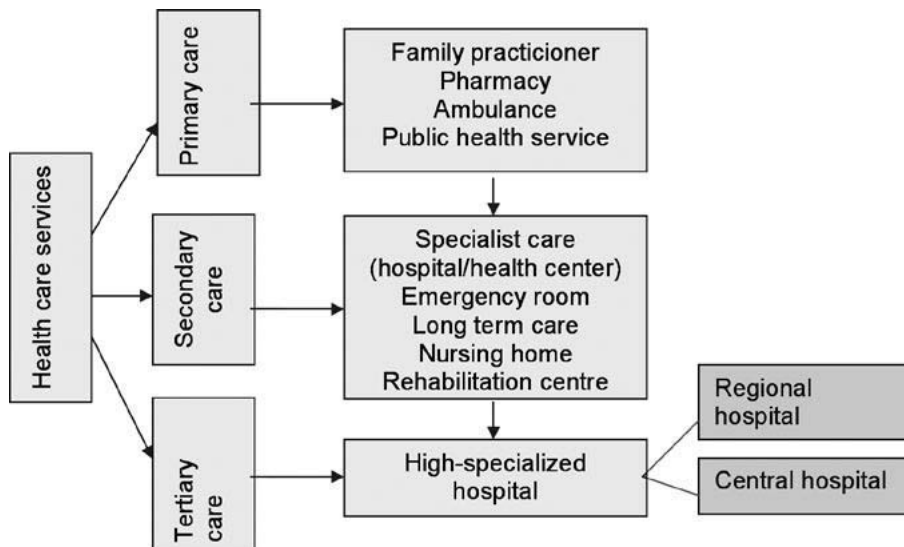


Figure 4. Health care provision in Estonia.

practitioner has the right to forward to higher medical institutions or consultations depending upon the seriousness of the given health problem. It is recommended to call beforehand and to make an appointment prior to the visit.

Pictures 13 – 14. East Tallinn Central Hospital.



All specialists' visits are organized through the family practitioner. No referral is needed to visit a psychiatrist, gynaecologist, dermatovenerologist, ophthalmologist, dentist, pulmonologist (for tuberculosis treatment), infection specialist (for HIV/AIDS treatment), surgeon or orthopaedist (for traumatology). In the case of a foreign student, it is advisable to choose all the specialists through the family practitioner or the medical advisors. Usually specialists have consultations in the polyclinics and there is a few-week waiting line. In the private clinics waiting lines are rather short.

In the case of **emergency treatment**, a person may always go to the emergency reception or call an ambulance. One can reach an ambulance on 112 (toll

free line) from all over Estonia. The attending physician decides whether the patient needs in-patient treatment.

Pharmacists can assist with simple medical problems. Even though, most of the drugs are issued upon a medical prescription written by a doctor, some of the painkillers, antacids, ointments, and other simple drugs could be obtained without one.

Dentists - Persons under 19 years of age receive dental treatment at prices set out in the list of health services, which means free of charge for the patients. The adults pay for their dental treatment and dentures themselves and the Health Insurance Fund compensates for these payments up to the rate fixed by the Minister of Social Affairs (300 kroons per one year in 2008). Higher compensation rates are established for pregnant women (450 kroons per one year in 2008), mothers of children up to 1 year of age and those having greater need for dental treatment because of sickness (both 450 kroons per one year in 2008). In case of dentures the Fund compensates once every three years for the amount paid for dentures by insured persons, who are at least 63 years old. This amount and the terms and procedure of payment shall be established by a Regulation of the Minister of Social Affairs. The amount is 4000 kroons per 3 years in 2008.

The types of hospital are regional hospital, central hospital, special

hospital, general hospital, rehabilitation hospital and nursing hospital.

Welfare and nursing care services may be provided by institutions that hold an activity license pursuant to the current legislation. The criteria for applying for an activity license and the minimum requirements are laid down by the state. Nursing care financed by the state is planned based on the size of the target group by counties, which is also the basis of financing nursing care by the health insurance fund. The new providers of nursing care services have to get a concord from the county in addition to the activity license.

Community care services (home nursing, day nursing, home care, day care) can be provided by individuals (self-employed persons), independent community care units (subunits of local government's social departments, non-profit organisations, commercial enterprises based on private capital etc) or institutions providing care or nursing care services. Services can be provided in a so-called mono-functional institution, but successful operations are also such providers of different services that have joined in one centre: care centre/health centre with a family health centre. A care centre can be made up of service providers located in geographically different locations.

A typical person requiring nursing care in Estonia is usually an elderly person with several chronic illnesses, who

requires help with treatment procedures and who does not cope with necessities of everyday life. Another typical case is a multi-problematic adult person (no age restriction) with partial incapacity of coping with life, i.e geriatric patient. In 2004 there were 47 institution-based service providers and 43 home nursing service providers. There were 112 general care homes (as of 2005), 94 seniors` day centres (2004) and 697 providers of domestic services.

Family physician is the key person in referring patients to nursing care services and in referring a local government`s social worker to welfare services. Should a person`s need exceed beyond just nursing care or welfare services, the organisation of services to the person is solved through case management principle. In this model case manager i.e. care co-ordinator takes the central position, whose aim is to guarantee the people in need a package of services that would be as suitable as possible and economic and see to it working smoothly.

Case manager has special training and is competent to assess the condition and the needs of a person and welfare and nursing care services necessary. Case manager must have access to the information concerning the services provided in the country, the list of service providers and be knowledgeable about the service organising principles. Case manager is a member of the service providers` team who is in

contact with the client during the entire period when the services are needed and has an overview of all data about the client concerning the care.

