National Health Plan 2009–2020

2008 (amended 2012)

1. Introduction

People's health remarkably influences their capability to cope in daily life, their social and economic contribution to build a country, as well as the general success of a country. Thus, health is an important national resource deserving targeted and scheduled development. Also, the right to protect one's health belongs to the basic human rights and the necessary prerequisites to achieve the best possible state of health must be guaranteed to everyone – every Estonian must have a possibility to live in an environment supporting health and an opportunity to make healthy choices.

Sub-objectives (strategic objectives) are established in the National Health Plan (NHP) to maintain and continually improve the health of the nation. An important place among the priorities of the Government of the Republic belongs to positive birth rate of the nation and longer health adjusted life expectancy, and those directions also form the basis for all the objectives and activities described in the present NHP.

The development of Estonia in the past years regarding the public health and the state in general is positive. To mention just a few most important aspects, the economy has grown, the decrease in the number of people has decelerated, the birth rate has increased and the lifetime of people has extended. The improvement of the health indicators of the Estonian people, e.g. the extension of the average lifetime, has taken place quicker than the average of the European Union. The Estonian health system has become one of the most cost-efficient ones in Europe as a result of the development in the past ten years.

To ensure continually quick development, facilitation of health-behavioural choices, development of health-supporting environment and improvement of integration of the parts of the social protection and health care system have become more and more important in addition to former directions of priority.

The priorities of the NHP are based on our common values like solidarity between people, equal opportunities and justice, access to high-quality health care services and increasing power of civil society. We share those values with other members of the European Union and thus several scheduled pan-European activities support the efforts of Estonia in achievement of the new public health objectives.

The strategic general objective of the field in the NHP 2009–2020 is a longer health adjusted life expectancy by decreasing premature mortality and illnesses. The National Health Plan details five thematic fields concerning increasing of social cohesion and equal opportunities, ensuring healthy and safe development for children, shaping an environment supporting health, facilitation of healthy lifestyle and ensuring the sustainability of the health care system. Also the priorities, sub-objectives (strategic objectives) and sets of measures established for the fulfilment of the strategic field of the development plan have been presented by those thematic fields.

Through various work groups and public discussions, many people from a number of international organisations, ministries, county governments, local governments, non-government organisations, private sector and various groups of stakeholders, target and interest groups have participated in the preparation of the development plan. The contribution of all those people has been very valuable and critical both in determination of new tasks and finding solutions for those. As constant changes are taking place in public health, the NHP is a document subject to constant supplementation and updating, and the continuous contribution of us all is important for the creation and application of new visions to ensure the development of Estonia.

In years 2011 to 2012 discussions took place to draft an application plan for years 2013 to 2016. During the discussions it was decided that in order to obtain a better idea of public health activities the wording of measures needs to be changed, target levels of sub-

objectives must be adjusted and new indicators added. The structure of the general document is comprehensible and smooth, articulation of topics provides a good overview of future objectives. Every field highlights the main issues as well as solutions thereto through scheduled activities, and the sub-objectives of the development plan can be implemented in the best way to achieve the strategic objective - longer, healthier and better life of the people. As a result of organisation of the strategic management of the country, the framework document of the NHP is becoming a development document of the health field into which an increasing number of former development plans of separate areas are being integrated. Thus, the NHP includes the national strategy for prevention of drug addiction until year 2012, national strategy for tuberculosis control for years 2008 to 2012, national strategy for prevention of cardiovascular diseases for years 2005 to 2020 and national HIV and AIDS strategy for years 2006 to 2015.

2. Necessity of the NHP

Estonia is a successful country. It is proved by quick economic development until today, membership of Estonia in the European Union (EU) and in various other international organisations. Economic development has facilitated constant improvement of the population health since year 1994 when the health of the nation was at its worst in the nearest history according to various indicators of mortality, illnesses and health behaviour.

Since the beginning of 1990ies, several visions of health policy have been drafted in Estonia, and on March 2nd, 1995 a previously prepared document of health policy was approved by a recorded decision of the Government of the Republic. Both drafting of the health policy and the objectives established have shown direction to the subsequent programmes of public health and health care activities, and have significantly facilitated the improvement of public health established as a target. The document is part of a longer process of developing national health and the health policy – the existing documents on the health policy have been constantly updated and new vision documents have been drafted by various work groups and discussions. During years, several important policy and strategy documents have been drafted, offering solutions and prevention opportunities for new tasks. Those documents form a basis without which also the present development plan would not exist. The creation of the present development plan started when the Government of the Republic approved the proposal for preparation of National Health Development Plan for years 2008 to 2015 on October 13th, 2006. The development of the plan was based on the consensus vision document "National Health Policy "Investment in Health"" drafted in the same year that passed extensive public discussions in most of the counties and the Social Committee of Riigikogu.

Changes accompanying the development of the society and environment have subjected us to new tasks to be solved, and thus a need has emerged for a new National Health Plan that would help to avoid problems in public health caused by longer average life expectancy, changes in the traditional family model, free labour movement and many other issues. To solve the new tasks it is necessary to review the previously completed activities and add new approaches for maintenance and improvement of public health.

Healthy citizens form the basis for national development. The healthier a person the more he/she can contribute to the development of the society and economy. Riigikogu, Government of the Republic, local governments, the private sector, non-government organisations and every citizen can contribute to the improvement of public health. Thus, the present development plan is designed for all the members of the society.

3. Values of the NHP

Human rights

Health is the basic right of a human being, and all members of the society must be provided with prerequisites to achieve a state of health as good as possible. A right to health and protection thereof, a right to a safer living, working and psycho-social environment have been established in our constitution, the Treaty Establishing the European Community, the European Social Charter and several other international documents. Article 152 of the Treaty of Amsterdam of the European Union sets protection of health as the highest priority for all decisions, projects and programmes that can influence the health of a person.

Joint responsibility for health

All political, economic or other decisions influence the health of a person and a nation to a greater or smaller degree. Responsibility for the health of a nation is joint responsibility concerning all sectors, organisations, groups and individuals of a society, and it forms a basis to the development of balanced environment, social and economic policy. Therefore, consideration of health impacts must be part of the decisions and planning of activities of all sectors and levels of society.

Equal opportunities and justice

Equal opportunities of health and other values are ideals of a democratic society. The National Health Plan is also aimed at achieving those ideals, helping to decrease the systematic differences in health indicators of the nation based on inequity, supporting the most vulnerable groups of the society by cooperation between various sectors and levels. Creation of equal opportunities in education, housing, work and health and health care services regardless of gender, nationality and social position is the prerequisite for continuous improvement in the health and quality of life of the people in Estonia.

Social inclusion

Active participation of persons, social groups and communities in making decisions and solving problems regarding themselves, their home area, the life of society and the environment will empower them and facilitate greater capability of solving one's health problems independently. Development of society aimed at healthy choices, empowerment of localities and an increase in social capital form a basis for development of health-supporting living environment.

Basing on evidence

Implementation of the directions of the National Health Plan relies on evidence-based knowledge for more efficient and transparent planning of resources. Scientific research helps to establish objectives for the national development plan and measure the achievement thereof, and supports the decision-makers in their work. Basing on evidence is one of the corner stones of the strategic development plans of the country and a factor supporting the balanced implementation thereof.

Considering international documents

The NHP follows the ideas of many international initiatives like the Almaty Declaration (1978), Ottawa Charter (1986), Jakarta Declaration (1997), UN Convention on the Rights of the Child (1989), European Social Charter (2000), Charter of Fundamental Rights of the EU

(2000), Lisbon Strategy (2000), Health Strategy of the EU 2008–2013 (2007), European Charter of Patients' rights (2002), European Environment and Health Strategy 2004–2010 (2004), European strategy for child and adolescent health and development of the WHO (2005), health for all policy framework of the WHO (2005), joint strategy of the European Union and the WHO "Health in All Policies" (2007), health strategy of the European Commission 2008–2013 "Together for Health" (2007) and other internationally recognised health documents.

4. Current situation

Population

At the beginning of year 2007, Estonia had 1.34 million inhabitants. Over a half of those were women, about one fourth under 20 years of age, over two thirds lived in town-like settlements, over two thirds were Estonian and over 80% were Estonian citizens. The preceding year was again characterized by a decrease in population, as the number of deaths exceeded the number of births, regardless of continuous increase in the number of births and decrease in the number of deaths. If the present situation continues, an increase in the population may be expected soonest after year 2013. even though due to a low birth rate of the past 15 years it may remain short-lived or even be postponed.

An estimated life expectancy in Estonia was 73 years in 2006, and if the positive developments of the past five years continue, we will reach the average level of the EU in 10–20 years, At the same time it is possible to accelerate the achievement of the average level of the EU, decreasing inequalities between different population groups. In 2006, the estimated life expectancy of men was 11 years shorter than that of women, and the difference has remained at approximately the same level since 1996. During the same period, the gender-based inequality of life expectancy in the European Union has decreased, and is currently almost twice smaller than in Estonia.

Differences based on education and other factors come in addition to the gender-based differences in life expectancy; for example, a woman with higher education is expected to live 13 years longer than a man with basic education.

Economy, employment and poverty

Since year 1995, the Estonian economy has developed well: employment rate and incomes have increased and unemployment and the share of persons living below the poverty threshold has decreased. For example, unemployment in 2006 was only 5.9% and 12.4% of families and 16.8% of children aged 0–15 lived below the poverty threshold.

At the same time, with positive changes the financial inequality between social strata has increased, being above the average of the European Union in Estonia in 2006. Personal expenses of people on health care (e.g. on dental care and medicines) have increased, deepening the impacts of financial inequality and increasing the part of society exposed to the risk of poverty due to health problems.

A combination of those factors with possible decrease in employment and incomes caused by the estimated deceleration of economic growth may bring along an increase in the number of persons living below the absolute poverty threshold due to health problems. Such a situation is most likely to occur in areas with the biggest unemployment, e.g. Ida-Viru County, and among more vulnerable groups of population, e.g. children and adolescent, old people, people with chronic diseases and families with a single parent.

Health Care

The efficiency and cost-efficiency of the Estonian health care system are good. In addition to national statistics, also independent international surveys, e.g. *Euro Health Consumer Index*, EHCI)[1], refer to that, according to which Estonia was among the best of the European Union regarding the expenses and health gain obtained in 2007.

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[1] Health Consumer Powerhouse. (2007). Euro Health Consumer Index 2007. Stockholm: Health Consumer Powerhouse.
http://www.healthpowerhouse.com/media/Rapport_EHCI_2007.pdf

The cost-efficiency of the health care system has increased year after year. It is indicated by an increase in the share of out-patient treatment and continuous development of the system of family physicians that has also facilitated the increasing efficiency of in-patient treatment. Development of the general health care system is, for instance, also indicated by a quick decrease in infant mortality to the average level of the EU. In 1995 the difference was still almost double.

In years, the health care system has become more patient-friendly. The Ministry of Social Affairs has organised satisfaction surveys in cooperation with the Estonian Health Insurance Fund since year 2000. The results of those surveys show that access to health services has improved and satisfaction with the services obtained has increased, even considering the continually increasing social expectations.

At the same time, continuous urbanisation, ageing of people and other factors may bring along problems of availability of health care service in the future, especially in rural areas and among less privileged people.

Health behaviour

In Estonia, the mortality of young people has continually decreased and so far the prevalence of chronic diseases has been small. Still, health behavioural choices made in youth significantly influence the health state of a person later in life. It must be admitted that from mid-1990ies the health behaviour of adolescents has remarkably deteriorated.

The share of adolescents who smoke and administer alcohol and narcotic substances has continually increased and the level of injuries among young people is still high: in 2006, 92 children and young people of age up to 19 died because of accidents, poisoning and traumas. At the same time physical activity of young people has decreased and unbalanced eating as well as body weight have increased, which together with previously mentioned health behaviour patterns is highly likely to lead to several health problems when grown up.

In several fields of health behaviour, changes similar to those for young people have taken place also for grown-ups, and at present the number of people who smoke, excessively drink alcohol and are overweight is increasing in the population. Still, there are also indicators of a decrease in health-jeopardizing behaviour: the number of deaths caused by accidents and suicides, for instance, has decreased. The number of people killed in traffic, however, is an exception, having stopped decreasing in the past years.

By promotion of healthy lifestyle it is probably possible to improve the state of health among the Estonian population quite significantly. In health behaviour, the role of an individual is more important than in any other field of health, and all citizens can contribute to the improvement of the health of the population.

Trends of illnesses

With the increase in life expectancy the number of people suffering from chronic diseases increases in the population, and illness limits the daily activities of nearly 90% of those. In 2006, a little over 50% of the population evaluated their state of health as good or rather good, and only slightly over one third of the people considered their life style healthy.

Cardiovascular diseases form a group of diseases causing the largest burden of disease; however, individual health behaviour (eating habits, alcohol consumption, smoking and physical activity) plays a very important part in development of those illnesses. In comparison with Western Europe and the Nordic countries, Estonia is especially characterized by development of those diseases and dying of those in a rather early age. Similar tendencies also for other groups of illnesses are indicated by the fact that more than a half of the total

burden of disease in the population of Estonia lies on people in productive age (aged 20 to 64).

Following cardiovascular diseases, tumours hold a second place in causing loss of health. Relying on modern knowledge of the reasons for and prevention of malignant tumours, it is possible to avoid about 40% of new cancer cases. Health-behavioural choices have an important role in achievement of such a result, especially in regard to ageing of people increasing the development of cancer.

Differently from the two previously mentioned groups of diseases, the role of injuries among general illness has decreased, but according to the burden of disease they cause it is still the third group of illnesses according to importance. The same is confirmed by a comparison of the number of deaths caused by injuries in comparison to the average of the EU – the number of avoidable deaths caused by injuries in Estonia exceeds it over four times, whereas disproportionally many injuries happen to children, adolescents and people in working age.

Of groups of illnesses that used to be less important, disorders of mental health, psychiatric diseases and communicable diseases are more and more prevalent, the latter mainly due to more frequent cases of HIV/AIDS and tuberculosis. Especially quick loss of health has been associated with HI virus, the cases of registered infection having been over 6000 by the middle of year 2007. Similarly to all other major groups of diseases, the risk behaviour of people plays an important role also in cases of mental health disorders and HIV infection; e.g. strong connection of alcohol to depression and suicides and the association of drug addiction and unprotected sex with spreading of HIV.

Environment and health

Public health is significantly influenced by the environment outside the human organism with its physical, biological, chemical, social and psycho-social factors, whereas the influence on health is often revealed only in years. As estimated, up to one third of the health loss of the population is directly associated with factors based on the living, working and learning environment. Environmental factors have the biggest influence on children. Even 40% of the negative impact of the environment to health falls on children below 5 years of age. In addition to children, also pregnant women and old people are very sensitive to environmental influences.

Natural environment has been rather well preserved in Estonia. Due to the natural characteristics of the ground water used, several areas in Estonia have problems with the quality of drinking water, first of all due to a high content of radionuclides, fluorine and iron in the drinking water.

It is certainly important also to mention the electricity production and chemical industry in North-Eastern Estonia based on oil shale, which on the one hand is of economic importance but on the other hand presents a major health risk in the area. The influence of air pollution on the development of chronic upper respiratory diseases , e.g. allergic cough and rhinitis, especially in larger towns, has become a more and more important regional environmental health problem. For example, in 2005 air pollution in Tallinn was attributable to up to 296 death cases[1].

In addition to the natural environment, a person's health is significantly influenced also by anthropogenic man-made environment, including learning and working environment. It is

[1] Orru, H., Teinemaa, E., Lai, T., Kaasik, M., Kimmel, V., Tamm, T., Merisalu, E. (2007). Välisõhu kvaliteedi mõju inimeste tervisele Tallinna linnas – peentest osakestest tuleneva mõju hindamine. Tartu: Tartu Ülikool, Keskkonnaministeerium. http://www.envir.ee/orb.aw/class=file/action=preview/id=959943/HIA_Tallinn_ohk_ARTH.pdf

possible to improve the conditions thereof with the help of an efficient health protection and work safety system. If such a system is not present, the number of accidents at work and occupational diseases increases, which result in the loss of working time and an increase in incapacity for work. The above has a direct negative influence on all the economy.

The most positive trend in the past years is a tendency to organise assessments of health risks when planning living, working and learning environments (including the infrastructure, towns and housing districts) in Estonia. At the same time it must be admitted that it is not a systematic activity, and it has not been followed by cost-efficiency analyses to choose the best environmental health interventions.

Health impacts on the economy

Several current strategic documents like the State Budget Strategy (RES) for years 2008 to 2011 and the Estonian National Strategy on Sustainable Development "Sustainable Estonia 21" (SE21). Population health and economic development of the country are also connected in the strategic documents of the EU. For example, the Lisbon Strategy emphasizes a need to improve the health of the population, thus ensuring the opportunity for economic development.

Associations between health and economy are very extensive: poor health decreases the number of people in working age, as well as the working hours and productivity of working people. 6–7% of the potential labour force in Estonia are inactive due to an illness, disability or injury – poor health decreases the likelihood of participation in the labour market by 40% for men and 30% for women. In total, poor health decreases the GDP in Estonia by 6 to 15%. The reason is a decrease in the current production and the work not done in the future. The influence of the current activities cumulate in time, for instance, if we could now decrease the mortality by 1.5%, it would be possible to increase the GDP obtained in 25 years by 14%. As expected, the combined influence of decreasing the mortality and illnesses on the development of the society and increase of wealth is even greater.

Healthier employees are more flexible and can adjust to changing conditions better, thus decreasing the staff turnover. At the same time, the capacity of the whole country to react to general changes in the economic environment improves. Needless to say, the positive influence of improvement of public health on the labour force and the economy of a country starts already in childhood – children with better health miss fewer classes, their ability to learn improves and their estimated contribution to development of sophisticated and innovative fields of economy is larger.

