Country Profile Estonia

Community-based Mental Healthcare Networks: Key Facts and National Priorities

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Version:	1.0
Date:	31.05.2023

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This report arises from the Joint Action on Implementation of Best Practices in the area of Mental Health, which has received funding from the European Union through the European Health and Digital Executive Agency (HaDEA) of the European Commission, in the framework of the Health Programme 2014-2020, GRANT NUMBER 101035969 — JA-02-2020. The content of this report represents the views of the author only and is his/her sole responsibility; it cannot be considered to reflect the views of the European Commission and/or the HaDEA or any other body of the European Union. The European Commission and the Agency do not accept any responsibility for use that may be made of the information it contains.

Introduction

The EU-Co-funded "Joint Action on Implementation of Best Practices in the area of Mental Health", short **JA ImpleMENTAL** has a duration of 3 years, lasting from October 2021 to September 2024. Detailed information can be found at the project's website JA ImpleMENTAL (ja-implemental.eu). It aims to promote and improve mental health structures, services, capacity and outcomes in participating countries in 2 specific areas:

- mental health reform (promoting community health services) and
- suicide prevention.

Two national best practices - mental health reform in Belgium and the Austrian suicide prevention programme SUPRA - serve as best practice examples. Selected components of these should be prioritised and implemented over the course of the JA in 14 i.e. 17 participating EU-countries. JA ImpleMENTAL comprises six Work Packages (WPs), four horizontal WPS and one for each best practice. **WP5 on community-based mental healthcare** aims to implement elements from Belgian Mental Health Reform, which is based on the principle of deinstitutionalization, i.e., the transition from care primarily provided in institutions to community-based care in order to improve mental health outcomes and quality of life and avoid unnecessary hospitalizations. In addition, the reform is based on the principles of rehabilitation and inclusion, decategorization, i.e., multisectoral cooperation, strengthening care in hospitals to make stays shorter, but with more intensive treatment, and the principle of consolidation, providing funds for pilot projects.

The present country profile is one of the major deliverables of the JA, presenting key facts of the national and local mental health system. It summarizes results of the recent situation analysis and needs assessment (SANA), lists lessons learned, recommendations, challenges and opportunities as well as outlining next steps necessary to scale-up, promote national/regional community-based mental health care services. The country profile forms a basis for strategy formulation, decision-making and commitment.

This country profile is based on a situation analysis conducted in two parts and subsequent needs assessment. For the situation analysis, two questionnaires have been developed by WP5, one for the analysis of the situation regarding the overall health system and community-based mental health care at national level, and another one for the analysis at implementational level. Following the data collection, a SWOT analysis was conducted by the countries to assess the needs in terms of community-based mental health care.

1 Situation Analysis (SA)

1.1 Country, Health and Social System at national level

Estonia is a democratic parliamentary republic with 15 counties, located in northeastern Europe on the southern coast of the Gulf of Finland, an arm of the Baltic sea. It is the smallest of the Baltic States, with 1.365 884 million inhabitants, of which approximately 30% live in rural area (1). The country has an area of 45,227 km² and is one of the least populous country in the world, with a moderate population density of 31.4 people per km^2 (1). The capital and largest city of Estonia is Tallinn, with population of 454,245 (2). The official language is Estonian that belongs to Finno-Ugric groups of language. This Baltic country gained first independence in 1918, after the First World War. The

independence was lost in 1940 after the beginning of Second World War, and restored again in 1991 (3). After regaining independence, Estonia has embarked significant economic reforms and by 1993 succeeded in reversing the declining trend of GDP (4). Estonia has joined to the North Atlantic Treaty Organization (NATO) and the European Union (EU) in 2004, to the Organisation for Economic Co-operation and Development (OECD) in 2010, and to the Eurozone in 2011. Overall, Estonia's life expectancy at birth has increased more than in any other EU country and is now closer to the EU average, although still two years below. The healthy life expectancy at birth has increased from 66.5 years in 1994 to 77.2 in 2021 (5). The average life expectancy for males is 72.8 years, while for females 81.4 years (2021). On average, women live 8.5 years longer than men (6). This gap in life expectancy by gender is much greater than the EU average of 5.6 years. In addition, the difference between genders in years of disability-free life also exists. In Estonia, men can expect to live disability-free for 54.9 years and women for 58 years (6).

