2010/2011

Estonian Human Development Report

Baltic Way(s) of Human Development: Twenty Years On

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Tallinn 2011

change are taken together, and it demonstrates only modest signs of recovery. The situation will hardly improve in future because of changes in population structures and the limited number of young people. Latvia will be one of the most quickly shrinking populations in Europe. Furthermore, current low fertility and continuous outmigration does not allow, despite improving life expectancy, for minimal improvement of this situation. Latvia will suffer from the highest population loss from the Baltic states in future.

Lithuania

Lithuania was least influenced by external forces in population development before the 1990s. Lithuania lost only 6% of its working age population in the last 20 years and the demographic history of this country has been the most stable, in comparison to the other Baltic states. Because of its smaller share of immigrant population, the outmigration was less apparent at the beginning of the 1990s. Despite the favourable beginning to the transition period, Lithuania could not hold this position during the 21st century, and there has been very little progress in the past 10 years. Emigration is the main source of population decline in the long term. Also, the hope of the country is in its emigration population. If the majority of them return from the foreign labour market, the demographic situation will improve. In the near future, the country might face high unemployment and accelerated outmigration or economic prosperity because of the increasing share of the working population.

This brief overview revealed that all three Baltic states will also face substantial demographic challenges in the future. The sharp fertility decline in the 1990s will also influence future population development. Namely, smaller birth cohorts for the transition period will define the absolute number of births in the future, and population decline will continue in all three countries. The situation in Estonia will be especially severe due to the small number of total population (1.3 million in 2010), which will set special challenges to the markets and the effective functioning of public administrative systems, but absolute decline will be steepest in Latvia. The economic outlook, population policies and general attitudes have an essential role in the future development of countries.

2.3. Life expectancy and mortality – achievements and challenges

Juris Krumins

Introduction

Life expectancy is a summary measure of health and mortality, and one of the components of human development index. It reflects the overall level of socio-economic development and has an impact on the reproduction of the population, ensuring the vital capacity of the labour force and on security in retirement ages. This chapter gives an overview of factors behind the mortality change in the Baltic states, compared with Poland, Finland, Sweden, Belarus and Russia.

Life expectancy trends

The current diversity in socio-economic trends across Europe has been determined, to a large extent, by diverse patterns of health and mortality since the mid-1960s and with a considerable clear-cut division along pre-1990 political borders (Meslé 2004, Nolte et al 2005). Since the collapse of the former USSR, the renewal of independence and market-based developments, health indicators have undergone diverse patterns between neighbouring countries in the Baltic Sea region and even between the three Baltic states (Katus & Puur 2003). Since the mid-1960s, life expectancy stagnated or even declined in the Baltic states (Krumins 1994). In 1990, the life expectancy in Estonia was 69.9, Latvia 69.5 and Lithuania 71.6 years and was only on the level of the mid-1970s. The fast transition to the market economy, the worsening of the macroeconomic situation and a decline in living standards caused life expectancy to decrease in many countries of the post-communist space at the beginning of the 1990s. The Baltic states and all other republics of the former USSR faced a particularly sharp decline. From 1990 to 1995, life expectancy for both sexes fell by 2.2 years in Estonia, 2.4 years in Lithuania and 3.2 years in Latvia (Figures 2.3.1 and 2.3.2). Psychosocial stress was found as the most plausible explanation for the health crisis in Latvia at the beginning of the transition to the market economy. Also, unemployment appeared to be an important source of stress, particularly because due to its highly unequal distribution across age groups, gender, regions, levels of education, and other socio-demographic characteristics (Krumins & Usackis 2000).

Figure 2.3.1. Female life expectancy at birth

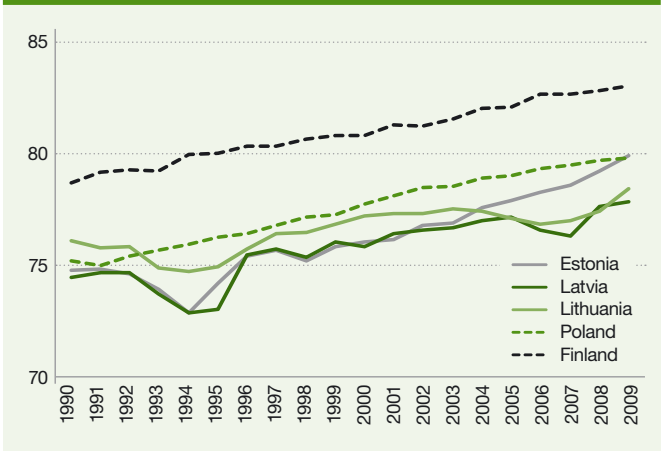


Figure 2.3.2. Male life expectancy at birth

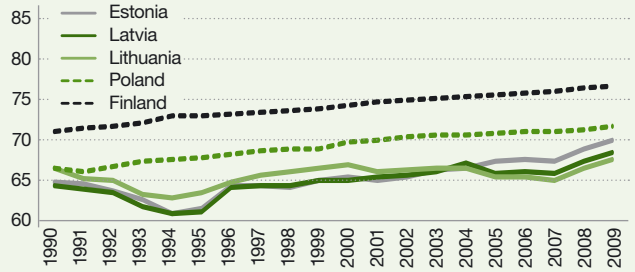


Table 2.3.1. Male life expectancy at birth (Eo)