5. Priorities of the development plan

The strategic general objective of the field in the NHP 2009–2020 is a longer health adjusted life expectancy by decreasing premature mortality and illnesses. The priorities for achievement of the strategic general objective of the development plan and based on those also the means have been divided between five thematic fields: increased social cohesion and equal opportunities, ensuring healthy and safe development for children, shaping of a living, working and learning environment supporting health, facilitation of healthy lifestyle and ensuring the sustainability of the health care system.

The priorities of all those thematic fields rely on one or more core values of the development plan: human rights, common responsibility for health, equal opportunities and justice, social inclusion, relying on evidence and consideration of international documents.

Highlighting of ***social cohesion and equal opportunities*** of the society tells all the members of the society that they are welcome and expected to participate in the activities and decisions of the society.

Ensuring healthy and safe development to children and adolescents gives them an opportunity to grow healthy and become active members of the society.

Healthy living, working and learning environment is equally important both to children and other members of the society. A clean and safe environment is a foundation enabling people to use their opportunities to maximum both as individuals and as a society, thus decreasing and eliminating environmental risks is of primary importance.

If the essence of the three fields above was creation of prerequisites and opportunities for health development, the main question regarding ***healthy lifestyle*** is whether and how we use those opportunities. Thus, in addition to creating opportunities it is necessary to increase people's awareness of those opportunities, healthy behaviour and influence of one's choices to one's health in order to live a longer, healthier and fuller life.

All factors deteriorating health are unfortunately not avoidable by creation of opportunities and individual choices. Existence of an ***efficient and patient-focused health care system*** and constant adaptation thereof to changing diseases, opportunities and wishes of patients is thus an important part of the National Health Plan.

6. Goal of the development plan

General objective of the strategic field – by 2020, the health-adjusted life expectancy has extended to 60 years in average for men and 65 years in average for women, and the average life expectancy has extended to 75 years for men and to 84 years for women.

Table 1. Strategic general objective of the field in the NHP with mid-term objectives.

Indicator	Basic level 2006	Fulfilment 2011	Year 2012	Year 2016	Target level 2020
Estimated life expectancy at the moment of birth – men. Source: Statistical Office	67.36	71.16	71.2	73	75
Estimated life expectancy at the moment of birth – women. Source: Statistical Office	78.45	81.09	81.1	82.5	84
Healthy (unrestricted) life expectancy at the moment of birth – men. Source: Statistical Office	48.0 (2005)	53.9	56	57.5	60
Healthy (unrestricted) life expectancy at the moment of birth – women. Source: Statistical Office	52.2 (2005)	57.7	60.5	62.5	65

As pointed out above, in addition to the strategic general objective of the field in the NHP, also five thematic fields important for achievement of the objective have been described, including the priorities and field-specific sub-objectives, as shown in Figure 1A. Figure 1 also shows that despite separation of fields in the NHP they still form a whole due to significant mutual influence and common topics.

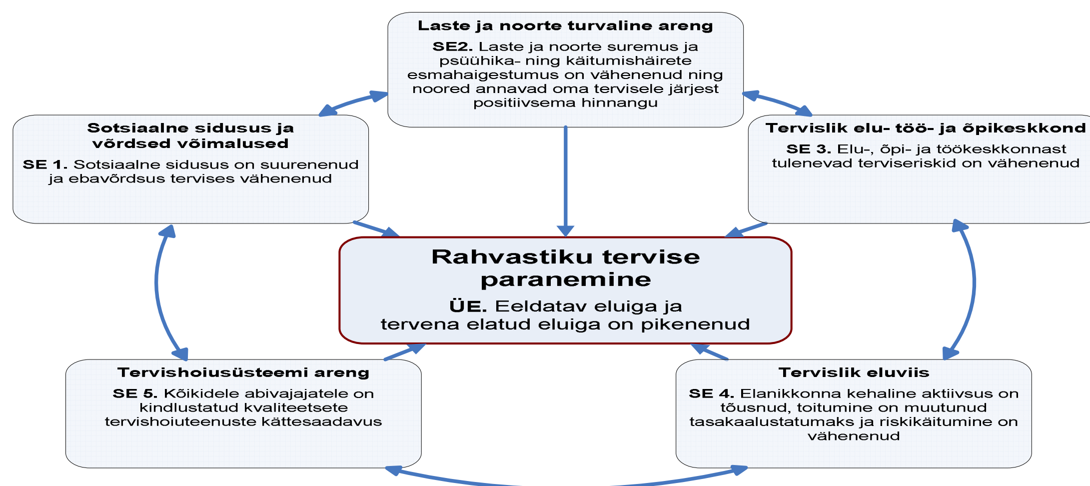

Figure 1. The NHP of period 2009 to 2012 provides the fields of priority and strategic objectives with the general objective.

SG – strategic objective of the field
GG – general objective of the National Health Plan

Figure 1 A The NHP 2013–2016 provides the fields of priority and strategic objectives with the general strategic objective.

GO – general strategic objective of the field
SO – sub-objective

7. System of monitoring changes in public health

For monitoring public health and planning prevention activities and services it is necessary to have a good overview of all those and several other topics. An overview of the structure of the surveillance and evaluation system is provided in Figure 2.

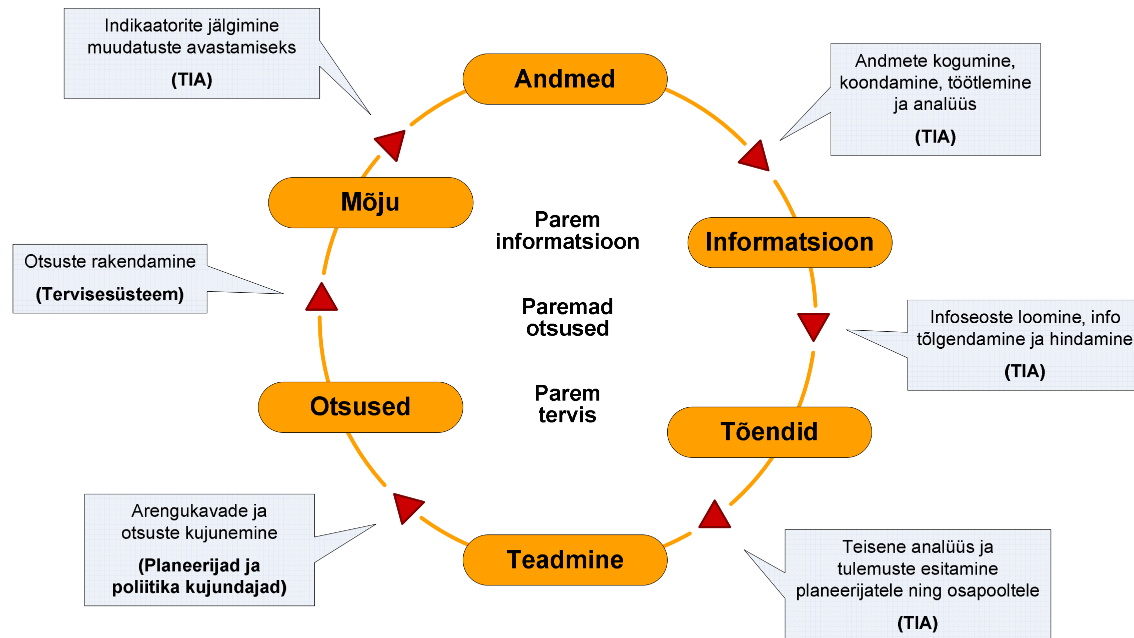

Figure 2. Structure of collecting and systematising health data and planning activities based on those.
HIA – health information and analysis

The surveillance system is used to collect information regarding the health state of various population groups, changes having taken place, as well as interventions carried out. In addition to collecting information, the described tasks of the surveillance system include also maintenance, preservation and primary analysis of the data. The biggest and most difficult task regarding those activities is to ensure the quality of the collected information and comparability of different data sources. For example, do the repeated questions of health behaviour studies of the population really measure the desired behavioural patterns and whether the same behavioural patterns have been measured throughout the years. Thereby, the collected data must be sufficiently detailed to enable a comparison of social groups and regional differences.

To monitor the results of the Estonian NHP, mainly data sources and surveys updated with unvaried regularity are used. Out of regular studies the most important ones include, for example, annual satisfaction surveys of users of health services, a survey of Health Behaviour Among Estonian Adult Population (ETETU) taking place every two years, surveys of pupils (HBSC and ESPAD) taking place every four years and the Estonian Health Survey (ETU) carried out at longer intervals. Out of surveys outside the health field, the Household Budget Survey (LEU) is one of the most important ones. Several indicators monitoring the Estonian health care system and health care expenses of patients are based on that.

Currently updated data sources include most of routine statistics like mortality figures in the register of deaths and illness statistics in the E-Service information system in the future.

Data collection is of primary importance but for actual gain it is necessary to create associations of information between different databases, interpret data and present results for public use. Thus, regular overviews of activities and results achieved are prepared during the application of the Health Plan, based on which it is possible to direct the activities of the following periods of the Health Plan, as necessary.

At the same time, activities carried out to monitor the impacts of the National Health Plan form a part of a larger system for evaluation of the impacts of interventions and policies and the functioning of the health system. Updating and unification of the evaluation system of policies is currently one of the important processes in Estonia and it is equally important to assess the impacts of all new policies on health within the updated system of evaluation of impacts, regardless of the main field of application thereof.

8. Persons participating in the drafting of the Health Plan

Many specialists of their field participated in the work of groups formed to draft the NHP and preparation of the Health Plan. Many thanks to those people.

Aira Varblane
Airi Värnik
Aljona Kurbatova
Anne Rähn
Anneli Susi-Persidski
Annika Soa
Diana Ingerainen
Eha Anslan
Eha Samra
Elo Paap
Ene Tomberg
Hede Kala
Heidi Gil
Helen Trelin
Heli Laarmann
Helvi Tarien
Iisi Saame
Ille Allsaar
Inga Villa
Ingrid Tilts
Inna Vabamäe
Irma Nool
Ivar Raik
Ivi Normet
Jaan Kiviall
Jelena Tomasova
Kadi Katharina - Viik
Kairi Kilp
Kaja Kuivjõgi
Kati Karelson
Katrin Karolin
Katrin Lõhmus
Kristel Ojala
Kristi Rüütel
Krystiine Liiv
Kädi Lepp
Lagle Suurorg
Leelo Männik
Liana Värava
Liis Rooväli
Maila Kuusik
Mairi Kaha
Mare Ruuge
Marge Reinap
Mari Laan
Marina Karro
Maris Salekeśin
Martin Kadai
Mihkel Kübar
Mikk Jürisson
Monika Sarapuu
Moonika Viigimäe
Natalia Kerbo
Natalja Jedomskihh-Eigo
Oliver Kruuda
Ott Roots
Reet Pruul
Rita Pihl
Sergei Bogovski
Sirje Tihhanov
Sirje Vaask
Taavi Lai
Tiia Pertel
Tiina Paldre
Tiina Ristimäe
Toomas Veidebaum
Triinu Tikas
Triinu Täht
Tõnu Seil
Urmas Sule
Ööle Janson
Ülla-Karin Nurm
Üllar Lanno
Ülle Rüüson

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Ministry of Economic Affairs and Communications, The Office of the Chancellor of Justice

9. Associations with other development plans

The NHP 2009–2020 summarizes many strategic documents that already exist or are under development. The common link between the programmes, strategies and development plans referred to in the present Health Plan is the public health. More detailed connections between the below strategies and development plans with the NHP and its strategic fields have been discussed in the source documents of the NHP.

Ministry of Social Affairs

- *Primary Healthcare Development Plan 2009-2015*

Primary health care is an important field of health care the functioning of which has a vital role in achievement of the main objectives of the health care system – better health of the population and meeting the expectations of the society – through the provision of essential services, including prevention of illnesses and complications thereof, as well as promotion of people's health. The objective of the Health Plan is to develop both basic primary services (family physician and nurse service, home nursing care service, physiotherapy service, midwife care service and school health care service) and services of the network (ambulance, in-patient nursing treatment service, occupational health service, dental care service, pharmacy service, mental health nursing service, etc.)

- *Development Plan of Hospital Network until 2015* (*Estonian Hospital Network Development Plan 2002)*

The purpose of the Estonian Hospital Network Development Plan is to ensure equal availability of specialised medical care. For that purpose the Government of the Republic establishes a list of hospitals and investments necessary for construction, renovation and reprofiling of the hospitals provided in the list. The task of the Estonian Health Insurance Fund is to conclude purchase agreements of health services with the hospitals provided in the list of hospitals for at least five years.

- *Development Plan of Nursing Care Network 2004–2015*

The development plan of nursing care determines services for patients who do not need expensive and sophisticated active treatment any more. The objective of the development plan is to facilitate the availability and quality of both out-patient and in-patient nursing treatment services and use the funds of medical insurance in targeted manner.

- *Strategy for Ensuring Children's Rights (terminated)*

General activities supporting children's health, development and well-being of children are carried out under the strategy, also activities for children requiring special attention (children living in poverty or exposed to the risk of poverty; disabled children, children with special needs; children belonging to national minorities and/or other marginal groups; children without parental care) are planned. Risk behaviour leading to deterioration of health indicators is frequent among children subject to social exclusion. Educational, economic and social factors are important factors influencing public health and health behaviour. A decrease in inequality caused by those factors and expressed in the health of children and young people helps to improve the health of the population as a whole. Therefore, the strategy of ensuring children's rights helps to implement the objectives provided in the NHP, especially in the field of health of children and young people. The strategy also supports the fulfilment of obligations provided in the UN Convention on the Rights of the Child, including the fulfilment of the obligations aimed at ensuring health protection.

- *Development Plan of Children and Families 2012–2020*

The main objective of the development plan is increasing of the well-being of children and families and increasing of the quality of life, thereby facilitating the increase in the number of births. To achieve the main objective, sustainability of the Estonian society is supported

through knowledge-based and common family policy and the quality of life and future prospects of children is improved by supporting positive parenthood. To provide families with stable feeling of security a system of combined benefits and services supporting adequate economic coping of families shall be created. To support high-quality daily life meeting the needs of all family members, equal opportunities shall be created for men and women for uniting work, family and personal life. To ensure child rights, a functioning child protection system shall be created to value each child and his/her development in the society, as well as safe environment supporting well-being.

- *Development Plan of Prevention of Relationship Violence (under development)*

The above development plan was not completed in the field of administration of the Ministry of Social Affairs, the Ministry of Justice created a Development Plan of Decreasing Relationship Violence for years 2010–2014.

The objective of the development plan was to shape a commonly coordinated policy for prevention and inhibition of relationship violence and unify the directions of development of the field with the objectives established by the European Union and the United Nations. The notion of relationship violence includes violence between a couple and in a family that very often influences the children growing in the family. Prevention of family violence creates opportunities for safe development of children, which in turn supports the acquisition of responsible and aware health behaviour patterns. Thus, the strategy supports the achievement of the objectives established in the NHP. Within the strategy, development of services and ensuring the availability thereof for the parties experiencing relationship violence is planned, awareness of people in matters related to relationship violence is increased, competence of specialists is enhanced.

- *National Cancer Strategy 2007–2015*

All the measures of the sub-fields of the strategy facilitate the achievement of the general objective of the National Health Plan, extending the life expectancy of people by decreasing premature mortality and illness due to cancer. One of the strategic objectives of cancer prevention is to achieve stable positive changes in the health behaviour of the population (including increasing the ability of people to make healthy choices, decreasing of smoking, alcohol consumption, etc.). The prevention activities of the strategy are aimed at the information work done at educational institutions regarding the damage by alcohol, decreasing the consumption of tobacco products among young people, avoiding passive smoking, helping smokers to give up tobacco, etc. To facilitate healthy eating habits information events are organised for producers, caterers and general public regarding the technology of food preparation.

- *National HIV and AIDS Strategy 2006–2015 (the activities of the strategy are integrated into the application plan 2013–2016 of the NHP 2009–2020)*

The whole strategy facilitates the achievement of the NHP, limiting the spreading of HIV infection and ensuring high-quality treatment to people with AIDS. The general objective of the strategy is to achieve a permanent tendency of decrease in spreading of HIV infection. This includes a objective to decrease the number of new HIV cases to 20 per 100,000 people by year 2015, and to prevent extension of the epidemic with the help of strategic activities (including the share of pregnant women infected by HIV under 1% of all the pregnant women). Areas of activity to stop the spreading of the HIV epidemic and decrease the influence of the epidemic are the following: prevention activities among various target groups, HIV testing and counselling; prevention, treatment and welfare services aimed at people infected with HIV and with AIDS; surveillance, monitoring and evaluation and development of human and organisational resource.

- *National Strategy for Prevention of Drug Addiction until 2012 (the activities of the strategy are integrated into the application plan 2013–2016 of the NHP 2009–2020)*

The strategy is a national multi-disciplinary long-term strategy of combating drugs, which as a whole is aimed at decreasing the psychological, social and physical damages caused to a person. The strategy has an integrated approach to demand for drugs (prevention, treatment, rehabilitation) and offering of drugs (activities of various power structures: police, customs, border guards), covering six fields: prevention, treatment and rehabilitation, decreasing of damages, decreasing of offering, drugs in prison and surveillance of the drug situation.

- *National Tuberculosis Control Strategy 2008-2012 (the activities of the strategy are integrated into the application plan 2013–2016 of the NHP 2009–2020)*

Tuberculosis is important in the context of public health in all its thematic fields. Socially less privileged people are subject to greater likelihood of catching tuberculosis, which in turn increases the risk of illness for other groups of the society, especially children. Increased illness means additional load on the health care system.

