



COUNTRY REPORT

ESTONIA

MIPEX

HEALTH STRAND



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# MIGRANT INTEGRATION POLICY INDEX *HEALTH STRAND*

## Country Report Estonia

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## READER'S GUIDE TO THE REPORT

This report was produced within the framework of the IOM's EQUI-HEALTH project, in collaboration with Cost Action IS1103 ADAPT and the Migrant Policy Group (MPG). Full details of the research and its methodology are contained in Sections I and II of the Summary Report, which can be downloaded from the IOM website at <http://bit.ly/2g0GIRd>. It is recommended to consult this report for clarification of the exact meaning of the concepts used.

Sections 5–8 are based on data from the MIPEX Health strand questionnaire, which covers 23 topics, in 10 of which multiple indicators are averaged. Each indicator is rated on a 3-point Likert scale as follows:

- 0 no policies to achieve equity
- 50 policies at a specified intermediate level of equity
- 100 equitable or near-equitable policies.

'Equity' between migrants and nationals means that migrants are not disadvantaged with respect to nationals. This usually requires equal treatment, but where migrants have different needs it means that special measures should be taken for them. Scores relate to policies adopted (though not necessarily implemented) by 31st December 2014. However, some later developments may be mentioned in the text.

To generate the symbols indicating a country's ranking within the whole sample, the countries were first ranked and then divided into five roughly equal groups (low score – below average – average – above average – high). It should be remembered that these are relative, not absolute scores.

The background information in sections 1-4 was compiled with the help of the following sources. Where additional sources have been used, they are mentioned in footnotes or references. It should be noted that the information in WHO and Eurostat databases is subject to revision from time to time, and may also differ slightly from that given by national sources.

Section	Key indicators	Text
1. Country data	Eurostat	CIA World Factbooks, BBC News ( <a href="http://news.bbc.co.uk">http://news.bbc.co.uk</a> ), national sources
2. Migration background	Eurostat, Eurobarometer ( <a href="http://bit.ly/2grTjIF">http://bit.ly/2grTjIF</a> )	Eurostat, national sources
3. Health system	WHO Global Health Expenditure Database <sup>1</sup> ( <a href="http://bit.ly/1zZWnuN">http://bit.ly/1zZWnuN</a> )	Health in Transition (HiT) country reports ( <a href="http://bit.ly/2ePh3VJ">http://bit.ly/2ePh3VJ</a> ), WHO Global Health Expenditure database
4. Use of detention		National sources, Global Detention Project ( <a href="http://bit.ly/29IXgf0">http://bit.ly/29IXgf0</a> ), Asylum Information Database ( <a href="http://bit.ly/1EpevVN">http://bit.ly/1EpevVN</a> )

These reports are being written for the 34 countries in the EQUI-HEALTH sample, i.e. all EU28 countries, the European Free Trade Area (EFTA) countries Iceland, Norway and Switzerland, and three 'neighbour' countries – Bosnia-Herzegovina, FYR Macedonia and Turkey.

All internet links were working at the time of publication.

<sup>1</sup> For the definition of these indicators please see p. 21 of the WHO document *General statistical procedures* at <http://bit.ly/2lXd8JS>

# 1. COUNTRY DATA

KEY INDICATORS		RANKING
Population (2014)	1.315.819	●○○○○○
GDP per capita (2014) [EU mean = 100]	73	●●○○○○
Accession to the European Union	2004	

**Geography:** Estonia is a lowland country bordering Latvia and Russia, with a sea border of 768,6 km (Baltic Sea and Gulf of Finland). The country covers 45.227 sq. km., including 1.521 Islands in the Baltic Sea, the largest islands being Saaremaa, Hiiumaa, and Muhu. Estonia is 55% covered in forests and has numerous lakes and rivers. The capital is Tallinn - with 439.517 inhabitants accounting for approximately 32% of the population; overall, 68% of Estonian population is living in urban areas.

**Historical background:** Following centuries under Danish, Swedish, German, and Russian rule, Estonia gained independence from Russia after World War I. Shortly after the beginning of World War II, Estonia was again occupied by Russia and then by Nazi Germany from 1941 until 1944, when it was retaken by the Soviets. Estonia officially regained its independence from the Soviet Union in 1991, and joined NATO and the EU in 2004.

**Political background:** The Constitution of Estonia came into force in 1992, making the country a Parliamentary Democracy. The country has an administrative division of 15 counties, 33 towns, and 194 rural municipalities.

