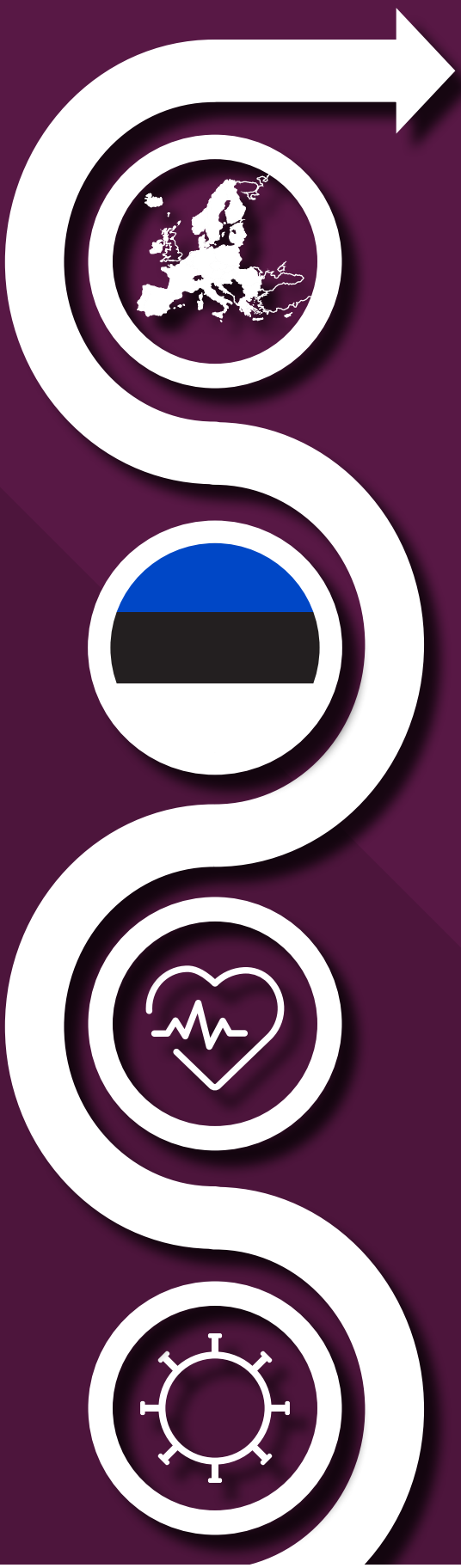


State of Health in the EU

ESTONIA

Country Health Profile 2025

OECD
BETTER POLICIES FOR BETTER LIVES

European Observatory on Health Systems and Policies
a partnership hosted by WHO

The *Country Health Profiles* series

The *State of Health in the EU*'s Country Health Profiles provide a concise and policy-relevant overview of health and health systems in the EU/European Economic Area. They emphasise the particular characteristics and challenges in each country against a backdrop of cross-country comparisons. The aim is to support policy makers and influencers with a means for mutual learning and knowledge transfer. The 2025 edition of the Country Health Profiles includes a special section dedicated to pharmaceutical policy.

The profiles are the joint work of the OECD and the European Observatory on Health Systems and Policies, in co-operation with the European Commission. The team is grateful for the valuable comments and suggestions provided by the Observatory's Health Systems and Policy Monitor network, the OECD Health Committee and the EU Expert Group on Health Systems Performance Assessment (HSPA).

Contents

Data and information sources

The data and information in the Country Health Profiles are based mainly on national official statistics provided to Eurostat and the OECD, which were validated to ensure the highest standards of data comparability. The sources and methods underlying these data are available in the Eurostat Database and the OECD Health Database. Some additional data also come from the Institute for Health Metrics and Evaluation (IHME), the European Centre for Disease Prevention and Control (ECDC), the Health Behaviour in School-Aged Children (HBSC) surveys, the Survey of Health, Ageing and Retirement in Europe (SHARE), the European Cancer Information System (ECIS) and the World Health Organization (WHO), as well as other national sources.

The calculated EU averages are weighted averages of the 27 Member States unless otherwise noted. These EU averages do not include Iceland and Norway.

This profile was finalised in September 2025, based on data that were accessible as of the first half of September 2025.

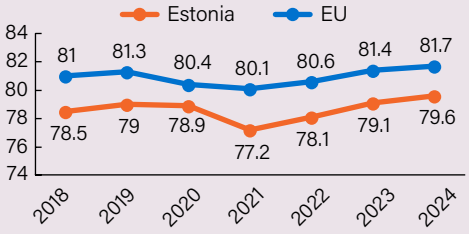
Demographic and socioeconomic context in ESTONIA, 2024

Demographic factors	Estonia	EU
Population size	1 374 687	449 306 184
Share of population over age 65	21 %	22 %
Fertility rate 2023[1]	1.3	1.4
Socioeconomic factors		
GDP per capita (EUR PPP)[2]	31 437	39 675
At risk of poverty or social exclusion rate[3]	22.2 %	20.9 %

1. Number of children born per woman aged 15-49.
2. Purchasing power parity (PPP) is defined as the rate of currency conversion that equalises the purchasing power of different currencies by eliminating the differences in price levels between countries.
3. At risk of poverty or social exclusion (AROPE) is the percentage of people who are either at risk of poverty, severely materially and socially deprived, or living in a household with very low work intensity.

Source: Eurostat Database.

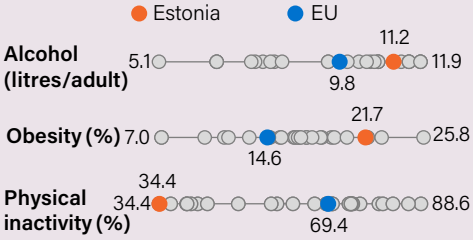
1 Highlights



Life expectancy at birth

Health Status

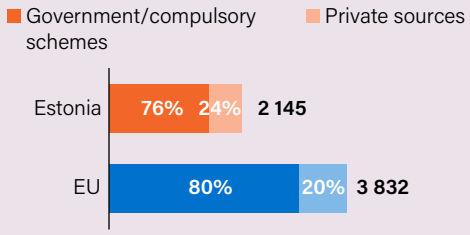
Life expectancy at birth in Estonia reached an all-time high of 79.6 years in 2024. It has consistently been below the EU average, and dropped further during the COVID-19 pandemic than the average across the EU, before rebounding steadily. Although total life expectancy at birth in Estonia has increased greatly since 2000, the gender longevity gap between men and women is the third largest in the EU.



Adults, 2022 (or nearest year)

Risk Factors

Obesity is on the rise in Estonia. While Estonian adults are the most physically active in the EU, more than one in five were obese in 2022 – well above the EU average. Estonian adolescents are among the least physically active, and levels of adolescent obesity are rising. Adult alcohol consumption is above the EU average and has remained stable.



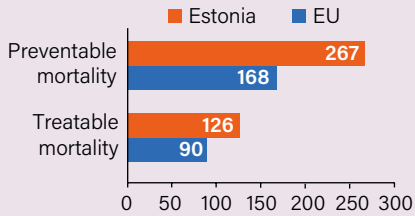
Health spending per capita (EUR PPP), 2023

The Health System

In nominal terms, per capita health spending in Estonia has nearly doubled since 2010, reaching EUR 2 145 in 2023. However, this is still well below the EU average, and the share of private funding sources in Estonia remains above the EU average. Private spending is primarily driven by out-of-pocket payments – especially for dental care and pharmaceuticals.

Health System Performance

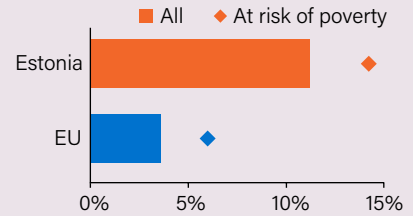
Effectiveness



Age-standardised rate per 100 000 population, 2022

Mortality rates from preventable and treatable causes in Estonia are both above the EU average. The largest contributor to preventable mortality in Estonia is alcohol consumption: one in four deaths from preventable causes are alcohol-related. Mortality from treatable causes is driven by ischaemic heart disease, hypertension and colon cancer.

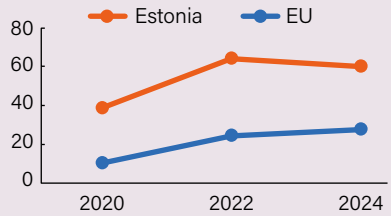
Accessibility



% reporting unmet medical care needs, 2024

Self-reported unmet medical needs in Estonia are higher than the EU average for people needing care – especially for people at risk of poverty. Self-reported unmet medical needs had been improving over time, but have worsened again since 2023. This mirrors national survey data on primary care satisfaction, which was the lowest in six years in 2023, driven by workforce shortages and capacity issues.

Resilience



% population accessing health records online

Digitalisation is a key component of a resilient health system, and Estonia is a leading EU country in digital health. This is reflected in a high level of digital tool usage by the general population. Although investment has slowed in the last few years, future plans include strengthening data integration and data governance.

Spotlight: pharmaceuticals

Per capita spending on retail pharmaceuticals in Estonia is among the lowest in the EU, although retail pharmaceutical expenditure as a share of total health expenditure is near the EU average. In 2023, 42 % of pharmaceutical expenditure was paid out of pocket, and spending on both over-the-counter and prescribed pharmaceuticals remains a key driver of financial hardship. Uptake of generic medicines has been slower in Estonia than in many other EU countries, indicating scope for future efficiency gains.

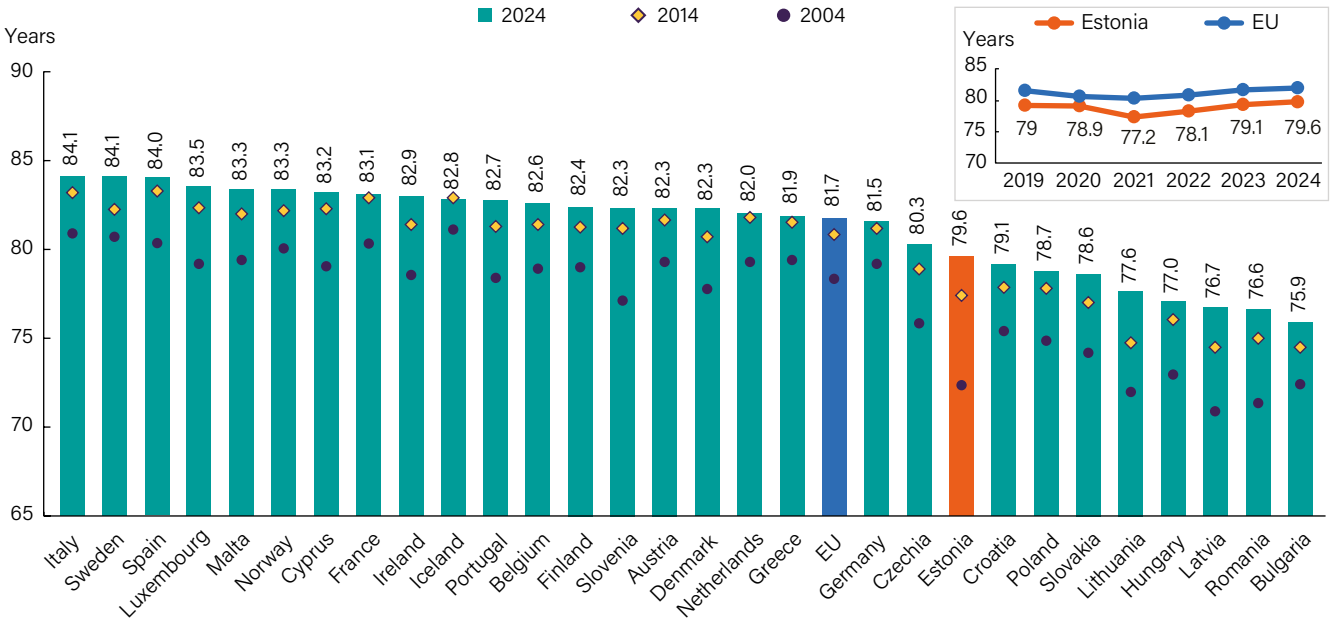
2 Health in Estonia

Social inequalities in life expectancy are large in Estonia

Life expectancy at birth in Estonia rose to its highest level of 79.6 years in 2024, which was 2.1 years below the EU average (Figure 1). Following a reduction in life expectancy due to the COVID-19 pandemic, life expectancy in Estonia rebounded and remains higher than it was in 2019.

Although the gender gap in life expectancy in Estonia has narrowed over the past two decades, there was an 8.6-year gap between the life expectancy of women and men in 2023. This is the third largest gap in the EU after Lithuania and Latvia, and much greater than the EU average gap of 5.2 years. Inequalities in life expectancy in Estonia by socioeconomic status are also large. The life expectancy of 30-year-old men with lower education levels was 10 years shorter than that of men with higher education levels in 2023, while the gap among 30-year-old women was 8.5 years (Statistics Estonia, 2025a).

Figure 1. Life expectancy in Estonia has increased greatly since 2014, but remains a few years lower than the EU average



Notes: The EU average is weighted. Data for Ireland pertains to 2023.
Source: Eurostat (demo_mlexpec).

Cardiovascular diseases are by far the main cause of death, followed by cancer

Almost half of all deaths in Estonia were attributed to cardiovascular diseases (CVDs) in 2022. Cancer was the second most frequent cause of death, accounting for 20 % of all deaths (Figure 2). External causes (including suicides and accidents) and COVID-19 were the third and fourth most common causes of death in 2022.