The amount of the patient`s financial participation in the following cases (in 2008):

- ◆ out-patient examination - a family practitioner can charge a visit fee of up to EEK 50, when making a home visit;
- ◆ specialised medical care - a visit fee up to EEK 50;
- ◆ transportation by ambulance in the case of emergency - free of charge;
- ◆ hospitalisation - an in-patient fee of up to EEK 25 per day and for up to 10 days per hospitalisation.

5. What are the National Characteristics?

5.1. The Most Common Diseases

◆ The healthy life expectancy in Estonia is essentially lower than the average level in the new and old EU Member States. Furthermore, the general average life expectancy in Estonia (men 66 and women 77 years) is even lower than the average level of the new Member States. In the average life expectancy, continuously increasing gaps between different social groups emerge. In Estonia, the average life expectancy of men with higher education is up to 13.5 years longer than that of men with basic education. Women with higher education are likely to live 19 years longer than men with basic education. No other European country displays such major differences. There is a pattern that health indicators are characterized by social position – the indicators of people with the highest income and educational level are the best, for those with average income and educational level the indicators are intermediate, and the indicators of people with the lowest income and educational level are the worst ones – and this is also evident in Estonia.

25 % of the population is still living below the absolute poverty line. The health indicators of our socially vulnerable groups are among the worst

in the European Union. The most alarming fact is that more than one third of the children up to the age 16 live in families, whose income is below the poverty line. The poverty risk group includes mainly long-term unemployed, low-paid workers, families with many children and single parent families. One fourth of the single elderly live below the absolute poverty line. The percentage of women among the people living in poverty and in the poverty risk group is higher than that of men; however, 2/3 of the homeless people are male, and this proportion has been constantly increasing over the last 10 years. The percentage of working-age people (in the age of 15-59) with primary education living in poverty is much bigger than that of the working-age people with higher educational level (31 % and 18 %, respectively). More than one fourth of the households live in lack of privacy, as they are forced to live together with another household. A quarter of households do not have washing facilities or an indoor toilet.

Compared to the average of the old Member States, the rate of preventable injury deaths is 4 times bigger in Estonia. Traffic injuries and deaths, drowning, slaughter and suicide cases are mainly the result of abusing alcohol. In Estonia, the number of up to 14-year-old children dying of injuries and intoxications is bigger than in any other Member State.

The prevalence of **mental disorders and addiction problems** increases continuously. The use of illegal drugs among the 15-16-year-olds has grown from the 7 % in 1995 to 24 % in 2003. Every third boy and every fifth girl in that age group smokes cigarettes. The consumption of alcoholic beverages increases constantly and has exceeded the amount of 12 litres of absolute alcohol per person from birth to death. Suicide has become the main cause of death among the 15-29-year-olds.

The prevalence of communicable diseases increases steadily – by the end of 2005, there were more than 5000 HIV-positives and as at 2004, 429 people were suffering from tuberculosis. The problem is multi-drug resistant tuberculosis and its rate of prevalence in Estonia is one of the highest in the world. The case rate of tuberculosis among HIV-positives increases, as well as the number of pregnant HIV-positives

Compared to the average figures of the old EU member states, cardiovascular and cancer morbidity and mortality are significantly higher (see figure 4).

Cardiovascular diseases

Cardiovascular diseases (hereinafter CVD) are the main reason for early loss of work capacity (at an age below 65) and death in Estonia. Estonia is a leader in CVD mortality in Europe and the whole world. There has been no significant change for the better over

the past 20 years. Illness continues to strike at an early age and during the working years.

The high rate of **premature morbidity and mortality** compared to developed countries in Europe poses a serious challenge to the socio-economic development of the nation. Of even greater importance is this lack of tendency to decline over the past six years against a background of a constantly negative population growth.

Cancer

Cancer is a prevalent disease, holding the second place among causes of death after circulatory system diseases: 3479 cancer death cases were registered in Estonia in 2005 which is 20% of all death cases (databases of Estonian Statistics, 2006). On European scale the total cancer incidence is average. According to the calculation, every third male and fifth female in Estonia becomes ill with a malignant tumor by the age of 75. During the last decade of the previous century breast-, prostate-, colon- and rectum-, bladder-, kidney-, uterus-, thyroid and skin cancer (including melanoma) and lymphoma became significantly frequent in Estonia

Over three decades, in years 1970 - 2000 the incidence rate of cancer has increased 1.8 times per 100 000 people. In 2000 the registered number of new cancer cases in Estonia was 6008, which is 1000 cases more than in 1990 and according to the data of Estonian

Cancer Registry the number of primary cases is constantly increasing (the initial data from year 2003. was 5976 cases).

National cancer mortality is the most important measure in cancer protection. There are almost 3,500 malignant tumour deaths in Estonia every year and according to the data of the last decade the index has not reduced. The main causes of Estonians' cancer deaths are lung cancer (20% of all cancer death cases), colon and rectum cancer (12%), liver cancer (9%) and breast cancer (7%) that caused about 1,700 death cases in total in Estonia in 2005.

According to the data from 2000. There were about 33,000 people living in Estonia who had been diagnosed with having a malignant tumour. As one person may have more than one malignant tumour, the total number of cases is about 35,000. In 2003 according to initial data there were more than 35,000 people who had cancer diagnosis and 37,500 cancer cases. The most common is skin cancer, breast cancer holds the second place. About 44% of patients have been diagnosed with having a cancer less than five years ago and they need both primary and post treatment. All these patients need simultaneously active cancer recurrence monitoring 56% of patients have been diagnosed having had a cancer more than five years ago and in oncology these patients are considered to be cured although their monitoring for cancer recurrence still continues.

Modern knowledge about causes and prevention of malignant tumours has proved that almost 40% of all cancer cases could be avoided. Nowadays we know many evidence-based opportunities to lower cancer risks. In order to succeed we need to dedicate enough attention to the factors that are avoidable, and which are mainly associated with risk behaviour and psychosocial environment which promotes it.