**Economic background:** Estonia has one of the higher per capita income levels in Central Europe and the Baltic region. It has a modern market-based economy and the government has pursued a free market, pro-business economic agenda and tight fiscal policies, which have resulted in a balanced budget and low public debt. The country is facing a labour shortage despite the government's efforts in amending immigration laws to allow an easier process of hiring qualified foreign workers. Currently (February 2017), the country has an unemployment rate of 6,5%. Estonia's economy faltered in 2013, mainly due to the continuing recession in the EU, and GDP growth dropped to 1,2% in 2015, due to lower demand in key Scandinavian export markets. However, in autumn 2016 the European Commission forecasted annual growth of 2,3% in 2017 and 2,6% in 2018.<sup>2</sup>

<sup>2</sup> <http://bit.ly/2lqgwcB>

## 2. MIGRATION BACKGROUND

KEY INDICATORS (2014)		RANKING
Foreign-born population as percentage of total population	4,0 <sup>2</sup>	●●○○○
Percentage non-EU/EFTA migrants among foreign-born population	75	●●●●●
Foreigners as percentage of total population	14,8	●●●●●
Non-EU/EFTA citizens as percentage of non-national population	96	●●●●●
Inhabitants per asylum applicant (more = lower ranking)	8.489	●○○○○
Percentage of positive asylum decisions	36	●●○○○
Positive attitude towards immigration of people from outside the EU (Question QA11.2, Eurobarometer)	31	●●○○○
MIPEX Score for other strands (MIPEX, 2015)	49	●●○○○

The history of migration to Estonia can be divided into two periods: first, post-WWII migration from other parts of the Soviet Union (1946-1991) and second, post-independence migration (after 1991). These two periods are characterised by very different political and legal frameworks. After the end of WWII, labour recruitment for rebuilding and developing the Soviet planned-economy (manufacturing) industry became a major reason for immigration. The largest wave of this immigration took place during the immediate post-war period, where in 1946-47 an average of 45.000 people arrived per year.

Immigration during the Soviet period changed the ethnic composition of the country. Pre-WWII ethnic groups such as Germans and Swedes emigrated before and during the war, and were replaced by mostly Slavic immigrants from other parts of the Soviet empire. The share of ethnic Estonians decreased significantly, reaching 61% during the last USSR census in 1989. The share of Russians increased from 8% in the interwar republic to 26% in 1989. Mostly as a result of immigration during the Soviet period, the foreign-born population in 2014 constituted 20% of the total Estonian population.<sup>3</sup>

At the beginning of the 1990s, Estonia established rather strict immigration laws setting the upper limit of yearly immigration to 0,5% of the resident population. While in recent years immigration to Estonia has shown a steady increase, the migration balance continues to be unfavourable; emigration exceeds immigration. Overall, immigration to Estonia remains strongly influenced by its geographic location – Finland and Russia accounting for most of the immigrant population – which is a consistent trend over the last six years and likely to continue. Surprisingly perhaps, given the scarcity of legal barriers to migration into Estonia for EU/EFTA nationals, only 4% of foreign nationals were citizens of EU/EFTA countries in 2014. The large number of Russians and foreign nationals with “undetermined citizenship” (see below – Eurostat counts these as “non-EU/EFTA citizens”) makes immigration from the EU/EFTA

<sup>3</sup> It is virtually impossible to calculate what the foreign-born population would be if these ‘statistical migrants’ were excluded – who were not migrants when they moved to Estonia, but were counted as such after independence; we have made a rough estimate of 4%.