Self-reported health status varies widely across income groups

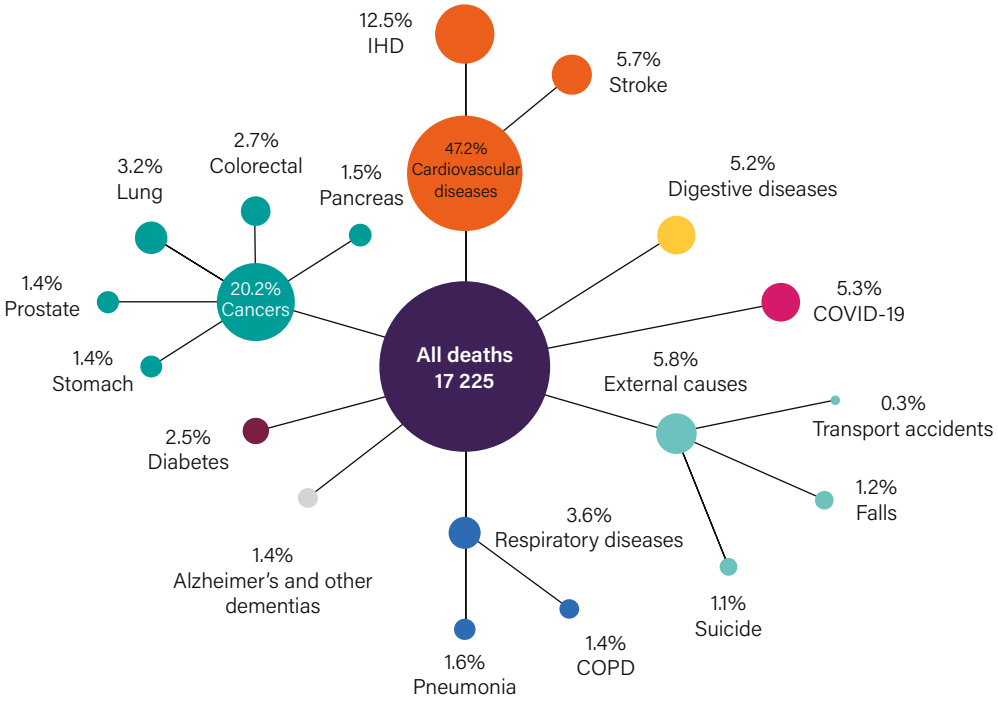
Over half of Estonian adults reported being in good health in 2024 (58 %) – a lower share than the EU average (68 %). As in other countries, women in Estonia are less likely to report being in good health than men. There is a large discrepancy across income groups: only 34 % of women in the lowest income group reported good health compared to 79 % of women in the highest.

Life expectancy at age 65 in Estonia is lower than the EU average, and fewer than half of these years are lived in good health

The proportion of people aged 65 and over in Estonia increased from 15 % in 2000 to 21 % in 2024. This share is projected to reach 28 % by 2050 as a result of rising life expectancy, a fertility rate below the replacement rate of 2.1 children per woman and the ageing population.

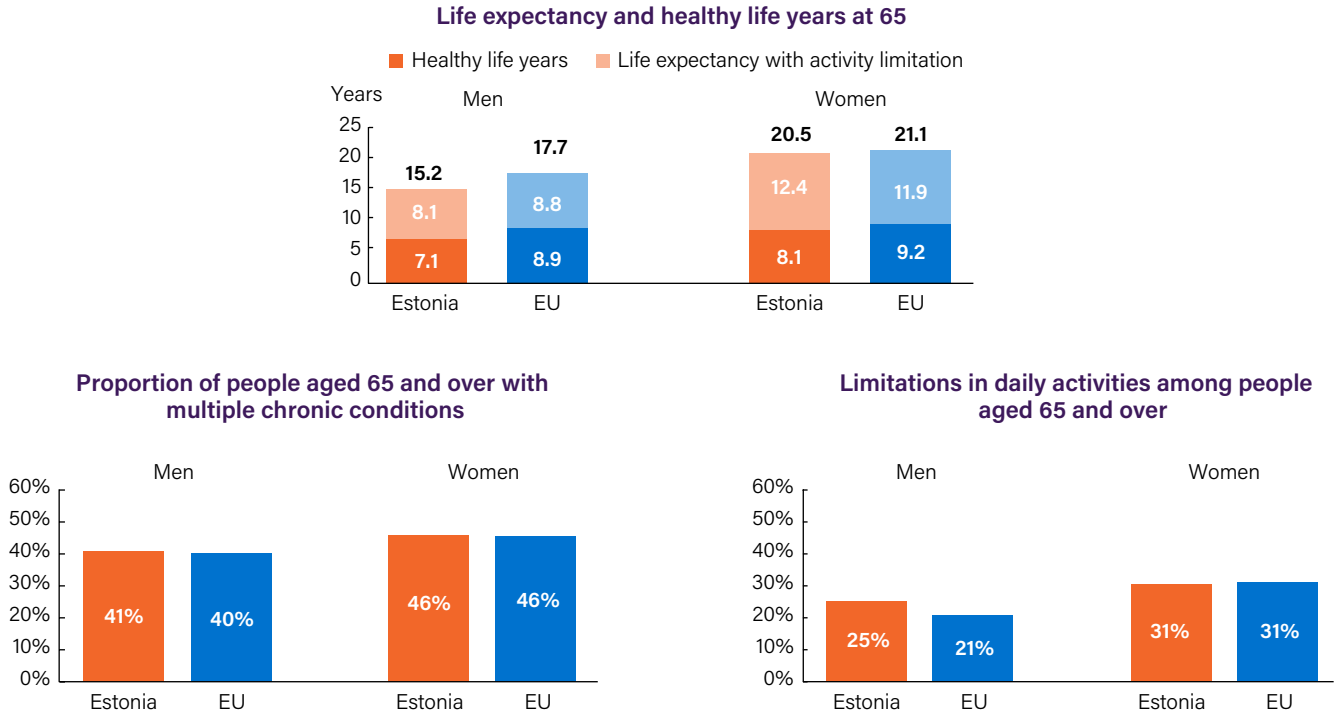
In 2022, women could expect to live another 20.5 years at age 65, while men could expect to live another 15.2 years. As in other EU countries, a large proportion of Estonian men and women aged over 65 live with multiple chronic conditions (over 40 %). The gender gap in healthy life years at age 65 is only a single year. This is because Estonian women tend to live longer, but with greater limitations in their daily activities (Figure 3).

Figure 2. Cardiovascular diseases were the cause of almost half of all deaths in Estonia in 2022



Note: IHD = ischaemic heart disease; COPD = chronic obstructive pulmonary disease.
Source: Eurostat (hlth_cd_aro); data refer to 2022.

Figure 3. Over 40 % of Estonian men and women aged over 65 live with multiple chronic conditions



Sources: Eurostat for healthy life years (tespm120, tespm130) and SHARE survey (for chronic conditions and limitations in daily activities); data refer to 2022 and 2021-22, respectively.

The incidence and prevalence of cardiovascular disease is higher in Estonia than on average in the EU

CVDs and cancer are not only the leading causes of death in Estonia but also leading causes of morbidity and disability, mirroring patterns across the EU.

In 2021, the age-standardised incidence rate of CVDs in Estonia, at 1 741 per 100 000 population, was the highest among EU countries, and the prevalence rate was also well above the EU average (Figure 4). CVDs accounted for 16 % of all hospital admissions in 2022. Ischaemic heart disease is the most frequent CVD, with an estimated 15 000 new cases each year in Estonia, representing 64 % of all CVDs.

Figure 4. About one in seven people were living with a cardiovascular disease in Estonia in 2021

23 789
New cases in 2021
Incidence rate (age-standardised), 1 741 per 100 000 population (1 157 in the EU)

189 483
Living with the condition in 2021
Prevalence rate (age-standardised), 13 903 per 100 000 population (12 965 in the EU)

Source: IHME, Global Health Data Exchange; estimates refer to 2021.

The incidence and prevalence of cancer is lower in Estonia than on average in the EU

According to the European Cancer Information System (ECIS) there were around 7 800 new cancer cases estimated for 2022 in Estonia, and 56 000 people were estimated to be living as cancer survivors in 2020 (Figure 5). Cancer prevalence in Estonia has rapidly increased over the past decade, although it remains slightly below the EU average (OECD/European Commission, 2025). In 2022, the most common newly diagnosed cancer sites in men were estimated to be prostate, lung and colorectum. Breast cancer was estimated to be the most common newly diagnosed cancer in women, followed by colorectal and uterine cancer.

The Estonian Cancer Control Plan 2021-30 aims to improve prevention, early detection and access to timely treatment to reduce cancer-related morbidity in Estonia. The short-term priorities were to reduce alcohol and tobacco consumption and to increase human papillomavirus (HPV) vaccination (see Sections 3 and 5.1).

Figure 5. About one in twenty-four people were living as cancer survivors in 2020 in Estonia

7 817
New cases in 2022
Incidence rate (age-standardised), 568 per 100 000 population (572 in the EU)

56 007
Living with the condition in 2020
Prevalence rate (age-standardised), 4 109 per 100 000 population (4 767 in the EU)

Notes: These are estimates that may differ from national data. Cancer incidence includes all cancer sites except non-melanoma skin cancer
Source: European Cancer Information System; estimates refer to 2022 for incidence and 2020 for prevalence.

3 Risk factors

Behavioural and environmental risk factors account for almost a third of all deaths in Estonia

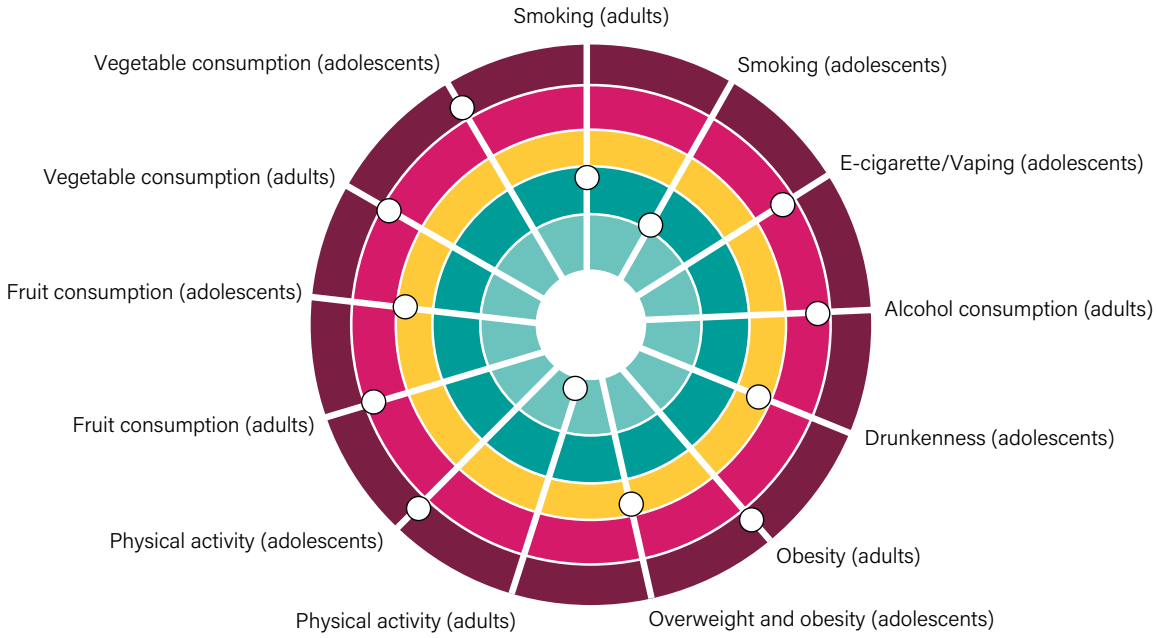
According to estimates from the Institute for Health Metrics and Evaluation (IHME), behavioural risk factors – including tobacco smoking, dietary risks, alcohol consumption and low levels of physical activity – were responsible for 29 % of all deaths in Estonia in 2021. More than half of these deaths were attributed to dietary risks (including low fruit and vegetable consumption and high sugar-sweetened beverages consumption). Air pollution in the form of fine particulate matter ($PM_{2.5}$) and ozone accounted for another 1 % of all deaths.

An agreement on intersectoral prevention from 2021 aims to coordinate prevention activities and improve their quality across sectors. A Prevention Council was established to monitor implementation and advise the Estonian Government on interdisciplinary prevention, crime, drugs and child protection policies.

Smoking has decreased overall, but 25 % of adolescents in Estonia use e-cigarettes or vapes

Smoking rates among adults and adolescents have declined significantly over the past decade in Estonia, and are now well below the EU average. Since 2010, the share of adults who are daily smokers has decreased by 13 percentage points – from 26 % in 2010 to 13 % in 2024. Similarly, the rate of 15-year-olds who reported smoking at least once in the last 30 days decreased from 21 % in 2014 to 12 % in 2022 – a percentage now well below the EU average (17 %). However, as in many EU countries, smoking habits have changed among young people, and a quarter of adolescents in Estonia reported smoking e-cigarettes/vapes in the last month (Figure 6). Tobacco product excise taxes were increased in 2025, and greater marketing regulation was implemented in 2019 (see Section 5.1).

Figure 6. Adults are comparatively physically active in Estonia, but not adolescents



Notes: The closer the dot is to the centre, the better the country performs compared to other EU countries. No country is in the white "target area" as there is room for progress in all countries in all areas.
Sources: OECD calculations based on HBSC survey 2022 for adolescents' indicators; Eurostat based on EU-SILC 2022 and OECD Data Explorer for adult indicators (2022 or nearest available year).

Heavy alcohol consumption remains a concern

In 2022, 22 % of 15-year-olds reported having been drunk more than once in their lifetime – a share that has halved since 2010, but remains above the EU average (18 %). Alcohol consumption among adults has not changed much in recent years and was 10.8 litres per capita in 2023 (compared to an EU average of 9.8 litres in 2022). Estonia periodically increased taxes on alcoholic beverages from 2008 until 2019, when excise taxes for beer, wine and other fermented beverages were cut by 25 %. A 2024 evaluation of alcohol policy in Estonia concluded that this tax cut and the COVID-19 pandemic increased alcohol-attributable mortality by 100 %, and that while there was a notable reduction in alcohol consumption and intoxication among minors, the target of reducing the annual population alcohol consumption to under 8 litres per capita was not achieved (WHO Regional Office for Europe, 2024). Alcohol excise taxes were increased by 5 % in 2025.

Adolescents in Estonia are increasingly overweight or obese

According to the EU-SILC survey, more than one in five adults in Estonia (22 %) were obese in 2022 – well above the EU average of 15 %. Adolescents are also increasingly overweight and obese: in 2002 only 7 % of 15-year-olds fell into this category, whereas in 2022 it was 21 %, which is equal to the EU average. Almost one in three primary school-aged children were overweight or obese in 2022, according to the WHO European Childhood Obesity Surveillance Initiative.