Considering the fact that cancer is costly illness for society, it is important to invest into preventative work. Therefore attention should be paid on reduction of tobacco and alcohol consumption and also the risks of work environment and living conditions, as well as on increase of a balanced nutrition and physical activity. These measures when implied together could reduce the general burden of cancer illnesses.

Equally with preventive work the effective modern methods of early detection and treatment should be elaborated and implemented to reduce the cancer incidence and mortality. The bases for early diagnosis are both the education of patients and implementing the screening programs that would help to discover cancer before the clinical symptoms occur. More evidence-based are national mass screening programs of servical (cytological tests and HPV DNA tests) and breast cancer (X-ray photograph of mammillary gland or mammography).

The treatment of cancer patients is directed to healing, prolonging life-span and improving life-quality. The accurate diagnosis based on laboratory and clinical tests is prerequisite to assure an adequate treatment. The main cancer treatment methods are surgical treatment, radiation- and chemotherapy.

At later-stages of cancer the patients should be guaranteed full palliative or symptoms alleviative care and nursery services that would reduce the patients' complaint and discomfort until 90%.

Estonian cancer strategy involves all areas of cancer protection: prevention, early detection, screening, healing and supportive care, and corresponding scientific researches. Elimination or reduction of known risk factors (especially smoking and other factors of living or work environment) could avoid remarkably significant share of cases. The number of malignant tumours that could not be prevented may be reduced by early detection (screening programs) and more effective treatment.

HIV and AIDS

What gives reason for concern is the fact that Estonia keeps ranking first in the number of new HIV incidences every 100th Estonian in the age group 15-49 is estimated to be HIV-infected. Multiresistant tuberculosis is another problem, whereas Estonia is amongst the first in the world as to the spread of the disease. Morbidity of tuberculosis

in HIV-infected persons is broadening, the number of HIV-positive pregnant women is also increasing.

By the end of 2005, a total number of 5063 HIV-positive cases have been registered in Estonia. The first HIV-case was registered in 1988. In 1988-1999, the cumulative number of registered HIV-cases in Estonia was 96. During the 2nd half of 2000, there was a drastic rise in the number of new HIV cases that also continued to grow in 2001. Starting from 2002, however, there has been a decline tendency in the number of registered new cases: in 2003, 840 new cases were diagnosed, in 2004 743 and in 2005 621 new cases have been diagnosed (data source: Estonian Health Protection Inspectorate).

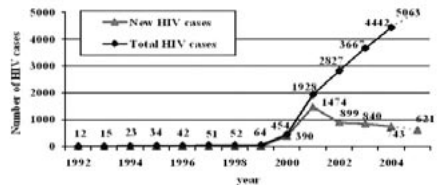


Figure 5. New HIV cases and the total number of HIV cases in Estonia in 1992 - 2005 (Source: Health Protection Inspectorate).

The first AIDS case was diagnosed in 1992. The total number of people diagnosed with AIDS throughout the years is 100 (end of 2005 data). In 2003, 11 people with AIDS were registered, in 2004 27, and in 2005 30 new AIDS cases were registered.

The majority of the HIV cases are concentrated in two regions – near the capital Tallinn and its surrounding Harju County, and a region close to the Russian border – Ida-Viru County. In the County of Tartu, there has been some increase in registered cases, but this is mainly due to the cases registered in Tartu prison. Due to the sudden increase in the number of HIV infected people since the autumn of 2000, the Ministry of Social Affairs proclaimed a concentrated epidemic of HIV among injecting drug users (IDU) on 14 February 2001 that is characterized by a 5% prevalence rate among the subpopulation of injecting drug users, but less than a 1% prevalence rate among pregnant women. Although there is insufficient data, increase in the share of transmission through heterosexual intercourse has been detected since 2002. According to the data gathered by anonymous AIDS consultation clinics, injecting drug users made up 90% of the HIV-positives (new cases diagnosed in the consultation clinics) in 2001, 72% in 2002, 66% in 2003, 52.5% in 2004 and only 44% in 2005. Although this data does not reflect the total number of HIV-positives, we can assume that the virus is starting to spread through sexual transmission from injecting drug users to their partners, who later pose a threat to the general public. In Estonia the prevention of HIV-infection and AIDS has been dealt with for more than 15 years. From 2002–2005 Estonian HIV-prevention work

has been carried out in accordance with the National Programme for HIV/AIDS prevention for 2002–2006 (NP), which was financed from the state budget and coordinated by the Ministry of Social Affairs. However, due to the growing epidemics, a need emerged for a new strategy that would better involve other governmental organizations, private sector and Civil Society.

In 2005 a new national HIV and AIDS Strategy was developed for the years 2006-2015 together with an Action Plan for years 2006-2009. The strategy was adopted with a government order on December 07, 2005. With the order, the Government also created a high-level multisectorial Governmental HIV and AIDS Committee as an advisory body to the Government for the central coordination of the implementation of the new strategy.

The Ministry of Social Affairs is now serving as the Secretariat to the new committee. Each implementing ministry is developing its own annual Action Plan with a tangible/precise budget (based on the 4-year Strategy Action Plan), which is presented to the Committee for approval. The ministries involved in the strategy implementation are the Ministry of Social Affairs (HIV-prevention, treatment and care), Ministry of Education (HIV-prevention in schools and among youth, health education), Ministry of Justice (HIV in prisons), Ministry of Interior (occupational safety - police and rescue

board), Ministry of Defense (VCT among army recruits) and Ministry of Population (targeting Russian-speaking youth through its Non-Estonians' Integration Foundation).