- *National Strategy for Prevention of Cardiovascular Diseases 2005–2020 (strategy has been prematurely terminated, activities have been integrated into the NHP 2009–2020)*

The general objective of the strategy is to achieve a permanent tendency of decrease in early illness and mortality of the population associated with cardiovascular diseases, and thus all measures applied within the strategy facilitate the extension of people's life expectancy. The strategy is implemented through five strategic fields concerning the main factors influencing cardiovascular diseases. Those are physical activity, eating habits, smoking, health care, dissemination of information and ensuring the capacity of the area. In general, the strategy is aimed at improvement of eating and movement habits of the population and giving up smoking. A part of the activities includes screening of people of high risk level and counselling on healthy life style, as well as training of family physicians, family nurses and health promoters of health organisations. The activities organised are aimed on the one hand at shaping people's attitudes, beliefs and values and on the other hand at creation of an environment supporting health.

- *Supporting of Infertility Treatment 2007–2010 (terminated)*

The document includes the current analysis of the situation concerning infertility, strategic objectives and measures aimed at mitigation of the consequences of infertility (creation of artificial fertilization possibilities for couples without children), investigating the causes of infertility (studies, statistics) and prevention of the causes of infertility (informing the public in order to shape responsible sexual behaviour; offering preventive and health-promoting sexual health services to young people, etc.). Thus, the development plan included in the NHP supports the achievement of the objectives established in the field of reproductive and sexual health.

- *Occupational Health and Safety Strategy 2010-2013 (the activities of the strategy are integrated into the application plan 2013–2016 of the NHP 2009–2020)*

The objective of the present strategy is to develop the working environment into one maintaining the health of employees. The sub-objectives of the strategy include the following: maintenance and promotion of employees' health and ability to work; improvement of the working environment so that it would be possible to work without any risks to health; development of the management system and work procedures in a direction supporting occupational safety and health, promoting positive psycho-social microclimate in a company and creating a prerequisite to an increase in productivity. Development of a health-supporting working environment and decreasing health risks based on the working environment have been discussed in the chapter of the NHP on decreasing health risks in living, working and learning environment.

State Chancellery

- *Estonia's European Union policy 2011–2015 (Estonia's European Union policy 2007–2011)*

The objective of the policy document is to determine the basic principles of the government's European Union policy. The document determines the direction of the EU development favoured by Estonia, the objectives and interests of the activities of Estonia and the opinions of the government about most important political fields of EU: health care services, occupational health and safety, E-Health, environmental protection, food, etc.

- *Action Programme of the Government of the Republic 2007–2011*

It has been drafted for implementing the "Programme of the Coalition 2007–2011". A separate work schedule that has been used so far for planning the work of the Government of the Republic shall not be drafted, as the action programme shall outline the activities of the Government for the next four years. As it is possible to update the action programme each year, if so required, drafting of an one-year work plan is not practical.

- *Action Programme of the Government of the Republic 2011–2015*

"Action programme of the Government of the Republic 2011–2015" has been drafted for implementation of the coalition agreement between the Estonian Reform Party and Pro Patria and Res Publica Union. The action programme is updated once a year, when after the fulfilment of primary tasks, necessary follow-up activities are added to the programme in order to achieve the objectives of the coalition.

- *Estonian National Strategy on Sustainable Development „Sustainable Estonia 21“*

Sustainable development is long-term coherent and coordinated development of the social, economic and environmental field, the purpose of which is ensuring high quality of life and a safe and clean living environment for people. Measures described in the NHP for decreasing health risks in living, working and learning environment have been established in order to achieve the same objectives.

Ministry of Finance

- *National Strategy for Using Structural Funds 2007–2013*

The strategy determines the general strategic approach to using structural aid. According to the strategy of structural funds the necessary operational programmes have been created to implement it where more detailed activities to be financed from the structural funds in 2007–2013 and the financial plan for those are determined. Three application plans are connected with the NHP:
- field of priority of the application plan of human resource development "Long and high-quality professional life";
- field of priority of the application plan of economic environment development "Promotion of information society";
- field of priority of the application plan of living environment development "Promotion of health care and social welfare infrastructure".

Ministry of the Environment

- *Environmental Strategy of Estonia until 2030*

Environmental strategy until year 2030 determines long-term directions for development in order to preserve a good state of the whole living environment. A good state of living environment has also been specified as a objective in the chapter of decreasing health risks in living, working and learning environment of the NHP.

- *National Radiation Safety Development Plan 2008-2017*

Radiation is one of the factors jeopardizing the health of a human being. Ensuring of radiation safety for protection of a human being and the environment has been established as a objective both

in the national radiation safety development plan and in the chapter of decreasing health risks in living, working and learning environment of the NHP.

Ministry of Internal Affairs

- *Development Plan of Supporting Civil Initiative 2007–2010 (terminated)*

The development plan establishes the main fields of activity of the country in supporting the development of the civil society, promotion of participation democracy and development of the public and the third sector that the NHP regards as a measure for development of one of the most important factors influencing health – social cohesion. The development plan focuses on five strategic objectives: competence and capacity of the public sector in cooperation with organisations and active citizens; unification of the principles of state funding of the third sector in various ministries and other state institutions; inclusion of citizens' associations into decision-making processes; effective information exchange between the public, private and third sector; promotion of civil initiative through increased awareness and supporting environment. The development plan contributes to the development of social capacities of localities, developing county support structures of civil initiative.

- *Development Plan of Civil Society 2011-2014*

The objective of the development plan of the field is to ensure favourable conditions for civil initiative and organisation of the civil society and strengthening of the partnership of the parties in the following directions of priority: civil education; organisation of the civil society and initiative and networks; charity and philanthropy (voluntary work and donations); inclusion; citizens' associations as partners in provision of public services; budgetary funding of citizens' associations; statistics and research information necessary for evaluation of the development of the civil society.

- *Estonian Regional Development Strategy 2005–2015.*

  Estonian Regional Development Strategy 2020 (June 21st, 2012 Order of Government No. 260) is under development.

The development plan discusses possibilities of regionally balanced development in Estonia and promotion thereof, including the objectives. Regarding public health, balanced regional development is of critical importance, as shortcomings in that field may mean lack of availability of health services for a certain part of the population, and regional differences in income may subject a certain part of the population to a more unfavourable situation also in making of health decisions. The issues of regional development are also closely connected with social cohesion and equality included in the first thematic field of the NHP.

- *National Planning "Estonia 2010" (terminated)*

The main emphasis is on shaping a balanced and sustainable conception of territorial development. Ensuring of a living, working and learning environment that is secure and safe for the health of people has been established as a objective also in the chapter about decreasing health risks in living, working and learning environment of the NHP.

- *National Planning "Estonia 2030+"*

The main emphasis is on shaping a balanced and sustainable conception of territorial development. Ensuring of a living, working and learning environment that is secure and safe for the health of people has been established as a objective also in the chapter about decreasing health risks in living, working and learning environment of the NHP.

- *Development Plan of Internal Security 2009–2013* *(no development plan was drafted)*

The objective of the development plan is a more specific determination of the term of internal security to make it unambiguously understandable both in the field of government of the Ministry of Internal Affairs and for related groups. An understanding of broad notion of

internal security and terms related thereto must be created in the society. Protection of health and a health care system are inseparable parts of internal security.

- *Main Directions of Estonian Security Policy until 2015*

Security is a state of the society created with the help of many parties, where a person feels protected and an actual safe living environment is ensured, decreasing the likelihood of being subjected to a situation of risk, increasing capability of responding to a risk and mitigating the damages caused upon realisation of risk. It is not possible to avoid or significantly decrease violations of order only by executive power of the state, also citizens, local governments, economic circles and non-government organisations must be included in the creation of a safe living environment. Five principles of security policy have been emphasized: responsibility of everyone, inclusion, cooperation, prevention and long-term planning. To implement the principles, eight main directions of security policy have been established: a safer feeling, safer traffic, more fire-safe living environment, more protected property, less accidents, a safer country, faster help and a more efficient security policy.

Ministry of Education and Research

- *Youth Work Strategy for 2006–2013*

Development Plan of Youth Area (December 6th, 2012 Order of Government No. 502) is under development.

Activities planned in the strategy for supporting the development of young people with risk behaviour create prerequisites for promotion of the health behaviour of young people and prevention of health disorders due to risk behaviour. Activities aimed at high quality and integration of the information and counselling activities of young people support the shaping of awareness and coping of young people. Counselling activities make it possible for young people to make informed decisions about their lives. This in turn creates a prerequisite for the development of responsible health behaviour, thus supporting
the achievement of the objectives established in the NHP.

- *Development Plan of the General Education System 2007-2013*

Under the development plan, opportunities are created for supporting the development of each student, as well as shaping of knowledge, skills, values and attitudes required in personal, professional and social fields of life, and a foundation is formed for life-long learning. The development plan supports the development of a child's readiness for school and smooth adaptation in school, creating possibilities for obtaining pre-school education. Good coping in school is also supported by activities aimed at early detection of special needs in a child's development. The achievement of the objectives of the NHP is strongly supported by a measure preventing withdrawal from general education schools included in the development plan of the general education system. The level of education and health behaviour are connected. Development of curricula also supports the promotion of the quality of health education and correspondence thereof to the modern requirements of health education. Measures aimed at motivation and professional development of teachers help to develop the psycho-social environment of a school
and facilitate a more social and development-focused dialogue between teachers and students, thus promoting coping. The development plan includes possibilities for renewal of the physical environment of a school. All the above activities and the development plan as a whole influence the health of the population since childhood and adolescence, and thus the development plan supports the achievement of the objectives established in the NHP.

- *Programme "Safe School" on Prevention of Bullying at School*

The programme helps to implement the strategic objective of the NHP to ensure a healthy and secure environment for the development of children and young people by prevention of violence and injuries and promotion of mental health. School is the environment where messages on health promotion reach a large target audience, but violent behaviour expressed in school environment may be a risk factor for health. Prevention of violent behaviour and the programme promoting a supportive and development-focused psycho-social environment facilitate the achievement of the objectives established in the NHP.

Ministry of Agriculture

- *Estonian Rural Development Strategy 2007-2013.*

The Estonian Rural Development Plan 2007–2013 is aimed at improvement of the quality of life in Estonia, including rural regions and localities. The development plan considers the peculiarities of Estonian rural life. In the chapter about decreasing health risks in living, working and learning environment of the NHP recommendations are provided to local governments for improvement of the quality of life in localities.

- *Development Plan of the Area of Government of the Ministry of Agriculture 2009–2012 (terminated)*

Within the measure of surveillance and rationalization fulfilment of food safety is ensured, one of the prerequisites being an efficient surveillance system of food and alcohol. Regular updating of necessary databases (including the results of surveillance and monitoring programmes and data about food consumption) is ensured based on which risk analyses are carried out and decisions are made regarding the establishment of necessary standards. Within the measure of availability of information and improving quality, the consumers and food processors are informed of recommended standards.

Ministry of Culture

- *Estonian Sport for All Strategic Development Plan 2006-2010 (terminated)*

The Sport for All development plan fulfils the objective of the NHP as a whole. The objective of the development plan is to facilitate an increase in movement activity and creation of improved opportunities for daily sports. The objective is to increase the number of persons engaging in regular sports to 45% of the population by year 2010. The main objective in the development plan is to increase the possibilities and forms of sports. The development plan consists of the following main fields of activity: sports locations, medical care for recreational sportsmen, information service and counselling, training, creation and distribution of information materials, organisation of sports for all, public relations and promotion plan for sports for all.

- *Sport for All Development Plan 2011-2014*

The general objective of the development plan is that 45% of the population regularly goes in for sports by year 2014. More extensive engagement of the population into sports is a complex task the success of which depends on both objective conditions (sports facilities, training equipment, competent personnel, organisational system, training, information system, etc.) and subjective factors (people's attitudes and value aspects in sports). The achievement of the objective established in the development plan is the task of several institutions that can be carried out by cooperation between various ministries, sports organisations, private sector and other institutions

- *Estonian Integration Plan 2008–2013 (By Order of the Government No. 236 dated June 11th, 2009 the general supervisor of the Integration Plan is the Ministry of Culture instead of the Office of Urve Palo)*

Integrating Estonia 2020 (October 11th, 2012 Order of Government No. 432) is under development.

The national programme is an action plan for government institutions and other institutions. The general objective of the integration policy is a creation of a coherent society where in addition to common interests, social institutions and values opportunities have been created for minorities to preserve their cultural character. The chapter of the Integration Plan on social-economical integration includes measures for decreasing the risk behaviour and increase healthy choices of non-Estonians.

Ministry of Justice

• *Development Plan on Reducing Criminal Activity among Minors 2007–2009* *(terminated)*
The general objective of the development plan is to reduce criminal activities among minors, including repeated violations of the law by minors, and improve prevention work done among minors. The development plan on reducing criminal activity among minors includes engagement in social and educational means aimed at crime prevention, increasing of the efficiency of juvenile committees and development of resocializing programmes of minor offenders.

• *Development Plan on Combating Trafficking in Persons 2006–2009* *(terminated)*
The objective of the development plan is to increase the awareness of people about trafficking in persons, dangers related therewith and possibilities of prevention thereof. An important part of the development plan includes activities of informing children and young people that are greatly connected with decreasing of the general risk behaviour of children and young people provided in the NHP.

- *Development Directions of Criminal Policy 2018*

The objective of criminal policy is ensuring the safety of the society by prevention of offences and response thereto, decreasing of damages caused by the offences and dealing with offenders. The primary objectives of the criminal policy are prevention of repeated crime and crime by minors. Prevention of crime by minors enables prevention of crime in adult life; prevention of repeated crime reduces the number of crimes and the risk of becoming a victim to crime. As the greatest harm is caused to the society by organised crime, including crimes related to finances, corruption, cyber crimes and trafficking in persons, as well as offences against persons including family violence, the greatest attention must be paid to prevention of and response to those crimes.

- *Development Plan on Reducing Violence 2010-2014*

The objective of the development plan to be approved by the Government of the Republic is to decrease and prevent violence in its various forms. The development plan highlights violence connected with minors, family violence and trafficking in persons. Types of violence and situations putting the most vulnerable target groups (women and children) at risk and with risk factors that are often interconnected (e.g. violence experienced in childhood influencing violent behaviour later in life) are discussed.

Ministry of Economic Affairs and Communications

- *Development Plan on Estonian Housing Area 2008-2013*

The development plan concerns one of the most important factors influencing health – housing. Partly, the development plan contributes to the prevention of homelessness as one of the factors having the most powerful negative impact on health. • The chapter about decreasing health risks in living, working and learning environment of the NHP analyses the environmental health indicators based on housing, e.g. composition of the internal air of the premises, temperature, amount of light, emission of radon, etc.

- *Transport Development Plan 2006-2013*

Transport Development Plan (September 6th, 2012 Order of Government No. 386) is under development.

The development plan is a strategic source document for development of the transport sector. The development plan includes vital issues like development of infrastructure to ensure safe traffic and improvement of the infrastructure of non-motorised transport both in settlements and on roads outside settlements. The development plan also considers the objectives of traffic safety development established in the Estonian National Traffic Safety Programme 2003–2015. An effective transport system means safe traffic organisation and a safe traffic environment for non-motorised transport. It supports the measures of decreasing health risks in living, working and learning environment (air pollution, etc.) established as objectives in the NHP.

- *Estonian National Traffic Safety Programme 2003–2015.*

The Estonian National Traffic Safety Programme establishes the objectives of traffic safety development and means for realisation thereof, with a purpose to reduce premature mortality of people due to injuries. The objective is to decrease the number of traffic accidents in Estonia by 50% during a decade and save the lives of 1000 people. One objective is to help people acquire correct attitudes in traffic and direct people towards safer traffic behaviour. The traffic safety improvement measures included in the plan are aimed at the groups of road users and fields through whom/which it is possible to influence the level of traffic safety most. One of the fields in the programme includes activities aimed at children and young people. As injuries are the biggest cause of the mortality of children, the programme aimed at the prevention of injuries caused in traffic also supports the achievement of the objectives of the NHP.

- *Development Plan of the Estonian Information Society 2013*

Development of the Estonian Information Society 2020 (September 27th, 2012 Order of Government No. 417) is under development.

Regarding social topics, the development plan establishes a objective of each person living a full life, using the possibilities of the information society in every way and actively participating in public life (nobody is left and nobody stays out!). To create an opportunity for members of the society to participate in the information society, it is necessary to ensure an opportunity for people to use digital information and communicate through various technological solutions or channels. On the other hand, it is necessary that people would be able and willing to use the possibilities created and would be motivated to participate in the decision-making processes of the society. The development plan describes the principles of defining, creation, implementation and application of e-services (E-Health projects) having a high impact in the public sector. E-services having the highest impact on increasing the efficiency of state government and economic development have been determined, acknowledged, implemented and, where necessary, made mandatory for legal persons.

Ministry of Defence

- *Military Defence Development Plan 2009-2018*

Development Plan of National Military Defence 2013–2022 (November 24th, 2011 Order of Government No. 488) is under development.

The development plan is aimed at the building of a safety network essential for the preservation of the independence of Estonia. According to the scenarios of danger, the necessary military skills are determined in the development plan and resources planned for development thereof.

Development plans across ministries

- *Plan of Competitive Strength "Estonia 2020":*

The Plan of Competitive Strength "Estonia 2020" establishes:

- objectives for increasing competitive strength for years 2015 and 2020 based on the programme of the coalition, objectives approved by the government in November 2010 and indicators included in the extended eurozone covenant;
- most important reforms regarding competitive strength are decided, in addition to the extended eurozone covenant, based on comprehensive discussions between ministries, a report of the main political challenges, analysis of the most important new recommendations and existing measures and accordance to the programme of the coalition for 2011–2015.
- additional obligations and particular changes are established, which the state shall undertake from June 2011 to implement the extended eurozone covenant.