Only 49 % of adults reported daily consumption of fruit and vegetables in 2022, which is below the EU average of 61 %. The proportion of 15-year-old adolescents who reported eating at least one portion of fruit or vegetables each day is even lower, at 30 %, which is close to the EU average.

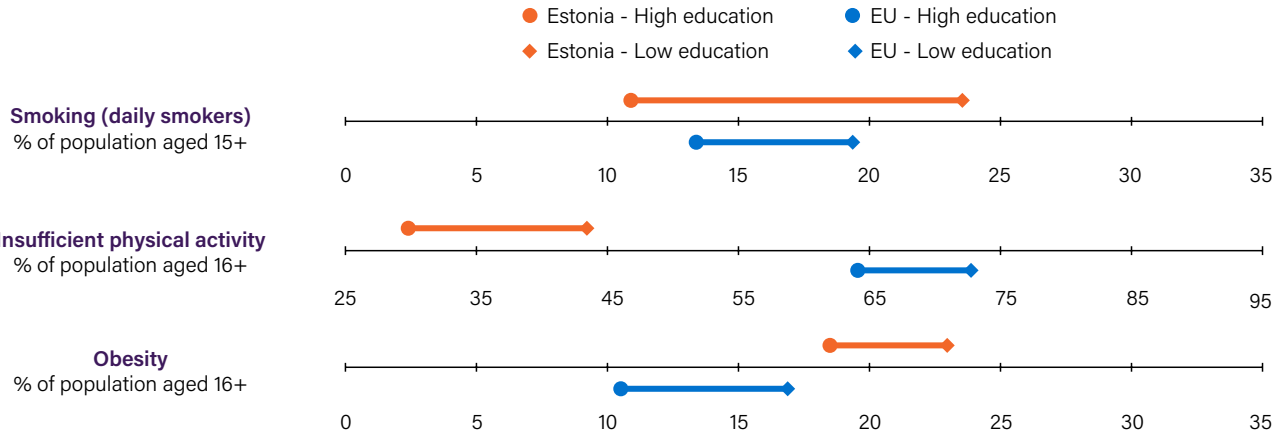
Adults in Estonia are the most physically active in the EU, while adolescents are among the least physically active

Adults in Estonia are among the most physically active in the EU, with 66 % reporting they engaged in physical activity more than three times per week in 2022. By contrast, 15-year-old adolescents are among the least physically active in the EU: only 12 % reported doing at least 60 minutes of physical activity daily compared to an EU average of 15 %.

Socioeconomic inequalities are particularly wide for smoking and physical activity in Estonia

People with lower education levels are more likely to smoke, be less physically active and be obese than people with higher education levels (Figure 7). This discrepancy is particularly large for smoking in Estonia, where 24 % of adults with low education levels smoked daily in 2019 compared to 11 % of adults with high education levels. The education gaps for the rates of physical activity and obesity are smaller but remain present.

Figure 7. Behavioural risk factors are more prevalent among people with lower education levels



Note: Low education is defined as the population with no more than lower secondary education (ISCED levels 0-2), whereas high education is the population with tertiary education (ISCED levels 5-8). Low physical activity is defined as people doing physical activity three times or fewer per week.
Source: Eurostat based on EHIS 2019 for smoking (hlth_ehis_sk1e) and EU-SILC 2022 for physical activity and obesity (ilc_hch07b, ilc_hch10).

4 The health system

The Estonian health system is centrally organised, with a single insurance fund managing public funding

Estonia's health system is based on a mandatory social health insurance model, primarily funded through payroll taxes earmarked for health at the level of 13 % of gross wages. This is supplemented by state transfers for non-working groups of the population. The Estonian Health Insurance Fund (EHIF) pools and manages public funds for health centrally. In 2024, an estimated 94 % of the population was covered by social health insurance, but individuals with informal or temporary employment remained at risk of being uninsured (see Section 5.2).

The Estonian health system is centralised and overseen by the Ministry of Social Affairs, while municipalities own public hospitals. Inpatient care and most specialist outpatient services are provided in publicly owned hospitals. Family physicians and dentists generally operate as private entrepreneurs; some specialist outpatient and long-term nursing care providers may also be privately owned.

Health spending has grown substantially in Estonia over the last decade, but it remains well below the EU average

In 2023, Estonia's current health expenditure was 7.5 % of GDP, which is higher than pre-pandemic levels (6.8 % in 2019). In nominal terms, per capita health spending in Estonia (adjusted for differences in purchasing power) has nearly doubled since 2010, reaching EUR 2 145 in 2023. However, per capita health spending remained 44 % below the EU average of EUR 3 832 (Figure 8). Recent increases in health spending were driven by wage increases for healthcare workers, with doctors' wages increasing by approximately 25 % and nurses' by 21 % in 2023.

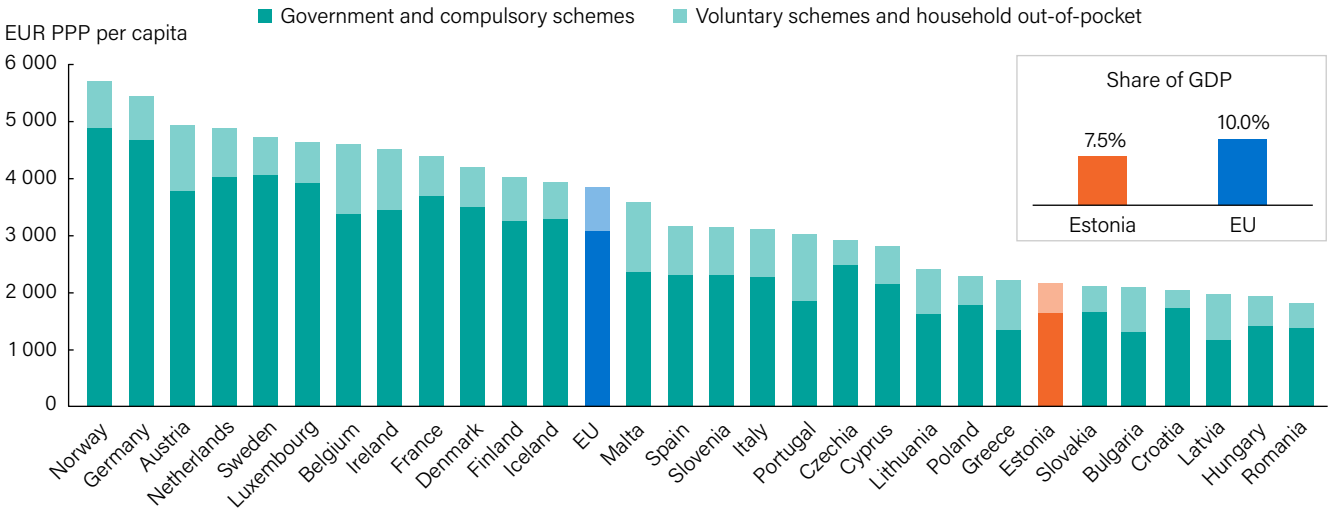
Public funds accounted for 76 % of health expenditure in 2023. The EHIF covered 67 % of current health expenditure, returning to its pre-COVID-19 share, while the share of central government expenditure declined from 7 % of current health expenditure in 2022 to 5 % in 2023.

Out-of-pocket (OOP) spending is substantial in Estonia, accounting for 22 % of current health expenditure in 2023. Voluntary health insurance schemes played a comparatively small role, making up 2 % of health spending in 2023 (see Section 5.2).

The largest share of health expenditure in Estonia goes towards outpatient care

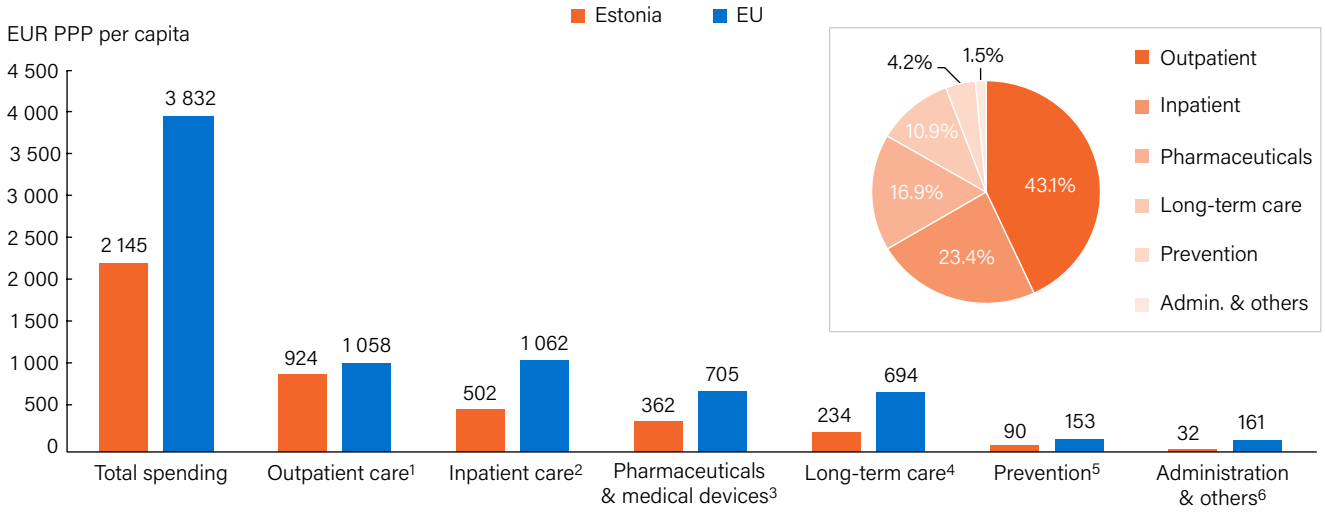
Spending by function shows that outpatient care – including primary care, specialist consultations and dental services – accounts for the largest share of current health expenditure, at 43 % in 2023 (Figure 9). Inpatient care made up 23 % of health expenditure, followed by pharmaceuticals and medical devices at 17 %, long-term care at 11 % and preventive care at 4 %.

Figure 8. Per capita expenditure on health in Estonia is relatively low



Note: The EU average is weighted (calculated by the OECD).
Sources: OECD Data Explorer (DF_SHA); Eurostat (demo_gind); data refer to 2023.

Figure 9. Most health expenditure in Estonia is spent on outpatient care



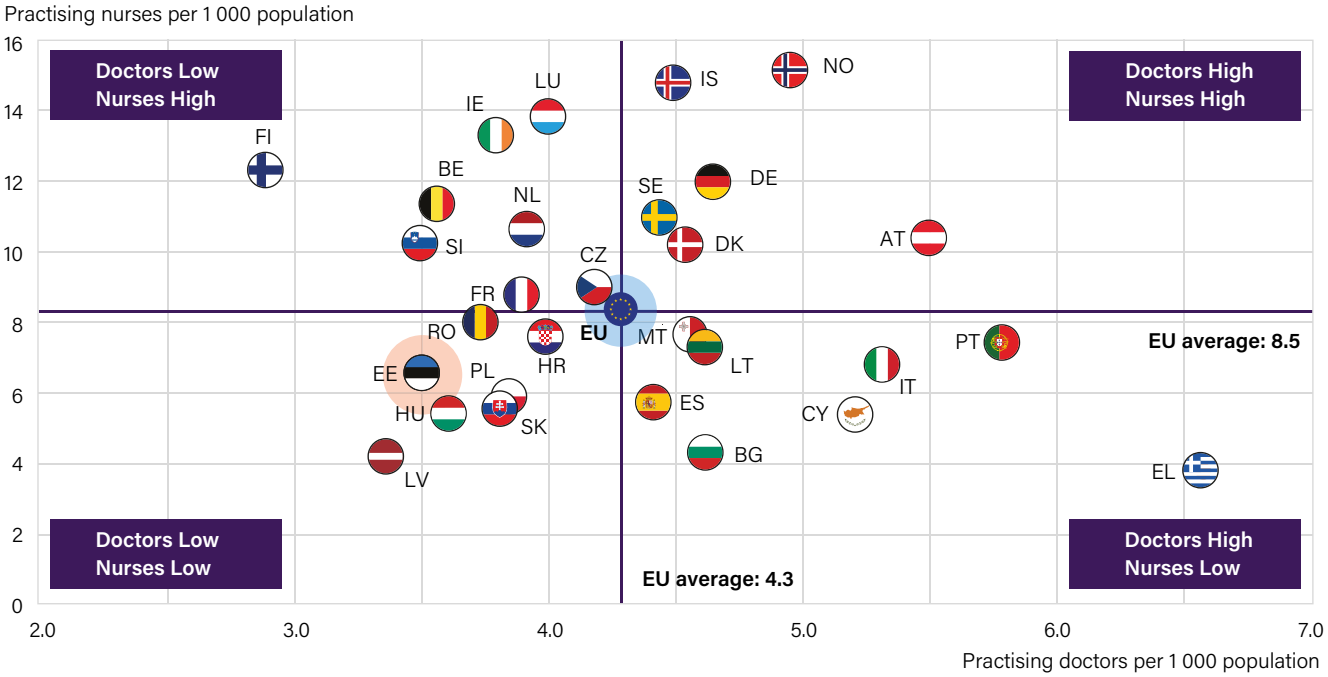
Notes: 1. Includes home care and ancillary services (e.g. patient transportation); 2. Includes curative-rehabilitative care in hospital and other settings; 3. Includes only the outpatient market; 4. Includes only the health component; 5. Includes only spending for organised prevention programmes; 6. Includes health system governance and administration and other spending. The EU average is weighted (calculated by the OECD).
Sources: OECD Data Explorer (DF_SHA); data refer to 2023.

Workforce shortages are acute in Estonia, particularly in primary care and mental healthcare

The density of health workers in the population has increased in Estonia over the last two decades, but population ageing and the rising burden of chronic conditions (see Section 2) challenge the pace of workforce development. In 2023, Estonia had fewer doctors and nurses than the EU averages, with 3.5 physicians (compared to 4.3 across the EU) per 1 000 population, and 6.6 nurses (compared to 8.5 across the EU) per 1 000 population (Figure 10).