Substance abuse

In Estonia the abuse of narcotic drugs and the range of problems related thereto are relatively new phenomena having developed into an issue demanding urgent attention over the last years of the twentieth century. In 1990-ies, particularly in the second half of this decade, Estonia witnessed an encouraging attitude towards the use of narcotic and psychotropic substances, as well as the handling thereof, posing threat to both the health of the user and the security of the living environment.

Medical and police statistics demonstrate that drug use has considerably increased over the past years, particularly among children and young people. Use of heroin, amphetamine and other narcotic drugs does not only have an adverse effect on the health and social position of a person, but also, results in the increase of the level of criminality and transmission of B-, C-hepatitis and HIV-virus in the society, which, in turn, are directly related to the drug problem.

Alcohol Consumption

Estonia is one the countries in the Baltic Sea region with highest alcohol consumption. According to the December 2003 survey of the Estonian

Institute of Economic Research 86% of the Estonian population (ages 16-75) consume alcoholic beverages. Drinking alcohol is more widely spread among men, young people and people with lower education, people from the North-East of Estonia and small towns.

Estonian inhabitants prefer wine and beer to strong alcoholic beverages. The latter are consumed more by the senior population. In the last 10 years consumption of beverages with average alcohol content has drastically increased in Estonia, and there is no declining tendency in terms of consumption of strong alcohol in respect to nationality and age (data pertaining to this information may be found in the regular international research on health).

General alcohol consumption in the last decades has increased worldwide; Estonia due to its alcohol consumption is considered among most unhealthy states (World Health Report 2002). Thus, 10, 06 litres of legal 100% alcohol was consumed per capita in 2002 (8,4 litres in 2001 according to the information of the Estonian Institute of Economic Research), which makes 12,14 litres of pure alcohol per person (persons over 14 years of age). The objective set by the WHO to the European countries is to reduce consumption of alcohol to less than 6 litres of pure alcohol per person aged over 15 by 2021 and to zero among the persons under 15 years of age. It is calculated that legal alcohol amounts

to 60% of the consumed alcohol on the average, therefore, in 2002, in fact 20,23 litres of 100% pure alcohol was consumed per person. (Comparison: in 2002 in Latvia 8,4 litres per capita among persons over 14).

Alcohol consumption by the young people is of particular concern, because a clear connection has been established between alcohol consumption (even moderate) among the young people and alcohol abuse in the older age. In Estonia alcohol has been tried by 60% of the young people aged 10-13, and 55% of the young people aged 14-15 had been drunk at least once. 52% of the young people aged 14-15 are regular alcohol drinkers, and 69% of the young people aged 16-18. Most children get intoxicated not by strong spirits, but because they drink light alcoholic beverages (beer, cider, long drink), which are not considered alcoholic beverages by children themselves according to research.

At the same time countries with traditionally high alcohol consumption such as France and Italy have considerably reduced consumption of alcohol per person due to effective implementation of national programmes (e.g. by 25% in Italy).

As already mentioned, Estonia belongs to the countries with high risks connected with alcohol consumption such as number of alcohol related psychosis, injuries, suicide and traffic

accidents as a result of driving while intoxicated.

Suicides

One of the most pronounced, though dramatic indicator of mental health is the prevalence of suicides. Suicides are considered the peak of the iceberg in problems regarding mental health, and the prevalence of suicides reflects social coherence. The prevalence of suicides in Estonia is extremely high in comparison with other countries. After the decline in the frequency of suicides in the 1980s, during a stricter alcohol policy and increased social activity, the suicide curve reached its peak by the mid-nineties, in the course of the development of early capitalism, and then started declining after this. Latvia, Lithuania, Belorussia and Russia have had similar suicide curves with Estonia (being different from the rest of Europe, including kin nations Finland and Hungary with a high suicide risk), confirming that the frequency of suicides is in association with social-political circumstances. Men commit suicide several times more frequently than women; it is especially the suicidal tendency of men that is changeable in the dynamics of societal conditions. There are several factors contributing to suicide, the ones of greater relevance are alcohol use and depression, the roots of which proceed from social networks.

Since the mid-nineties, the prevalence of suicides has reduced. The mechanical approach would let us suppose that

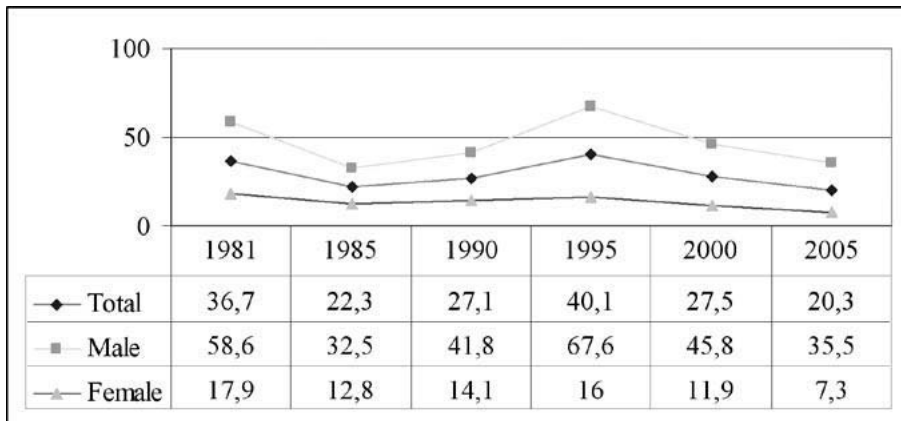


Figure 6. Suicide rates per 100 000 by gender 1981 – 2005.