Countries	Eo, years		Changes 1990–2009	
	1990	2009	years	%
Estonia	64.68	69.84	5.16	8.0
Latvia	64.18	68.31	4.13	6.4
Lithuania	66.52	67.51	0.99	1.5
Poland	66.57	71.34*	4.77	7.2
Finland	71.02	76.74	5.72	8.1
Sweden	74.93	79.29*	4.36	5.8
Belarus	66.26	64.61**	–1.65	–2.5
Russia	63.79	60.47***	–3.32	–5.2
EU members before 2004	73.04	77.97	4.93	6.7
New EU members after 2003	66.76	70.99	4.23	6.3
CIS	64.75	62.77*	–1.98	–3.1

*Note: * 2008, ** 2007, *** 2006*

Calculations based on the European Health for All Database (HFA-DB). WHO Europe; latest data available from the national statistical offices.

Table 2.3.2. Female life expectancy at birth (Eo)

Countries	Eo, years		Changes 1990–2009	
	1990	2009	years	%
Estonia	74.97	80.07	5.10	6.8
Latvia	74.63	78.09	3.46	4.6
Lithuania	76.36	78.56	2.20	2.9
Poland	75.63	80.11*	4.48	5.9
Finland	79.07	83.56	4.49	5.7
Sweden	80.65	83.36*	2.71	3.4
Belarus	75.84	76.25**	0.41	0.5
Russia	74.42	73.27***	–1.15	–1.5
EU members before 2004	79.79	83.47	3.68	4.6
New EU members after 2003	74.92	79.12	4.20	5.6
CIS	74.33	73.63*	–0.70	–0.9

*Note: * 2008, ** 2007, *** 2006*

Calculations based on the European Health for All Database (HFA-DB). WHO Europe; latest data available from the national statistical offices.

In the following years, the situation improved significantly – decline was replaced by growth. The life expectancy level of 1990 was surpassed in Estonia in 1996, in Latvia in 1998, but not until 1999 in Lithuania. The situation continued to improve at the beginning of 21st century, but not so fast as has been expected. A total growth in life expectancy during the last twenty years among the three Baltic states was highest in Estonia, followed by Latvia and Lithuania (Table 2.3.1 and 2.3.2). The life expectancy increase for men and women in Estonia was even higher than the average increase in the new and old EU member states. Lithuania lost the leading position among the Baltic states due to limited improvement in the last twenty years and it had the lowest life expectancy among the Baltic states in 2009. Latvia remained in-between its two neighbours.

The least improvement was achieved in male life expectancy. Male life expectancy in the Baltic states presently is substantially lower (by 8–10 years) than in the old EU member states and is lagging behind, by 1–3 years, the average of the new EU member states that joined the EU in 2004 and later.

The absolute and relative growth in male life expectancy from 1990–2009 exceeds the growth in female life expectancy (see Table 2.3.1 and 2.3.2). This is a general trend for both the old and new EU member states, excluding Lithuania. The life expectancy increase for men in the Baltic states in the past twenty years align a middle trajectory between the most successful Eastern and Central European countries (Slovenia, Czech Republic, Poland) and those lagging behind – Belarus, Russian Federation, Ukraine and Moldova. The increase in women's life expectancy in the Baltic states is more favourable and is approaching the average level of the new EU member states. Estonia has already surpassed the mean of female life expectancy of new EU member states since 2003.

Changes of mortality by age

Trends in aggregate indicators such as life expectancy should be supplemented by age-specific mortality rates demonstrating diverse changes in mortality for different age groups. Nowadays, the traditionally higher impact of infant and child mortality on life expectancy has been replaced by the growing role of mortality in the working ages.

Since the mid-1990s, infant mortality in all three Baltic states has shown a continuous downward trend. Also, the under-5 mortality rate from 1990–2008 has declined in Estonia 2.6 times, and in Latvia and Lithuania 1.9 times. However, its level still exceeds the under-5 mortality rate in Finland and Sweden by 2–3 times, although it is lower than in Belarus and Russia (Table 2.3.3).

The significant impact on life expectancy changes in all transition countries has been determined by age-specific mortality changes in the working ages (Vallin et al 2001). The three Baltic states are not exceptions, but there are some differences among them. In Estonia, both for men and women, the probability of dying during working ages has declined, as in Poland, Finland and Sweden. In Latvia, the slight decline is only observed for women (Table 2.3.4). On the contrary, Lithuania demonstrates an increase in mortality in working ages for both men and women, as in Belarus and Russia.

The impact of recent mortality pattern on life expectancy can be characterized by the reduction of life expectancy through deaths before the age of 65 (in years). Countries according to the descending order of that indicator are as follows – Russia 12.3, Belarus 9.3, Latvia 8.5, Lithuania 8.2, Estonia 7.5, Poland 6.6, Finland 4.6 and Sweden 3.3. These figures reflex inequality to face death among

mentioned populations and indirectly demonstrate how achievable lower indexes of mortality can be due to progress in the reduction of avoidable mortality. More favourable socio-economic growth plays a significant role in it.

Healthy life expectancy

From the point of quality of life, it is important to take into account not only fatal but also non-fatal health outcomes. Such an integrated measure of health and mortality is disability-adjusted life expectancy, also called healthy life expectancy, which is based on the life tables for each country, surveys assessing physical and cognitive disability and general health status as well as detailed information on the epidemiology of the major disabling conditions in each country.