The density of family physicians has not increased substantially over the past decade, hovering around 0.7 per 1 000 population. The shortage of health professionals in family medicine and mental healthcare in some parts of Estonia – particularly in rural areas – remains acute, and threatens the resilience of the health system. Although some action has been taken (see Section 5.3), the limited number of new medical graduates and the retirement of primary care workers further exacerbate the challenge of maintaining an adequate health workforce.

Figure 10. The densities of doctors and nurses in Estonia are below the EU averages



Notes: The EU average is unweighted. The data on nurses include all categories of nurses (not only those meeting the EU Directive on the Recognition of Professional Qualifications). In Portugal and Greece, data refer to all doctors licensed to practise, resulting in a large overestimation of the number of practising doctors. In Greece, the number of nurses is underestimated as it only includes those working in hospitals.
Source: OECD Data Explorer (DF_PHYS, DF_NURSE); data refer to 2023 or nearest available year.

5 Performance of the health system

5.1 Effectiveness

Around a quarter of preventable deaths in Estonia are attributed to alcohol consumption

Although it is above the EU average, overall avoidable mortality among people aged under 75 has declined in Estonia. This is driven by a decline in preventable mortality, which decreased by 12 % from 304 deaths per 100 000 population in 2012 to 267 deaths per 100 000 in 2022.

Alcohol-related causes of death continue to contribute the most to preventable mortality in Estonia, with a record high of 24 % of preventable deaths attributed to this cause, reflecting high consumption levels (see Section 3). Lung cancer and ischaemic heart disease are the other leading causes of death contributing significantly to preventable mortality, suggesting strong links to the high prevalence of behavioural risk factors – particularly smoking. Although smoking prevalence has declined in Estonia (see Section 3), the increasing use of novel tobacco and nicotine products among Estonian adolescents has raised concerns and led to a strong policy response (Box 1).

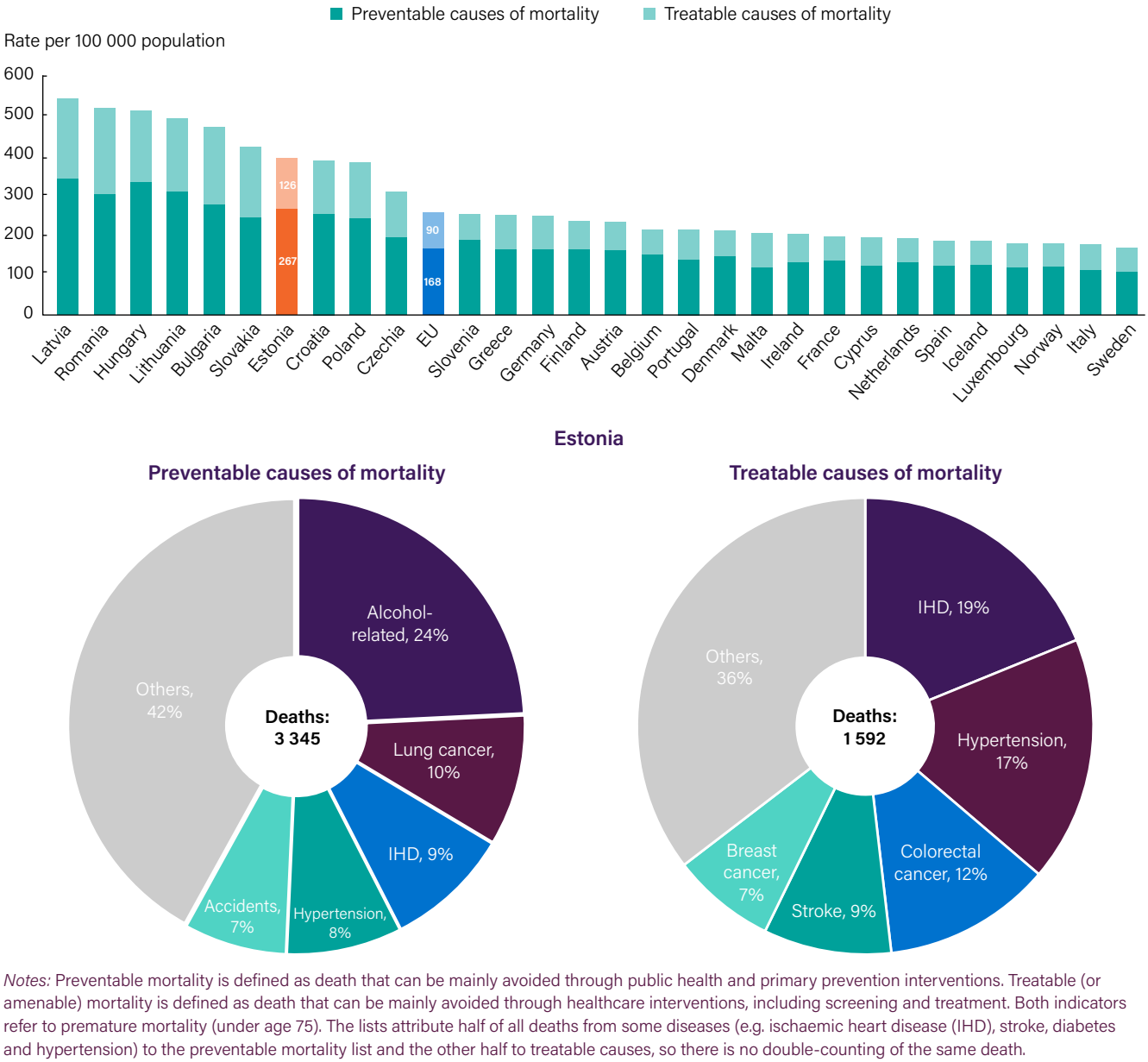
Deaths that are avoidable through more effective healthcare (mortality from treatable causes) decreased substantially between 2012 and 2022, by about 23 % – from 163 deaths

Box 1. Increased use of e-cigarettes and oral nicotine products among young people in Estonia has led to stronger regulation of these products

While fewer adults and adolescents overall smoked in 2022 than in previous years, use of e-cigarettes and oral nicotine products has increased rapidly among young people (see Section 3). In 2019, amendments to the Tobacco Act came into effect, banning the display of tobacco products and related items at points of sale. The Act also prohibits flavours and fragrances other than tobacco in e-cigarette liquids, and bans remote sales of tobacco products. Packaging must carry health warnings, and sales are restricted to individuals over 18 years of age.

Nicotine product regulation in Estonia falls primarily under the Tobacco Act, and taxation under the Alcohol, Tobacco, Fuel and Electricity Excise Duty Act. New excise taxes came into effect on 1 July 2025. E-cigarettes are now taxed at EUR 0.23 per millilitre of e-liquid, and nicotine pouches at EUR 0.23 per gram. Higher rates apply from January 2026.

Figure 11. Estonia's preventable and treatable mortality rates remain higher than in many EU countries



Notes: Preventable mortality is defined as death that can be mainly avoided through public health and primary prevention interventions. Treatable (or amenable) mortality is defined as death that can be mainly avoided through healthcare interventions, including screening and treatment. Both indicators refer to premature mortality (under age 75). The lists attribute half of all deaths from some diseases (e.g. ischaemic heart disease (IHD), stroke, diabetes and hypertension) to the preventable mortality list and the other half to treatable causes, so there is no double-counting of the same death.
Source: Eurostat (hlth_cd_apr); data refer to 2022.

per 100 000 to 126 deaths per 100 000. The leading causes of treatable deaths in 2022 were ischaemic heart disease and hypertension, as well as colorectal cancer (Figure 11).

More than half of the eligible population participates in cancer screening

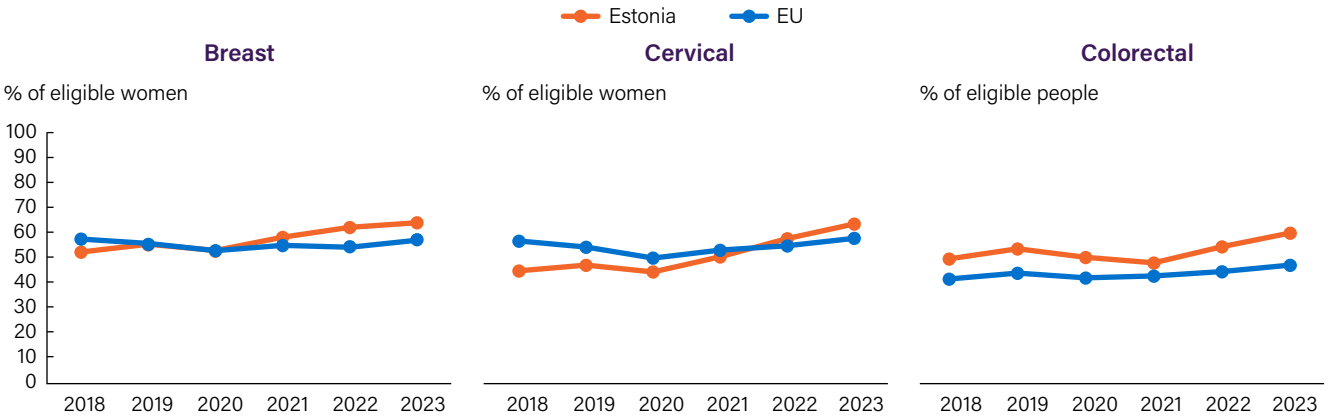
Since 2018, participation in population-based cancer screening programmes for breast, cervical and colorectal cancers has improved markedly in Estonia. By 2023, participation among the eligible population had risen by over 10 percentage points for breast (to 65 %), cervical (to 64 %) and colorectal cancer screening (60 %) (Figure 12).

Several targeted policy actions have contributed to these positive developments in early cancer detection (OECD/European Commission, 2025). In cervical cancer screening, Estonia transitioned to HPV-based testing in 2021 and introduced home-sampling kits in 2023, which helped improve accessibility and uptake. For breast cancer screening, online booking became fully available at all screening providers in 2024, compared to only one hospital offering this option in 2023. To enhance access, especially in rural areas, three mobile mammography units operate throughout the year, bringing screening services closer to users. Challenges remain in colorectal cancer screening. The programme only targets individuals aged 60-68, while 50-74 is the most common target age group in Europe, and the limited availability of diagnostic testing continues to hinder improvements.

Childhood immunisation rates in Estonia decreased after the COVID-19 pandemic, with some recovery

Vaccination uptake in Estonia is below the EU average. While seasonal influenza vaccination among people aged 65 reached an all-time high of 31.5 % in the 2021/22 winter season (from 0.9 % in 2011/12), routine childhood immunisation rates declined after the COVID-19 pandemic, and measles vaccination coverage of children under 1 year was just 83.3 % in 2024 for the first dose. This is partly attributed to widespread misinformation

Figure 12. Uptake of cancer screening programmes has increased overall in Estonia



Notes: All data refer to programme data. Colorectal programme data are based on national programmes that may vary in terms of age group and frequency. The EU average is unweighted.
Sources: OECD Data Explorer (DF_KEY_INDIC) and Eurostat (hlth_ps_prev)

about vaccines circulating during the COVID-19 pandemic and declining vaccine confidence. Consequently, the Ministry of Social Affairs has published a tool to improve vaccine management and communication strategies (Ministry of Social Affairs, 2024a).

In response to the sharp drop in HPV vaccine uptake in 2023, Estonia made significant adjustments to its HPV vaccination programme. First introduced in 2018 for girls aged 12-14, the target group was extended to include both boys and girls aged 12-18 from February 2024. Additionally, the schedule was simplified from a two-dose to a single-dose regimen (in line with WHO recommendations). Uptake reached 63 % in 2024 (Figure 13).

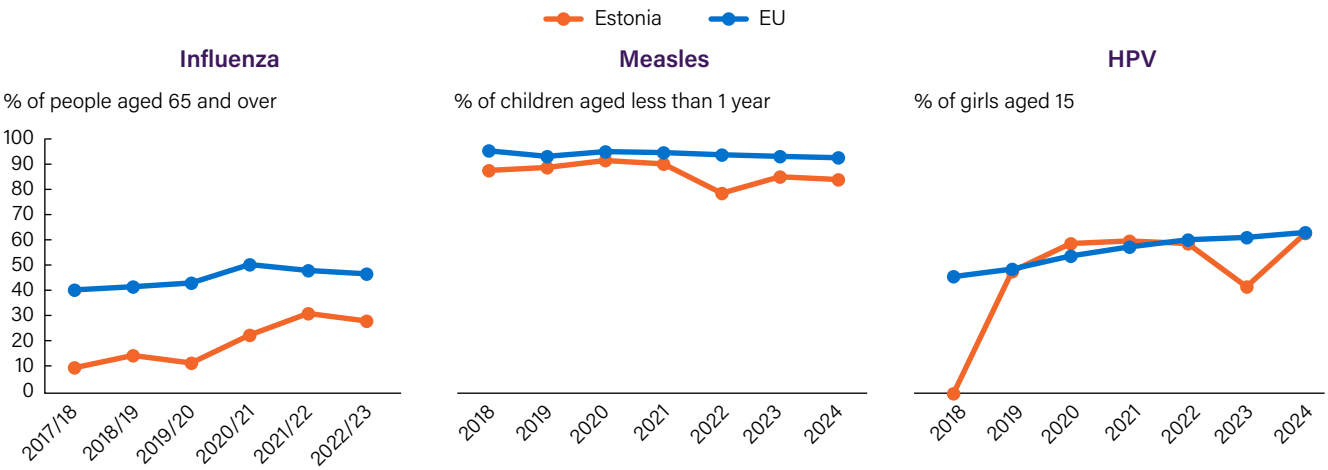
Estonia has one of the lowest hospitalisation rates for asthma and chronic obstructive pulmonary disease in the EU

Estonia's consistently low hospitalisation rates for conditions that can be managed effectively in outpatient settings – such as asthma, chronic obstructive pulmonary disease, congestive heart failure and diabetes – reflects the country's ongoing success in moving care into the community (see Section 5.3). In 2023, Estonia recorded one of the lowest hospitalisation rates for asthma and chronic obstructive pulmonary disease in the EU, at 82 admissions per 100 000 population. Hospitalisation rates also remained well below the EU averages for congestive heart failure (208 admissions compared to 239 admissions per 100 000 population) and diabetes (93 admissions compared to 116 admissions per 100 000 population) (Figure 14). Several pilots have trialled a risk-based treatment management service in family medicine. This initiative aims to improve monitoring of at-risk patients and prevent the progression of chronic conditions through more proactive care (Tervisekassa, 2024a).