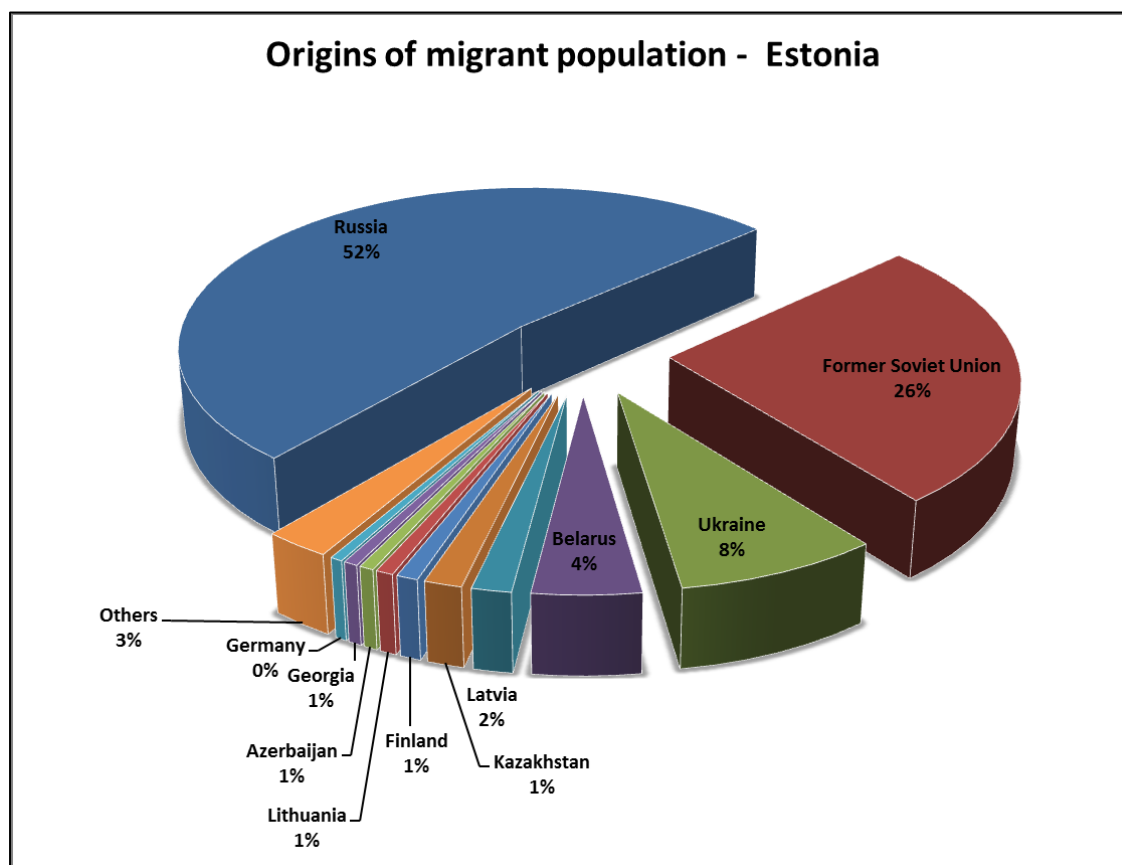
seem even smaller. In recent years, migrants to Estonia have originated mostly from Russia and Ukraine. Russian nationals alone accounted for almost half (40%) of new arrivals during the period 2008-2014, and Ukrainians a quarter (23,7%). USA and China are in third and fourth place respectively, although both with significantly smaller numbers. Table 1 shows figures from the 2011 census for country of birth and citizenship. Figure 1 shows the figures for foreign-born residents in more detail.

**Table 1. Estonian population by country of birth and citizenship (Population Census 2011)**

Country of birth	Number	Percentage
Estonia	1.102.092	85
European Union	12.052	1
Other European countries	168.742	13
... Ukraine	21.156	2
... Belarus	11.593	1
... Russia	134.948	10
Citizenship	Number	Percentage
Estonian	1.102.618	85
Russian Federation	90.510	7
Undetermined	85.961	7
Other	15.366	14

Source: Statistics Estonia

**Figure 1. Foreign-born population in 2014 by country of birth (Eurostat)**





A word is in order about the group of people with so-called “undetermined citizenship” (or in EU terminology, “recognized non-citizens”). These are in fact long-term Estonian residents, many of whom were born in Estonia, who had Soviet Union passports but did not choose any citizenship when their passport expired. Unlike stateless people, they have the right to apply for Estonian citizenship through the regular naturalisation process, but for a number of personal and practical reasons they have chosen not to do so. The number of people with undetermined citizenship was high immediately after the collapse of the Soviet Union (approximately 32% of the population), but has gradually decreased over the last 20 years due to naturalisation.

From the above discussion it will be clear that the relation between citizenship and country of birth in Estonia is very complex. A migrant is normally defined in terms of country of birth, with citizenship being used as a proxy indicator. However, the indicator one chooses makes a lot of difference to the picture that emerges. Many people born in Estonia are classified as ‘non-nationals’ because they have undetermined status; many who had moved from other Soviet republics before 1991 became “statistical migrants’ overnight when the republic they were born in became a foreign country. Whichever indicator is used, its meaning will not be the same as in countries which have not experienced a similar history.

**Asylum seekers:** The number of asylum seekers has been relatively low, and Estonia has traditionally received the lowest number of asylum applications received annually by EU Member States. Starting in 1997, when Estonia signed the 1951/67 Refugee Convention, this number has averaged about 30. The year 2014 saw a significant increase in asylum applications from Ukraine due to the military conflict in Eastern Ukraine (92 applications out of total of 99 lodged in 2014 and first half of 2015). The main countries of origin of asylum seekers since 1997 have been Ukraine, Russian Federation, Georgia, Syria and Afghanistan (see Table 2).