The last available indicator of healthy life expectancy in the three Baltic states was below the average of new EU member states by 1–4 years, but the difference with the old EU member states is remarkable: 7–10 years in 2007. Healthy life expectancies demonstrate almost the same sequence as that of conventional life expectancies in the respective year. The value of female and male healthy life expectancy in 2007 is higher in Estonia than in Lithuania and Latvia and is lower than in Finland or Sweden (Table 2.3.5).

Female healthy life expectancy in Estonia, Latvia and Lithuania exceeds significantly – more than 9 years – the healthy life expectancy of men. In Sweden, this difference is 2.6 years, but in Russia it is almost 11 years.

The proportion of healthy life from the total life expectancy in 2007 for the Baltic states ranged from 88–91%. For men, that share was 1–2 percentage points higher than for women. It allows us to conclude that men's self-assessed life is little bit healthier than women's.

Causes of death

The three main groups of causes of death determine the majority of overall changes in mortality and life expectancy – diseases of the circulatory system, cancer and external causes of death. More than 4/5 of all deceased are attributed to these three groups of causes.

Death due to circulatory system illness peaked in the mid-1990s in all three Baltic states (Krumins 2003). From the mid-1990s, a renewed general downward trend of mortality from the diseases of the circulatory system both for men and women (Figure 2.3.3 and 2.3.4) has become apparent in all three Baltic states. The traditionally lower levels of mortality from circulatory system began to increase once again in Lithuania at the turn of the 21st century, and these have only demonstrated a decline since 2006. The Baltic states are holding the medium position in terms of circulatory system deaths between Russia and Belarus with rather high mortality and the old EU member states, which demonstrate a continuing sustainable linear decline in cardiovascular mortality.

The situation is much more varied in the group of malignant neoplasms (Figure 2.3.5 and 2.3.6). Male mortality from this particular cause of death is high and rather stable in all of the three Baltic states, exceeding the average mortality level of the new EU member states and demonstrating an increasing gap with the EU old member states. For women in the Baltic states, mortality trends

Table 2.3.3. Under-5 mortality rate (probability of dying by the age of 5 per 1,000 live births)

	1990	2000	2008	2008 compared with 1990 (%)
Estonia	16	11	6	38
Latvia	17	13	9	53
Lithuania	13	11	7	54
Poland	18	9	7	39
Finland	7	4	3	43
Sweden	7	4	3	43
Belarus	24	17	13	54
Russia	21	20	11	52
WHO European region	32	22	14	44
Global	90	78	65	72

Calculations based on World Health Statistics 2010. Geneva: WHO 2010: 49, 51, 53, 55, 57.

Table 2.3.4. Probability of dying between the ages of 15 and 60 per 1,000 population

	Male				Female			
	1990	2000	2008	2008 compared with 1990 (%)	1990	2000	2008	2008 compared with 1990 (%)
Estonia	301	318	249	83	107	120	84	79
Latvia	311	320	311	100	118	117	115	97
Lithuania	287	293	314	109	107	103	114	107
Poland	263	216	205	78	102	86	77	75
Finland	183	143	129	70	70	63	57	81
Sweden	114	87	76	67	66	56	48	73
Belarus	282	354	330	117	107	125	111	104
Russia	318	445	396	125	117	161	147	126
WHO European region	215	229	208	97	97	98	90	93
Global	246	236	213	87	173	163	146	84

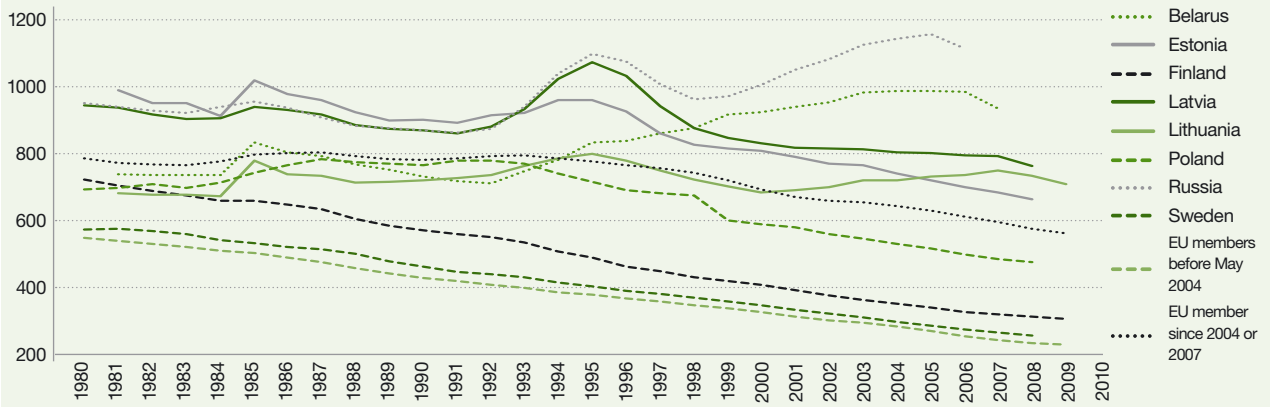
Calculations based on World Health Statistics 2010. Geneva: WHO 2010: 49, 51, 53, 55, 57.