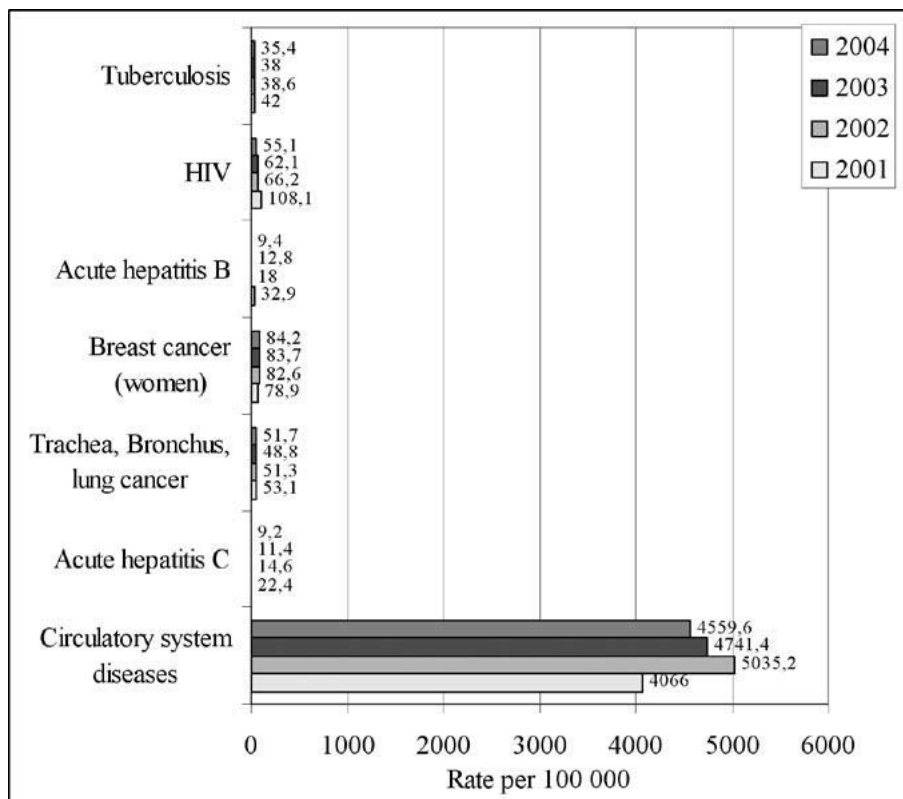


Figure 7. Incidence of selected diseases 2000-2004 per 100 000.

Table 2. Suicides per 100,000 people per year in selected countries.

Rank	Country	Year	Males	Females	Total
1	Lithuania	2005	68,1	12,9	38,6
2	Belarus	2003	63,3	10,3	35,1
3	Russia	2004	61,6	10,7	34,3
4	Kazakhstan	2003	51,0	8,9	29,2
5	Slovenia	2003	45,0	12,0	28,1
6	Hungary	2003	44,9	12,0	27,7
7	Guyana	2003	42,5	12,1	27,2
8	Latvia	2004	42,9	8,5	24,3
14	Finland	2004	31,7	9,4	20,3
15	Estonia	2005	35,5	7,3	20,3
30	Germany	2001	20,4	7,0	13,5
32	Sweden	2002	19,5	7,1	13,2
51	Netherlands	2003	12,7	5,9	9,2
60	United Kingdom	2004	10,8	3,3	7,0

the system, pushed out of balance, made an oscillation and stabilises at the former level. Proceeding from social-Darwinist standpoint, this might mean that those who did not cope in struggle for existence, have dropped out and the remaining population is more viable. The more pleasant conclusion would be that the situation in Estonia has stabilised and the particularly difficult times are passing. Certainly, we should not disregard the fact that psychiatric and psychological assistance is more competent and acceptable to those in need of help, and that suicidology-related awareness is increasing both among the specialists, support-

providing organisations and the entire population.

Suicidal behaviour is closely associated with the consumption of alcohol and a depressive frame of mind. Only during the 1990's it was perceived that the prevalence of depression and its deteriorating impact on the quality of life has been persistently underestimated, and that by registering merely the people who turn to doctors with their mood disorders is not sufficient enough for obtaining an overview regarding the prevalence of depression. For measuring depression and emotional distress, it is expedient

to conduct interview surveys, the most thorough overview being given by the Estonian Health Interview Survey 1996, organised by the Estonian Institute of Experimental & Clinical Medicine (EKMI). This shows that during the last month, depression and emotional distress occurred in 6.7% of men, whereas also in the youngest cohort, the prevalence of depression was 4.4%, and in 14.9% (depression) and 18.8% (emotional distress) of women. The prevalence of depression was the largest in the oldest age groups, ranging to 11-15% in men and to 21-27% in women. The interview being carried out during the winter period probably increased the indicators of the prevalence of depression to a certain extent. Nevertheless, the outcomes are comparable with other countries and indicate that the prevalence of depression has also been underestimated in Estonia, and that it is relatively high, especially among the oldest part of the population.

More statistics can be found on the Ministry of Social Affairs website at: www.sm.ee

5.2. Legislation

- ◆ Estonian health care is mainly based on the following acts:
- ◆ Estonian Health Insurance Act (28 June 2004) establishes clearer regulation of all aspects of the health insurance system, including validity

periods, benefits, reimbursement lists and levels for health services and drugs, maximum level of cost sharing for insured people and contractual relationships between the Estonian Health Insurance Fund and providers.

- ◆ The Health Services Organisation Act (12 October 2005) provides the organisation of and the requirements for the provision of health services.
- ◆ Public Health Act (14 June 1995) establishes the status, structure, functions and financing of the public health network in Estonia.
- ◆ Accessibility Requirements for Health Services (09.07.2004) establishes the requirements for the accessibility of health services (general and specialised medical care, ambulance, emergency care and nursing care) and requirements for waiting lists.
- ◆ The Law of Obligations Act (01.07.2007) regulates definition of contract for provision of health care services. By a contract for the provision of health care services, one person (the provider of health care services) undertakes, in his professional activities, to provide health care services to another person (the patient), particularly by examining the patient in the interests of his or her health and observing the rules of medicine, by consulting and treating the patient or offering obstetrical care to the patient, and by informing the patient of his or her state of health and the progress and results of his or her treatment.