**Table 2. Asylum seekers by country, top 5 countries, numbers - 1997-2015 (30 May 2015)**

Country of origin	Number
Ukraine	99
Russian Federation	81
Georgia	73
Syria	47
Afghanistan	38

Source: Police and Border Guard Board (PPA)

**Undocumented migrants:** As in other countries, no official statistics are available that would provide comprehensive information about the number of undocumented migrants (UDMs) in Estonia. According to Eurostat figures, 720 third country nationals were found to be illegally present in Estonia in 2014.<sup>4</sup> However, this data covers only UDMs recorded by the state. It is estimated that the number of undocumented migrants ranges from 5.000 to 10.000. This corresponds to 0,4-0,8% of the total population (Baldwin-Edwards and Kraler 2009; CLANDESTINO 2009). Nevertheless, the reliability of these estimates is rather low (CLANDESTINO 2009). Because of its geographical location (its proximity to the Scandinavian welfare states, and the large number of irregular migrants in the Russian Federation),

<sup>4</sup> Eurostat database.

Estonia is believed to be a transit country for asylum seekers coming from the south and east. These people remain unlawfully in the country only for a short period. The highest percentage of UDMs consists of persons with expired temporary residence permits. Some of them have been living in Estonia for years. Due to the low number of asylum applications, it is not likely that unsuccessful asylum seekers form a significant proportion of UDMs.

### 3. HEALTH SYSTEM

KEY INDICATORS (2013)		RANKING
Total health expenditure per person (adjusted for purchasing power, in euros)	1.108	●○○○○○
Health expenditure as percentage of GDP	6,5	●○○○○○
Percentage of health financing from government National health system (NHS) / social health insurance (SHI)	17	SHI
Percentage of health financing from out-of-pocket payments (higher percentage = lower ranking)	20	●●●○○○
Score on Euro Health Consumer Index (ECHI, 2014)	677	●●●○○○
Overall score on MIPEX Health strand (2015)	27	●○○○○○

Estonia has a centralized health care system. The Ministry of Social Affairs and the Minister of Health and Work develop and administer Estonia's national health policy. On a daily basis, the health care system is overseen by the agencies of the Ministry of Health, including the State Agency of Medicines, the Health Board (responsible for supervising healthcare providers, ensuring communicable disease surveillance and enforcement of health protection legislation) and the National Institute for Health Development (a research and development agency on public health). The financing of public health care is organized through the Estonian Health Insurance Fund (EHIF). Additionally, the eHealth Foundation operates the national e-Health system, which is an information exchange platform connecting all providers and allowing data exchanges with various other databases. The Ministry of Social Affairs is responsible for financing emergency care for uninsured people, as well as for ambulance services and public health programmes. The contribution of the local municipalities to health financing is relatively small, at just over one percent of total health expenditure. Some services, such as facilitation of access to healthcare for people with special needs, can be regulated and financed by local governments, however, municipalities have no defined responsibility for covering health care expenditure and thus their financing practices vary widely. Private expenditure comprises approximately 20% of all health care expenditure, mostly in the form of co-payments for medicines and dental care.

Both in terms of health expenditure per capita and as a percentage of GDP, Estonia spends relatively little on its health system. In spite of this, it manages to achieve an average score on the Euro Health Consumer Index. As we shall see below, however, it has one of the lowest scores on the MIPEX Health strand; it cannot be regarded as a 'migrant-friendly' system.

Whereas the regulation and funding of public health care are coordinated nationally, the provision of services is almost entirely decentralised. The majority of hospitals are either private legal entities owned by local governments, foundations established by the state, or other public bodies. General practitioners are private legal entities.

### **Mandatory Health Insurance**

Estonia belongs to the group of countries in the EU where the entitlement to the state-funded public healthcare is based on social insurance contributions (Bismarck system). Entitlements are laid down by the national government in the Health Insurance Act; there are no variations at regional or local level. The health tax (13% of social taxes) is paid by the employer from the taxable income of the employee.

This system provides health insurance coverage for those who are employed and pay social tax, which includes all legal migrants in employment. Groups exempted from social tax but included in the state health insurance coverage are as follows: pregnant women, persons under 19 years of age, school pupils and students (with a certain age limit), foreign students with permanent residency, persons receiving a state pension granted in Estonia, as well as insured person's dependent spouses who are no more than 5 years away from attaining the age requirement for old-age pensions.<sup>5</sup> The extent of coverage under the national compulsory health insurance is the same for all, irrespective of their type of residence permit.