The NHP contributes to one of the objectives of the plan of competitive strength to increase the health adjusted life expectancy by improving health behaviour, further decrease of accidents and development of the health care infrastructure.

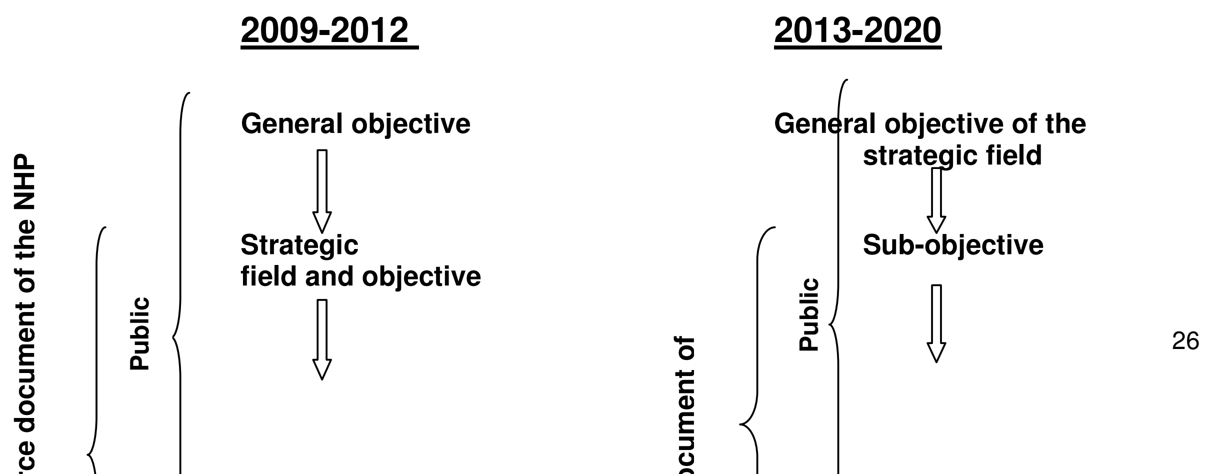
- *Principles of the Security Policy of Estonia*

The Principles of the Security Policy of Estonia include the basic guidelines fully stating the concept of security in Estonia, providing all important fields of ensuring security. The objective of the security policy – to ensure the independence, territorial integrity, constitutional order and security of the people of Estonia – is based on the constitution. The objective and principles of the security policy create a framework for evaluation of the security environment and determination of directions of activities necessary for ensuring security.

10. Means for achievement of the objectives of the development plan

Below, more detailed overviews are provided about all sub-objectives of the development plan, including the description of the field and a list of the main issues, as well as lists of the main priorities and measures and indicators used for monitoring of the achievement of results.

At the same time, the present development plan details only the main parts of the fields, relying on more comprehensive overviews provided in the source documents of the development plan. As the NHP is a summary document including the activities described in several previous development plans and strategic documents, individual activities have generally not been detailed in the present development plan or its source documents. Thematic mapping of the NHP and the documents connected therewith is shown on Figure 3.



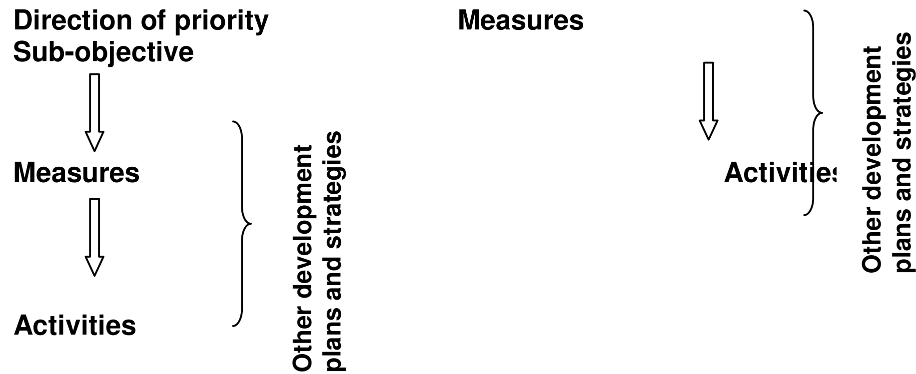


Figure 3. Division of topics between the NHP, the source document thereof and other related documents.

I Social cohesion and equal opportunities

Description of the field

Social cohesion means the ability of the society to ensure the well-being of each member, combating social splitting and avoiding exclusion.

Coherence has a direct connection to health – the bigger the coherence the better health indicators. High level of coherence also supports social security which in turn is an important factor influencing health. Social security is characterized by figures of employment, poverty and stratification. The existence of excluded social groups is a significant risk to the health of the people, whereas equal opportunities and equal access to services increase the social security and coherence and improve health indicators.

The health policy in Estonia is based on the principle that people must have equal opportunities to good health, regardless of their social-economical status, education, nationality etc.

Prevention of poverty and social exclusion is one of the most difficult tasks in ensuring the economic and social development in Estonia. Reducing of poverty and exclusion are based on a principle that work is the best way to mitigate poverty. Another important principle is offering integrated services as social and labour market services that must be interconnected. An important starting point is development of a system of universal services and benefits to avoid the appearance of a stigma of poverty and exclusion accompanying the special measures. At the same time the problems of certain risk groups that cannot be

solved by a system of services and benefits must be acknowledged, and special measures considering the needs of particular groups must be used.

The national and local authorities have considerable powers to influence the development of social cohesion by shaping the legislation, financing decisions and priorities of the society. The public sector can influence the initiatives and development of non-government organisations, including individuals and interest groups into decision-making. Plan-based development of cohesion and inclusion of socially sensitive groups creates both trust and a growth in the social and economic security, which are important factors influencing the health of the population.

Mental health is closely connected with the general well-being and coherence in the society, changes and problems in the society are also expressed in deteriorated indicators of mental health. Prejudice and poor availability of services cause a situation where the problems of mental health also cause social exclusion and difficulty of coping. By changing attitudes in the society and development of services it is possible to prevent the accumulation of mental health problems and mitigate the influence thereof on coping of people.

Main problems of the field

Estonian society has quickly polarised during the past fifteen years and the figures of social cohesion are significantly lower in Estonia in comparison to the countries of Northern and Western Europe[1].

Great inequality can be noticed between different national groups, health indicators are strongly related to gender, education, ethnic origin and income.

Social inequality is decisively expressed in the health of children and young people. The poverty of parents is inevitably extended to the children. The social-economical conditions of childhood predict the state of health of grown-ups better than the social status. Childhood illnesses and deaths are often indirectly caused by social exclusion, adverse living conditions, poverty and careless health behaviour.

The system of mental health services is disunited, services are not available enough and may not correspond to the needs of people. Inadequate awareness and prejudice limit the accessibility of timely help for those in need.

By adequate and timely intervention we can prevent the emergence of a new generation of excluded people.

Priorities of the field based on the foregoing:

- Reducing social inequality in health.
- Empowerment of groups and communities.

The sub-objectives (SO) and measures (M) of the field are based on the foregoing:

The sub-objective (SO) is based on the foregoing

[1] Raska, E., Raitviir, T. (2005). Eesti edu hind. Eesti sotsiaalne julgeolek ja rahva turvalisus. Tallinn: Eesti Entsüklopeediakirjastus.

SO 1. Social cohesion has increased and inequality in health has decreased.

The achievement of the sub-objective of the field is monitored by the following indicators:

Table 2. Indicators of achievement of the sub-objective of the field of social coherence and equal opportunities.

Indicator	**Basic level 2006**	**Fulfilment 2011**	**Year 2012**	**Year 2016**	**Target level 2020**
Share of the people covered by medical insurance in the population Source: Statistical Office and Health Insurance Fund	95.2% m: 93.3% w: 96.8%	93.0% m: 90.4% w: 95.1%	99%	99%	100%
† Relative poverty rate after social benefits (number of persons whose equivalent income is lower than 60% of the equivalent net income median of the members of the household) Source: Statistical Office	18.3% m: 16.3% w: 20.0% (2005)	17.5% m: 17.6% w: 17.4% (2010)	16.8%	16.5% (16%)	15% (16%)
Poverty risk of children (share of children of up to 15 years of age living below the poverty threshold) Source: Statistical Office	19.8% m: 20.8% w: 18.8% (2005)	19.4% m: 19.0% w: 19.9% (2010)	19%	18%	17%
† Share of long-term (over 12 months) unemployed among the workforce Source: Statistical Office	2.3% m: 2.9% w: 1.7% (2007)	7.1% m. 7.8% w: 6.3%	5.7% (1.7%)	3.7% (1.3%)	2.5% (0.8%)
Mortality coefficient of suicides per 100,000 people Source: Statistical Office and National Institute for Health	18.4 m: 30.9 w: 7.7	16.3 m: 28.8 w: 5.5	15	12.5	10
† Corrected target level of indicator, previous target level in brackets					

The following measures shall be used to achieve the sub-objective of the field:

2009-2012	**2013-2016**
M 1 To update the legislation to motivate the social responsibility of local governments and organisations and implementation of the NHP M 2 To enhance the system of social guarantees to avoid the situation of socially sensitive groups of people falling below poverty threshold jeopardizing coping.	M 1 Reduction of inequality in health through social-economical factors of influence

M 4 To contribute to social fields influencing health most (e.g. prevention of unemployment, poverty, homelessness and exclusion M 5 To develop programmes based on inclusion activating the unemployed, and update the legislative measures increasing motivation to work	
M 3 To develop the capability of county and rural municipalities to evaluate and analyse the health of the population, as well as plan and implement health-promoting measures of intervention. M 7 To support voluntary initiatives and activities of the third sector	M 2 Development of public health and empowerment of communities and localities in health promotion
M 6 To develop a network of health services meeting the needs of socially sensitive groups M 8 To promote the awareness of people regarding mental health, paying attention to recognition of early signs of depression and ensuring the availability of high-quality services	M 3 To support the mental health of people

Measures of 2009–2012 are shown as activities in application plan 2013-2016.

Measures to be applied at governmental level

The task of the governmental level is to develop the priorities of the sub objective of the field, prepare measures for application of the priorities (in cooperation with the local governments, if necessary), modernise the legal system necessary for implementation thereof and plan resources necessary for the implementation of the measures. To ensure sufficient information for people enabling them to make informed choices in order to reduce health risks.

Recommended activities to be applied at the level of local governments

Local government organises the application of activities within its scope of competence (including the creation of necessary legal grounds). Ensures sufficient information for people enabling them to make informed choices in order to reduce health risks.

- Start the work of health councils and health work groups based on partnership at local governments, engage socially sensitive groups.
- Integrate the objectives of the NHP into the development plans of local governments or create a health development plan of a local government.
- To develop the social infrastructure at a local level, support the activities of cooperation and support networks and create an environment facilitating self-initiative and social activity of people.

- To develop measures increasing the quality of life and coping.
- To ensure the availability of health-related information for socially sensitive groups regarding their rights, benefits and services aimed at them, using forms of communication understandable to them.

Recommended activities to be applied at the level of organisations

To facilitate the achievement of the sub-objective of the field by creating a health-supporting physical and social environment.

- To integrate the topic of health development of staff into the development plans of organisations.
- To create an environment facilitating health development and managing health risks at a workplace.
- To create motivating conditions for socially sensitive groups.

Recommended activities to be applied at the level of individual

Every person can reduce risks to health by making informed choices in organisation of daily life.

- To care for the well-being and mental health of oneself and persons connected with oneself, looking for professional help and encouraging others to turn to professional helpers.

II Safe and healthy development of children and adolescents

Description of the field

In childhood and adolescence, a foundation is formed for health-awareness and health-saving behaviour of a person. Health is influenced by family relations, living conditions, natural and man-made environment, day care and school environment, as well as the general social-economical environment, including the organisation of the educational and health care system, and unemployment and poverty in the country. The social network surrounding them and life style of parents, grandparents and friends has a great influence on children. The health and development of a child or a young person must be regarded considering the family and environment where the child spends most of his/her time. To promote the health of children, activities must be first of all directed to sensitive periods of life, namely the pregnancy of a mother and infancy and teenage years of a child. Investment into education equals investment into health.

The school and activities taking place at school play an important role in the formation of the values, social skills, health and coping of a child. Interruption of the path of education and population health are interconnected. The lower the educational level, the worse are health indicators and the shorter the average life expectancy. Paying timely attention to development and health disorders and risk factors, it is possible to prevent many problems. The modern understanding of early intervention is based on flexible cooperation between health care, social and educational fields, moving from the medical model more towards the social model. Children and young people living in families with social problems, modest educational and financial background need attention. Activities aimed at supporting their health and development help to decrease the inequality expressed in the health indicators of the population to a considerable degree.

Relying on the phases of life, in the chapter of safe and healthy development of children, general support measures aimed at different stages of development are planned in order to promote the sexual and reproductive health of future parents, physical and mental health and social development of children, and prevention of disorders of mental health, injuries, violence, chronic diseases and risk factors thereof.

Health problems of children due to physical, chemical and biological environmental factors and recommendations, principles and measures for prevention thereof have been provided in the chapter of the development plan regarding environmental health. The influence of eating patterns, physical activity and risky behaviour (smoking, consumption of alcohol and drugs) to the health of children and young people, and principles and measures for prevention of health problems connected therewith have been provided in the chapter of the development plan regarding healthy choices.

A prerequisite for monitoring changes taking place in the field of children's health is strategic development of data systems and analysis. The collection of information on children's health is based on a recommendation of the World Health Organisation according to which the information must be as detailed as possible to enable focusing of activities on various target groups and making periodical analyses regarding the availability and influence of services in various social groups and areas.

Main problems of the field

- Risks in the health behaviour of pregnant women (a high level of induced and repeated abortions, smoking during pregnancy), educational level of mothers and infant mortality after the 28th day of life are continually strongly related, a higher risk to the health of newborns is connected with the pregnancy and labour of teenagers, illnesses of premature newborns have become more frequent.

- High mortality of children and young people caused by injuries and poisoning.

- Low awareness of parents regarding the health and peculiarities of the development of infants and toddlers (feeding, safe environment, etc.), a need to increase the share of infants fed with breast milk.

- Irregularity of preventive health inspections of pre-school children, delayed immunisation, delayed detection of special needs of development.

- High frequency of tooth caries among pre-school children, increased frequency thereof with age.

- Risky sexual behaviour (more frequent infection of teenage girls with the HI virus), clear lack of a decrease in the age coefficient of abortions among women aged 15 to 19 (number of abortions per 1000 women of the same age).

- Increased frequency of chronic diseases (asthma, diabetes) or risk factors of chronic diseases (being overweight, increased blood pressure) among children and young people, possible delayed diagnosing of chronic diseases for children living at a bigger distance from centres.

- Problematic relationships in family, inadequate communication skills, lack of training-counselling system of parents, insufficient networking to decrease health risks of children of problematic families.

- Insufficient availability of help provided by children's psychologists, treatment and diagnostics teams of children's psychiatry, social workers, school psychologists and speech therapists.

- Lack of an integrated system of learning and treatment facilities for children with special needs.

- A need for updating and development of an evidence-based information environment reflecting the possibilities of protection and promotion of children's development and health for parents, teachers and other specialists working with children.

- The aggregated health statistics regarding children and young people collected by routine procedures does not provide an overview by different target groups (level of education, social-economical situation, nationality) and cannot provide a basis for planning preventive activities aimed at the target groups.

Priorities of the field based on the foregoing:

- Promotion of the physical and mental health and social development of children and young people.

- Prevention of injuries and violence among children and young people.

- Prevention of chronic diseases and risk factors thereof among children and young people.

The sub-objectives (SO) and measures (M) of the field are based on the foregoing:

The sub-objective (SO) is based on the foregoing

SO 2. Decreasing mortality and primary morbidity in mental and behavioural disorders among children and young people, and an increasingly more positive assessment given by children and young people to their health.

The achievement of the sub-objective of the field is monitored by the following indicators:

Table 3. Indicators of achievement of the sub-objective of ensuring healthy and safe development to children and young people.

Indicator	Basic level 2006	Fulfilment 2011	Year 2012	Year 2016	Target level 2020
† Infant mortality coefficient (number of deaths of children under 1 year of age per 1000 children born alive). Source: Statistical Office	4.4 m: 5.7 w: 3.1	2.5 m: 2.4 w: 2.5	3.6	2.2 (3)	1.7 (2.6)
† mortality coefficient of children and young people between 0 and 19 years of age per 100,000 citizens. Source: Statistical Office	61.2 m: 82.2 w: 39.1	37 m: 41.2 w: 32.5	46	34 (39)	31
† mortality coefficient of children and young people between 0 and 19 years of age caused by injuries, poisoning and accidents per 100,000 citizens. Source: Statistical Office	30.1 m: 42.1 w: 17.5	15.8 m: 18.2 w: 13.3	23	12 (19)	7 (15)
Primary illness coefficient of mental and behavioural disorders of children and young people aged 1 to 19 per 100,000 citizens. Source: National Institute for Health	2,251 m: 2,597 w: 1,886	1987 m: 2,455 w: 1,492	2,058	1,929	1,801
The share of children aged 11, 13 and 15 characterizing their health as very good. Source: National Institute for Health, HBSC	31.3% m: 34.2% w: 28.5% (2005/ 2006)	29.3% m: 32.1 w: 26.6 (2009/ 2010	32.9%	33.8%	34.7%
* The share of infants aged 6 months partly or fully on breast feeding. Source: National Institute for Health	–	55.3%	–	66%	75%
* New indicator (basic level year 2011) † Corrected target level of indicator, previous target level in brackets					

The following measures shall be used to achieve the sub-objective of the field:

2009-2012	2013-2016

SO 2-1 Indicators of reproductive health and infant health have improved.	M 1 Promotion of reproductive and infant health
SO 2-2 Mortality of pre-school children caused by injuries and poisoning and primary cases of mental and behavioural disorders have decreased.	M 2 Health promotion of pre-school children
SO 2-3 Mortality of school-aged children and young people caused by injuries and poisoning and the number of primary cases of mental and behavioural disorders have decreased, and young people's evaluation of their health is increasingly positive.	M 3 Health promotion of school-aged children

Measures to be applied at governmental level

The task of the governmental level is to develop the priorities of the sub objective of the field, prepare measures for application of the priorities (in cooperation with the local governments, if necessary), modernise the legal system necessary for implementation thereof and plan resources necessary for the implementation of the measures. To ensure sufficient information for people enabling them to make informed choices in order to reduce health risks.