A new stroke patient pathway aims to address persistently high 30-day mortality rates in Estonia

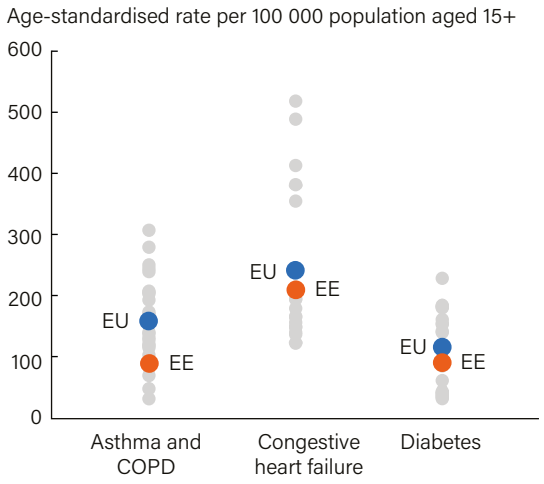
Indicators of secondary care quality in Estonia have also shown modest improvement. The 30-day mortality rate for acute myocardial infarction fell from 13.6 deaths per 100 patients aged 45 and over in 2013 to 12.7 deaths per 100 in 2023. Between 2013 and 2023, the 30-day mortality

Figure 13. Vaccination uptake for measles in Estonia has decreased in recent years, while HPV vaccination uptake fully recovered after a drop in 2023



Notes: The EU average is weighted for influenza (calculated by Eurostat) and unweighted for measles and HPV.
Sources: Eurostat (hlth_ps_immu) and WHO/UNICEF Joint Reporting Form on Immunization (JRF).

Figure 14. Estonia has fewer avoidable hospital admissions than the EU average



Note: Admission rates are not adjusted for differences in disease prevalence across countries.
Source: OECD Data Explorer (DF_HCQO); data refer to 2023 or latest available year.

rate for stroke patients aged 45 and over decreased from 18.9 to 15.3 per 100 admissions, based on linked patient data. However, these rates remain above the EU average.

To enhance outcomes, Estonia implemented a nationwide ischaemic stroke care pathway in January 2025. This standardised approach outlines role-specific protocols for stroke nurses, coordinators and family physicians. Stroke care has been centralised in six designated hospitals, and a new role – stroke pathway coordinator – has been introduced. These coordinators assess individual needs; develop treatment plans; oversee implementation; and ensure coordination across health, social and community services.

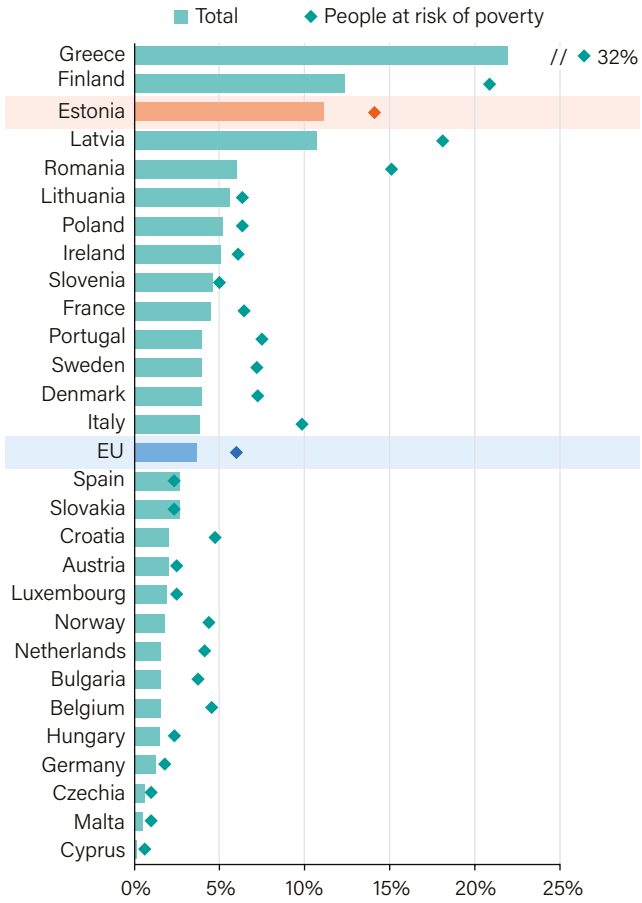
5.2 Accessibility

Unmet healthcare needs in Estonia are substantially higher than the EU average

In 2024, three times as many people in Estonia who expressed a need for healthcare reported unmet needs due to long waiting times, cost or distance to travel (11.2 %) compared to the EU average (3.6 %) according to the EU-SILC survey. These figures were even more striking among those at risk of poverty: 14.2 % of individuals on low incomes in Estonia who expressed a need for healthcare reported forgoing necessary care, compared to 6 % across the EU (Figure 15).

The income-based inequality in unmet needs was particularly pronounced in dental care: of the 9.1 % of EU-SILC respondents in Estonia who expressed a need for dental care and reported unmet needs due to cost, waiting times or distance to travel, over one in five (20.3 %) were from households at risk of poverty. This highlights affordability challenges, and reflects Estonia's high reliance on OOP payments for dental care.

Figure 15. Long waiting times, cost or distance are a more common cause of unmet medical needs in Estonia than in many other EU countries



Notes: The EU average is weighted. Data refer only to individuals who reported having medical care needs. People at risk of poverty are defined as those with an equivalised disposable income below 60 % of the national median disposable income.
Source: Eurostat (hlth_silc_08b); data refer to 2024.

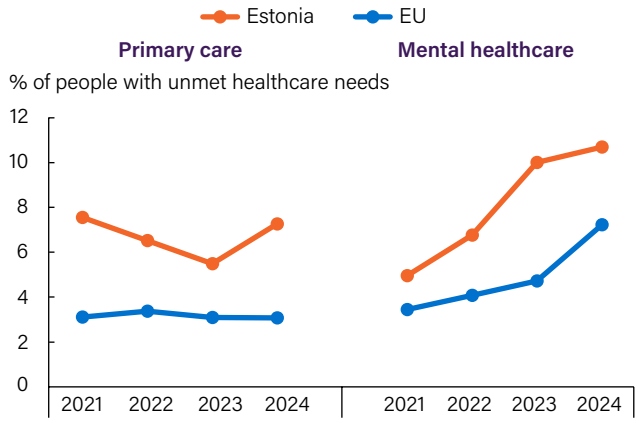
Unmet needs in primary and mental healthcare are above the EU average

Access indicators to primary care and mental healthcare show a mixed picture (Figure 16). According to the Eurofound Living and Working in the EU survey (2025), 7 % of adults in Estonia reported unmet needs for primary care examinations or treatment in 2024, compared to 3 % across the EU.[1] National survey data, collected by the EHIF on an annual basis, reveal that satisfaction with access to family physicians and primary care services fell to 76 % in 2023 – the lowest in six years – indicating growing concerns resulting from workforce shortages and capacity issues (see also Section 5.3).

In a project that concluded in August 2025, the EU Technical Support Instrument has supported Estonia's Ministry of Social Affairs in delivering substantial reform of primary care as part of a package of measures introduced in 2023 to ensure access to general medical care and improve the continuity of treatment. Measures include the extension of teleconsultations in primary care, increasing the level of support for general practitioners in remote areas and extending the rights of nurses to prescribe medicines to patients.

[1] The data from the Eurofound survey are not comparable to those from the EU-SILC survey because of differences in methodologies.

Figure 16. Unmet needs for mental healthcare in Estonia have increased since the pandemic



Note: Primary care includes access to a general practitioner/family doctor or a health centre.
Source: Eurofound Living and Working in the EU survey (2025).

The EU Technical Support Instrument is also supporting a project to improve mental health management in primary healthcare (Box 2) and Estonia is currently piloting a mental health stepped care model that aims to provide increased accessibility and condition-appropriate care (Ministry of Social Affairs, 2024b).

Eurofound data also show that unmet needs in mental healthcare increased in Estonia from 5 % of adults in 2021 to 11 % in 2024, while the EU average also increased from 3 % in 2021 to 7 % in 2024. Several policy initiatives in Estonia aim to improve access to mental healthcare. Following the adoption of the Green Paper on Mental Health in 2023, Estonia launched the Mental Health Action Plan 2023-26 and the first Suicide Prevention Action Plan (2025-28). This comprehensive strategy aims to reduce suicide rates and promote greater awareness and understanding of mental health issues.

There are gaps in social health insurance coverage for the working-age population

Estonia's mandatory social health insurance model covered an estimated 94 % of the population in 2024 (see Section 4). While minors and pensioners are automatically enrolled, eligibility for the working-age population (aged 20-59) is primarily linked to employment status. Coverage in this age group is only 88 %, as individuals in unstable, part-time or informal work are at risk of being uninsured (Statistics Estonia, 2025b).

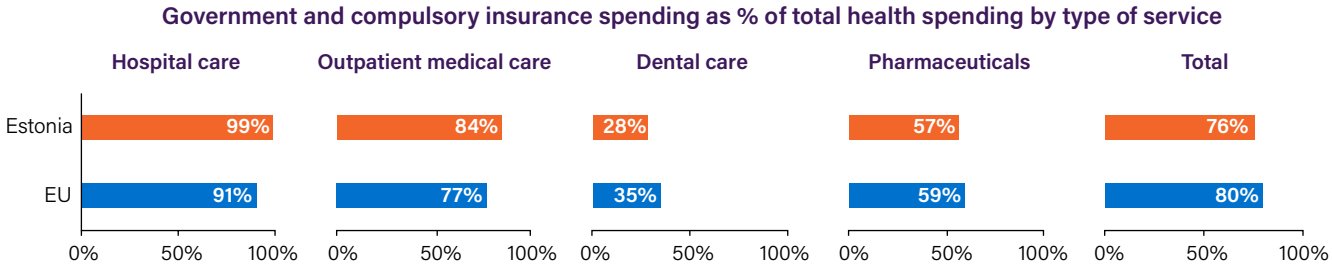
The benefits package for insured individuals is broad, but uninsured patients are only covered for emergency care, cancer screening, drug cessation and substitution services, and care for some communicable diseases. Most health services require copayments, although these are waived or subsidised for some people.

In 2023, Estonia had one of the highest levels of public coverage for hospital care in the EU: 99 % of hospital expenditure was publicly funded, compared to an EU average of 91 %. Public funding for outpatient medical care was similarly high, covering 84 % of spending compared to an EU average of 77 % (Figure 17). However, increases in formal copayments from 2025 (see below) are not reflected in the 2023 figures. Public financing is more limited for dental care

Box 2. Estonia's health sector is supported by significant EU funding across multiple instruments

The EU's Technical Support Instrument (TSI) supported several projects in Estonia: to devise an implementation strategy for improving mental healthcare in the primary health settings (March 2025 and ongoing), to improve digital skills in healthcare (2023-25), a primary care reform (2022-25) and designing the new Heath Systems Performance Assessment framework (2021). Under the Recovery and Resilience Plan (RRP), Estonia allocated EUR 72 million to health (7.6 % of total RRP funds).[2] The reforms and investments aim to address health workforce shortages, modernise digital health governance, strengthen primary and hospital care, and support the construction of a new health centre in Viljandi (European Commission, 2024). Additionally, under the EU4Health work programmes (2021-25), Estonian beneficiaries received funding via joint actions and direct grants amounting to EUR 16 million. It was primarily dedicated to crisis preparedness (28 %), cancer initiatives (40 %) and digitalisation (17 %), as of September 2025.

Figure 17. Public funding covered almost all hospital care provided in Estonia in 2023



Notes: Outpatient medical services mainly refer to services provided by generalists and specialists in the outpatient sector. Pharmaceuticals include prescribed and over-the-counter medicines and medical non-durables. The EU average is weighted.
Source: OECD Data Explorer (DF_SHA); data refer to 2023.

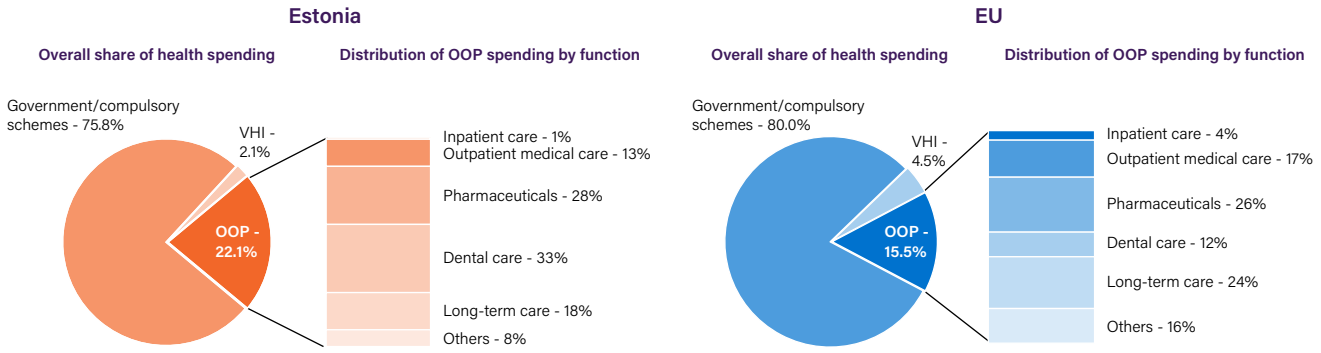
[2] Recovery and Resilience Fund data are based on the information available as of 20 September 2025; potential future amendments may affect these figures.

and pharmaceuticals. Reforms introduced in 2017-18 sought to ease the burden of private spending in these areas by setting annual caps on OOP costs for pharmaceuticals and expanding dental benefits for unemployed individuals and those receiving basic subsistence support, although prescription copayments were also increased in 2025 (see Section 6).

Copayments for outpatient and inpatient health services were quadrupled in 2025

OOP payments are substantial in Estonia, accounting for 22 % of current health expenditure in 2023 (Figure 18). The largest share of OOP spending was on dental care (33 %) – the largest proportion of OOP spending on dental care in the EU. Pharmaceuticals (28 %) and long-term care (18 %) are the next largest contributors to OOP expenditure in Estonia.