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<sup>5</sup> Health Insurance Act (2002), §5 (4). RT I 2002, 62, 377  
<https://www.riigiteataja.ee/en/eli/ee/520012014001/consolide/current>

## 4. USE OF DETENTION

### Detention policy

The legal framework for detention of third country nationals is provided in the Aliens Act of 1993, the 1998 Obligation to Leave and Prohibition on Entry Act (OLPEA), and the Act on Granting International Protection to Aliens (AGIPA) of 2006.

The legal provisions on the use of **administrative detention for migrants subjected to an expulsion order** are in the OLPEA. The migrant is to be detained for an initial 48 hours following the order of expulsion, which can be extended with up to three days by an administrative court. Short-term detention can be carried out at the offices of the Border Guard, the Citizenship and Migration Board, or at police stations, detention facilities or expulsion centres. If the expulsion has not been carried out during the initial period, the migrant is detained in police detention facilities for up to thirty days, or in an expulsion centre for up to two months. The detention of the migrant for administrative reasons continues until the expulsion of the migrant, but can only be extended two months at a time.

The AGIPA provides the legal framework for **administrative detention of asylum seekers**. When first encountered, the asylum seeker can be detained for a maximum period of 48 hours, in order to carry out the initial administrative procedure for the asylum application. This initial period can be extended if the authorities have difficulty gathering information or cooperation by the asylum applicant is unsatisfactory. If a migrant in detention (whether in a prison, an expulsion centre, or a detention facility) subsequently applies for asylum, they remain in detention until the end of the asylum procedure (EMN 2013).

A number of international bodies have critically addressed the detention practice in Estonia, including the UN Special Rapporteur on the Human Rights of Migrants. Observers have repeatedly drawn attention to the lack of a maximum period for migrant detention. The Global Detention Project found that the majority of detained migrants in Estonia in recent years were citizens of the Russian Federation. In the case of *Mikolenko v. Estonia*, which was brought before the European Court of Human Rights, the Russian applicant claimed that the authorities in Estonia had carried out the detention to force him to apply for a Russian Passport. The court ruled that the initial detention had been carried out lawfully for the purpose of expulsion, but also that ultimately, his detention had gone beyond reasonable lengths, as the applicant had been held for nearly four years. This was ruled to be in violation of Article 5 of the European Convention on Human Rights, the right to liberty and security.

### Detention Facilities

Estonia has generally had a low number of asylum applicants and other migrants. The 2014 EMN Synthesis Report (EMN, 2014) found that in 2013, Estonia had the lowest number of third country nationals detained compared to the other Member States included in the EMN Report.

Estonia only has one dedicated migration detention facility, called a pre-removal detention centre – the Harku Expulsion Centre, with a capacity of 42 (26 men and 16 women). Staff at the centre are either Police or Border Guard employees, or officers from a private security company. Irregular migrants awaiting deportation can also be held in prisons or police holding facilities. The Global Detention Project

highlighted the North Prefect Police Station and the Illuka Reception Centre for Asylum Seekers as facilities which occasionally detain migrants.

### Detention Conditions

The legal framework for minimum standards and conditions in detention facilities is set out in the OLPEA. However, the Global Detention Project found that the Act also has several questionable provisions, including detainees being charged for special diets, and shower access being guaranteed only once a week.

As regards the access to medical care for detainees in Estonia, the 2014 EMN study found that emergency and essential medical care is provided, and if needed the detainees are transferred to hospitals or the central hospital for prisons in the country. However, psychosocial support is only provided through a clinical psychologist's visit only twice per month, and only in English and Russian.

General healthcare services at the detention centre are provided based on the regulations of the centre. According to information received from the director of the centre, there is a nurse present for two hours every day and a general practitioner twice a week for four hours at time. The nurse performs check-ups daily for those detainees who need and who request them. The general practitioner organizes referrals to specialists and drafts or makes changes in the detainees' healthcare schemes. An ambulance is summoned by one of the guards when a detainee is acutely unwell. Similarly to asylum seekers, all detainees have to go through a preliminary health check on the day of their arrival or on the next day at the latest.