SO 2-1 Measures of 2009–2012 are shown as activities in application plan 2013-2016.

- Promote awareness of people on reproductive and sexual health; prevent unwanted pregnancies and sexually transmitted diseases; decrease social and health problems caused by infertility.

- Promote health and health behaviour of pregnant women, breast feeding of infants.

- Increase the availability of free high-quality health care, counselling and support services to pregnant women and families with infants.

- Ensure the availability of high-quality perinatal diagnostics and screening programmes of genetic diseases, as well as high-quality counselling service for pregnant women and infants.

- Increase the awareness and skills of parents to promote infant health and support development; promote the awareness of parents on the nature, influence and prevention of family and relationship violence, as well as possibilities for decreasing damages.

- Promote peri- and postnatal medical care by development of perinatal help indicators and regular monitoring. Create a system of medical monitoring and development therapy for the improvement of the quality of life of high-risk newborns after active treatment.

- Enhance the regular preventive health inspection of children aged up to 1 year for early detection of development and health disorders, counselling of parents and ensuring inclusion in immunization.

- Regularly monitor and evaluate the indicators and influencing factors of the sexual-reproductive health of the population and infant health, organising surveys, developing medical registries and the health information system and specifying the composition of the data collected.

<u>Recommended activities to be applied at the level of local governments</u>
Local government organises the application of activities within its scope of competence (including the creation of necessary legal grounds). Ensures sufficient information for people enabling them to make informed choices in order to reduce health risks.

- To create motivating conditions for the service providers in order to ensure the availability of services (providing premises, organising transport, etc.); to promote cooperation and networking between various specialists (health care professionals, social workers, teachers, etc.) with a purpose to ensure the sustainability of services and correspondence thereof to the needs of families and children.

<u>Recommended activities to be applied at the level of organisations</u>

To facilitate the achievement of the sub-objective of the field by creating a health-supporting physical and social environment.

- To facilitate the application of the principles of uniting family and professional life in order to support pregnant women and parents with small children, as well as creation of working conditions supporting healthy habits in workplaces.

<u>SO 2-2 Measures of 2009–2012 are shown as activities in application plan 2013-2016.</u>

- Increase the awareness and skills of parents to promote the health and support the development of toddlers and pre-school children.

- To enhance regular preventive health inspections carried out for early detection of development and health disorders of pre-school children, counselling of parents, maintenance of inclusion in immunization and prevention of dental diseases.

- Increase the capacity of pre-school child care institutions in promotion of children's health, supporting of children's readiness for school, ensuring inter alia high-quality age-appropriate health education of pre-school children and teaching of social skills according to the national curriculum.

- Promote the capacity of general medical care providers and the local government to prevent injuries of small children.

- Monitor and evaluate regularly the development and health indicators of small children, developing the health information system, carrying out surveys, specifying the composition and indicators of the data collected.

<u>Recommended activities to be applied at the level of local governments (in addition to SO 2-1)</u>

Local government organises the application of activities within its scope of competence (including the creation of necessary legal grounds). Ensures sufficient information for people enabling them to make informed choices in order to reduce health risks.

- Create possibilities for ensuring the availability of pre-school education and free pre-teaching to all pre-school children.

- Increase the availability of support services (speech therapy, psychological help, special needs education) for children with special developmental and educational needs, if necessary, in cooperation with county counselling centres.

- Determine the risks of injury and poisoning among children and young people and apply relevant prevention measures.

Recommended activities to be applied at the level of organisations

To facilitate the achievement of the sub-objective of the field by creating a health-supporting physical and social environment.

- To apply principles and measures in pre-school child care institution for promotion of children's health and development and prevent health disorders and injuries, in cooperation with parents and the local government.

SO 2-3 Measures of 2009–2012 are shown as activities in application plan 2013-2016.

- To prevent withdrawal of students from schools.

- To increase the capacity of schools and teachers to promote the health of children, developing age-appropriate high-quality health education, teaching of social skills according to the national curriculum and high-quality training opportunities outside the curriculum.

- To enhance activities aimed at prevention of injuries and poisoning, as well as promotion of mental health of pre-school children.

- To increase the availability of psychological help for pupils; to enhance the assistance for children with mental and behavioural disorders or those having experienced family violence or situations of crisis.

- To ensure modern and qualified long-term learning, treatment and rehabilitation opportunity for children and young people with serious mental and behavioural disorders with services provided by specialists in at least one residential educational institution.

- Improve the efficiency, quality and reliability of school health care service with a purpose to prevent health disorders and development of risk behaviour and reduce limitations to using educational opportunities due to health; to increase the efficiency of tooth disease prevention for pre-school children.

- Ensure group and individual supervision and mentoring opportunities for teachers in order to prevent burnout of teachers and promote the psycho-social environment of school.

- Promote the activity of counselling committees and schools in supporting of students with special needs and coping with health disorders.

- Monitor and evaluate regularly the development and health indicators of school-aged children, developing the health information system, carrying out surveys, specifying the composition and indicators of the data collected.

Recommended activities to be applied at the level of local governments

Local government organises the application of activities within its scope of competence (including the creation of necessary legal grounds). Ensures sufficient information for people enabling them to make informed choices in order to reduce health risks.

- Develop networking (movement of information) between the school, parents and social pedagogues / social workers to prevent withdrawal of young people with risk behaviour from school and offer young people individual opportunities to continue education, if necessary.

- Ensure the availability of the services provided by social pedagogues / social workers, medical personnel and teachers of health education in schools, speech therapists, psychologists and other specialists in schools of areas.

- Develop cooperation with the third sector to improve training opportunities for young people, including open youth centres.

Recommended activities to be applied at the level of organisations

To facilitate the achievement of the sub-objective of the field by creating a health-supporting physical and social environment.

- Apply principles and measures for promotion of the health, development and social skills of children and young people and prevention of injuries and violence in schools, clubs and hobby groups in cooperation with young people and the local government.

Recommended activities to be applied at the level of individual

Every person can reduce risks to health by making informed choices in organisation of daily life.

- A recommendation to parents, teachers and other grown-ups is to acquire additional knowledge about the peculiarities of children's health and development, age-specific needs; to develop skills of conflict-solving, negotiation and other social and parental skills.

- A recommendation to children and young people is to care about their health and that of others, acquire additional knowledge and social skills for that purpose, be an active partner in planning and implementing learning and hobby activities, including health-promoting activities.

III Healthy living, working and learning environment

Description of the field

The environment surrounding a person often influences the state of health more than perceived. For better management of the field this chapter describes the environment surrounding us outside the working and learning environment as living environment. The living, working and learning environment can be exposed to various (chemical, physical, biological) risk factors mainly from products, buildings, structures, vehicles and industrial establishments. People are subjected to the above risk factors either by immediate contact or through air, water and food. Also, contact with risk factors can take place through other people or animals. The negative influence of risk factors from living, working and learning environment may often be revealed only in years (e.g. by development of an allergy, nervous disorder or tumour). A person's health is often simultaneously influenced by several environmental risk factors. Thus, the influence of the environment is complex and depends on the nature of the environmental factors, as well as the duration of influence thereof.

The chapter of the present document regarding living, working and learning environment does not discuss social and psycho-social environmental factors but focuses on the negative influence of the biological, chemical and physical factors of the natural and man-made environment on a person's health.

Problems of the field:

- People are not sufficiently aware of the health risks from the living, working and learning environment and measures for management thereof.
- The evaluation, management and information system of health risks from the living, working and learning environment and the so-called system of implementing good practices (targeted development of health-promoting behaviour and health-supporting environment) is not efficient enough.
- The state-level preparedness to prevent spreading of communicable diseases, epidemics and pandemics is insufficient.
- The number of sick days caused by accidents at work and associated with work is large and causes loss to the economy of the state.
- Compliance with occupational health and safety requirements and product and food safety and health protection requirements is insufficient, and therefore the state supervision requires enhancement.
- Accessibility to living, working and learning environment and usability of those environments has not been guaranteed to all members of the society, including people with special needs.
- There is no systematic overview of risk factors present in the living, working and learning environment, and information about risk factors is not collected in systematic way.

*Priorities of the field***:**

- Increasing the awareness of various target groups of the health risks from the living, working and learning environment and measures for management thereof.
- Enhancement of the system of evaluation, management and information of health risks from the living, working and learning environment.
- Increasing the preparedness of the state to prevent the spreading of communicable diseases and epidemics and pandemics.
- Enhancement of supervision in the living, working and learning environment.
- Improvement of the organisation of occupational health and significant improvement of the quality of occupational health services and ensuring the availability thereof for all employees.
- To improve and maintain inclusion of the population in immunization.

The sub-objectives (SO) and measures (M) of the field are based on the foregoing:

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

The achievement of the sub-objective of the field is monitored by the following indicators:

Table 4. Indicators for the achievement of the sub-objective of the field of health-supporting living, working and learning environment.

Indicator	Basic level 2006	Fulfilment 2011	Year 2012	Year 2016	Target level 2020
† Respiratory disease mortality rate per 100,000 citizens Source: Statistical Office and National Institute for Health	36.9 m: 57.2 w: 19.6	31 m: 44.2 w: 19.8	34.5	31 (33)	31 (31.4)
† Number of fatal occupational accidents per 100,000 employees Source: Labour Inspectorate and Statistical Office	4.5	3.1	3.6	2.7 (3)	2.4
† Number of working days lost due to occupational accidents per 100 employees Source: Health insurance Fund and Statistical Office	20	16.7	18	16 (17)	15
Health impact of work: percentage of employed persons who believe that their work deteriorates their health Source: European Working Conditions Survey	59.2% (2005)	43.5% (2009)	50%	40%	30%
Number of people in the population infected with food-induced communicable diseases per 100,000 citizens Source: Health Board	303	340	250	200	200
Percentage of population supplied with drinking water conforming to requirements Source: Health Board	73%	72%	86%	88%	90%
Percentage of persons diagnosed with or treated for asthma among the age group 16–64 Source: National Institute for Health, survey of health behaviour	2.1% m: 1.8% w: 2.4%	2.7% m: 2.3% w: 3.0% (2010)	1.8%	1.7%	1.5%
† Annual average concentration of fine particles (PM10) in the air of Estonian cities (µg/m³) Source: Statistical Office, Estonian Environment Information Centre	20.7 (2005)	14.6	18	14 (16)	14
* Inclusion of 2-year-old children in immunization against measles, mumps and rubella (MMR) Source: Health Board	–	93.9%	–	≥95%	≥95%

* New indicator (basic level year 2011)
† Corrected target level of indicator, previous target level in brackets

The following measures (M) shall be used to achieve the sub-objective of the field:

2009-2012	2013-2016
M 1 Modernise the legal system facilitating the maintenance and improvement of the living, working and learning environment. M 2 Enhance the system of evaluation, management and information system of health risks from the living environment (including climate changes) and working and learning environment. M 3 Enhance the surveillance system of the living, working and learning environment (at different levels), develop strong and coordinated cooperation. M 4 Increase the awareness of people of health risks from the living, working and learning environment. M 5 Train experts for evaluation of health risks from the living, working and learning environment and enhance the quality of evaluation service of health risks. M 6 Organise training sessions for specialists of county and rural municipality governments on environmental health risks and management possibilities thereof. M 7 Organise surveys in order to assess the influence of environmental factors in the living, working or learning environment on health and publish the results of the surveys. M 8 Develop the cooperation of family physicians with occupational health doctors and health protection specialists to ensure prevention and effective treatment of health disorders and illnesses, considering the connection of negative impacts on health and the living, working or learning environment. M 11 Include occupational health and safety in the curricula of establishments providing general and professional education. M 12 Improve the organisation of occupational health, significantly improve the quality of occupational health services and availability of the services for all employees. M 13 Develop an insurance system for accidents at work and occupational diseases and coordinate the application thereof. M 14 Ensure access to the living, working and learning environment and usability thereof by all members of the society	M 1 Development of health-supporting living environment and reducing of health risks based on the living environment. M 2 Development of healthy learning environment and reducing of health risks based on the studying environment. M 3 Development of health-supporting working environment and reducing of health risks based on the working environment.

M 15 Make instruction materials on making the living, working and learning environment safer for health available to relevant target groups.	
M 9 Increase the share of people included in immunization. M 10 Ensure state-level preparedness to prevent spreading of communicable diseases, epidemics and pandemics, including updating of the necessary laboratory base.	M 4 Organisation of surveillance, prevention and control of spreading of communicable diseases.

Measures of 2009–2012 are shown as activities in application plan 2013-2016.

Measures to be applied at governmental level

The task of government institutions is to develop the priorities of the sub-objective, prepare measures for application of the fields of priority (in cooperation with the local governments, if necessary), modernise the legal system necessary for implementation thereof and plan resources necessary for the implementation of the measures. To ensure sufficient information for people enabling them to make informed choices in order to reduce health risks.

Recommended activities to be applied at the level of local governments

Local government organises the application of activities within its scope of competence (including the creation of necessary legal grounds) in living, working and studying environment. Ensures sufficient information for people enabling them to make informed choices in order to reduce health risks.

- Determine risk factors and consider them in planning and construction activity and inform people of risk factors.
- Increase the awareness of people of environmental health risks and measures for control thereof.
- Rely on principles making the living, working and studying environment accessible and usable for all members of the society in designing the public space (both internal and external).

Recommended activities to be applied at the level of organisations and enterprises

Facilitate the implementation of the priorities of the sub-objective of the field, informing people of health risks and actively participate in shaping of the priorities of the sub-objective.

- Organise evaluation of health risks in designing of strategic directions and consider those (including application of risk management measures).
- Assess health risks in a company.
- Increase the awareness of people on prevention of health risks and possibilities for reducing them.

- Facilitate health-promoting activities in workplaces.
- Consider guidelines and standards in organisation of work to reduce health risks from the living, working and studying environment.

Recommended activities to be applied at the level of individual:

Every person can reduce risks to health by making informed choices in organisation of daily life. Every person is responsible for shaping his/her living conditions at home. Thereby one must consider the possible health risks to oneself and people close to oneself, as well as neighbours, and if possible, health risk management activities must be applied already in the planning and building phase of home.

- Be aware of risks based on the living, working and studying environment and use the activities for preventing or reducing risks in one's daily life and workplace.
- Inform other people of health risks connected with the living, working or studying environment.

IV Healthy lifestyle

Description of the field

This chapter provides an overview of possibilities to increase healthy choices and reduce risk behaviour of people. The aim of facilitating healthy choices and healthy lifestyle is connected with all the other chapters of the development plan but this chapter mainly focuses on health risks and shaping of health behaviour. In regard to healthy choices the main target group

includes children and young people, as investment into the health of children and young people is one of the most effective methods to ensure the good health of future grown-ups.
Risk factors of illnesses and injuries are often interconnected, and therefore it is important to view the prevention thereof as a whole. The main behavioural factors influencing health are small physical activity, unbalanced diet and risk behaviour, e.g. consumption of alcohol, tobacco and illegal drugs, gambling, risky sexual behaviour and unsafe behaviour in traffic (exceeding the speed limit, neglecting the use of seat belts and reflectors, etc.).
Health behaviour is directly influenced by personal attitudes, beliefs, values, awareness, skills and motivation. Living environment surrounding people with its environmental, social-economic and psycho-social influences greatly determines the decisions a person makes in regard to his/her health and how he/she treats the health of other people.
To facilitate healthy lifestyle measures for shaping health awareness and a health-supporting environment must be implemented in cooperation with representatives of other fields of life. Availability of opportunities facilitating physical activity and nutritious food must be increased, availability of substances causing physical and mental addiction and demand for those must be reduced, and safe behaviour in traffic, household and during leisure activities must be facilitated.

Main problems of the field

- Most of young students lack sufficient physical effort to ensure normal physical development. Physical activity among grown-ups is also low, especially in older age groups and lower social-economic groups.

- Information work does not focus sufficiently on increasing the daily physical activity. Support to sports-related hobbies in and outside of schools is insufficient. The extent and quality of medical care, information service and counselling for people going in for sports (including young sportsmen and -women) does not meet the needs. The training system of specialists in the field of sports for all is weak. A network of accessible sporting facilities at close distance based on the location of housing areas and schools has not been developed. Not all settlements have sports grounds and playgrounds located as close to the homes or schools of children and their parents as possible.

- Fruit, vegetables, rye bread and fish are eaten less than recommended and cooking fats, sweets, meat products and salt are eaten more than recommended.

- There are no integrated intervention activities in schools and workplaces aimed at catering in canteens, by food sellers or buffets. Inclusion of food processors into facilitation of healthy eating is small. There is no national system for training and professional qualification of nutrition specialists. Food with high content of fat, salt and sugar and small nutritional value is advertised to vulnerable target groups.

- There are no regular surveys on determination of attitudes and factors influencing the movement and eating habits of the population and various risk groups, monitoring of the trends in children's overweight (including the monitoring of anthropometric indicators) and planning effective interventions.