5.3. Health Care Funding and Health Insurance

◆ In Estonia compulsory health insurance has been established. The source of income of health insurance is 13% of the social tax or 13% of the employee's gross salary paid by the employer.

The Health Insurance Fund covers the costs of health services by the person in case of illness regardless of the amount of social tax paid for the person concerned. The purpose of health insurance in Estonia is to cover the costs of health services provided to insured persons, prevent and cure diseases, finance the purchase of medicinal products and medicinal technical aids, and provide the benefits for temporary incapacity for work and other benefits.

Health insurance is based on the solidarity principle: health service is not dependent on the amount of social tax paid for the specific person. The health insurance fund pays the cost of health service to the medical institution for the insured person.

In Estonia all persons are entitled to receive emergency care regardless of having health insurance or not.

In case you need health care while staying in Estonia:

- ◆ Check if the provider of health care service has a contract with Estonian Health Insurance Fund (private care is not refundable).
- ◆ Present your European health insurance card.
- ◆ In case you do not have a European health insurance card, request your institution of the place of residence to fax the Certificate provisionally replacing the European health insurance card.
- ◆ In case you do not have a European health insurance card and it is not possible to get the Certificate provisionally replacing the European health insurance card, the doctor has a right to present you the bill.
- ◆ Make sure you get the so called doctor's explanation form (list of the health care services received).
- ◆ In case of reimbursement, present the paid bills, documents of payment and doctor's explanation form to institution of the place of residence.
- ◆ Only the necessary medical care is reimbursed (which has become necessary during your stay in Estonia).

Compensation of medical expenses

Provided the person had no European health insurance card when getting health care in another Member State, the local health care institution has the right to submit the invoice to the patient which should be paid at the site.

The original invoice and the document certifying the payment should be retained, as on the basis of the latter compensation could be applied for from the Estonian Health Insurance Fund. The Health Insurance Fund processes only previously paid invoices. In arrival to Estonia submit the original checks together with the document certifying the payment and filled application (you find the application form on the website of the Health Insurance Fund) to the local department of Health Insurance Fund.

In case of Spain there is an exception. Estonian Health Insurance Fund reimburses the costs that occurred in Spain on the basis of § 34.4 and §34.5 of EC regulation 574/72. According to this, the costs of healthcare provided for Estonian insured persons in Spain will be reimbursed on the basis of the reference prices in the list of health services of the health insurance fund established by a regulation of the Government of the Republic. For comparing the health services provided to you, please fill in the questionnaire for applying for the reimbursement of health care costs in Spain.

The Estonian Health Insurance Fund sends the original invoices and the document proving the payment to the competent institution of the state having provided health care (except Spain). The institution of another state decides on the basis of its legislation, whether and within which scope the

expenses are covered (the patient's co-payment, private doctor expenses etc. are not subject to refund). Information is forwarded to the Estonian Health Insurance Fund and within 14 days from the receipt of the positive response the Health Insurance Fund makes the payment to the patient's bank account in Estonian kroons.

The above provided scheme should be followed also in case health care was received in the country where the patient should first fully pay the specific sum (e.g. medicines in many countries). When the person has not managed to apply for the compensation from the local health insurance fund of the country, he/she could do it through the Estonian Health Insurance Fund when returning to Estonia. As the inquiry is made to another country, the procedure takes 2-3 months or longer in average.

Student

The students making for abroad to study should submit the document certifying the studies in the educational institution of the foreign country to the Estonian Health Insurance Fund for the continuation of health insurance.

The document should include:

- ◆ Name of the educational institution;
- ◆ Address of the educational institution;
- ◆ First name and surname of the student;
- ◆ Personal identification code of the student;
- ◆ Duration of the study period;

- ◆ First name and surname of the representative of the educational institution, data of the communication devices and signature.

The certificate could be in foreign language, but the Estonian Health Insurance Fund has the right, if needed, to require the translation of the document into Estonian. The data could be submitted on the form found on the website of the Health Insurance Fund. The submission of all data required is significant.

The students insured in Estonia are recommended to apply for the European health insurance card from the Estonian Health Insurance Fund. On the basis of the latter the pupil or the student gets necessary health care while staying in the country of studies or in any other Member State.

5.4. Challenges for the Future

- ◆ A principal aim of the health policy for the year 2015 is to considerably raise the average life expectancy, which today is one of the lowest in Europe – up to 60 years for men and up to 70 years for women.

The main part of the target group of nursing care consists of people aged 65 years and above, who also account for 25% of the current in-patients. In 2004, there were about 218,658 people aged 65 or older in Estonia, comprising 16.2% of the population, but according to a demographic prognosis the number of elderly people in Estonia will continue to grow until the year 2050, and the share of over-65-year-olds among them will grow by 25%.



Figure 8. Development model 2015.

In order to improve the accessibility of nursing care the number of hospital beds for active treatment has been and will be decrease in the future. According to the calculations based on regional development plans (10 bed per 1000 habitants aged 65 and older), 2220 nursing care beds are needed in Estonia by 2015.

The envisaged model (figure 7) foresees movement of a patient between different services according to the different care needs. The arrows in the development model point from active care at the top towards home nursing care at the base, indicating the change in the focus of development planned for the coming decade.

5.5. Health Care Quality Policy

The growing role of the patient as the user of health care services and the promotion of the concept of patient's rights have increased the importance of issues regarding the quality of management of the health care system. In relation to the change of principles of financing the health care system and implementation of the mandatory health insurance, the quality of health care in relation to resource utilisation came under assessment.

