

Mental health services in Estonia

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Tartu

General information

- Independence reestablished 1991
- EU, NATO, Eurozone member state
- Population about 1,3 million, decreasing continuously
- State managed to maintain fiscal and economical balance during economical depression
- Main social problems: high unemployment rate, sustainability of services (medicine, social services), impact of inflation

Financing of mental health services

- Budget of the state (min. Of Social Welfare, min. Of Justice, health insurance), Budget of municipality ca 77,8%
- Private sector 22,2% (mainly household expenses ca 19%)
- National Health Account about 5,5% from GDP

Health Insurance

- Health Insurance Act from 1992 (new version from 2002)
- Health Insurance Fund is performing health insurance. Ca 94% of population is covered. Budget: 13% from social tax of employees salaries (33% as a whole)
- From covered persons 45% pay health insurance tax, state pays 4% and 51% are covered as equal to others
- Sick Fund has general budget and delivers resources according to population in region. Delivering resources to providers is more complex (historical principles and length of the queue)

- Mental Health Act: responsibilities of the state and municipality to provide psychiatric care
- Providing psychiatric care is licensed activity
- Preventive activities in mental health are managed from Ministry of Social Affairs
- Access to and availability of social services for people with mental health problems is the responsibility of municipality
- No assignment from family doctor is needed to apply to psychiatrist

Mental Health Act

The Mental Health Act was adopted on 1997. It establishes the criteria for involuntary treatment as well as several other regulations for the provision of psychiatric care.

Since 2007 patients falling under the involuntary hospitalisation criteria are under strict supervision of the court.

In 2007 15% of the hospitalised patients were admitted as involuntary and in 67% of the cases the court prolonged the hospitalisation beyond 48 hours.

Currently the drafting of the new mental health act has started, in order to improve the deficiencies of the existing legislation.

Patients do not have to pay neither for outpatient visits nor for inpatient care (except for a small fee 3.20 EUR) and most of the medication for treatment of psychosis and other severe mental disorders is also free of charge. Per prescription drugs (incl antidepressants, excl anxiolytics) are reimbursed for up to 50 % of the cost for one prescription but to the limit of 13 EUR.

That still heads to substantial expenses for the patient in long term and is often seen as a problem in the financing of health care. In comparison to other European countries Estonia has a relatively high (up to 26%) level of own contributions (medication and dental care being the leading areas).

Social care & mental health

- Social Care Act 1995, financed by budget of the state, delivered to municipalities according to real amount of persons needed and capability to provide services
- Mental health IS NOT political priority to the state. Project based activities (Mental Health Politics Basic Document from 2002) still waiting for further developments. No active public health projects or disorder prevention projects actually in progress

Main problematic areas in mental health (according to Basic Document)

- Increase and earlier appearance of psychiatric disorders
 - High suicidality
- Increase and earlier appearance of substance abuse and alcohol abuse disorders
 - Inhomogenous quality and accessibility to services, insufficient regulation for services
- Lack of coordination and financing of services, inefficient use of resources

Estonian Psychiatric Association

Estonian Psychiatric Association was established in 1989 as an independent society; the history however goes back to 1921, when the Association of Neurologists, Neurosurgeons and Psychiatrists was founded.