- There are no regular risk surveys regarding eating and food safety.

- Alcohol is consumed often and in large quantities, especially among minors. The causal role of intoxication in deaths

caused by injuries is remarkable.

- Alcoholic beverages are easily accessible for young people. Surveillance of the fulfilment of the alcohol regulation is insufficient. Intense advertising of alcohol in the media can be observed, as well as abundance of public events promoting the consumption of alcohol. A system for early detection of alcoholism, counselling on recovery from alcoholism and treatment options of alcohol dependency has not been developed.

- The tendency of decrease in the number of daily smokers is smaller among women in comparison to men. The share of smokers is larger among people with lower income, non-Estonians and unemployed. People start smoking in increasingly younger age. The prevalence of hookah and smoke-free products, mostly snuff, is increasing among young people. The share of people spending time in smoke-filled home premises is large among the population with lower level of education.

- The age of first-time illegal drug users is constantly dropping. The number of persons injecting drugs, crimes associated with drugs, injection of stimulants and mixed use, as well as spreading of HIV infection among injecting drug addicts have increased.

- The availability of services helping to overcome dependency has not been ensured for everyone in need. Support services for the people close to addicts are not sufficiently available. The number of children's psychiatrists, child protection specialists and social workers is insufficient and their work load is large.

- Sexual transmission of HIV has become more frequent. The number of new infected grown-ups has increased due to insufficient use of protective means.

- Problems accompanying dependency have increased, including health problems, misuse of addictive substances, bankruptcy, social isolation and violence and crimes have increased.

- Prevention of injuries is hindered by insufficient collection of information. Various institutions use different methods, there is no institution collecting and comparing different flows of information. Information regarding injuries is registered unevenly and incompletely in health institutions.

- Since 1998 when the number of new cases of tuberculosis reached the highest level in Estonia (48 new cases of tuberculosis per 100,000 citizens), the general number of cases has decreased more than twice thanks to the national programme (19.7 cases of tuberculosis per 100,000 citizens in 2011). Today, the biggest problem in Estonia is a very high ratio of multi-drug-resistant (MDR) cases, including the extra-drug-resistant (XDR TB) cases and people with tuberculosis infected with HIV. In 2011, 24% of the primary cases and 52.7% of previously treated cases of lung tuberculosis were multi-resistant; the share of people with tuberculosis infected with HIV increased to 13.2% of all the cases of tuberculosis.

Priorities of the field based on the foregoing:

- Shaping of health-supporting social norms and values in the Estonian society.

- More active inclusion of the private sector (including media) and non-governmental organisations into the creation of an environment facilitating healthy choices.

The sub-objectives (SO) and measures (M) of the field are based on the foregoing:

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

The achievement of the sub-objective of the field is monitored by the following indicators:

Table 5. Indicators of achievement of the sub-objectives of the field of healthy lifestyle.

Indicator	Basic level 2006	Fulfilment 2011	Year 2012	Year 2016	Target level 2020
Percentage of overweight persons in the age group 16–64. Source: NIHD, Health Behaviour Study	30.5% m: 37.3% w: 26.1%	31.7% m: 36.6% w: 28.4% (2010)	28%	26%	25%
Percentage of obese persons in the age group 16–-64. Source: NIHD, Health Behaviour Study	15.2% m: 14.9% w: 16.5%	16.9% m: 17% w: 16.8% (2010)	13%	13%	12%
Percentage of overweight school students. Source: School health reports of EHIF	7.8 % (2006/ 2007)	10.5% (2011/ 2012)	7%	6.5%	6%
Number of new HIV infection cases per 100,000 citizens. Source: Health Board	47.2 m: 60.4 w: 35.9 (2007)	27.6 m: 36.9 w: 19.7	30	20	15
Percentage of pregnant women with HIV among all pregnancies.. Source: Health Board, National Institute for Health	0.3%	0.49% (2007)	<1%	<1%	<1%
Percentage of young people (age group 15–16) who have tried illegal drugs. Source: National Institute for Health, ESPAD	33.5 % m: 37% w: 23% (2007)	32 m: 36% w: 27%	29	24	21
Number of fatal accidents, poisonings and injuries per 100,000 citizens Source: Statistical Office	121 m 201 w: 53	85 m:144 w: 34	95	78	61
† Number of people killed in traffic accidents with participation of intoxicated drivers. Source: Estonian Road Administration	53	14	35	14 (25)	14 (15)
* Number of people under 65 having died of cardiovascular diseases per 100,000 citizens Source: Statistical Office	–	94 m: 150 w: 41	–	73	56
* Share of persons aged 16–64	–	36.3%	37%	45%	53%

regularly going in for sports Source: National Institute for Health, survey of health behaviour		m: 36.9% w: 35.8% (2010)			
* Annual consumption of absolute alcohol per citizen in litres Source: Estonian Institute of Economic Research	–	10.2	–	<8	<8
* Share of daily smokers aged 16–64 Source: National Institute for Health, survey of health behaviour	–	26.2% m: 36.8% w: 18.7% (2010)	–	21.5%	18.3%
* Number of primary cases of tuberculosis per 100,000 citizens Source: National Institute for Health, Register of Tuberculosis	–	19.8 m:29.8 w: 11.2	–	16	14
* New indicator (basic level year 2011) † Corrected target level of indicator, previous target level in brackets					

The following measures shall be used to achieve the sub-objective of the field:

2009-2012	**2013-2016**
SO 4-1 Physical activity of the population has increased.	M 1 Increasing the physical activity of the population
SO 4-2 Eating habits of the population have improved.	M 2 Improving the eating habits of the population
SO 4-3 Risk behaviour of the population has decreased	M 3 Decreasing of damage to health and society caused by alcohol M 4 Decreasing of damage to health and society caused by tobacco M 5 Prevention and reducing of the consumption of narcotic substances and decreasing of damage to health and society M 6 Prevention and decreasing of injuries M 7 Prevention of new cases and achievement of a permanent tendency of decrease in spreading of HIV/AIDS M 8 Protection of the population from infection of tuberculosis

<u>Measures to be applied at governmental level</u>

The task of the governmental level is to develop the priorities of the sub objective of the field, prepare measures for application of the fields of development (in cooperation with the local governments, if necessary), modernise the legal system necessary for implementation thereof and plan resources necessary for the implementation of the measures. To ensure sufficient information for people enabling them to make informed choices in order to reduce health risks.

SO 4-1 Measures of 2009–2012 are shown as activities in application plan 2013-2016.

- Increase the awareness of people of health-supporting physical movement and possibilities of sports, and integrate the topics of sport for all (including consideration of the physical abilities of children) into the basic and in-service training of teachers and state curricula; ensure the availability of relevant materials and trainings for target groups and related groups.

- Ensure supportive environment and infrastructure facilitating physical activity (including health-promoting networks, school sport, counselling service on sports and medical services).

- Regularly monitor and assess the sports habits of the population, factors influencing those habits and interventions aimed at those; update the database of sports statistics.

Recommended activities to be applied at the level of local governments

Local government organises the application of activities within its scope of competence (including the creation of necessary legal grounds). Ensures sufficient information for people enabling them to make informed choices in order to reduce health risks.

- Update the development plans of local governments regarding the evaluation results of sporting facilities at close distance and according to recommended standards of sports locations; invest into building of an infrastructure facilitating sports activities.

- Increase the possibilities for people to spend leisure time being physically active.

Recommended activities to be applied at the level of organisations

To facilitate the achievement of the sub-objective of the field by creating a health-supporting physical and social environment.

- Distribute information on sports activities to the personnel and set physically active people as examples.

- Promote physical activity in an organisation.

- Develop information and training centres with all-Estonian sports associations, regional sports associations and health organisations and sports and health tracks in cooperation with the public sector.

Recommended activities to be applied at the level of individual

Every person can reduce risks to health by making informed choices in organisation of daily life.

- Increase knowledge of the positive influence of physical activity and use the possibilities and services of sports activities.

- Support the people close to oneself in shaping habits of going in for sports, offering positive example and actively engaging others.

SO 4-2 Measures of 2009–2012 are shown as activities in application plan 2013-2016.

- Increase the awareness of people of balanced and nutritious eating patterns, and integrate the topics related to eating and food into the basic and in-service training of teachers and state curricula; ensure the availability of relevant materials and trainings for target groups and related groups.

- Ensure an environment supporting healthy eating choices of people and observation of the principles of balanced eating in institutional catering.

- Develop counselling service on nutrition and ensure the availability thereof to risk groups.

- Regularly monitor and assess the eating habits of the population, trends of overweight (including the monitoring of anthropometric figures) and relevant interventions and carry out a risk-usefulness evaluation analysis on nutrition (eating, food safety, etc.).

Recommended activities to be applied at the level of local governments

Local government organises the application of activities within its scope of competence (including the creation of necessary legal grounds). Ensures sufficient information for people enabling them to make informed choices in order to reduce health risks.

- Integrate the topic of balanced eating and catering into the development plans of local governments.

- Support institutional catering and organise the following of legislation on food and nutrition and inspection thereof within the field of competence.

- Develop and implement a conception of supporting services to ensure nutritious eating for vulnerable groups.

- Support organisations and projects with a objective of facilitating healthy eating.

Recommended activities to be applied at the level of organisations

- To facilitate the achievement of the sub-objective of the field by creating a health-supporting physical and social environment.

- Decrease the content of salt, sugar and fat in products, where possible, make nutritional information of products easily accessible for a consumer.

- Create positive role models in the media; ensure that advertising does not mislead the consumer or use the gullibility of vulnerable groups; broadcast media-based study programmes aimed at healthy eating.

- Promote healthy eating in an organisation.

Recommended activities to be applied at the level of individual

Every person can reduce risks to health by making informed choices in organisation of daily life.

- Increase knowledge of balanced and nutritious eating and labelling on food; use the possibilities and services aimed at healthy eating.

- Support the people close to oneself in shaping eating habits, offering positive example and actively engaging others.

SO 4-3 Measures of 2009–2012 are shown as activities in application plan 2013-2016.

- Increase people's awareness of risk behaviour and integrate topics related to risk behaviour into the basic and in-service training of teachers and state curricula; teach skills of life in general and professional educational institutions, extending it to young people with risk behaviour and most vulnerable young people; ensure the availability of appropriate materials and trainings for target groups and related groups (including trainings for young people by young people); develop the possibilities for spending leisure time in cooperation with partners.

- Establish stricter limitations to advertising and promotion of addictive substances and implement measures of social marketing and anti-advertising.

- Enhance surveillance of the legislation governing the handling and consumption of addictive substances and apply inevitable and efficient sanctions in regard to violators of law.

- Ensure the availability of extensive and high-quality services of decreasing damages (including counselling and substitution treatment), injecting equipment and condoms to various target groups.

- Carry out prevention of risky sexual behaviour and HIV in various target groups, providing information, shaping attitudes and skills, organising trainings and ensuring the availability of testing and means of protection.

- Ensure the availability of high-quality addiction counselling, addiction treatment and rehabilitation services for people in need.

- Develop support networks for vulnerable groups and increase the number of competent persons working in the field of risk behaviour prevention, addiction treatment and rehabilitation, organising training and in-service training of specialists.

- Develop and implement principles for excessive use and abuse of alcohol, injuries and gambling addiction.

- Carry out regular surveillance of behaviour, prevalence of addictive substances and consequences of the consumption thereof, surveys of factors influencing risk behaviour and evaluation of interventions.

Recommended activities to be applied at the level of local governments

Local government organises the application of activities within its scope of competence (including the creation of necessary legal grounds). Ensures sufficient information for people enabling them to make informed choices in order to reduce health risks.

- Integrate the topic of prevention and reduction of risk behaviour into the development plans of local governments.
- Ensure an appropriate number of qualified child protection specialists and social workers for local governments.
- Facilitate the creation and operation of self-help and support groups.
- Support organisations and projects for prevention and solving of risk behaviour either financially or by other resources necessary for the operation.
- Promote life style free of addictive substances and create alternative possibilities for spending leisure time.

Recommended activities to be applied at the level of organisations

To facilitate the achievement of the sub-objective of the field by creating a health-supporting physical and social environment.

- Create positive role models in media with the help of media organisations, and offer media-based entertaining study programmes to reduce risk behaviour.
- Consider prevention principles of risk behaviour in product development and marketing, avoiding products and advertisements appealing to minor consumers; retail sellers must prevent alcohol sale to minors.
- Civil associations and NGOs must develop cooperation; initiate, plan, develop and implement prevention activities with government organisations; ensure the conformity of the organisation's activity to international standards.

Recommended activities to be applied at the level of individual

Every person can reduce risks to health by making informed choices in organisation of daily life.

- Update one's knowledge and skills, using opportunities, services and means aimed at decreasing risk behaviour, and support healthy behaviour of people close to oneself.
- Avoid the consumption of alcohol and tobacco in public places and use safety equipment (seat belts, condoms, etc.).

V Development of the health care system

Description of the field

According to the latest surveys, the health care system influences the health of people for up to 30%. As the society develops, new challenges emerge, and in order to answer those, balance and compromise between different interest groups of the society are required.

Every decision regarding health care policy influences the well-being and health of the population. Management of health care system means creating balance between needs and opportunities, ensuring the availability of high-quality health care service meeting the needs of people through optimum use of resources.

After regaining independence, great changes have taken place in the Estonian health care system. Health care reforms started in 1992 with adoption of solidary insurance-based funding of health care bringing along separation of the providers and the funding of health care service, as well as contractual relationships between the Health Insurance Fund and the providers of health care service. Another important change in the Estonian health care system is reorganisation of the network of service providers through the primary system focused around family physicians and an optimised hospital network.

The public sector has a remarkable role in the Estonian health care system to organise health care and ensure the availability of health care services. At the same time, several principles of the private sector have been applied in order to facilitate the functioning and flexibility of the health care system. Therefore, all health care service providers operate under private law. Family physicians are mainly self-employed entrepreneurs or owners and employees of business organisations and hospitals, foundations or limited companies. In order to better guarantee the correspondence of the operation of hospitals to public interests, the owners of hospitals are the state, local government or another organisation governed by public law directing the daily activities of the executive managements of hospitals through hospital councils.

The health care system must be patient-focused to ensure consistency of treatment. An important prerequisite is cooperation and coordination between the primary, specialised medical care and nursing care / welfare services. Knowledge of patient is another important aspect, which means, on the one hand, a skill to find one's way in the health care system, and on the other hand awareness of one's health problems and treatment possibilities.

Main problems of the field

Funding

- Limited income of medical insurance, which puts the sustainability of health care funding at risk due to ageing of the population leading to increased needs and more expensive services,
- A rather high rate of self-participation amount in payment for health care services and medicines, which is a problem mainly in regard to people with chronic diseases and lower income.

Resources

- Human resources and capacity of the infrastructure of health care service providers are limited.
- Competence evaluation of health care professionals is not sufficiently coordinated.
- There is no evaluation system for identifying the need for
- expensive medical equipment.
- Availability of medicines is uneven.
- Inefficiency of the hospital network, e.g. some beds are not used in the hospitals of the

network, which indicates a need for continued reorganisation of services.

Services

- Due to the ageing population, a need for nursing care / welfare services increases.
- Long waiting lists for medical specialists.
- Small share of in-patient services in specialised medical care.
- The availability of primary health care services is uneven.

Management

- Low awareness of people of where to turn to protect one's rights if a person is not satisfied with the health care service provided.
- Different management, organisation and financing of nursing care and welfare services.
- Insufficient exchange of information between providers of different health care services.
- No system of activity indicators of health care service providers.

Priorities of the field based on the foregoing:

- The health care system must be fair, ensuring the availability of high-quality health care services by optimum use of resources.
- The health care system including qualified and motivated health care professionals must be patient-focused.
- Funding of health care takes place according to the principle of solidary medical insurance, ensuring equal availability and quality of health care services for everyone covered by medical insurance.
- The financing system of health care must be sustainable in long term in order to ensure the availability of high-quality health care services and offer protection to people against financial risks.

The sub-objective (SO) is based on the foregoing:

SO 5. All people have access to high-quality healthcare services through optimal use of resources.

The achievement of the sub-objective of the field is monitored by the following indicators:

Table 6. Indicators of achievement of the sub-objective of health care system development.

Indicator	Basic level 2006	Fulfilment 2011	Year 2012	Year 2016	Target level 2020
Number of doctors per 100,000 citizens. Source: National Institute for Health	322	323	320	320	320
Number of nursing staff per 100,000 citizens Source: National Institute for Health	680	640	761	830	900
† Percentage of people who are fairly or very satisfied with the quality of medical care. Source: MoSA, survey “Satisfaction of Residents with Healthcare Services”	69% (2007)	72.4%	70%	76% (71%)	80% (72%)
Percentage of people who believe that accessibility of medical care is good or very good. Source: MoSA, survey “Satisfaction of Residents with Healthcare Services”	60% (2007)	51.4%	62%	65%	68%
Percentage of household expenditures of the total healthcare expenditures. Source: National Institute for Health	24%	17.6%	<25%	<25%	<25%

† Corrected target level of indicator, previous target level in brackets

Measures applied for achievement of the sub-objective of the field, based on the foregoing:

2009 – 2012	2013 - 2016
SO 5-1 Development of a patient-focused health care system through improved knowledge of people and improved coordination of medical care at different levels	M 1 Protection of patients' rights, ensuring the safety and quality of health care services
SO 5-2 Ensuring the availability of high-quality health care services through the development of primary health care services, optimisation of the hospital network of active treatment and development of nursing care / welfare services	M 2 Ensuring primary health care meeting the expectations and needs of the society, including nursing and midwifery. M 3 Organisation of specialised medical care in order to ensure the availability of need-based high-quality specialised medical care services. M 5 Ensuring preparedness for health emergencies and provision of available ambulance service
SO 5-3 Ensuring long-term sustainability of health care, thereby insuring the financial protection of people in the event of a health risk	M 4 Ensuring sufficient resources for the operation of the health care system (motivated and competent employees, optimum funding and modern infrastructure, safe, high-quality and available medicines, blood

	products and medical equipment)

Measures to be applied at governmental level

The task of the governmental level is to develop the priorities of the sub objective of the field, prepare measures for application of the fields of development (in cooperation with the local governments, if necessary), modernise the legal system necessary for implementation thereof and plan resources necessary for the implementation of the measures. To ensure sufficient information for people enabling them to make informed choices in order to reduce health risks.