Figure 18. The share of OOP spending on health in Estonia is much higher than in the EU overall



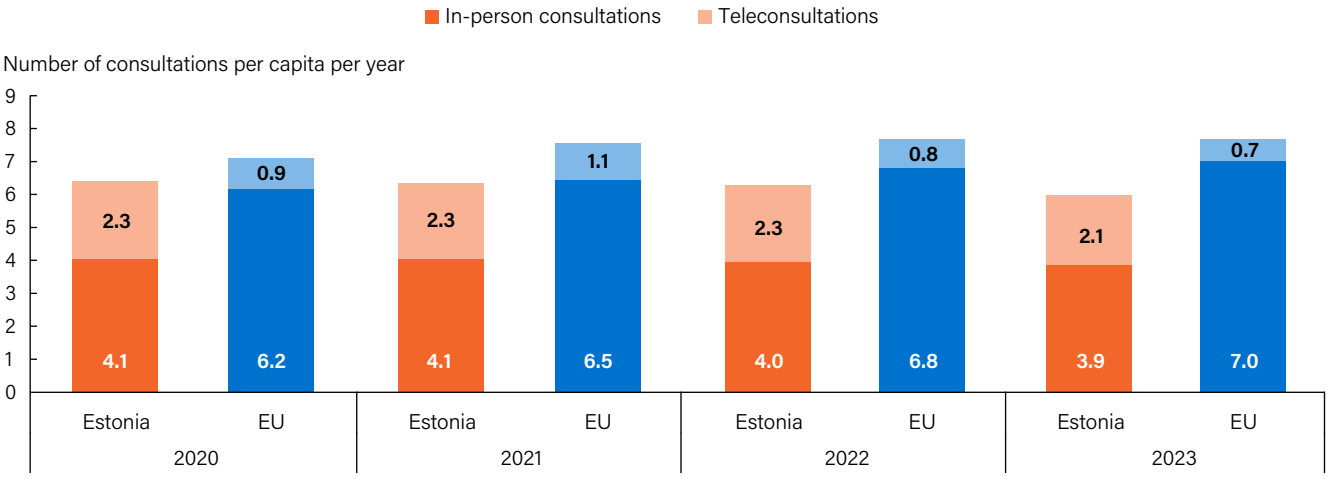
Note: VHI refers to voluntary health insurance, which also includes other voluntary prepayment schemes. The EU average is weighted.
Source: OECD Data Explorer (DF_SHA); data refer to 2023.

Recent policy changes implemented in April 2025 are not reflected in this distribution. Copayment fees for outpatient specialist consultations were quadrupled from EUR 5 to EUR 20, and daily inpatient fees increased from EUR 2.5 to EUR 5. These increases far exceed inflation and could have implications for catastrophic health spending in Estonia after the share of households experiencing catastrophic health expenditure declined slightly from 7.4 % in 2015 to 7.2 % in 2020 (WHO Regional Office for Europe, 2025).[3]

Further improvements in telemedicine and digital health aim to increase accessibility of services

Amid acute workforce shortages and growing concerns about the accessibility of healthcare – in terms of both geographical coverage and waiting times – Estonia has been actively investing in digital health solutions to ease pressure on the system and enhance access to care. A key focus has been on expanding telemedicine services and upgrading the national digital infrastructure to support a more people-centred and efficient healthcare system (see also Section 5.3).

Figure 19. Teleconsultations make up around one third of physician consultations per capita



Note: The EU19 average is weighted (calculated by the OECD).
Source: OECD Data Explorer (DF_CONSULT).

[3] Catastrophic health spending occurs when OOP health payments exceed 40 % of a household's capacity to pay, potentially forcing households into financial hardship.

Since 2020, Estonia has steadily expanded the scope of reimbursed telemedicine services. Initially launched in response to the COVID-19 pandemic, teleconsultations in both primary and specialist outpatient care have become a permanent part of the health benefits package (see Figure 19). In addition to teleconsultations, the EHIF also reimburses teletherapy services in fields such as speech therapy, rehabilitation and mental healthcare. Delivered via secure digital platforms, these services are designed to expand access to therapy and information – particularly for patients living in remote areas or those who have mobility challenges (Tervisekassa, 2024b).

5.3 Resilience

Health system resilience – the ability to prepare for, manage (absorb, adapt and transform) and learn from shocks and structural changes – has become central to policy agendas. Key priorities include easing pressures on service delivery, strengthening health infrastructure and workforce capacity, adapting crisis preparedness strategies, supporting digital innovation, and safeguarding long-term sustainability.

Estonia is strengthening crisis preparedness

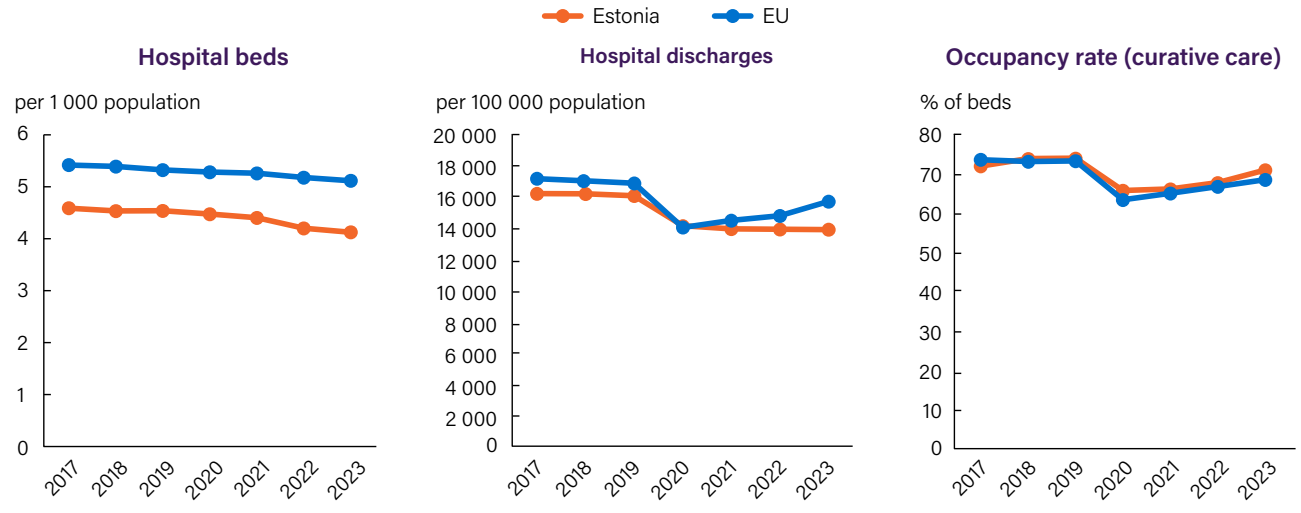
Estonia's self-assessed preparedness capacity for public health events, measured in the International Health Regulations (IHR) States Parties Self-Assessment Annual Report (SPAR), reached a score of 73 % in 2024, which was only slightly below the EU average of 75 %.[4] Estonia reported lower capacities in laboratory services, infection prevention and control, points of entry, and border health management. These weaknesses are particularly relevant, given that communicable disease outbreaks and mass poisonings are identified as national health risks (Health Board, 2024).

The country's preparedness efforts are guided by the Emergency Act (reformed in 2022) and coordinated by the Health Board. Policy measures aimed at strengthening operational resilience are also part of the current Hospital Network Development Plan.

Estonia continues to reduce hospital bed numbers

Reflecting a long-term strategic shift towards outpatient care, Estonia's hospital bed capacity per 1 000 population declined by 9 % between 2018 and 2023, with continued reductions throughout the pandemic years (Figure 20). Curative care bed occupancy rates are close to the EU average and dropped below 70 % between 2020 and 2022. Meanwhile, hospital discharge rates remained relatively stable at a level 13 % below the pre-pandemic rate rather than rebounding significantly post-2020. Estonia's Hospital Network Development Plan (adopted in December 2024) aims to consolidate the network from 20 to 17 facilities by 2040. The plan also centralises high-tech services, decentralises mental healthcare and palliative care, integrates health and social care, and improves crisis preparedness. The plan will require substantial long-term investment (an estimated EUR 1.8 billion by 2040) but remains unfunded at the time of writing.

Figure 20. Hospital discharge rates in Estonia remained below the pre-pandemic rate, while they rebounded in other countries



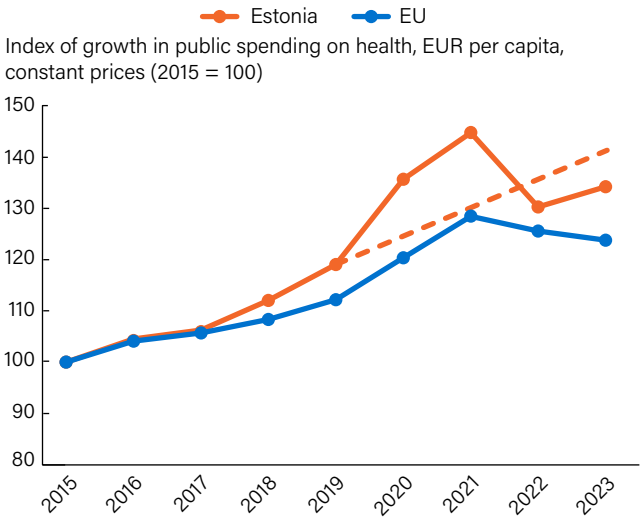
Note: The EU averages are weighted.
Sources: Eurostat (hlth_rs_bds1) and OECD Data Explorer (DF_KEY_INDIC).

The share of public spending on health has been readjusted, but is higher than the pre-pandemic level

Following exceptional annual growth exceeding 10 % in 2020 and further increases in 2021 due to pandemic response measures, Estonia's public spending on health per capita decreased in 2022. In 2023, expenditure remained 4 % below the hypothetical trajectory projected from pre-pandemic growth patterns (2015-19) (Figure 21). Nonetheless, the share of health expenditure in total government spending was 15 %

[4] The detailed methodology for producing the percentages can be found at https://www.who.int/publications/i/item/WHO-WHE-CPI-2018.17.

Figure 21. Public spending on health per capita has grown more in Estonia than on average across the EU



Notes: The EU average is weighted (calculated by the OECD). The dashed line represents the projected trend based on pre-pandemic (2015-19) data.
Source: OECD Data Explorer (DF_SHA).

in 2023 – notably higher than the pre-pandemic average. Several EU funding instruments also support the health system in Estonia (see Section 5.2, Box 2).

More health workforce is needed, now and in the future

Estonia faces health workforce shortages – particularly in family medicine, psychiatry and nursing, and in rural areas. Furthermore, in 2022, 43 % of doctors were aged 55 and over, suggesting further workforce shortages as these doctors retire (see Section 4). In response, Estonia adopted a national strategic framework in 2023 to alleviate workforce shortages. A core component of the framework involves expanding the training pipeline: admission quotas for medical and nursing students have recently been increased, and further increases in nursing admissions are planned until 2025-26. However, training up the health workforce takes time, and the current medical and nursing graduate output per 100 000 population is below the EU average (Figure 22).

Higher residency admission quotas for specialties were set in 2022. Curricula updates in 2022-23 and the introduction of part-time and flexible residency options in 2020 aim to enhance training relevance and accessibility. However, it is still difficult to attract candidates to family medicine residencies.

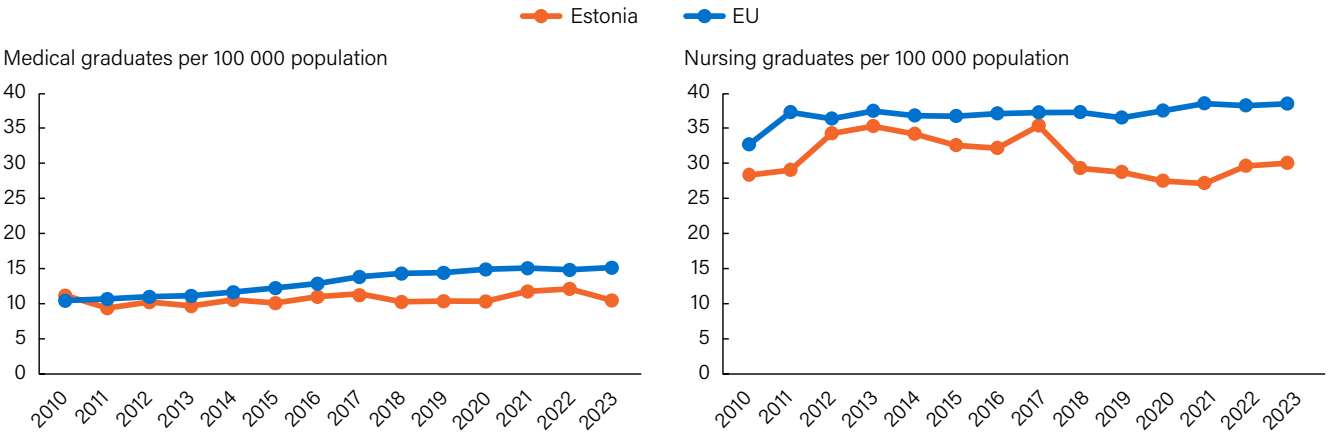
Beyond training, retaining the existing workforce is crucial. Substantial numbers of Estonian health workers applied for a certificate to practise abroad before the COVID-19 pandemic. Many nurses have also left the profession. The "Nurses back to healthcare" training was launched in 2015 to support trained nurses not working in healthcare to re-enter the profession. The course is five months long, includes both theoretical lessons, simulations and an internship and has brought over 200 nurses back into the profession since its launch. Course participants assess the training as generally positive and have identified opportunities for increased support and curriculum development (Kööp and Tupits, 2025).

The remuneration of both doctors and nurses in Estonia has increased considerably over the past decade. Estonia has also made exemplary use of task-shifting since the 2000s to enhance professional engagement – particularly for nurses.