Problems arise with patients who are unable to speak either English or Russian. There is a lack of qualified translators for less common languages, though in some instances phone translation is used.<sup>6</sup>

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<sup>6</sup> Police and Boarder Guard Board, e-mail conversation with the head of the detention centre, Pärtel Preinvalts on 20 April 2015; phone conversation with the legal specialist of the Estonian Human Rights Centre on 16 April 2015.

## 5. ENTITLEMENT TO HEALTH SERVICES

Score 39    Ranking ●○○○○○

### A. Legal migrants

#### Inclusion in health system and services covered

Based on the Health Insurance Act, mandatory health insurance applies to all employed persons. While the same system covers Estonian permanent residents and legal migrants who work, it leaves vulnerable migrant workers who become unemployed and migrants who have not entered the country for employment - such as short-term residency foreign students, migrants' family members. All of these groups are required to have a valid health insurance policy covering any costs of medical treatment as a result of illness or injury during the period of stay in Estonia.<sup>7</sup>

#### Special exemptions

In addition to pregnant women and minors, victims of human trafficking and victims of torture have also been included on the list of vulnerable groups entitled to state-funded health coverage on equal basis with permanent residents.

#### Barriers to obtaining entitlement

Estonian public services are based on the population registry, where all legal migrants are registered upon issuance of their residence permits. A personal identification code is issued which allows information to be exchanged between state administrative units via the e-governance system. Due to the well developed e-services, no additional documents are required.

However, according to a study carried out among highly qualified migrants in Estonia, practical barriers in access to health care services exist mainly on two counts. First, there is not enough information in languages other than Estonian about available services and the mandatory health insurance system (see next section). Second, bureaucratic procedures make reimbursements for private insurance holders cumbersome and slow, and additionally the trustworthiness of private health insurance providers from abroad are sometimes questioned by Estonian health providers. The latter creates additional challenges for and situations of insecurity for foreign students with obligatory private insurance (Institute of Baltic Studies 2014).

### B. Asylum seekers

#### Inclusion in health system and services covered

Asylum seekers are entitled to the same state-funded services as long-term residents, including emergency dental care. A regulation issued by the Minister of Social Affairs stipulates that in case the asylum seeker has "sufficient funds" to cover the health-care service and medicine cost, he or she is

<sup>7</sup> Aliens Act (2009), § 45. RT I 2010, 3, 4. <https://www.riigiteataja.ee/en/eli/ee/516012014004/consolide/current>

obliged to cover the costs.<sup>8</sup> However, no objective criteria or procedure to establish the existence of “sufficient funds” are described.

Access to state-funded health care services is via collective centres of accommodation. Therefore, although the regulation does not exclude asylum seekers who do not live in the collective centres, it is not clear how in practice the access to the state-funded health care services is provided for those asylum seekers who live independently.<sup>9</sup>

Moreover, the Estonian Chancellor of Justice noted during his control visit to the Vao Asylum Reception Centre in 2014 that not all health services asylum seekers are entitled to or are required to pass are provided at the centre. This mostly concerned the preliminary health checks that were not carried out despite regulations. Additionally, translation services were not always available. The Chancellor was also concerned that free access to dental care for children needs to be provided by the centre and that parents need to be regularly informed about the free dental care for children.<sup>10</sup>

### Special exemptions

See ‘legal migrants’.

### Barriers to obtaining entitlement

Administrative discretion is involved in determining whether an asylum seeker has sufficient funds to cover the costs. There are no objective criteria for making this determination.

## C. Undocumented migrants

### Inclusion in health system and services covered

Although general healthcare services are provided at the detention centre, this item concerns UDMs living in society. They have equal access to emergency care,<sup>11</sup> and they may or may not also have access to health care of a more extensive kind under certain unpredictable circumstances (e.g. at the discretion of the professional involved), or in return for payment of the full cost of treatment. In case of emergency care, however, the provision of care is predictable, as the rules do not allow health-care staff to exercise their discretion as to who does or does not receive care. With this Estonia clusters into the group of EU Member States with minimum rights to access to health care based on the comparative study conducted in 2012 (Björngren Cuadra 2012). The pathways into irregularity play a role here and in Estonia’s case, undocumented migrant status is in most cases related to the non-extension of the first temporary residence permit. Such migrants may escape detection by the authorities.

### Special exemptions

See ‘legal migrants’.

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<sup>8</sup> Minister of Social Affairs (2013). *Varjupaigataotleja ja väljasaadetava tervisekontrolli ja neile osutatavate tervishoiuteenuste neile riigieelarvest rahastamise ulatus ja kord*. § 5 (2). Regulation adopted on 16.12.2013 no 40. RT I, 10.12.2013, 8. <https://www.riigiteataja.ee/akt/110122013008>

<sup>9</sup> *ibid*.