Table 2.3.5. Healthy life expectancy (years), 2007

	Male	Female	Female over male	Average
Estonia	61.3	70.6	9.3	65.9
Latvia	59.2	68.4	9.2	63.8
Lithuania	58.3	67.8	9.5	63.0
Poland	64.1	70.2	6.1	67.1
Finland	69.6	74.7	5. 1	72.1
Sweden	72.3	74.9	2.6	73.6
Belarus	58.3	66.1	7.8	62.2
Russia	54.6	65.5	10.9	60.1
EU members before May 2004	...	...	...	73.0
EU members since 2004 or 2007	...	...	...	66.7
CIS	...	...	...	59.7
WHO European region	64	70	6	67
Global	58	61	3	59

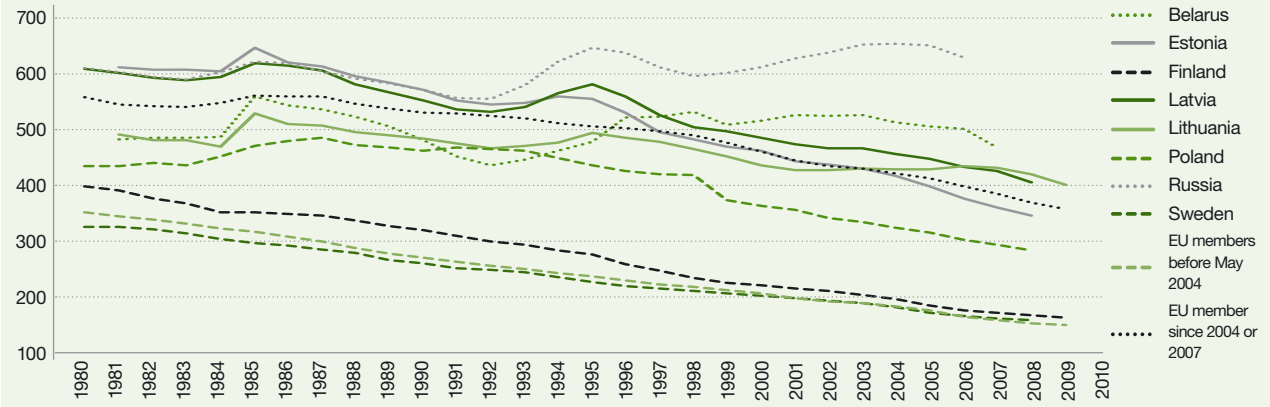
Source: European Health for All Database, latest data available from the national statistical offices. World Health Statistics 2010. Geneva: WHO 2010: 48, 50, 52, 54, 56. Estimates take into account the Global Burden of Disease estimates for the year 2004.

Figure 2.3.3. Standardized death rates for diseases of the circulatory system in selected countries for males



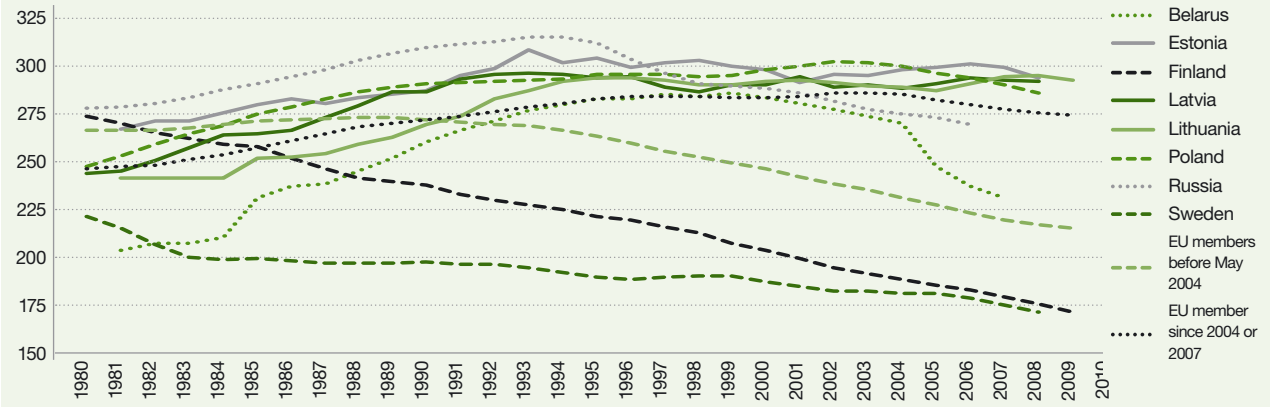
Source: European Health for All Database

Figure 2.3.4. Standardized death rates for diseases of the circulatory system in selected countries for females



Source: European Health for All Database

Figure 2.3.5. Standardized death rates for malignant neoplasms in selected countries for males