SO 5-1 Measures of 2009–2012 are shown as activities in application plan 2013-2016.

- To protect the rights of patients and increase their awareness of their rights in the health care system.
- Modernise and organise the legal system necessary for the organisation of first aid trainings.
- Promote teaching on health care in schools.
- Organise satisfaction surveys of patients and personnel, analyse results and provide feedback.
- Develop and apply a system of quality indicators of services.

Recommended activities to be applied at the level of local governments

Local government organises the application of activities within its scope of competence (including the creation of necessary legal grounds). Ensures sufficient information for people enabling them to make informed choices in order to reduce health risks.

- Enhance cooperation with family physicians in implementation of information activities of the health care system and prevention programmes.

Recommended activities to be applied at the level of organisations

To facilitate the achievement of the sub-objective of the field by creating a health-supporting physical and social environment.

- Organise patient satisfaction surveys, analyse the results, provide feedback and implement improvement activities.
- Organise personnel satisfaction surveys, analyse and publish the results and implement improvement activities.
- Develop quality management systems; introduce those to patients and employees.
- Develop and implement customer service standards.
- Organise counselling and trainings on coping with an illness for patients and people close to him/her, and distribute information materials.
- Organise first aid trainings.

Recommended activities to be applied at the level of individual
Every person can reduce risks to health by making informed choices in organisation of daily life.

- Apply a healthy lifestyle.
- Participate in first aid trainings.
- Increase awareness of health care through life-long learning.

SO 5-2 Measures of 2009–2012 are shown as activities in application plan 2013-2016.

- Ensure the availability of optimum standardised ambulance service for all in need.
- Promote the cooperation of the ambulance service and other service providers in order to ensure preparedness for effective operation in emergencies (trainings and practices, necessary resources).
- Develop home nursing service and other primary health care services.
- Ensure general medical care outside the working hours of family physicians.
- Centralise the planning and organisation of primary health care services.
- Improve the availability of specialised medical care by shortening waiting lists.
- Direct people in need of nursing care services to treatment and/or welfare services of proper level, increase the share of in-patient and home services.
- Ensure an optimum number of motivated employees.
- Motivate health promotion and prevention of illnesses.
- Develop a modern health care infrastructure, relying on the development of medicine and need for medical care.
- Enhance the cooperation and exchange of information between various service providers, as well as cooperation and exchange of information with other fields (educational system, social welfare, etc.).
- Apply the principles of E-Country and innovative solutions.
- Enhance surveillance activities, increase the number of clinical audits.

Additional activities in the application plan for 2013–2016 SO 5 measures
M 2. Ensuring primary health care meeting the expectations and needs of the society, including nursing and midwifery;
M 3. Organisation of specialised medical care in order to ensure the availability of need-based high-quality specialised medical care services and

M 4. Ensuring sufficient resources for the operation of the health care system (motivated and competent employees, optimum funding and modern infrastructure, safe, high-quality and available medicines, blood products and medical equipment)
under:

- Continue to optimise the hospital network, creating legal grounds and supporting financing measures for the operation of general hospitals.
- Continue to strengthen competence centres of the hospital network by continually investing into modern infrastructure and specifying legal prerequisites.
- Develop and implement the development directions of the hospital network and primary health care until year 2020.
- Support investments into the infrastructure of primary health centres in magnet areas of the population, ensuring available and diverse primary services.

The objective of additional activities is to focus on a continuous need for organisation of the hospital network and direction to strengthen the primary level with investments, and develop and implement the directions of development of primary health care and the hospital network until year 2020.

<u>Recommended activities to be applied at the level of local governments</u>
Local government organises the application of activities within its scope of competence (including the creation of necessary legal grounds). Ensures sufficient information for people enabling them to make informed choices in order to reduce health risks.

- Participate in development and maintenance of the infrastructure of primary health care services.

- Develop integrated nursing care service.

<u>Recommended activities to be applied at the level of organisations</u>
To facilitate the achievement of the sub-objective of the field by creating a health-supporting physical
and social environment.

- Analyse the satisfaction of health care professionals and increase it through a motivation
- system.

- Organise, evaluate and support in-service training of health care professionals.

- Prioritise health promotion and prevention of illnesses.

- Regularly organise competence evaluation.

- Enhance cooperation with Tartu University and institutions of higher education on health care to plan, train and recruit personnel.

- Develop a modern infrastructure, relying on the development of medicine and need for medical care.

- Apply modern IT and communication equipment (including telemedicine).

<u>SO 5-3 Measures of 2009–2012 are shown as activities in application plan 2013-2016.</u>

- Cover the population of Estonia with medical insurance.
- Predict the need for medical care, considering the regional aspects of the burden of disease.
- Ensure the safety, quality and availability of medicines, blood products and medical equipment.
- Ensure the financial sustainability of the medical insurance system.

<u>Recommended activities to be applied at the level of local governments</u>
Local government organises the application of activities within its scope of competence (including the creation of necessary legal grounds).

• Ensure medical care for people without medical insurance in the extent not covered by emergency care.

11. Management system of the development plan

An important part of the NHP 2009–2020 is a set of measures of the field for achievement of the objectives of the development plan and a system of indicators to monitor the movement towards the objectives. A large part of the indicators is connected with various surveys of the population organised every two years, thus all indicators can be updated every two years.

For efficient implementation of the NHP, the following are necessary: an overview of previous activities, evaluation of mid-term targets achieved as a result of those activities, modernisation of priorities and activities and implementation of the planned changes. At the same time, those activities take place with different regularity. For example, implementation of measures and financial resources necessary for that are planned each year but changes in public health take place rather slowly and it is more reasonable to monitor those after a longer interval. There are three management cycles of the NHP:

- annual, including an overview of the activities in the development plan and current management decisions regarding the financing and implementation of activities;
- biennial, including (in addition to current management decisions) also updating of the indicators in the development plan, drafting of a fulfilment report and a decision of the government regarding the previous activities and possible new directions. Biennial updating of the indicators is based on the frequency of the population survey taking place with such frequency;
- every four years, including also the activity of a research council in addition to the previous.

For drafting of reports regarding the fulfilment of the development plan and the final report, ministries submit a summary to the Ministry of Social Affairs regarding the implementation of measures and activities of the whole period in their field of responsibility. The Ministry of Social Affairs drafts a report, obtains the approval of ministries and submits it to the Government of the Republic for approval latest on June 30th (final report latest on June 30th, 2021).

Management bodies

2009-2012 application period:

As stated above, every four years a comprehensive evaluation of the National Health Plan and reviewing of objectives is organised consisting of four main parts with a control body for each part. Those four parts rely on various activities necessary for the management of the development plan, and are shown in Figure 4B with approximate times during the year.

2013-2016 application period:

Every four years a comprehensive evaluation of the National Health Plan and reviewing of objectives is organised consisting of three main parts with a control body for each part. Those three parts rely on various activities necessary for the management of the development plan, and are shown in Figure 4C with approximate times during the year.

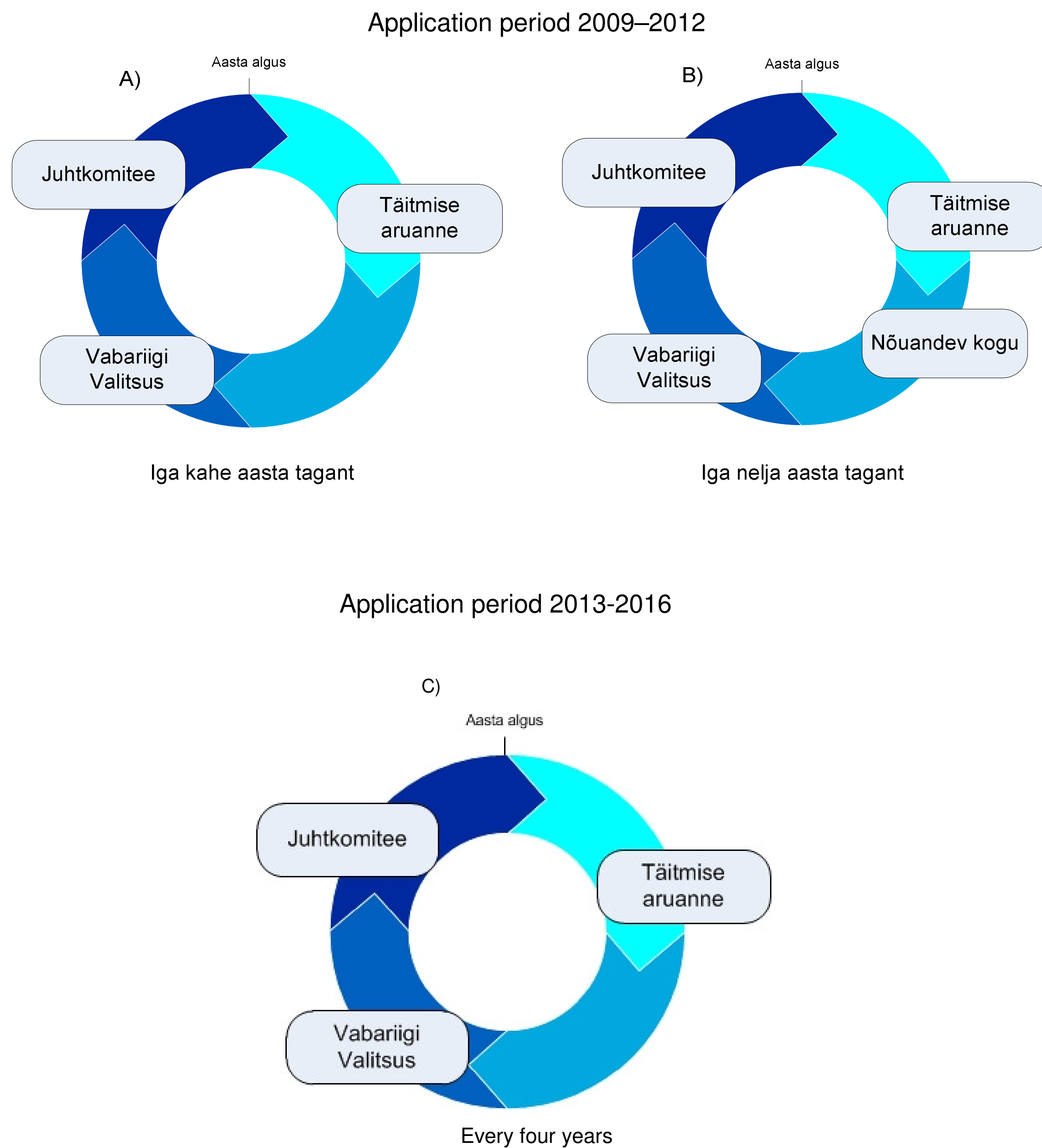


Figure 4. One-year management cycle of the National Health Plan with different management bodies.

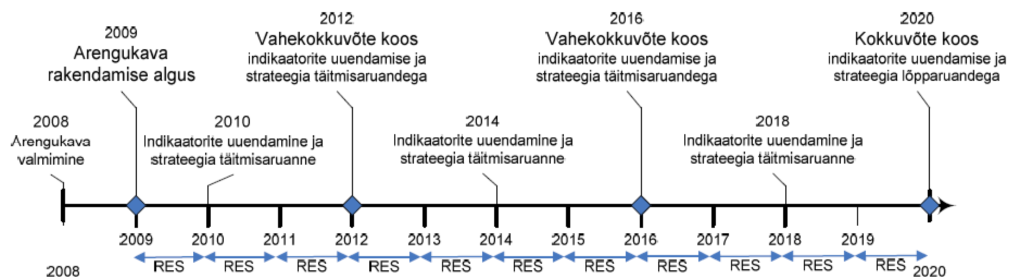
The composition of management bodies of the National Health Plan and detailed content of their activities is the following:

1. Groups of experts of fields and a report of results/activities
   Information on the results of the indicators in the National Health Plan, activities carried out during the previous year and success in achievement of the strategic objectives of the development plan is collected at the Ministry of Social Affairs. Based on expert groups of fields having participated in the preparation of the NHP, expert

groups are formed also for evaluation of the results of the development plan. An overview of activities drafted by the Ministry of Social Affairs and expert evaluation based on that form a basis for summaries of the previous period of the development plan, which in turn provide input for the activity of the next management body.

2. Government of the Republic
   A report on the previous period of the NHP having preferably passed a round of approval in the management committee is submitted to the Government of the Republic for discussion. The purpose of the discussion is to ensure the conformity of the plan of further activities of the NHP with the development directions and activities planned by the state. According to the results of a meeting of the Government of the Republic, the priorities and interim objectives for the next period are established for the application of the NHP, implementation of which is the responsibility of the management committee of the NHP.
   A report of the previous period of the National Health Plan is submitted to the Finance Committee of Riigikogu for examination.

3. Management committee
   The management committee of the NHP consists of representatives of various ministries, whose tasks preferably include planning and implementation of the state budgeting strategy (RES). Also, one representative of local governments and one representative of non-governmental organisations belongs to the management committee. If necessary, specialists and representatives of various fields may be engaged in the activity of the management committee.
   The task of the management committee is to plan particular activities for the next period of the NHP and financial means necessary to implement those. The above is based on an analysis of the results of the activities of previous periods, recommendations of the advisory body and objectives established by the government. Every member of the management body is responsible before the management body for organisation of the activities of his/her ministry or related group, achievement of the objectives in his/her field of administration and provision of information necessary for groups of experts for reporting on the development report.



Joonis 5. Rahvastiku tervise arengukava tulemuste kokkuvõtete tegemise ajakava.
RES – riigi eelarvestrateegia

Different management cycles of the NHP have been integrated in Figure 4 where in addition to the annual update of the overview of events (as it forms a basis for the activity of the management body) updating of the indicators of the development plan and a more comprehensive evaluation of activities accomplished have been provided.

Implementation of the NHP is coordinated by the Ministry of Social Affairs. In addition to institutions in the field of administration of the Ministry of Social Affairs, also the Ministry of Defence, Ministry of the Environment, Ministry of Internal Affairs, Ministry of Education and Research, Ministry of Agriculture, Ministry of Culture, Ministry of Justice, Ministry of

Economic Affairs and Communications, local governments and civil organisations participate in the implementation of the development plan.

12. Application plan and cost estimation of the development plan

As the NHP is a framework document applied mainly through the development plans approved or developed by the Ministry of Social Affairs and development plans of fields in the administration field of other ministries, a need for additional financing is planned during the process of drafting and supplementing of development plans of fields and the state budgeting strategy and the State Budget Act. The NHP is mainly implemented through financing of the field of administration of the Ministry of Social Affairs and budgetary financing of other ministries. Additional finances are planned while drafting the state budget based on annual field of administration of the Ministry of Social Affairs " Financial Framework and Activity Plan: New Initiatives and Main Growths" for the field of administration of the Ministry of Social Affairs. The total estimated cost of the NHP in period 2009–2020 is 1,066.29 billion kroons, including 311.07 billion kroons in period 2009–2012. Finances for the NHP in the field of administration of the Ministry of Social Affairs are planned according to table in the field of administration of the Ministry of Social Affairs "State Budget Strategy 2009–2012 – Financial Framework and Activity Plan: New Initiatives and Main Growths" submitted to the Ministry of Finance in March 2008. As an exception, amounts are added to the funds applied for in March in order to implement the conception of extending medical insurance to persons without medical insurance (discussed in a meeting of the Government Cabinet on April 24th, 2008) and the estimated receipt of the social tax in the budget of the Estonian Health Insurance Fund is increased, relying on the estimation of the Ministry of Finance of receipt in spring. Estimated costs of other ministries are added in approval rounds, considering the costs of existing development plans. The figures are indicative; actual possibilities for funding of the development plan depend on the division of the limits to activities in the field of government of the Ministry of Social Affairs and other ministries provided in the financial plan of "The State Budgeting Strategy 2009–2012" approved by an order of the Government of the Republic on May 30th, 2008. Activities in the NHP and a more detailed cost estimation is specified during the annual drafting of the state budgeting strategy.

Table 7. Estimation of the costs of the NHP by
strategic objectives in period 2009–2012. All ministries (millions of kroons).
NHP GO – strategic objective of the NHP

NHP GO	Field	2009	2010	2011	2012
1	Social cohesion and equal opportunities	30,665.90	35,868.88	39,946.60	43,464.61
2	Safe and healthy development of children and adolescents	207.52	216.55	227.44	231.78
3	Living, working and studying environment promoting health	6,061.61	7,437.14	4,891.59	4,870.98
4	Healthy lifestyle	729.31	714.39	724.84	509.59
5	Development of health care system	16,462.61	18,600.66	20,634.65	22,628.97
TOTAL		**54,126.96**	**62,837.62**	**66,425.12**	**71,705.93**

Table 7 A. Estimation of the costs of the NHP by
strategic objectives in period 2013-2020. All ministries (thousands of euros).
NHP SO – sub-objective of the NHP

NHP SO	Field	2013	2014	2015	2016	2017	2018	2019	2020
1	Social cohesion and equal opportunities	4,840	3,830	2,194	1,540	1,582	1,625	1,669	1,713
2	Safe and healthy development of children and adolescents	9,671	9,750	9,768	9,826	10,097	10,371	10,650	10,933
3	Living, working and studying environment promoting health	3,752	4,991	5,135	5,119	5,260	5,402	5,547	5,695
4	Healthy lifestyle	39,696	40,851	43,845	46,238	47,512	48,803	50,113	51,444
5	Development of health care system	924,427	955,662	997,707	999,043	1,026,566	1,054,456	1,082,760	1,111,524
TOTAL		982,385	1,015,083	1,058,650	1,061,766	1,091,018	1,120,658	1,150,739	1,181,309

*2017–2020 have been calculated according to the level of year 2016, and costs have been estimated according to the Consumer Price Index (CPI) http://www.struktuurifondid.ee/abimaterjalid-tasuvusanaluusi-koostamiseks/
3.10.2012 Estimation of the Ministry of Finance

* The cost estimation does not reflect foreign funds 2014+

Table 8. Estimation of the costs of the NHP by ministries
In period 20092012 (millions of kroons).