We currently have 230 members and 5 sections

biological psychiatry

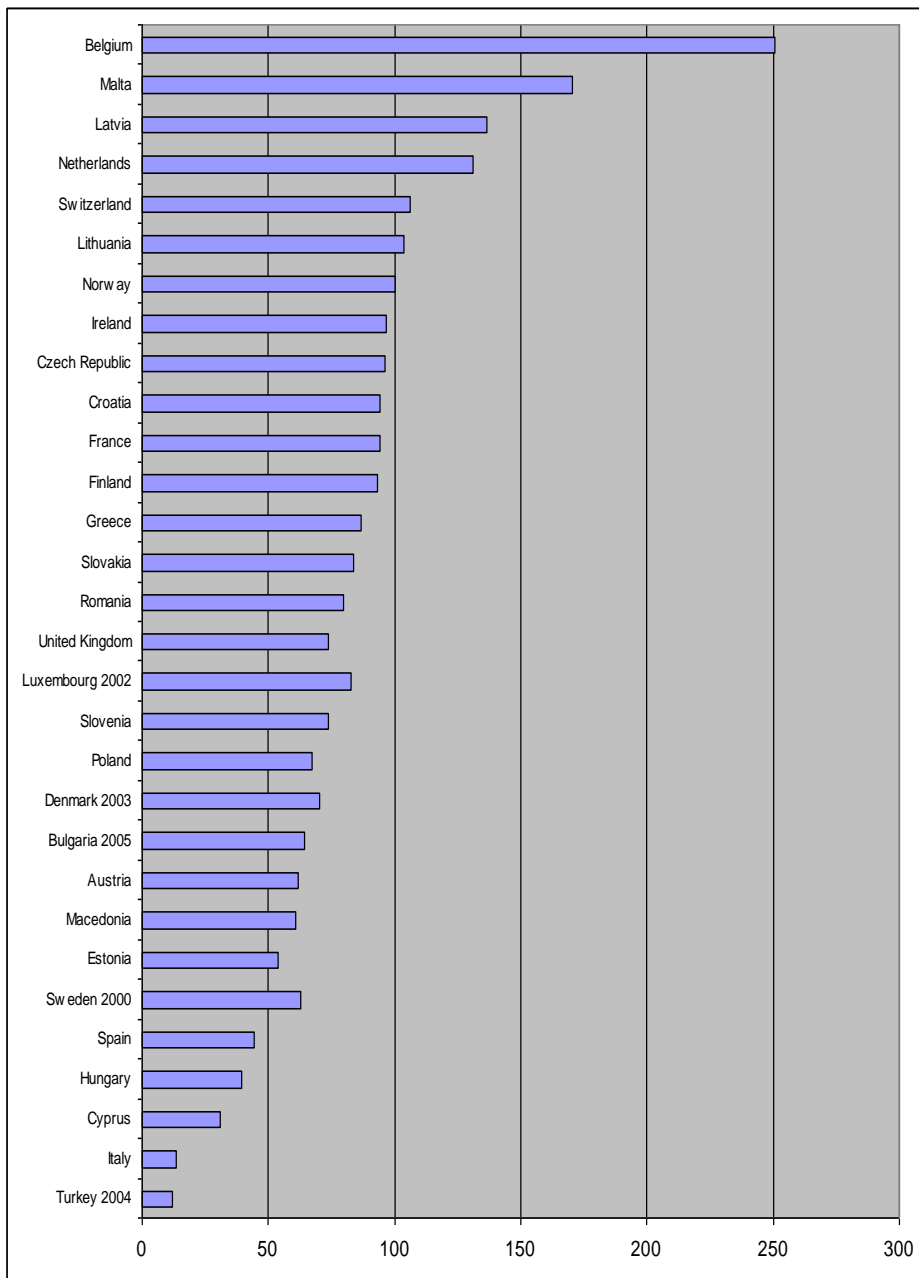
child- and adolescent psychiatry

forensic psychiatry

eating disorders

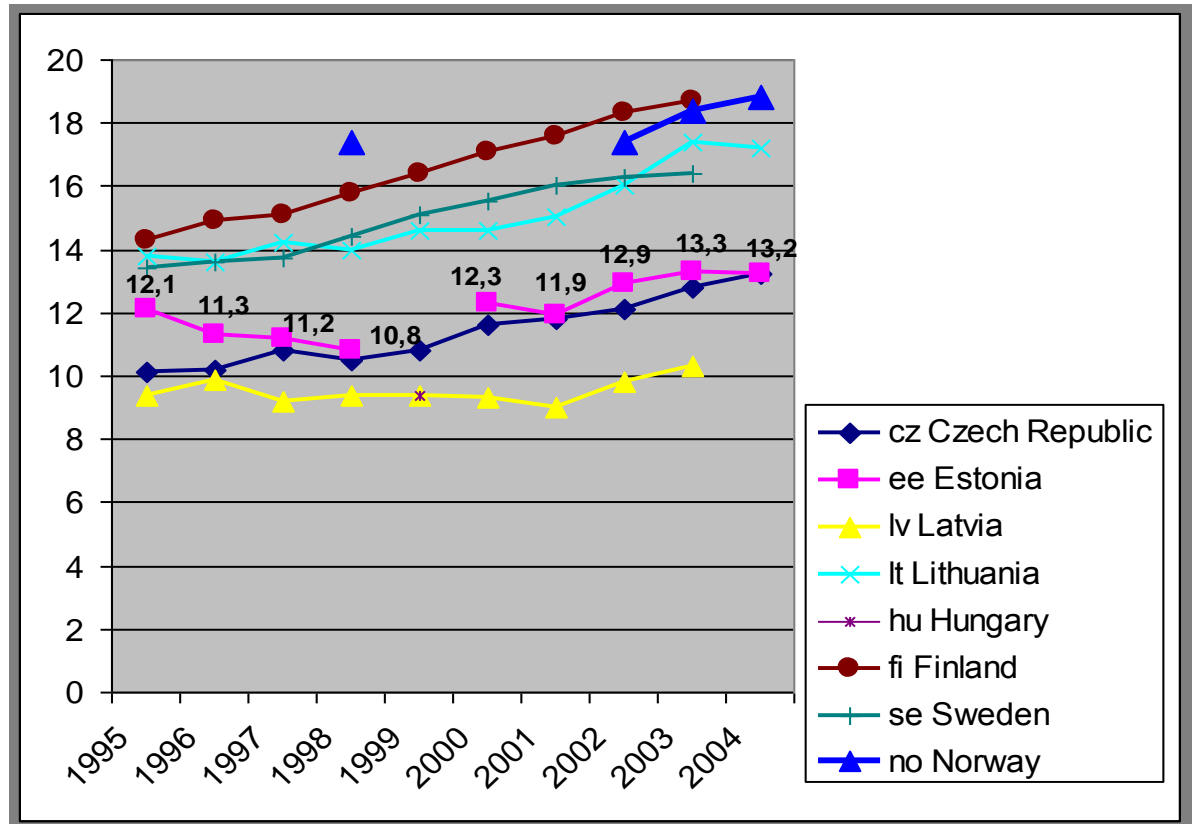
psychiatric trainee' section

We run a voluntary CME evaluation system (every 5 years)



In 1990 the number of psychiatric beds in Estonia was 2450. After that a fast decline started, due to reforms in the whole health care system . The number was 1550 in 1995 and 717 in 2008

- The main obstacle to the development of outpatient services is the shortage of psychiatrists. As can be seen from the figure, Estonia is lacking behind in comparison to Scandinavian countries.
- The difference is even bigger if we compare the numbers of psychiatric nurses, psychologists and social workers



Another clear problem is the free movement of labour. Since Estonia joined the European Union the principle of recognition of diplomas has made jobs in neighbouring countries (particularly Finland) very attractive for Estonian doctors.

For several years more than half of the psychiatric trainees obtained their first job after graduation outside Estonia.

Action plan for the future I

- Development plan for psychiatry, performed by our association, updated 2004, activity of the ministry, impact is questionable, but still the only valid document
- Main areas of concern: to provide adequate amount of specialists and maintain sustainable postgraduate education of psychiatrists incl children and adolescent specialists, psychiatric nurses and clinical psychologists

Action plan for the future II

- Develop and improve of accessibility of outpatient care and psychotherapy
- Improve of the conditions of hospital care
- Establish adequate care settings for nonstable/revolving door mentally ill patients
- Develop treatment settings providing integrative care and rehabilitation
- Develop children and adolescent psychiatry setting

Action plan for the future III

- Develop forensic psychiatry, provide adequate care in prisons, establish principles for outpatient forensic psychiatry
- Develop treatment and rehabilitation settings for substance abuse patients
- Develop liaison and elderly psychiatry

Conclusions

- Our efforts should stop outflow of young specialists abroad.
- Our association should act more in politics to set priorities of ministry and health insurance fund
- Availability, accessibility and too high working load have to be improved
- More joint activities with Nordic countries may improve knowledge and quality of our specialists