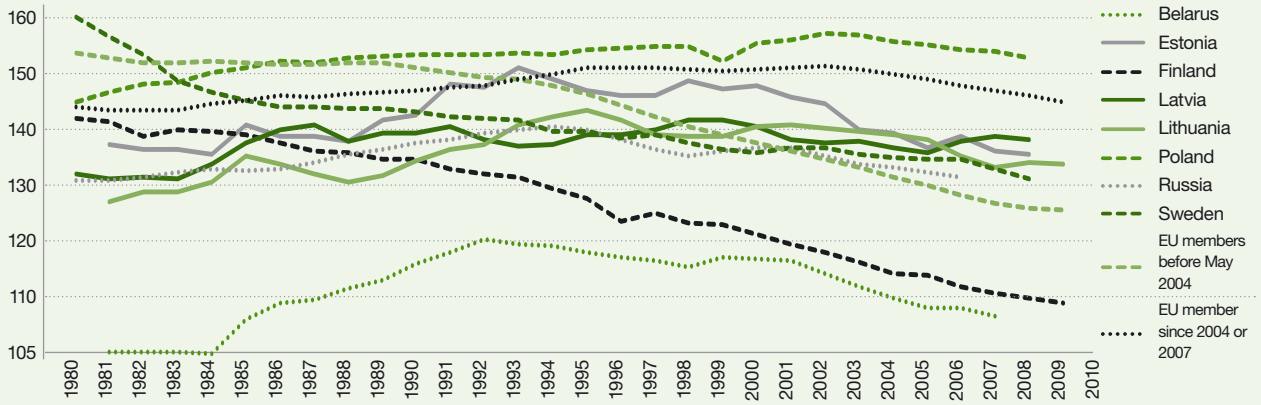


Source: European Health for All Database

from malignant neoplasms are more favourable, especially in Estonia, where achieved levels of female mortality are below average.

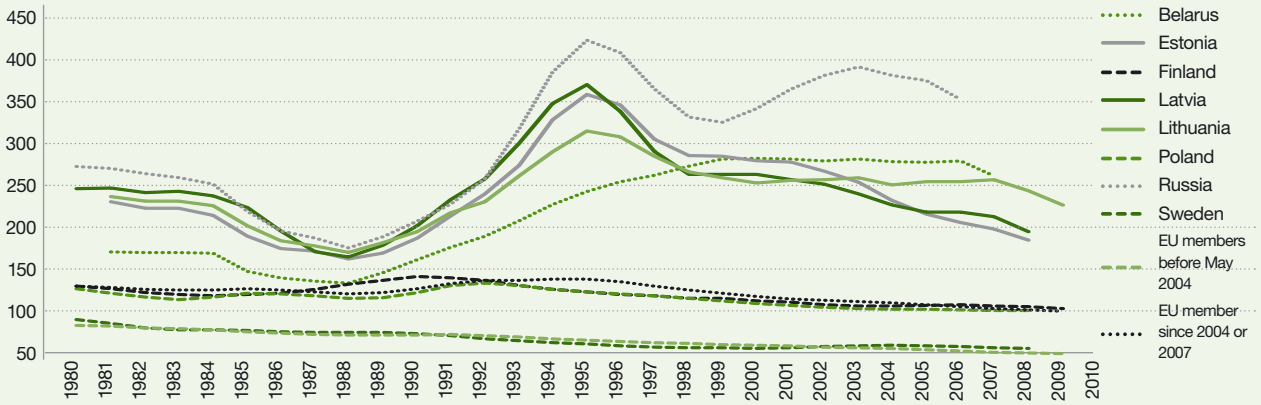
The most significant differences between the Baltic states and the new and old EU member states exist in mortality from external causes of death – injuries, traffic accidents, suicides, homicides and other (see Figure 2.3.7 and 2.3.8). Traditionally, males are more prone to this mortality type (Meslè & Hertrich 1999). Once again, a peak of deaths from external causes was very typical for the mid-

Figure 2.3.6. Standardized death rates for malignant neoplasms in selected countries for females



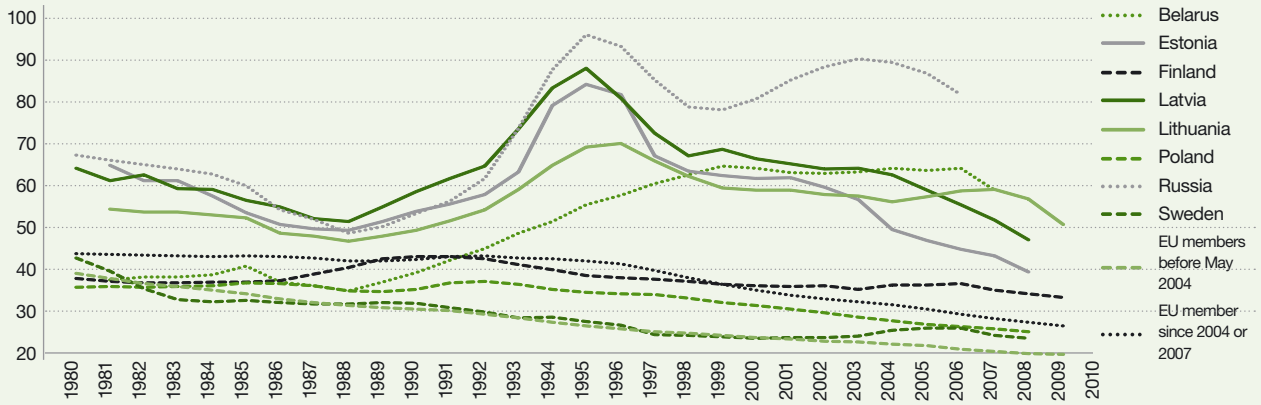
Source: European Health for All Database

Figure 2.3.7. Standardized death rates for external cause injury and poison in selected countries for males