Table 1: Population structure: year, expressed as number of persons, by age and sex

Age group	Sex		Total
	Male	***Female***	
<20	145788	138589	284377
20 - 64	392227	383046	775273
65+	176746	95400	272146
Total	**714761**	**617035**	**1331796**

Source: Statistics Estonia, 2023

The EUROSTAT data show that at-Risk-of-Poverty rate was 22.80% in 2022, being a record high, while a record low was 15.80% in 2010 (7). Income inequality, expressed as the Gini Coefficient was 0,319 in 2021 (8). The unemployment rate was 5.4% in 2022. The total healthcare expenditure relative to GDP has increased since 2000 to 7.5 percent of GDP in 2021, but is lower than EU average (9.9% of GDP) (9). For example, in per capita terms, spending on health in 2019 was EUR 1 733, which is less than half the EU average (4). The government's total expenditure on mental health as % of total government health expenditure was 3.7% (10). Estonia invested in 2019, around 27 million Euros in mental health and substance abuse facilities. This was an increase of almost 17 million Euros since 2010 for these institutions and almost two million since 2018 (4).

The Estonian health care system is based on the health insurance that employs the principle of solidarity (11). Funding for the unified health insurance of Estonia comes from the insurance tax (social tax), which is paid on the income of workforce. National health insurance coverage is supervised and medical expenses are paid by the *Estonian Health Insurance Fund* (EHIF) that operates as a semi-autonomous public organisation, pooling most of the public funding for health and organising the purchasing of health care (11). Most adult patients covered by the national health insurance are still required to pay medical fees, such as in-patient fees, co-payments towards prescriptions, etc. The key institutions responsible for planning, management, regulation and funding of health system functions are the Ministry of Social Affairs and institutions under its management (State Agency of Medicines, Health Board), as well as National Institute for Health Development and Estonian Health Insurance Fund) (11). All major hospitals in Estonia are publicly owned; they provide inpatient care and the majority of outpatient specialist care. Most primary health and dental care providers are private, as are some providers of outpatient specialist and nursing care (3). A primary care network of mostly private family doctors acts as the first point of contact for health care in Estonia. Secondary health care

services are available at hospitals and outpatient care clinics; Estonia's two largest hospitals, located in Tallinn and Tartu, account for around half the total volume of specialist services provided in the country (3).

1.2 Mental Health System at national level

Mental health care in Estonia is regulated by several laws and regulations. In addition to the Health Insurance Act (last amendment in 2023), the Health Services Organization Act (last amendment in 2023), the 1997 Mental Health Act (last amendment in 2022) regulates the organization of mental health care and defines the financial obligations of the state and local governments in the organization of such care. The Mental Health Act (12) defines procedures and conditions for mental health care provision and involuntary treatment. It applies to all psychiatric patients and basically follows the 1991 United Nations principles on protecting the rights of those with mental health disorders.

Mental health care in Estonia is part of specialized medical care and includes the diagnosis, treatment, rehabilitation and prevention of mental disorders (3). It is provided mainly by psychiatrists, mental health nurses and psychologists, and in outpatient and inpatient settings; the latter is mostly used in the event of short-term crises or for solving complex differential diagnostic and treatment problems. To access mental health care, a patient may turn directly to a specialist for an outpatient consultation without a family doctor's referral, while for most disease areas family doctors perform a gatekeeping function (3). Psychiatric beds are mostly integrated into larger multispecialty hospitals. As part of the overall trend, the number of psychiatric beds decreased from 185.8 per 100 000 population in 1990 to 52.6 in 2004 and has stabilized since then (3, 10).

The vision for the future of mental health in Estonia is described in four national strategies; (1) the long-term national development strategy "Estonia 2035"(2), the Population Health Development Plan 2020-2030 (*Rahvastiku Tervise Arengukava 2020– 2030) (13)*, the Green Paper on Mental Health (*Vaimse Tervise Roheline Raamat, 2021*) and the Mental Health Action Plan 2023-2026 (Vaimse Tervise tegevuskava 2023-2026) (13–16). The Ministry of Social Affairs developed the Mental Health Action Plan 2023-2026, in cooperation with stakeholders, with an aim to respond to needs in development of mental health care and to set more specific targets. It describes the existing problems and expected changes in comparison with current situation. The Action Plan covers five main areas; (1) sector development and innovation, (2) promotion, prevention and self-help, (3) community-based support, (4) mental health services, (5) organising mental health and psychosocial support in crises (16).