Data are routinely used for decision making

Estonia has a formal requirement that analytical assessments need to be prepared for all legislative plans, and numerous topic-specific analyses are conducted for decision making. Estonia conducted its first health system performance assessment exercise in 2010, but regular assessments stalled due to insufficient institutional support, resources and limited stakeholder engagement. Estonia developed a new health systems performance framework for regular assessments in 2023, with OECD and EU TSI support (see Section 5.2, Box 2). The first report using the new framework is expected in late 2025 or early 2026.

Figure 22. There are fewer medical and nursing graduates per 100 000 population in Estonia than across the EU

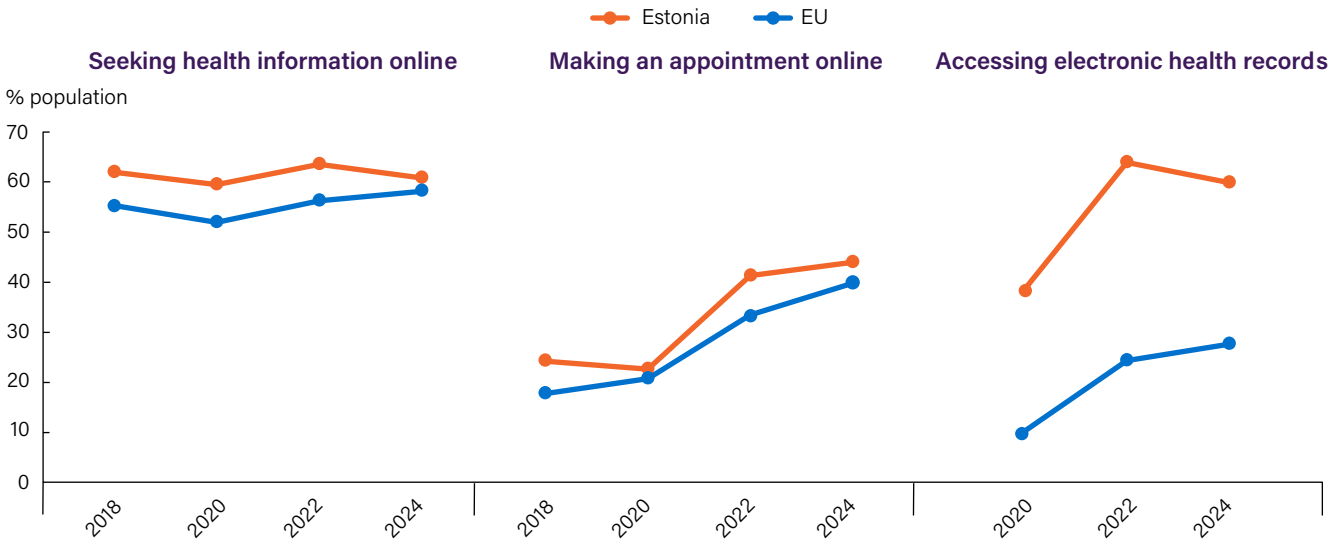


Notes: The EU average is weighted (calculated by the OECD). Data include graduates from all nursing programmes, not limited to those meeting the EU Directive for general nurses.
Source: OECD Data Explorer (DF_GRAD).

Estonia is one of the EU leaders in digital health, but some challenges persist

Estonia stands out as an early adopter of digital health, underpinned by consistent investment in health information and communications technology (ICT). The investment rate was on a par with the EU average in the five years prior to the COVID-19 pandemic, but has fallen below the EU average since and was EUR 1.65 million per 100 000 population in 2023 (compared to an EU average of EUR 2.29 million per 100 000). Public use of online resources for accessing health records and making appointments increased markedly between 2020 and 2024 (Figure 23). While access inequalities exist, digital engagement is strong across all socioeconomic groups. For example, 69 % of people with higher and 44 % of people with lower levels of education access health records online (compared to EU averages of 40 % of people with higher and 17 % of people with lower education levels).

Figure 23. Large parts of the population in Estonia use online resources to access health information and care



Source: Eurostat (isoc_ci_ac_i).

In 2024, the EHIF, in collaboration with the Health and Welfare Information Systems Centre, launched a new national Health Portal, replacing the previous patient portal that had been in use for over 15 years. The Health Portal is a one stop shop where patients can access their health records and test results and can book and view upcoming appointments.

Despite Estonia's overall digital maturity – reflected in a third-place ranking in the EU according to the 2024 Digital Decade eHealth Indicator Study (European Commission et al., 2024) – data integration challenges persist. At present, comprehensive linking across health datasets is not feasible, hindering advanced monitoring and research capabilities. The digital health strategy and initiatives under the Hospital Network Development Plan and Recovery and Resilience Facility-supported reforms aim to improve health data and digital health governance to overcome these limitations.

The health system in Estonia is preparing for climate change to mitigate climate risk

Environmental issues such as air pollution and climate change already have an impact on the health status of populations across Europe in various ways, including through respiratory diseases and heat-related illnesses, with children and older people particularly vulnerable. In Estonia, heat-related deaths among those aged 65 and over increased by an estimated 38 % in 2014-23 compared to 1990-99 (Romanello et al., 2024). Climate projections foresee an increased risk of heat, floods and vector-borne diseases in Estonia by the year 2100 (Ministry of Climate Change, 2021). The Development Plan for Adaptation to Climate Change until 2030 sets out changes to the health sector to mitigate climate risk. Climate change is also considered as part of the Population Health Development Plan 2020-30 (European Climate and Health Observatory, 2025).

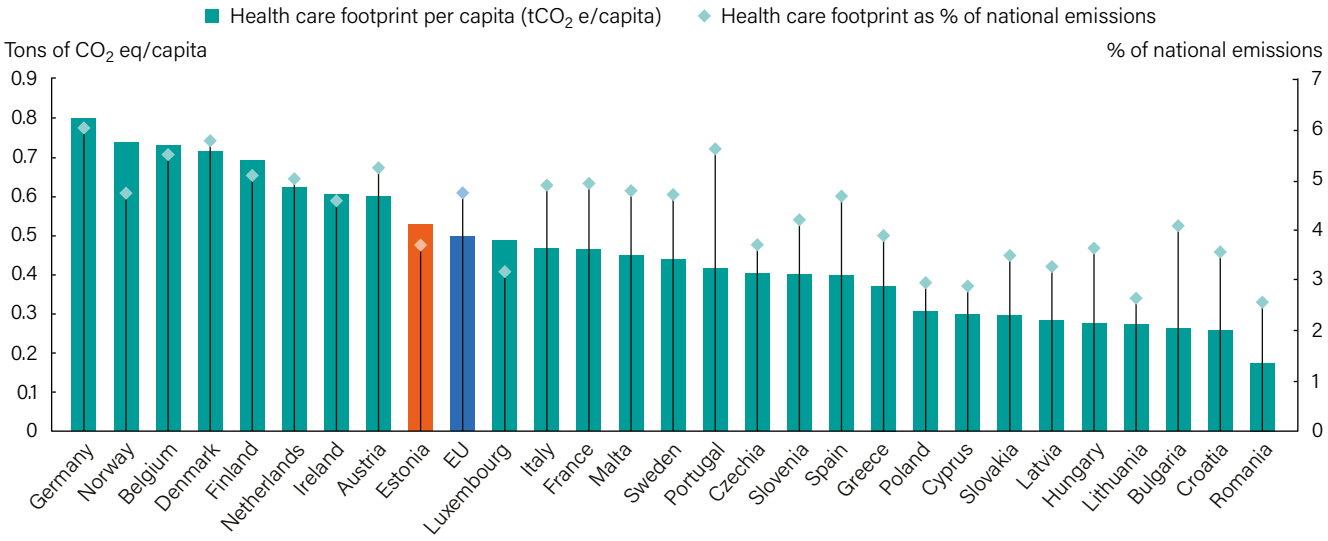
Health systems contribute to climate change. In 2018, the health sector in Estonia contributed 3.7 % to the country's overall greenhouse gas emissions (Figure 24), although the majority of healthcare emissions are indirect, arising from supply chain activities rather than direct operations. The Hospital Network Development Plan will require hospitals to adopt sustainable practices, such as switching to renewable energy sources, improving waste management and adhering to circular economy principles.

Antibiotic consumption in Estonia is among the lowest in the EU

Curbing excessive antibiotic use is fundamental to tackling antimicrobial resistance, a priority reinforced by the EU Council's 2030 targets that were adopted in 2023.[5] Estonia has much lower antibiotic consumption rates than most other EU countries and met the EU Council's 2030 reduction

[5] Council Recommendation on stepping up EU actions to combat antimicrobial resistance in a One Health approach, 2023/C 220/01.

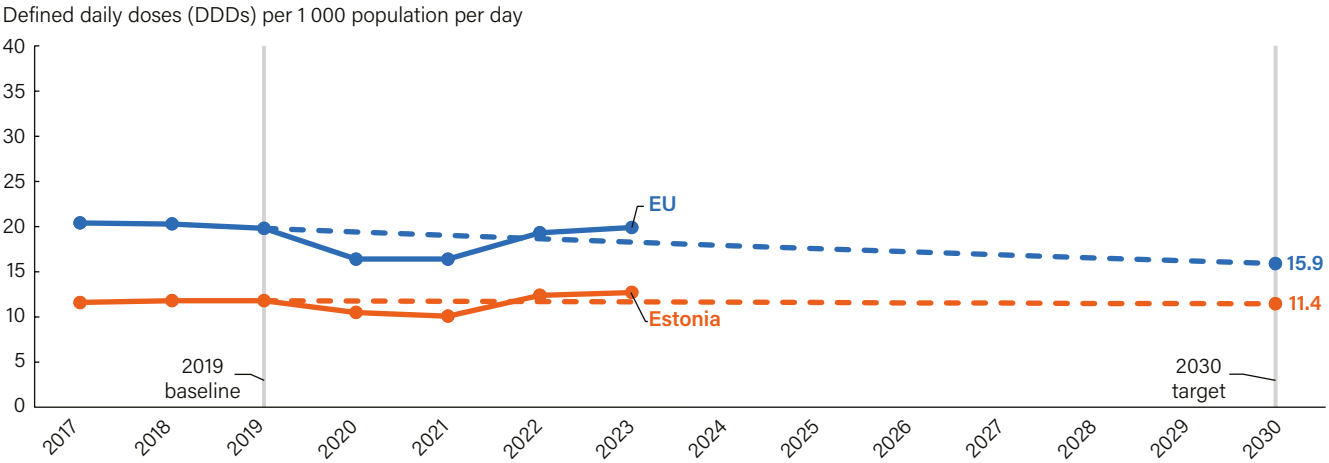
Figure 24. The environmental impact of the health sector in Estonia is near EU average



Note: The chart reflects 2018 data.
Source: OECD (2025), Decarbonising Health Systems Across OECD Countries, https://doi.org/10.1787/5ac2b24b-en.

target of 11.4 defined daily doses per 1 000 population in 2020 and 2021, largely due to reduced transmission of non-COVID-19 respiratory infections. However, mirroring EU trends, consumption rebounded to 12.7 defined daily doses per 1 000 population in 2023 as infection rates rose following the pandemic, suggesting that underlying prescribing behaviours may not have fundamentally shifted (Figure 25). The Estonian antimicrobial resistance strategy 2025-30 was confirmed by the antimicrobial resistance steering group in November 2024, following a 2022 study on the routes of antimicrobial resistance spread in Estonia that outlines possible containment strategies.

Figure 25. Antibiotic consumption in Estonia in 2023 was nearly 8 % above its 2019 level



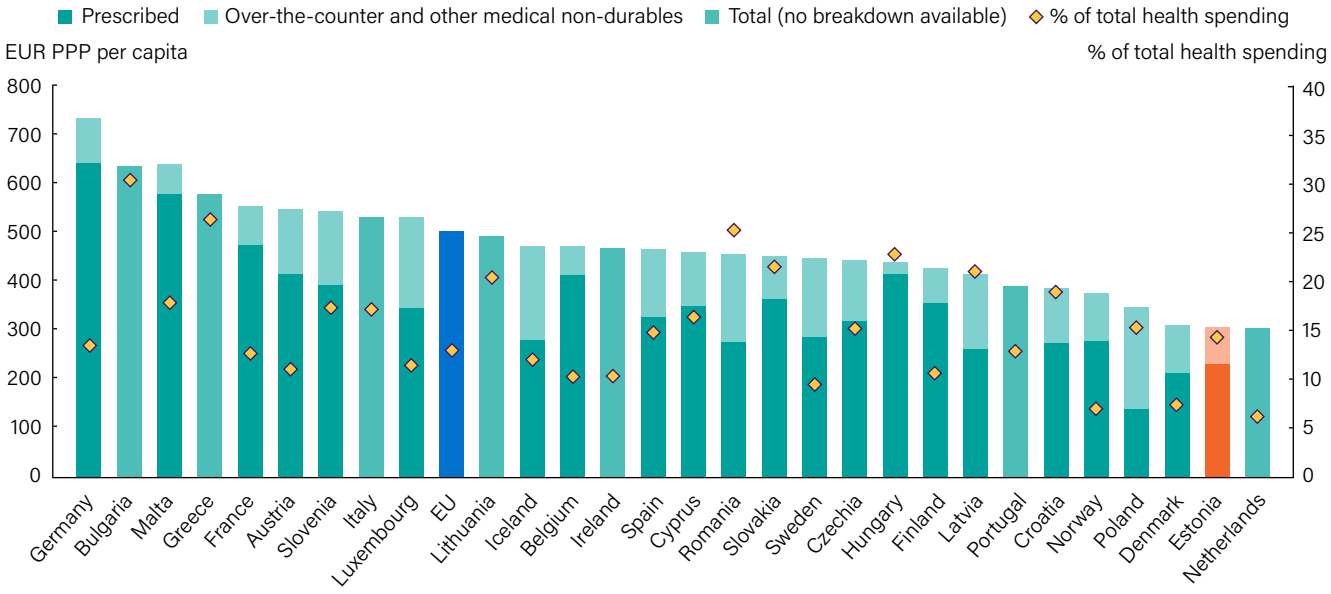
Notes: The EU average is weighted. The chart shows antibiotic consumption in hospital and the community. The dashed line illustrates the policy target pathway to meet the 2030 reduction targets.
Source: ECDC ESAC-Net.6.