Source: European Health for All Database

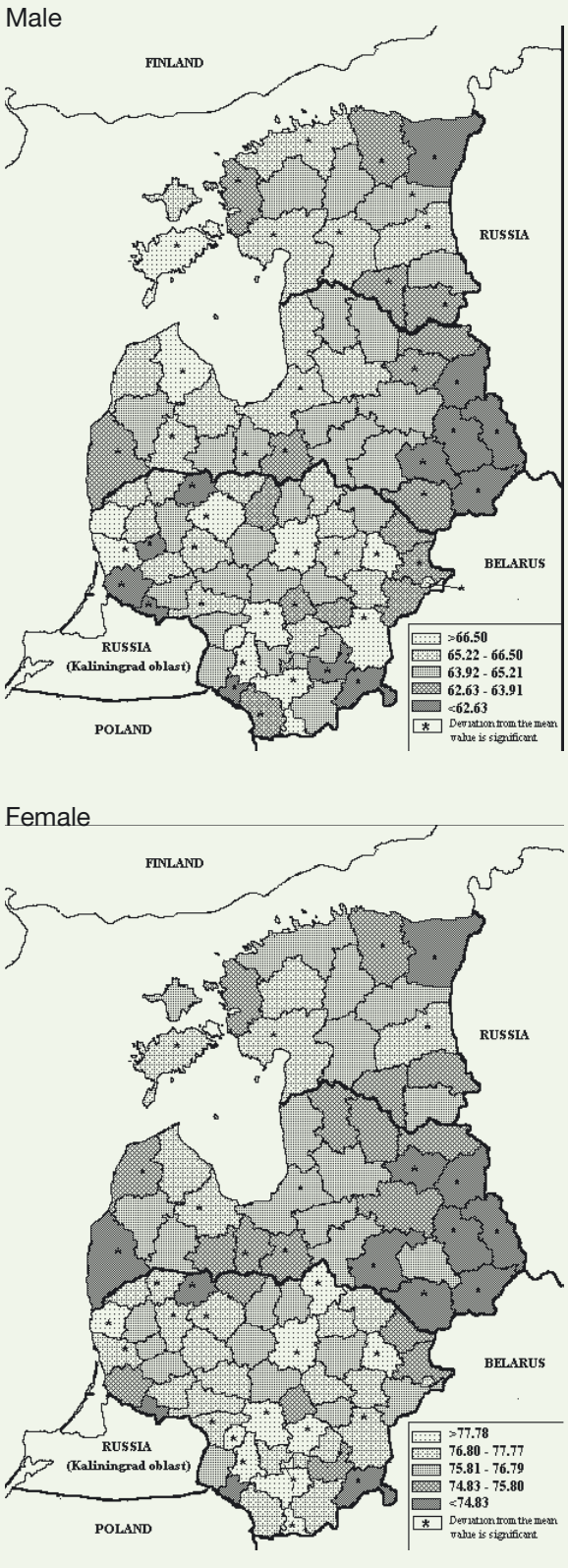
Figure 2.3.8. Standardized death rates for external cause injury and poison in selected countries for females



Source: European Health for All Database

1990s in all the Baltic states. From the mid-1990s, there is a decline among both men and women in mortality from external causes of death in all three Baltic states, which ceased in Lithuania with the turn of the new century. The Baltic states are again holding the medium position between Russia with high violent mortality and the new EU member states. It could take a long time and a significant effort for the Baltic states to reach the mortality level of the old EU member states for external causes of death, especially for the male population.

Figure 2.3.9. Life expectancy at birth for men and women, regional differences



Source: Krumins et al 2009

Geographical differences in mortality and life expectancy

Mortality is regionally quite dispersed in the Baltic states. A long and healthy life differs in accordance with place of residence. There are many factors behind regional differences in life expectancies – unsafe physical environment, socio-economic differences in population composition, material living conditions, behavioural risk factors, availability and quality of health services, amount and composition of in and out migration and other factors (Vallin et al 2001).

The geographical variations in mortality in the Baltic states received insufficient attention until now. Studies have been conducted on the regional disparities of mortality and morbidity in each country, but very little has been published on the three Baltic states together (Zaborskis et al 1995, Jozan & Prokhorskas 1997, Krumins et al 1999, Krumins et al 2006). Atlases on mortality (Eurostat 2002 and 2009) describe mortality at NUTS 2 level from 1994 to 1996 and 2002 to2004, but each Baltic state is represented only by one NUTS 2 region.

Administrative units in the Baltic states vary by surface area, number and composition of population. They also differ by their socio-economic characteristics and level of urbanization. Taking into consideration existing urban-rural differences in mortality, regional analyses of mortality can be performed in two ways. The first approach is based on the entire administrative units including towns. According to the second approach, towns are considered separately.

First, we studied the general mortality level by using the standard mortality ratio (SMR) for all causes of death and life expectancy indicators, followed by cause-specific standard mortality ratio analysis by administrative units. The mortality rates for period around the population censuses of 1998–2001 were taken as reference of mortality to study the geographical variations in the three countries (Figure 2.3.9).

The main conclusions from the regional analysis of mortality in the three Baltic states are the following. Mortality and life expectancy in the Baltic states is structured by a North-East to South-West axis. The eastern excess mortality pattern is rather strong in the eastern part of Latvia and the North-East of Estonia, while the Lithuanian profile finds some extension in Eastern Poland and West Belarus.