<sup>10</sup> Chancellor of Justice (2014). ‘Kontrollkäik varjupaigataotlejate majutuskeskusesse’. <http://bit.ly/2kLeB2f>

<sup>11</sup> Health Services Organisation Act (2001), § 5, RT I 2001, 50, 284.

<https://www.riigiteataja.ee/en/eli/ee/512122013005/consolide/current>



**Barriers to obtaining entitlement**

For UDMs not living in a detention centre, the fact that they may not be included in the population registry and therefore have no personal identification code can be a barrier to accessing care. The criteria for a medical 'emergency' also depend on the exercise of clinical judgement.

## 6. POLICIES TO FACILITATE ACCESS

Score 45    Ranking ●●○○○

### Information for service providers about migrants' entitlements

There have been no significant changes to the legal framework regulating the access to health care services in recent years. In Estonia, the general practice of the legislative and policy-making institutions is to inform concerned organisations (such as service providers) and target groups via direct e-mails about forthcoming changes in regulation or in policy. It can be therefore argued that health service providers receive up-to-date information about migrant entitlements, although it is not clear how effectively this information is passed on to individual health professionals.

### Information for migrants concerning entitlements and use of health services

Immigration in Estonia is a relatively recent and small-scale phenomenon, so most policy measures to facilitate migrants' access to health services are fairly recent. Research carried out among highly-skilled immigrants from EU and third countries has shown that there exist mainly linguistic barriers in access to health care services, as information is often available in Estonian only (Institute of Baltic Studies 2014). However, the same study recorded that migrants are in general satisfied with the quality of and access to health care services, and no major obstacles were reported. Whether the same would be found with less highly-skilled migrants is uncertain.

A lack of reliable and easily understandable information about the health care system and health care services has also been noted. Information about access to healthcare services is provided in English and Russian via the responsible state agencies' websites, as well as in printed brochures. Brochures are distributed in the state institutions where migrants are provided services such as Police and Border Guard Board service points, Social Insurance Board service points, and at municipal social services.

Recent developments include an online portal in English, Russian and Estonian, containing information for newcomers on eleven topics (including health), published by the Ministry of Culture.<sup>12</sup> In addition, all foreign nationals with less than five years of legal residency in Estonia can participate free of charge in a Welcoming Programme aimed at supporting adaptation, including information about health care. The programme includes also an 80-hour A1 state language course.<sup>13</sup>

For asylum seekers, information on healthcare entitlements is provided by social workers in the asylum centres. The International Organisation for Migration (IOM) Tallinn office has prepared a handbook as well as video material for migrant cultural adaptation.<sup>14</sup> They include a chapter on health services and are translated into English, Russian, French, Arabic, and Dari. Additionally, each asylum seeker has an opportunity to receive help from a trained support person whose task is to help asylum seekers with information and access to all necessary services.

<sup>12</sup> <http://integratsiooninfo.ee/en>

<sup>13</sup> <http://www.emnetherlands.nl/dsresource?objectid=4331&type=org>

<sup>14</sup> Preparation of the handbook was financed by European Refugee Fund and Estonian Ministry of the Interior.

**Health education and health promotion for migrants**

Due to the small number of migrants and lack of major concerns with respect to their healthcare access, Estonia is not carrying out any national, regional or local health education and health promotion programmes.

**Provision of 'cultural mediators' or 'patient navigators' to facilitate access for migrants**

No 'cultural mediators' or 'patient navigators' to facilitate access for migrants are provided, with the exception of support persons for asylum seekers and refugees (see further below).

**Is there an obligation to report undocumented migrants?**

Healthcare professionals or organisations are not required to report undocumented migrants to the police if they seek medical help. However, the law also does not explicitly forbid them to do so. Studies have shown that undocumented migrants often experience a fear of being reported to police or immigration authorities by health workers or administrative staff, and that this anxiety constitutes a barrier to seeking health care (Björngren Cuadra 2012).

**Are there any sanctions against helping undocumented migrants?**

There are no sanctions on professionals to deter them from helping migrants who cannot afford to pay, and there are also no professional codes of conduct regarding such situations.