The principles of quality requirements were set with the Health Services

Organisation Act passed in 2001, enabling to establish requirements to the quality of health care services and minimum requirements to health care workers and providers of health care services. With the act that was enforced in 2002 all health care workers and providers of health care services were given three years (until 31.12.2004) for aligning their activities with current requirements.

In 2005, a document called "Securing the quality of health services in Estonia" was prepared and it will be used as a basis for the continued development of the quality system strategy for health services for the years 2006-2010. The quality policy of Estonian health care was prepared with the help of experts from the health care quality organisation CBO of the Netherlands. In the second half of 1990s, satisfaction surveys of patients and employees were launched.

Pursuant to the regulation of the Minister of Social Affairs "Quality Assurance Requirements" for Health Services", healthcare providers have to establish a quality management system and implement a list of activities which ensure safe and necessary services for patients. The Law of Obligation Act, which took effect in the summer of 2003, provides for various patients' rights, e.g informing patients and obtaining informed consent of patients for the provision of health services.

Many healthcare providers organise periodic surveys to find out their patients' satisfaction and analyse complaints. A number of practice guidelines have been compiled with the purpose of improving the professional quality, e.g checking hospital infection, assessing patient's state before surgery, blood transfusion etc. Complications are documented and analysed, more complicated cases are analysed, treatment outcomes are assessed, and medical documentation is checked – this also includes checking correctness of filling in the documentation on health insurance.

The responsibilities of healthcare providers also include preparation of job descriptions for their employees and implementation of various requirements for various positions, devising education plans for employees, assessment of employee satisfaction and assessment of activity indicators of the organisation. More and more attention is paid to putting management systems in order and implementation of management quality principles in organisations which provide health services.

6. What is European Health Policy Like?

6.1. Background

◆ **European Union's recent general health policy lines** were set out in 2002 with the concept of a **Europe of Health** in 2002. Work was undertaken on addressing health threats, including the creation of a **European Centre for Disease Prevention and Control (ECDC)** (2004), developing cross-border co-operation between health systems and tackling health determinants. The Community's **health information system** provides a key mechanism underpinning the development of health policy. This development work has already resulted for example in European health insurance card.

Naturally work and efforts in promotion of health had taken place during previous years. One significant effort being programme of **Community health monitoring programme (1997-2002)**. The aim of the programme was to produce a health monitoring system to monitor the health status in the Community, facilitate the planning, monitoring and evaluation of Community programmes and to provide member states with information to make comparisons and to support their national policies.

Before existing Programme of Community Action in the Field

of **Public Health** was drawn lot of previous work and programmes had been carried out. Development of health indicators (Programme of Community action on health monitoring) has resulted in European Community Health Indicators (ECHI). Other programmes have been e.g. pollution related diseases programme, the cancer programme, the drugs prevention programme and rare diseases programme. Previously carried out work has resulted in following programme.

Aim has been on prevention and finding joint indicators and monitoring systems to facilitate comparison of health status and determinants effecting it.

6.2. Present situation

Programme of Community action in the field of public health (2003-2008)

The Council and Parliament set in 2002 as overall aim “**to protect human health and improve public health**” and as **general objectives**:

A. to improve information and knowledge for the development of public health; that is to be reached by e.g. following measures:

◆ developing and operating a sustainable **health monitoring system to establish comparable**

quantitative and qualitative indicators at Community level ...

concerning health status, health policies and health determinants, including demography, geography and socioeconomic situations, personal and biological factors, health behaviours such as substance abuse, nutrition, physical activity, sexual behaviour, and living, working and environmental conditions, paying special attention to inequalities in health;

- ◆ developing an **information system for the early warning, detection and surveillance of health threats**, both on communicable diseases, including with regard to the danger of cross-border spread of diseases (including resistant pathogens), and on non-communicable diseases;
- ◆ improving the **system for the transfer and sharing of information and health data** including public access and by improving analysis of **health policy developments** and of other Community policies and activities.

B. to enhance the capability of responding rapidly and in a coordinated fashion to threats to health; that is to be reached by following types of measures:

- ◆ enhancing the capacity to **tackle communicable diseases** by supporting the further implementation of Decision No 2119/98/EC on the *Community network on the epidemiological*

surveillance and control of communicable diseases;

- ◆ supporting the network's operation in relation to common investigations, training, continuous assessment, quality assurance
- ◆ developing strategies and mechanisms for preventing, exchanging information on and responding to non-communicable **disease threats, including gender-specific health threats and rare diseases**
- ◆ exchanging information concerning strategies in order to **counter health threats from physical, chemical or biological sources in emergency situations**
- ◆ exchanging information on **vaccination and immunisation strategies**;
- ◆ enhancing the **safety and quality of organs and substances of human origin, including blood, blood components and blood precursors**
- ◆ implementing vigilance networks for human products, such as **blood, blood components and blood precursors**;
- ◆ developing strategies for **reducing antibiotic resistance**.

C. to promote health and prevent disease through addressing health determinants across all policies and activities; that is to be reached by following types of measures:

- ◆ preparing and implementing strategies and measures, including those related to public awareness, on **life-style related health**

determinants, such as nutrition, physical activity, tobacco, alcohol, drugs and other substances and on mental health, including measures to take in all Community policies and age- and gender-specific strategies;

- ◆ analysing the situation and **developing strategies on social and economic health determinants,** in order to identify and **combat inequalities in health and to assess the impact of social and economic factors on health;**
- ◆ analysing the situation and developing strategies on **health determinants related to the environment**
- ◆ analysing the situation and exchange information **on genetic determinants and the use of genetic screening;**
- ◆ developing methods to evaluate quality and efficiency of health promotion strategies and measures;
- ◆ encouraging relevant training activities related to the above measures.