Table 2: Facilities, number of beds and hospital admissions related to mental health (2022)

Indicator at national level		Number	Rate per 100.000 adult/minor population
Mental health hospitals	Facilities	3	0.3
	Beds	128	12.1
	Admissions (annual)	NA	NA
Psychiatric wards/units in general hospitals	Wards/units	6*	0.6
	Beds	663	62.6
	Admissions	9328	880.1
Mental health inpatient facilities specifically for children and adolescents	Facilities	4	1.5
	Beds	53	19.5
	Admissions	955	351.3

Source: National Institute for Health Development, 2021

Table 3: Mental health workforce (2021)

In MH service (all)		
	Total number	Rate
Psychiatrists	204	1,5
Child psychiatrists	---	---
Mental health nurses	312	2,3
Psychologists	298	2,2
Social workers	75	0,6
Speech therapists	104	0,8
Occupational therapists	72	0,5
Others (e.g. school mental health focal ponts, art therapists etc.)	75	0,6
Total	**1140**	**8,6**

Source: National Institute for Health Development, 2021

1.3 Population profile in pilot area

The target group of the pilot project are patients in compulsory outpatient treatment. A patient in compulsory treatment has had a serious (but treatable) mental disorder at the time of the commission of the offence. Severe mental disorder (SMD) is a disorder in which the person was not able to understand the prohibition of his act or control his behaviour. Examples of the main severe mental disorders of compulsory treatment patients: Psychotic disorders, including schizophrenia, delusional disorder, substance abuse psychosis. Compulsory psychiatric treatment may be administered in the form of out-patient treatment if the person does not pose danger to himself or herself and the society upon subjection to compulsory psychiatric treatment and it is likely that the person adheres to the treatment regime.

In Penal Code the compulsory psychiatric treatment has been described as follows (17):

(1) If, at the time of commission of an unlawful act, the person lacks capacity or if he or she, after the making of the court judgment but before the service of the full sentence, becomes mentally ill or feeble-minded or suffers from any other severe mental disorder, or if it is established during preliminary investigation or the court hearing of the matter that the person suffers from one of the aforementioned conditions and therefore his or her mental state at the time of commission of the unlawful act cannot be ascertained and he or she poses danger to himself or herself and to the society due to his or her unlawful act and mental state and is in need of treatment, the court shall order compulsory psychiatric treatment of the person.

(2) The treatment specified in subsection 1 of this section shall be provided by a health care provider holding an activity licence for compulsory psychiatric treatment.

(3) Compulsory psychiatric treatment shall be applied until the person recovers or ceases to pose danger. Termination of a treatment shall be ordered by the court.

(4) If a punishment is imposed on a person after compulsory psychiatric treatment, the period of compulsory psychiatric in-patient treatment shall be included in the term of the punishment. One day of day care compulsory in-patient treatment corresponds to one day of imprisonment (17).

In 2022, for the outpatient service (18):

- 79 patients received the service
- 27 of them were directly referred by the court
- The service was terminated for 8 patients
- 3 patients were referred from the outpatient service to the inpatient service.

In 2022, for the inpatient service (18):

- 104 patients received the service
- Currently, there are 67 patients, including 6 women.

Outpatient service (18):

- January 2022 - 52 patients
- January 2023 - 73 patients

1.4 Community-based mental health care at pilot level

The state has taken a direction towards the development of supportive community-based services and the application of deinstitutionalization principles, with the aim of ensuring the proportion and availability of supportive services, providing the best possible care according to the capacity of service users, as well as guidance, supervision, and community development without directing individuals to live in care institutions. To achieve this, it is necessary to increase the awareness of service providers through quality training (deinstitutionalization, inclusion, prevention), guidance on activities, and programs that increase skills and knowledge related to intervention methods (15).

It is noted that community services should not be a replacement for evidence-based mental health services funded by the state. For the system to function properly, it is necessary for all levels to work as a consistent integrated service provided by a multidisciplinary team, and it is important to continuously develop them at the same time. There are knowledge and skills available for developing community-based mental health services and interventions, but the entire level needs a systematic approach and organization (15).

Cross-sectoral collaboration in pilot project

The aim of the pilot project is to ensure continuity, sustainability, and improved connection to the social network for individuals with chronic mental health problems undergoing psychiatric compulsory treatment, both during inpatient and outpatient services, as well as in the subsequent rehabilitation process. The aim of cooperating with different target groups (professionals in health or non-health sectors) is developing and implementing a network model involving people from the health, social welfare, and law enforcement sectors. Target groups of the pilot project:

- **Patients in compulsory treatment** - individuals with chronic mental health problems who have committed a crime and are subject to court-ordered psychiatric compulsory treatment.
- **Close relatives of patients in compulsory treatment** - family members or other individuals depending on their living arrangements.