6 Spotlight on pharmaceuticals

Estonia's spending on pharmaceuticals per capita is among the lowest in the EU

In Estonia, spending on retail pharmaceuticals is the second lowest among EU countries, amounting to EUR 311 per capita (adjusted for differences in purchasing power), compared to the EU average of EUR 510 per capita. Of this amount, approximately 76 % (EUR 236 per capita) is spent on prescribed medicines in Estonia. Overall, retail

Figure 26. As a share of total health spending, Estonia's expenditure on retail pharmaceuticals is slightly above the EU average



Note: This figure represents expenditure on pharmaceuticals dispensed through retail pharmacies for outpatient use only. It excludes medications administered in hospitals, clinics or physician offices.
Source: OECD Data Explorer (DF_SHA); data refer to 2023, except for Norway (2022).

pharmaceutical expenditure accounts for 15 % of Estonia's total health expenditure – slightly above the EU average of 13 % (Figure 26).

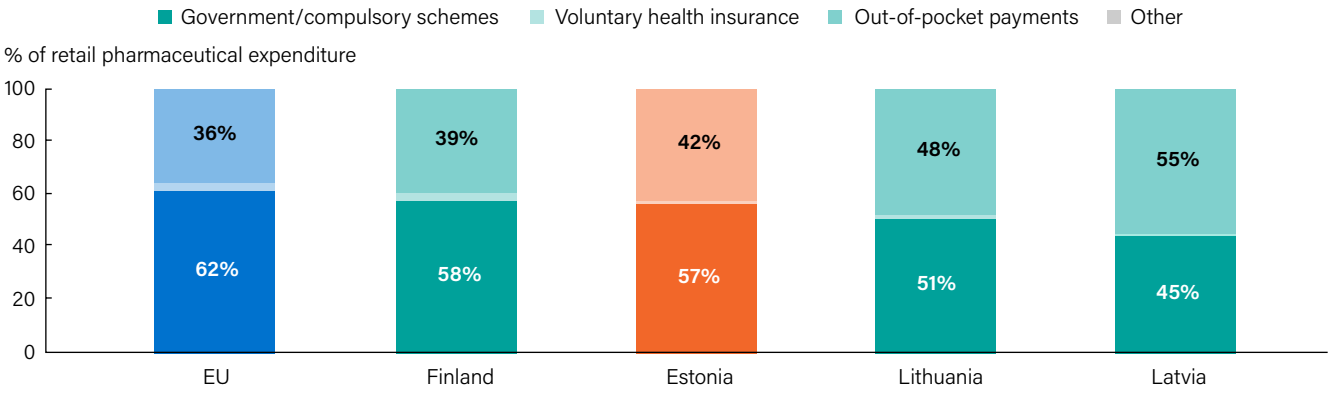
Between 2013 and 2023, total pharmaceutical expenditure in Estonia grew at an average annual rate of around 2 %, rising from EUR 290 to EUR 335 per capita (in constant prices). Total pharmaceutical expenditure peaked in 2021 at EU 364 per capita and has plateaued since. Spending on pharmaceuticals dispensed within the hospital sector recently declined from a high of EUR 68 per capita in 2020 to approximately pre-pandemic levels of EUR 59 per capita in 2023, but its share of overall pharmaceutical expenditure has remained stable over the past decade.

Out-of-pocket spending on medicines has reduced, but remains a cause of catastrophic health spending in Estonia

In 2023, 42 % of retail pharmaceutical expenditure was paid out of pocket (Figure 27). Outpatient medicines remain a major driver of financial hardship: in 2020, they accounted for nearly 59 % of all OOP health payments. In that year, catastrophic health spending on outpatient medicines was split almost evenly between over-the-counter medicines (30 %) and prescribed medicines (29 %) (Võrk, Habicht & Köhler, 2023).

The 2018 reforms to address high OOP spending on prescription pharmaceuticals lowered the annual ceiling on OOP spending, and automated benefits so that they are applied at the point of purchase. Prior to this, many people were unaware of available benefits, or faced administrative barriers to accessing them (WHO, 2025). As a result of these

Figure 27. Some 42 % of expenditure on retail pharmaceuticals comes from out-of-pocket payments in Estonia



Note: The EU average is unweighted.
Source: OECD Data Explorer (DF_SHA); data refer to 2023, except for Norway and Malta (2022).

changes, the share of people claiming reduced copayments when collecting a prescription rose from 0.4 % in 2017 to 15.6 % in 2018 and 16.9 % in 2020 (Võrk, Habicht & Köhler, 2023). In 2025 the fixed fee per pharmaceutical prescription increased from EUR 2.50 to EUR 3.50.

The time to reimbursement for new medicines is around the EU average

The two indicators most commonly used to assess the timeliness and breadth of access to new medicines are the average time elapsed between EU marketing authorisation and public reimbursement, and the proportion of centrally-approved medicines available nationally. Both metrics are reported in the European Federation of Pharmaceutical Industries and Associations' Patients WAIT Indicator Survey (Newton et al., 2025). While neither indicator comprehensively measures meaningful patient access to effective treatments, they provide a basis for discussion.

According to the WAIT Indicator Survey, the average time to reimbursement decision in Estonia for medicines approved by the EU in 2020-23 was 608 days – above the EU average of 578 days. As of January 2025, 24 % (42 out of 173 products) of centrally-authorised medicines approved between 2020 and 2023 had achieved reimbursement status in Estonia. This is below the EU average of 46 % (80 products). Reimbursement decisions in Estonia are informed by health technology assessment (HTA). While the new HTA regulation came into force at EU level in January 2025, a new national HTA guideline came into effect in Estonia, also in January 2025, with both clinical and economic evaluations forming the evidence base for decisions. The National Medicines Policy 2030 outlines several priorities to improve access to new medicines, and a Pharmaceutical Policy Implementation Plan is being developed.

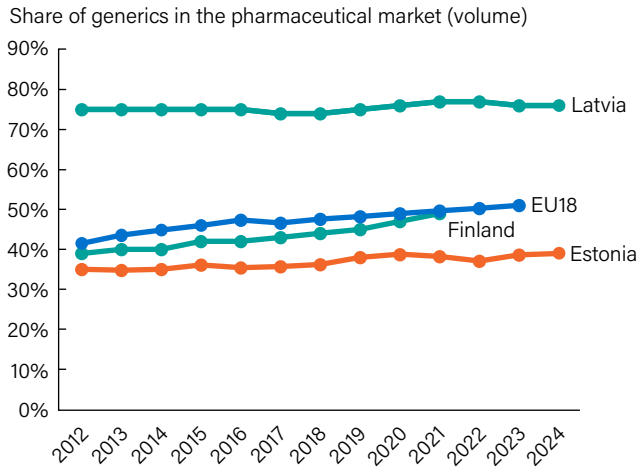
There is scope to use more generic medications in Estonia

The share of generic medicines by volume in Estonia's pharmaceutical market grew modestly from 35 % in 2014 to 39 % in 2024 (Figure 28), compared to 51 % (2023) among the 18 EU countries for which data are available and the 76 % in neighbouring Latvia (2024). Estonia does not use pharmaceutical budgets for prescribers (doctors or family nurses); nor does it have mandatory generic substitution in pharmacies. However, regulations require prescription by international non-proprietary name (INN). If prescribing by brand name, a justification must be documented (such as patient refusal or unavailability of a cheaper option). When a medicine is prescribed by INN, pharmacists are obliged to offer generic alternatives and inform patients of price differences.

Estonia has a small pharmaceutical research and development sector

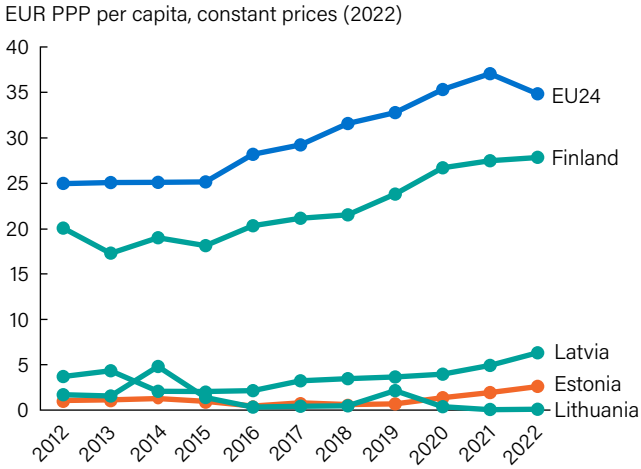
Estonia has a comparatively small pharmaceutical sector and limited capacity for pharmaceutical innovation. Per capita business expenditure on pharmaceutical sector research and development (R&D) is well below the EU average, but not too dissimilar to business spending on R&D in neighbouring Latvia and Lithuania (Figure 29). An average of 2 international patent applications per year were filed from applicants based in Estonia every year for the decade spanning 2012-22, out of an average of 1 725 applications per year filed from applicants in all EU countries in the same period. In contrast, 14.5 trials per million population were conducted in Estonia in 2024 compared to 18.4 trials per million population on average across the EU, although the number of new clinical trials per year has recently reduced by two thirds; from a high of 61 in 2016 and 2017 to 20 new trials in 2024. Clinical trials conducted in Estonia tend to be late-phase, multi-national trials that are industry sponsored. The National Medicines Policy 2030 endorses greater support for drug development, including directing more investment towards pharmaceutical R&D.

Figure 28. The generics share of the pharmaceutical market in Estonia has been below the EU average



Notes: The EU average is weighted.
Source: OECD Data Explorer (DF_GEN_MRKT).

Figure 29. Pharmaceutical research and development expenditure in Estonia is below the EU average, but similar to expenditure in neighbouring countries



Note: The EU average is weighted (calculated by the OECD).
Source: OECD Data Explorer (DF_ANBERDi4).

7 Key findings

- After a temporary decline during the pandemic years, life expectancy in Estonia rebounded and reached an all-time high of 79.6 years in 2024. Socioeconomic health inequalities are large: people from higher socioeconomic groups report better health, lead healthier lifestyles and live 8-10 years longer than people from lower socioeconomic groups. There are also large gender health disparities: Estonian women live considerably longer than men, but also report worse health for longer.
- Alcohol consumption among adults has remained stable over the past decade. It was around 10 % higher than the EU average in 2022, and remained above 10 litres per capita in 2023 despite policy efforts aiming to reduce consumption to under 8 litres per capita. An increase in adolescent vaping rates has also prompted stricter regulation of e-cigarettes. Adults in Estonia are the most physically active in the EU, but Estonian adolescents are among the least physically active.
- There is a shortage of health professionals in family medicine and mental healthcare – particularly in rural areas. Estonia had fewer doctors and nurses per 1 000 population in 2023 than the EU averages. Moreover, in 2022, 43 % of doctors were aged 55 and over, suggesting that workforce shortages are likely to worsen in the future. While efforts have been made to increase health workforce training capacity, current medical and nursing graduate output is below projected requirements and below the EU averages.
- There was a sharp drop in the uptake of vaccinations in Estonia following the COVID-19 pandemic. The Ministry of Social Affairs has responded by commissioning a study to improve vaccination management and communication strategies, and the vaccination schedule for human papillomavirus has been updated in response to the decreased uptake. While human papillomavirus vaccination uptake reached a new high in 2024, measles vaccination uptake was still below the vaccination coverage rate in 2021, falling to 83.3 % in 2024.
- Some 22 % of current health expenditure was from out-of-pocket payments in 2023. Despite lowered annual ceilings on copayments, out-of-pocket payments on outpatient medicines constitute a major driver of financial hardship. Large increases in outpatient specialist consultation, prescription and daily inpatient fees were introduced in 2025; these may further erode the health system's financial protection and exacerbate unmet needs for care, which are already high.
- Estonia has reduced excess hospital bed capacity over time. Between 2018 and 2023, bed capacity per 1 000 population declined by over 9 %, but curative care bed occupancy rates have consistently been below 70 % since 2020. Overall, chronic conditions are managed well in the community, with low hospital admission rates. The Hospital Network Development Plan, which was adopted in December 2024, aims to consolidate the hospital network further – from the current 20 facilities to 17 facilities by 2040.
- Estonia is one of the EU leaders in digital health. It stands out as an early adopter of digital health tools, and has invested consistently in health information and communications technology. Public use of online resources for accessing health records and booking appointments increased markedly between 2020 and 2024, and is well above the EU average for all socioeconomic groups. Scope for better cross-linking between different health databases for research and decision making has been identified, and improvements to data governance are under way.
- Estonia's new national HTA guideline came into effect in 2025, with both clinical and economic evaluations forming the evidence base for reimbursement decisions. Estonia has scope to increase the use of generic medicines to reduce costs and improve access to medicines. The share of generic medicines in Estonia's pharmaceutical market was 39 % in 2024, which is below the EU average (51 % in 2023).

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Country abbreviations

Austria	AT	Czechia	CZ	Germany	DE	Italy	IT	Netherlands	NL	Slovakia	SK
Belgium	BE	Denmark	DK	Greece	EL	Latvia	LV	Norway	NO	Slovenia	SI
Bulgaria	BG	Estonia	EE	Hungary	HU	Lithuania	LT	Poland	PL	Spain	ES
Croatia	HR	Finland	FI	Iceland	IS	Luxembourg	LU	Portugal	PT	Sweden	SE
Cyprus	CY	France	FR	Ireland	IE	Malta	MT	Romania	RO		

State of Health in the EU
Country Health Profiles 2025

The *Country Health Profiles* are a key element of the European Commission's *State of Health in the EU* cycle, a knowledge brokering project developed with financial support from the European Union.

These Profiles are the result of a collaborative partnership between the Organisation for Economic Co-operation and Development (OECD) and the European Observatory on Health Systems and Policies, working in tandem with the European Commission. Based on a consistent methodology using both quantitative and qualitative data, the analysis covers the latest health policy challenges and developments in each EU/EEA country.

The 2025 edition of the *Country Health Profiles* provides a synthesis of various critical aspects, including:

- the current state of health within the country;
- health determinants, with a specific focus on behavioural risk factors;
- the structure and organisation of the health system;
- the effectiveness, accessibility and resilience of the health system;
- an account of the pharmaceutical sector and policies within the country.

Complementing the key findings of the Country Health Profiles is the *Synthesis Report*.

For more information, please refer to: https://health.ec.europa.eu/state-health-eu_en

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