6.3. Future

Programme for Community Action in the Field of Health 2007-2013

The new Community Action in the field of Health sets three broad objectives. These objectives align future health action with the overall Community objectives of prosperity, solidarity and security. This will

help to create synergies with other Community programmes and policies – which is inevitable as health issues and their origins derive from existing environment, society and economy. It is to form a continuum for predeceasing programme 2003-3008. The objectives of new programme are to:

1. Improve citizens' health security

- ◆ to protect citizens against health threats including working to develop EU and Member State capacity to respond to threats
- ◆ to cover actions such as those in the field of patient safety, injuries and accidents, and community legislation on blood, tissues and cells and in relation to the International Health Regulation.

2. Promote health for prosperity and solidarity

- ◆ to foster healthy active ageing and to help bridge inequalities, with a particular emphasis on the newer Member States.
- ◆ to incorporate action to foster cooperation between health systems on cross-border issues such as patient mobility and health professionals.
- ◆ to cover action on health determinants such as nutrition, alcohol, tobacco and drug consumption as well as the quality of social and physical environments.

3. Generate and disseminate health knowledge

- ◆ to exchange knowledge and best practice in areas where the Community can provide genuine added-value in bringing together expertise from different countries, e.g. rare diseases and cross-border issues related to cooperation between health systems
- ◆ to cover key issues of common interest to all Member States such as mental health.
- ◆ to expand EU health monitoring and develop indicators and tools as well as ways of disseminating information to citizens in a user-friendly manner, such as the health portal.

Despite being reduced in scope compared to the original proposal, the modified Programme proposal is broad enough to be able to accommodate key health issues as well as those which may arise unexpectedly and need urgent attention.

Glossary

Family physician (perearst) – a specialist who has acquired the corresponding speciality and who practices on the basis of the practice list of the family physician, or as a specialist without a practice list.

Health care professionals (tervishoiutöötajad) – doctors, dentists, nurses and midwives if they are registered with the Health Care Board

Health care providers (tervishoiutenuse osutajad) – health care professionals or legal persons providing health services.

Health care services (tervishoiuteenus) – the activities of health care professionals for the prevention, diagnosis or treatment of diseases, injuries or intoxication in order to reduce the malaise of persons, prevent the deterioration of their state of health or development of the diseases, and restore their health.

Mentoring (mentorlus) – career development through role modeling, networking, interpersonal support, and teaching.

Nursing (õendus) – out-patient or in-patient health services which are provided by nurses and midwives together with family physicians, specialists or dentists, or independently.

Nursing process (õendusprotsess) – fundamental method using assessment, planning, interventions, and evaluation to deliver care.

Practice list of a family physician (perearsti nimistu) – a list of persons who are to be serviced by the family physician.

Specialised medical care (eriarstiabi) – out-patient or in-patient health services which are provided by specialists or dentists and health care professionals working together with them.

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Chapter 6.

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Amended proposal for a DECISION OF THE EUROPEAN
PARLIAMENT AND OF THE COUNCIL establishing a second
Programme of Community action in the field of Health
Brussels, 24.5.2006/ COM(2006) 234 final/ 2004/0042 A (COD)

http://ec.europa.eu/health/ph_overview/pgm2007_2013_en.htm

Annex 1.

Table 3. Example of nursing care plan for a patient undergoing hip joint replacement surgery.

Problem	Aim of the nursing care	Nursing activity	Evaluation
Pain, caused by surgery	No pain or pain < 2 according to VAS No signs of shock caused by pain	Assess pain severity using VAS Give morphine 10mg as prescribed every 4 hours Assess pain relief 30 minutes after administration of morphine Follow side effects of morphine Measure temperature, pulse, blood pressure and observe pulse oximetry every 4 hours	Pain severity 1 according to VAS No signs of shock
Risk for postoperative urinary retention, caused by laying after surgery	No urinary retention	Monitor and record urine output hourly In case of no retention remove urinary catheter 24 hours postoperatively Encourage patient to drink fluid to avoid dehydration	No urinary retention
Risk of infection, caused by surgery and little physical activity	No infection Patient understands the importance of physical activity and breathing exercises	Show the right technique of deep breathing exercises and explain the importance of exercises to prevent the accumulation of secretions in the lungs which can lead to chest infections.	No signs of infection Patient can perform deep breathing exercises and understands their importance
Risk of developing pressure ulcers, caused by little physical activity	No pressure ulcers	Assess the risk of pressure ulcers. Explain the importance of rigid nutrition and physical activity. Assess skin integrity.	No pressure ulcers
Little physical activity, caused by pain	No pain or pain < 2 according to VAS Patient performs physical exercises and understands the importance of physical activity	Assess pain severity using VAS Give morphine 10mg as prescribed every 4 hours Assess pain relief 30 minutes after administration of morphine Follow side effects of morphine Teach patient quadriceps exercises: tightening the thigh muscle and pushing the knee backward into the bed, and help to stabilise the knee Teach patient how to perform ankle rotation and ankle flexion, which helps to prevent pooling of blood in the calf veins leading to deep vein thrombosis	Pain severity 1 according to VAS Patient can perform the exercises and understands their importance.
Overweight, caused by imbalanced nutrition and knowledge deficit	Patient understands the importance of weight loss Patient knows the principles of balanced nutrition	Consult with dietician Teach to reduce fat, potassium, cholesterol, fluids and calories according to the needs Explain the importance of weight loss and physical activity	Patient understands the importance of weight loss, principles of nutrition and physical activity
Anxiety over prosthesis, caused by little knowledge	No anxiety	Give patient and family total information about prosthesis, about limitations in everyday life and how to adjust furniture	No anxiety

Care Work and Nursing at Hospitals and Health Centres – Estonia

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