The geographical variation of mortality has increased during the period of socio-economic transition in the Baltic states, particularly from diseases of the circulatory system and slightly from neoplasms, but it has declined for external causes of death (Table 2.3.6). Geographical variations of mortality are the largest among exogenous causes of death (infectious diseases, respiratory diseases, violent deaths).

Additional analyses showed that there is a clear continuum running from the regions of high cardiovascular mortality in the north down to the regions of low mortality in the south. The prevalence of mortality from respiratory diseases varies in exactly the opposite direction. Cancer mortality does not reveal a geographical pattern. Cancer mortality is higher in the towns and cities than in the countryside. Everywhere in the towns, mortality for external causes is low, with a very narrow range of differences between them in all of the three Baltic states. The geographical variation of this group of causes is typically shaped by rural areas.

Mortality, as well as the assessment of general public health status by region, still strongly depends on the level of socio-economic development of the regions. Therefore, reforms only covering health care systems could not diminish geographical mortality differences. In order to accelerate the convergence of regional life expectancy lev-

els, greater attention should be paid to the reduction of geographical differences in the health of the population and to the impact of a broad range of policies that are related to public health.

Inequalities in the face of death

Inequalities in the face of death still continue to exist among population sub-groups. Some inequalities are rather stable, while some of them are changing in different ways (Stankuniene et al 1999, Monden 2004). One of the most analyzed and discussed phenomenon is the gap between **male and female** life expectancy. Despite its moderate decline since the mid-1990s, excess male mortality in the Baltic states is still a serious health and socio-economic issue affecting the reduction of the female-male life expectancy gap, which is slowly approaching the average level for the new EU member states, exceeding it by 1.7–2.9 years. In the old EU member states, female life expectancy excess has been systematically declining over the last twenty years – from 6.8 years in 1990 to 5.5 years in 2009. In the new EU member states that excess diminished insignificantly – from 8.2 to 8.1 years during the same period. The three Baltic states have one of the highest male to female life expectancy gaps in Europe. This gap has practically not changed (10.2 years) in Estonia; in Latvia it has decreased from 10.5 to 9.8 years, but in Lithuania it has even increased from 9.9 to 11.1 year over the last twenty years. In Iceland, the European country with the highest life expectancy (81.9 years in 2009), the female-male life expectancy gap has reached 3.9 years, while in Russia (the European country with the lowest life expectancy) it has increased from 10.6 to 12.8 years between 1990 and 2006.

Inherited from the Soviet period, **urban-rural** differences continue to be apparent in welfare, health and mortality. Rural excess mortality results in the urban-rural life expectancy gap, which in Latvia is rather stable: 2.0 years in 1990, 2.4 years in 2000 and 2.2 years in 2008 (CSB 2009). The urban life expectancy gap is higher among men (1.8–3.0 years) in comparison with women (0.9–1.3 years) in Latvia. The advantage of urban life is also observed in Lithuania, where the gap between urban and rural life expectancy in 2000 was 3.3 years, but in 2009 was 3.1 years (Statistics Lithuania 2011). In Estonia, there are no recent life table calculations separately for urban and rural population. In 1989, the urban-rural life expectancy gap for men in Estonia was 2.1 years and 1.7 years for women.

Urban-rural differences in mortality are mainly determined by the higher level of premature mortality due to external causes of death among rural males. For females, differences are caused by the higher mortality in older ages due to cardiovascular diseases in rural areas (Jasilionis 2003). Differences are mainly determined by the higher level of education of the urban population and the lower effectiveness of health care services and health policy measures in rural areas.

Educational inequalities are an important factor in explanations of mortality changes and differences in general and by particular groups of causes of death (Shkolnikov et al 2006, Ezendam et al 2008, Leinsalu et al 2009, Stirbu et al 2010). Large differences by education in mortality and life expectancy are present in all three Baltic states over the last twenty years. On the onset of the transition to the market economy, the gap between the higher educational level and primary education or less were 12.6 years for Latvian males at age 25 and 7.1 years for females of the same age (Krumins 1993). During the 1990s, the declining mortality of the higher educated and the rising mortality of the lower educated resulted in an enormous mortality gap in Estonia. In 2000, male graduates aged 25 could expect to live 13.1 years longer than corresponding men with the lowest education; among women, the difference was 8.6 years (Leinsalu et al 2003). In Lithuania, on the eve of 21st century, life expectancy at age 30 differed by 11.3 years between men with the highest and those with the lowest educational levels, mainly due to the excess mortality of the latter between 40 and 60 years of age (Jasilionis et al 2007).

Table 2.3.6. Absolute changes in geographical distribution of SMR in the Baltic states between 1987–1990 and 1998–2001 (+ increase; – decrease)

	Change	Standard deviation	Coefficient of variation
All causes	+0.27	+0.03	+2.9
CVD	+0.54	+0.03	+3.0
Neoplasms	+0.49	+0.01	+0.5
External causes	–0.52	–0.07	–3.3

Source: Krumins et al 2006: 109.