## 7. RESPONSIVE HEALTH SERVICES

Score 0

Ranking ●○○○○

### Interpretation services

The numbers of immigrants and refugees who would need interpretation services or cultural mediators for accessing health services remains low, and thus the demand for such services has not been voiced by migrants or their organisations. Some interpretation is provided to asylum seekers who reside in collective centres of residence: face-to-face or telephone interpretation methods are used. However, this service is not guaranteed and is provided on ad hoc basis conditioned on the availability of people knowing the specific language.<sup>15</sup> Beyond this, there are no qualified interpreters available for patients with inadequate proficiency in the official language.

### Requirement for 'culturally competent' or 'diversity-sensitive' services

There are also no standards or guidelines prepared by the state or any other institution that would require health services to take into account individual and family characteristics, experiences and situations, respect for different beliefs, religion, culture or competence in intercultural communication. Studies on migrant integration have not pointed to the need to adapt health services more to the migrants needs (see Institute of Baltic Studies 2011, 2014). The integration programme prepared by the Ministry of the Interior for newly arriving immigrants<sup>16</sup> includes information about the health services, but there are no national programmes aimed at adapting the services to the needs of different migrant groups or providing support services for migrants in accessing health services. However, in the light of the adoption of the European Union's new Agenda on Migration (EC 2015), which provides for the voluntary relocation and resettlement of refugees and asylum seekers into Estonia, the number of migrants in need of more responsive health services is set to increase.

### Training and education of health service staff

None.

### Involvement of migrants

None.

### Encouraging diversity in the health service workforce

None.

### Development of capacity and methods

None.

<sup>15</sup> Chancellor of Justice (2014). 'Kontrollkäik varjupaigataotlejate majutuskeskusesse'. <http://bit.ly/2kLeB2f>

<sup>16</sup> <https://www.settleinestonia.ee>

## 8. MEASURES TO ACHIEVE CHANGE

Score 25    Ranking ●●○○○

### Data collection

In Estonia data about migrant status, country of origin, or ethnicity is not recorded in medical databases or clinical records. However, data on ethnicity is included in some national surveys on health. Statistics Estonia complies health related data based on the Estonian social survey that includes questions on ethnicity, migration history, country of origin, and citizenship. Information based on these characteristics is available (though not publicly) about the access to the health services and health status.

### Support for research

There have been no major studies carried out specifically on the health status of migrant population. However, data is available and ethnic minority groups are included in the data collection for surveys about the health situation of general population. An annual survey on health issues carried out by the National Institute for Health Development (2015), *Health Behaviour among the Estonian Adult Population*, and other health studies include information on ethnicity.<sup>17</sup> While in public issues concerning health service provision for migrants and ethnic minorities have been voiced with respect to the language barrier, no studies on identifying the extent and impact of the language barrier have been carried out.

### "Health in all policies" approach

Migrant health care issues have not been of public concern. There has been no mainstreaming of health issues to policies related to migrants and ethnic minorities. The Estonian national integration strategy *Integrating Estonia 2020* does not include references to health issues or the impact of health issues.<sup>18</sup>

### Whole organisation approach

Ethnic minority or migrant health is not a priority among service provider organisations and health agencies. Considering the low number of migrants and the general lack of concern regarding health service provision for migrants, this attitude is understandable.

### Leadership by government

There is no specific government plan of action on migrant health as no such need has been identified.

### Involvement of stakeholders

The government has involved migrants and refugee representative organisations such as Estonian Refugee Council (*Eesti Pagulasabi MTÜ*) in the design of national policies, including health policies, on an ad hoc basis during the consultations on new national integration strategy of preparation of adaptation courses. The Russian-speaking population as well as newly arrived migrants have been consulted during the preparation of a national integration strategy that included discussions about

<sup>17</sup> For the full list of health-related studies please see the database of National Institute for Health Development:  
<http://www.tai.ee/en>

<sup>18</sup> <http://www.kul.ee/en/integrating-estonia-2020>

health service access and language barriers related to that (Institute of Baltic Studies 2013). Legal migrants have also been consulted via general studies covering access to services for all migrant groups.

#### **Migrants' contribution to health policymaking**

See previous section.

## CONCLUSIONS

The MIPEX 2015 survey found that integration policies in the Baltic States and Central Europe were generally rather poor, but Estonia's were the best in this group. The highest scores were obtained on the strands Labour market mobility, Family reunion, Education and Permanent Residence. Scores on the Health strand, however, were markedly lower: only Latvia, Slovenia, Croatia and Poland ranked lower. Despite the low numbers of migrants, the government has recently taken important steps to improve integration policies, but these have left health policy largely unaffected. Hardly any steps have been taken to adapt health care services to be more responsive to the specific needs of migrants. The small number of migrants has not put any pressure on Estonian policies or health services to be more responsive.

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