Ministry	2009	2010	2011	2012
Total Ministry of Social Affairs (SOM)	**47,815.17**	**55,198.31**	**61,378.33**	**66,974.79**
including SOM health field	17,174.56	19,366.30	21,462.50	23,543.34
including the rest of SOM	30,640.61	35,832.01	39,915.82	43,431.45
Total other ministries	**6311.79**	**7639.31**	**5046.79**	**4731.14**
including Ministry of Education and Research (HTM)	17.00	17.00	17.00	17.00
including Ministry of Culture (KuM)	115.35	40.51	0	0
including Ministry of the Environment (KKM)	3.35	2.58	1.9	2.51
including Ministry of Agriculture	1.33	7.73	0.63	4.78
including Ministry of Justice	1.63	0	0	0

including Ministry of Economic Affairs and Communications	6112.62	7505.88	4969.43	4684.84
including Ministry of Internal Affairs	41.75	44.90	34.80	0
including the Office of the Minister of Population	18.45	20.72	23.00	22.00
including RM	0.3	0	0	0
TOTAL NHP	**54126.96**	**62837.62**	**66425.12**	**71705.93**

Table 8 A. Estimation of the costs of the NHP by ministries in period 2013–2016 (thousands of euros).

(in thousands of euros)

Ministry	**2013**	**2014**	**2015**	**2016**
Total Ministry of Social Affairs (SOM)	**114,416**	**110,621**	**113,945**	**117,059**
Total other ministries	**867,969**	**904,462**	**944,705**	**944,707**
including Ministry of Education and Research (HTM)	30,299	30,299	30,299	30,299
including Ministry of Culture (KuM)	1,444	1,444	1,444	1,444
including Ministry of the Environment (KKM)	231	157	157	157
including Ministry of Defence	12	12	12	12
including Ministry of Agriculture	1,756	1,902	1,922	1,922
including JM	413	443	443	443
including Ministry of Economic Affairs and Communications	64	64	64	64
including RM	10	263	0	0
including Ministry of Internal Affairs	2,817	465	450	453
including VV	0	230	231	230
including EHK	830,925	869,184	909,684	909,684
TOTAL NHP	**982,385**	**1,015,083**	**1,058,650**	**1,061,766**

* The cost estimation does not reflect foreign funds 2014+

Terms

HEALTH INEQUALITIES – a general term used in determination of differences, abnormalities and unevenness in health achievements of individuals and groups.

HEALTH INEQUITY – the term denotes inequality in health considered unjust or based on some form of unfairness.

MINIMUM MEANS OF SUBSISTENCE or POVERTY THRESHOLD – the smallest quantity of means of subsistence enabling the maintenance and restoration of capacity for work. The calculation of the minimum means of subsistence is based on a statistically average person, where relying on expert evaluations and empirical calculations it is attempted to imitate consumption similar to the actual consumption covering the basic needs of a human being (food, clothing, housing) and cover other costs in the extent necessary for socially acceptable standard of living.

LIVING ENVIRONMENT – living environment is the natural and man-made environment surrounding us outside the working and studying environment.

QUALITY OF LIFE – understanding of individuals of their position in the cultural and value system where they live with objectives, expectations, standards and worries related to the position.

PREMATURE MORTALITY – mortality before the estimated life expectancy of the age group. In the event of death of a person before the estimated life expectancy of the age group the person loses years of life the amount of which is indicated with term YLL (*Years of Life Lost*), i.e. the loss of years due to premature mortality, which forms a part of the burden of disease of the population or loss of health.

PRIMARY HEALTH CARE – an important field of health care made available for a fee affordable to the country and the society and by practically and scientifically justified and socially acceptable methods.

ETIOLOGICAL CAUSE – a factor directly causing an illness or state.

GINI COEFFICIENT – inequality factor in society. The calculation of the Gini coefficient is based on the average monthly expenditure of a member of a household (also incomes of a household member may be used). The Gini coefficient is zero if the expenses of all households and one if the same household has had all the expenditures. The close the coefficient is to one the greater is the differentiation in the society. The Gini index is the same figure expressed by percentage and in such an event the coefficient is multiplied by 100.

BURDEN OF DISEASE – loss in public health expressed in the total number of years of healthy life decreased by years of life lost due to premature mortality and illness and external factors. The number of lost years of life is indicated by abbreviation DALY (*Disability adjusted life years*) used as a synonym for the burden of disease and loss of health.

PROTECTIVE FACTOR – a factor the influence of which can prevent or reduce the influence of health-damaging factors. Health-specific protection factors (including personal motivation to protect one's health and perceived direct support or pressure from a group to engage in activities supporting health) have a direct influence on health. A more indirect but at the same time very important influence on health comes from distal protection factors like personal characteristics, inclusion in social organisations and positive close relationship of children and young people with grown-ups.

PHYSICAL ACTIVITY – any movement of the body caused by muscle work and causing larger energy consumption than the energy consumption of the basic metabolism (rest level) of the organism. Various activity from organised sports to going to work or school or activities in open air.

BODY MASS INDEX (BMI) – a value showing the relationship between the square of the body weight and height obtained by dividing the body mass (kg) by the square of the height (m^2).

ENVIRONMENTAL HEALTH – the term includes aspects of a person's health, including the quality of life, influenced by the physical, chemical, biological, social and psycho-social factors; influences the theory and practice of evaluation, correction and control of environmental factors potentially adversely affecting the health.

CLINICAL AUDIT – a process aimed at improvement of patient treatment and improvement of its results using comparison of treatment and other services with previously worded criteria in order to achieve results, and making changes in treatment and other procedures based on the comparison (process of managing work quality).

CHRONIC DISEASE – long-term illness, deficiency or disability that has lasted or probably lasts 6 months or more.

SPORTING FACILITIES AT CLOSE DISTANCE – locations for movement and sports at close distance from housing areas (up to 15 minutes from place of living) in daily environment of a person, mainly used by the inhabitants of the area for daily movement and sports. Sporting facilities at close distance consist of sports and playgrounds for children and young people, as well as sports halls and grounds for hobby sports and areas for movement and sports.

MONITORING AND EVALUATION – continuous collection of information about a programme, project or activity and the course thereof and episodic evaluation of the achieved results in comparison to the plans.

NOISE – any disturbing sound caused by mechanical resonance of a solid body or upon aero- or hydrodynamic movement of gas, steam and liquid when the pressure or direction of movement suddenly changes.

LOCALITY – network of people connected either by place of living, workplace, ethnicity or another factor of association.

LOCAL DEVELOPMENT – activation, encouragement and stimulation of people to express their health needs and for supporting them in collective activities through increasing competence and sharing know-how with a purpose to develop the activity potential of a locality in order to promote health.

POSTNEONATAL MORTALITY – mortality of infants from the end of the first month of life until the age of one year.

POPULATION HEALTH – the term expresses an attempt to improve the health of all the population or groups thereof, and reduce inequality in their health.

PUBLIC HEALTH – science and activity for promotion of health, prevention of diseases and extension of life expectancy; social and political conception of promoting the health, extending the life expectancy and improving the quality of life for of all the population carried out through health promotion, prevention of diseases and other forms of health interventions.

PUBLIC HEALTH POLICY – driven by state responsibility to promote the state of health of the population. The objective of the public health policy is to create a supportive environment to enable people lead a healthy life, make healthy choices possible or easier for the citizens and make the social and physical environment more healthy.

RISK FACTOR – social, behavioural, economic or biological factor causing or influencing the deterioration of the state of health, a decrease in the influence of factors having a favourable effect on the state of health or an increase in the susceptibility to diseases.

RISK BEHAVIOUR – special form of behaviour causing greater susceptibility to one or more illnesses or a general deterioration of the state of health.

SURVEILLANCE – constant and/or regular collection and analysis of data according to similar methodology. According to the information collected, surveillance can be divided into two categories: surveillance of factors putting health at risk and behavioural surveillance. Relying on the methods of collecting surveillance information, both types of surveillance can be divided into two types: passive surveillance i.e. routinely registered data and analysis thereof and active surveillance i.e. data collected by surveys and regular analysis thereof.

INTERSECTORAL COOPERATION – a recognised association between various sectors of the society formed in order to achieve health results or interim health results in a way more efficient and sustainable than separate performance of the health sector.

STAKEHOLDERS – people or organisations directly or indirectly influenced by the process of a programme/project.

SOCIAL COHESION – social cohesion is understood as the level of inequality and the strength of social relations and connections. Means for increasing social cohesion are of two types – reducing social stratification, inequality and exclusion and strengthening social relations, connections and communication. The European Council uses the following definition of social cohesion: "Social cohesion is the capacity of a society to ensure the well-being of all its members, minimising disparities and avoiding marginalisation"

SOCIAL INCLUSION – social inclusion is by nature the opposite of social exclusion and can be defined as an opportunity for everyone to fully participate in the life of the society, access resources and services important for oneself, work and be economically active. The above resources and services mean, for example, an opportunity to work and access to social insurance, education, health care services, culture and leisure activities, and information technology.

SOCIAL NETWORKS – social relationships and connections between individuals potentially offering access to social support of health or mobilising it.

SUSTAINABLE DEVELOPMENT – sustainable development has been defined as development satisfying the needs at present, maintaining an opportunity for future generations to satisfy their needs; incorporates several elements and all fields, including the health care sector that must support the achievement thereof.

HEALTH ADJUSTED LIFE EXPECTANCY or HALE – an indicator of population health; calculation considers the mortality of the population as well as the influence of illnesses in the population deteriorating the quality of life. The value of the indicator equals the life expectancy of an average member of the population at maximum possible health. Example: in 2006, the life expectancy of men in Estonia at the moment of birth was 67 years. A part of that time is spent by being ill, and if a particular disease deteriorates the quality of life by 50% in comparison to the best (ideal) imaginary level of a person without any health-related limitations, the health adjusted life expectancy of the person in the event of duration of the illness of six months decreases by a quarter of a year (0.5 of best health x 0.5 years = 0.25 years of best possible health). Thus, if the health-adjusted life expectancy of men in 2006 would be, for instance, 50 years, they would not be able to use 17 years in average during their lifetime due to spending the time being ill.

HEALTH – in 1948, WHO defined health as a state of complete physical, social and mental well-being and not just lack of illnesses and disabilities; health is not a objective in life but means for daily life; a positive notion emphasizing social and individual resources and physical capabilities.

HEALTH DEVELOPMENT or SALUTOGENESIS – a process of continuous and progressive improvement of the state of health of individuals and the population (the Jakarta Declaration describes health promotion as an important element of health development).

HEALTH PROMOTION – WHO defines health promotion as a process of enabling people to increase control over, and to improve, their health (the content of the term was determined in the first international conference on health promotion in 1986 in a document known as the Ottawa Charter); in interpretation of health promotion a distinction need to be made between health promotion as an expected result (short- and long-term objectives) and as a strategy (processes and activities).

DETERMINANTS OF HEALTH – a number of personal, social, economic and environmental factors determining the state of health of individuals and the population.

HEALTH PROTECTION – health service belonging under disease prevention with valid mandatory norms and regulations; health protection concerns means and ways to avoid the deterioration of the population health and its objective is to ensure a physical, chemical and biological environment safe for health.

HEALTH EDUCATION – includes knowingly created learning opportunities, including some forms of communication to improve knowledge of health, including the acquisition of new knowledge and development of life skills promoting the health of an individual and the society.

HEALTH EXPECTANCY – an evaluation based on social standards and opinions and professional standards describing the length of full life of the population without illnesses and disabilities.

HEALTH BEHAVIOUR – any activity of an individual, regardless of the state of health at the moment or previous state of health, to promote, protect or maintain health, regardless of the ultimate effectiveness of the behaviour.

HEALTH IMPACT ASSESSMENT – a combination of methods and/or procedures enabling the evaluation of the influence of a political decision, programme or project on the health of the population.

HEALTH POLICY – a clear decision within an institution (especially government) determining the priorities and parameters of an activity in response to the health needs, available resources and political pressures.

HEALTH STATUS – description and/or measurement result of the health of an individual or the population at a moment in time, opposed to likening standards, usually refers to health indicators.

HEALTH SECTOR – includes organised public and private health services, including health promotion, disease prevention, diagnostics, treatment and nursing care services), activity of health care departments and ministries, non-government organisations and groups associated with health and professional associations.

HEALTH SYSTEM – a system for provision of health services the main parts of which are health care and public health systems. The primary task of the first one of the sub-systems is provision of medical services (e.g. in hospital, at primary level and in nursing care) and the primary task of the second one is organisation of health promotion and prevention.

HEALTH OUTCOMES – a change in the state of health of an individual, a group of people or the population that can be contributed to planned intervention or a series of interventions, regardless whether such an intervention was planned as an activity changing the state of health.

EQUITY IN HEALTH – equity means impartiality; in health it means the distribution of the possibilities for well-being according to people's needs.

HEALTH FOR ALL – knowledge of the mankind about health enabling leading of socially and economically full life.

HEALTHY EATING HABIT – eating habit with certain quantitative and qualitative characteristics like correspondence of the energy value to individual needs and permanent correspondence to the principles of eating.

SUPPORTIVE ENVIRONMENTS FOR HEALTH – environments offering protection from health-jeopardising circumstances and enabling people to increase their abilities and develop self-trust in health; includes people's living environment, their home, where they work and play, as well as access of people to health resources and empowerment thereof.

POVERTY – deprivation of the living standard and participation in social-economic participation (e.g. an opportunity to study and an opportunity to be recognised by fellow citizens) considered vital in the society due to insufficiency of tangible resources; division: absolute poverty, relative poverty, deep poverty and poverty jeopardising coping.

EMPOWERMENT FOR HEALTH – a person's internal sense of control over one's live, including knowledge and faith in one's competence and efficiency of one's performance; a lack thereof is expressed by noticeable lack of strength to accomplish anything, the person is excluded and expresses the syndrome of acquired helplessness.

NETWORK – a group based on the dedication and trust of individuals, organisations and institutions organised on non-hierarchical basis in order to deal with general problems or concerns, under active and systematic surveillance.

OVERWEIGHT AND OBESITY – excessive consumption of food energy, whereas excessive energy is produced by low or insufficient energy use, which is stored in the body in the form of fat. Persons with body mass index (BMI) of 25–29.9 kg/m^2 are considered overweight and persons with BMI of 30 kg/m^2 are considered obese. In certain events, BMI of over 25 kg/m^2 is considered as overweight. Criteria for determination of overweight for school children are: 7–9 years of age BMI>19 kg/m^2, 10–12 years of age BMI>22 kg/m^2, 13–15 years of age BMI>24 kg/m^2, 16–18 years of age BMI >25 kg/m^2. In the event of children, the criterion of overweight

depends on the age, information is published in the web page of the Ministry of Social Affairs:
http://www.sm.ee/est/HtmlPages/KMIpoeg/$file/KMIpoeg.jpg
http://www.sm.ee/est/HtmlPages/KMItüdr/$file/KMItüdr.jpg

Abbreviations used

SO	– sub-objective
AIDS	– clinical condition of the HIV infection (*Acquired ImmunoDeficiency Syndrome*)
DG SANCO	– Directorate General for Health and Consumers of the European Commission (*Direction Générale de SANté et protection des COnsommateurs*)
EHCI	– Euro Health Consumer Index
EHK	– Estonian Health Insurance Fund
EC	– European Commission
ESA	– Estonian Statistical Office
ESPAD	– *European School Survey Project on Alcohol and Other Drugs*
ETETU	– survey of Health Behaviour Among Estonian Adult Population
ETU	– Estonian Health Survey
EU	– European Union
EWCS	– *European Working Conditions Survey*
HBSC	– *Health Behaviour in School-aged Children*
HIV	– *Human Immunodeficiency Virus*
HTM	– Ministry of Education and Research
JuS	– Ministry of Justice
KaM	– Ministry of Defence
KKM	– Ministry of the Environment
KKM ITK	– Information and Technology Centre of the Ministry of the Environment
KuM	– Ministry of Culture
LEU	– Household Budget Survey
MKM	– Ministry of Economic Affairs and Communications
NGO	– Non-Government Organisation
PõM	– Ministry of Agriculture
RaM	– Ministry of Finance
RES	– State Budget Strategy
NHP	– NHP
SE	– General Goal of Strategic field
SE21	– Sustainable Estonia 21 (development plan)
SiM	– Ministry of Internal Affairs
GDP	– Gross Domestic Product
SoM	– Ministry of Social Affairs
SVH	– Cardiovascular Diseases
TAI	– National Institute for Health
TI	– Labour Inspectorate
HIA	HIA – Health Information and Analysis
TKI	– Health Inspectorate
VV	– Government of the Republic

WHO	– *World Health Organization*
GG	– General Goal of the present development plan
UN	– United Nations

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