Socio-economic and political transformation has affected **ethnic differences** in mortality and life expectancy in multi-ethnic societies, including the Baltic states. The standardized life expectancy (by place of residence) of Latvians surpassed that indicator for the largest minority group – Russians – in Latvia at the end of the 1970s and 1980s by 1.7 years. The mortality gap between Latvians and Russians measured with age-standardized death rates has increased from 10 to 17 per cent for men from 1988 to 1995, and from 13 to 14 per cent for women for the same period (Krumins & Usackis 2000). Increasing ethnic differences are also typical for Estonia. In the period from 1989–2000, the advantage of Estonians in life expectancy increased from 0.4 to 6.1 years among men and from 0.6 to 3.5 years among women (Leinsalu et al 2004). In Lithuania with its more ethnically homogeneous population, the difference in life expectancy at age 30 among Lithuanians and Russians is 1.82, while among Lithuanians and Poles it is 3.15 years (Jasilionis et al 2007). Ethnic differences in mortality are partially attributed to differences in educational level and the urban-rural place of residence. Differences in life expectancy are mostly generated by cardiovascular diseases and external causes of death.

Differences between the most unfavourable and most favourable groups are huge. For example, from 2001 to 2004, the life expectancy gap at age 30 amounted to more than twenty years for men who had a higher education and were married, Lithuanian and living in an urban area (47.7 years) in comparison with men who had lower than secondary education and were non-married, non-Lithuanian and living in an urban area (27.3 years). The results are more than 15 years for women who had a higher education and were married, non-Lithuanian and living in an urban area (55.8), compared with women who had lower than secondary education and were non-married, non-Lithuanian and living in a rural area (40.0 years) (Jasilionis et al 2007).

Concluding remarks

We have reached a point when many of us are finding answers to questions such as: How successful was the advancement of the three Baltic states in the past twenty years in terms of human development, improvement of health and increase in life expectancy? Have we achieved more in comparison with the first decennials of independence during the 1920s and 1930s? Are the recent trends in mortality showing a break up with the Soviet-type excess mortality pattern and stagnating life expectancy? What are underlying factors behind the observed changes and policy implications?

Scholars from different fields and countries conduct intensive research in search of comprehensive answers to these issues. It is clear that one can find many explanations to cumulative process like mortality change in social development and people's health during the preceding decades. The Soviet health care system and social policy together with echoes from wars and post-war Stalinist repressions hindered the decline in mortality. Several countries (like Finland and Portugal) with a comparable or lower level of pre-war life expectancy outpaced the Baltic states during the post-war period.

The renewal of independence and the following period of market-led reforms and social transformations resulted in a further decline of mortality in all three Baltic states. Successive economic growth accompanied by growing social inequality predetermined a lasting or even growing socio-economic and demo-geographic differentiation of mortality.

The change in life expectancy in the three Baltic states in the last twenty years aligns to a middle trajectory between the most successful Eastern and Central European countries and those countries lagging behind. Estonia became a leader among the Baltic states in terms of life expectancy in recent years and Lithuania is lagging behind Estonia and Latvia. Cardiovascular diseases and violent deaths are still playing considerable role in excess mortality, especially for men.

Despite the increasing life expectancy, it would probably take a long time and a significant effort for the Baltic states to narrow the mortality and life expectancy gap with more advanced European countries, especially for the male population. The challenge for the coming decades is to find an answer to this. Let us repeat this comparative analysis in another twenty years!

2.4. Health care policy in the Baltic countries from 1990 to 2010

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Two decades ago, the Baltic countries emerged from an ineffective centralized system of health care financing and administration, which was mainly characterized by an over emphasis on the hospital-based approach. Since the beginning of the 1990s, fundamental health care reforms have been implemented in all three countries. The reforms have changed health care systems in the same direction, but they have also differed considerably in some key aspects. This paper discusses the health care reforms implemented in the Baltic countries and the health care choices made in regard to financing, infrastructure, the number of employees and the availability of health services.

Health care financing reforms

In Estonia, the Government of the Republic made a decision on 28 May 1990 to implement "insurance-based medicine",[17] and on 12 June 1991 the Republic of Estonia Health Insurance Act was adopted, creating a national health insurance system with the aim of "payment of the costs related to preserving the health of residents of the Republic of Estonia, the costs related to their temporary incapacity for work and their medical treatment as a result of illness or injury, and benefits in the event of pregnancy and childbirth".[18] In the same year, a regulation on the organization of health care services was also adopted[19], and the principles established in these two founding documents have, in essence, endured in Estonia to this day.

In 1991, Estonia had 22 local health insurance funds. In 1994, the number of local health insurance funds dropped to 17, and the Central Health Insurance Fund was established as a type of levelling fund controlled by the Health Insurance Council (made up of 15 members, including the representatives of the state, the employees and the employers). The consolidation of health care financing was finalized in 2002 with the establishment of the Estonian Health Insurance Fund, a public agency fully responsible for providing equal health insurance to all insured individuals. Throughout this time, the main source of financing for all health care services in Estonia has been the 13% tax on wages specifically earmarked for health care (as part of the social tax).

The principles of health care financing have been changed on multiple occasions in both Latvia and Lithuania. Latvia started out with the option of combined financing from the state and local government budgets and then moved on to central financing from the state budget in 1998, although various formulae were still used to combine specific sources of financing and the size of the budget, and 8 regional health insurance funds were

17 Interview with Georg Männik

18 12/06/1991 The Republic of Estonia Health Insurance Act * RT 1991, 23, 272

19 In the form of the 8 November 1991 Regulation on approval of the "Statutes of the health insurance fund", the "Procedure for the calculation and payment of compulsory health insurance benefits" and the "Procedure for the payment of health insurance contributions" * RT 1991, 41, 504