- **Compulsory treatment provider** - Viljandi Hospital, which aims to provide psychiatric treatment and reintegrate patients in compulsory treatment into society. Later, during outpatient treatment, information exchange is organized between the compulsory treatment provider and other network members. The outpatient mobile treatment team includes a psychiatrist, mental health nurse, social worker, (clinical) psychologist, and other specialists may also be involved as needed.
- **Social and child protection workers of the local government** - the specialist responsible for case management (e.g., social worker), who, in addition to case management, monitors the behaviour of the compulsory psychiatric patient during outpatient psychiatric treatment and their compliance with court or prosecutor-imposed obligations, and facilitates their social adaptation to influence them to refrain from unlawful behaviour. If the forensic psychiatric patient has children, a child protection worker may also be involved if necessary.
- **The healthcare professionals working in Primary Health Centre** - involving specialists like mental health nurses, family nurses, home nurses, family doctors, clinical psychologists in promoting collaboration to ensure better coping with compulsory patients in outpatient treatment.
- **Local police officers** - in addition to identifying and solving problems that disrupt community safety, the local police officers are also monitoring compliance with behaviour requirements in public places and are preventing and inhibiting the commission of crimes.
- **Social Insurance Board** - the Social Insurance Board assesses whether a person seeking special care needs special care services or whether they can be helped with other social welfare support measures, including services offered by the local government.

The availability of needs-based services for individuals with mental health problems depends on the collaboration between social welfare, healthcare, and the legal system. To ensure continuity of care and rehabilitation for individuals with chronic mental health problems undergoing outpatient compulsory treatment, a mobile multidisciplinary team conducts necessary consultations closer to the patient's place of residence. The service's significance lies in assessing treatment adherence, daily functioning, and the home situation. Additionally, involving and promoting collaboration with the regional support network is crucial for identifying the needs of individuals undergoing outpatient compulsory treatment and ensuring support systems during and after the treatment (15).

2 Needs Assessment (NA)

This analysis is based on the information compiled for situational analysis (SANA 1, 2) within the framework of WP5. The focus is on the pilot project "Developing community-based mobile psychiatric care in Estonia", based on the example of the mobile outpatient compulsory treatment service provided by Psychiatric Clinic of Viljandi Hospital. The internal strengths and weaknesses of the mobile team and the hospital as an organization, as well as the external opportunities and threats arising from community/state decisions, are the main points of focus in the SWOT analysis. The working group that conducted the SWOT analysis consisted of specialists who will be providing mobile outpatient psychiatric compulsory treatment services in Psychiatric Clinic of Viljandi Hospital. They have extensive experience in the field of mental health and psychiatric clinics. In addition, the pilot team has consulted with other hospital specialists who have been involved in the development of other outreach services for different diagnostic groups.

Table 5: SWOT Analysis

Factor	Contents				
Strengths	1. **Specialists** with long-term experience and professional training in a mobile team- psychiatrist, mental health nurse, psychologist, social worker	2. There is a mobile mental health cabinet (**bus**) to provide the service	3. The **number of patients** undergoing compulsory outpatient treatment is increasing	4. **Small country - Cooperation with the community** and social system in different regions of Estonia	5. Goals at the national level to **reduce the number of hospitalizations**- referring patients to the right services
	6. **Hospital management** supporting innovative solutions and encouraging participation in international projects	7. Piloting **nationwide mobile service for SMD-s**- service is provided in rural areas where access to ambulatory psychiatric care depends on local public transport arrangements	8. **National priorities for the development of the field of mental health.**	9. **MH services are available** to patients and covered by Health Insurance Fund	10. **Prevention and early intervention as a national priority** in mental health
Weaknesses	1. **Shortage of specialists**	2. **Lack of evidence-based assessment and diagnostic scales and instruments**	3. **Data availability**- health data and social sector data (from different databases) do not match	4. **Lack of quality standards** for treatment and rehabilitation of psychiatric and behavioural disorders	5. **Lack of systematic approach and organization to develop community-based mental health services**
	6. High workload of mobile team members, **risk of burnout**	7. **Lack of service financing model** for mobile outpatient compulsory treatment service, which may prevent the provision of the service in the long run	8. **Cooperation with local network members across Estonia** - creating cooperation ties with specialists from different municipalities requires a separate resource	9. **Referral of patients directly to the outpatient service**	10. **Stigma** regarding compulsory treatment patients
Opportunities	1. **Political will** to develop mental health services	2. **Small country**- increases the opportunities for promoting cooperation with different regions	3. **Cooperation with different educational institutions and professional associations**	4. Good cooperation with **policy makers** and the Department of Mental Health of the Ministry of Social Affairs	5. **Cooperation with service providers from other countries** (best practise exchange in JA ImpleMENTAL project) in the development of mobile service
Threats	1. **Lack of mental health specialists** in Estonia	2. **Stigmatization** (of compulsory treatment patients) at the end of inpatient treatment	3. **Project based funding** for community services	4. **Lack of funding** in the health system	5. **Lack of access (treatment/ therapy) and fragmentation (follow-up) of services**

3 Reflection on SANA results

The system of mental health support services is still fragmented, and its funding is heavily biased towards specialized medical care, but even the help provided at that level is far from sufficient, and its availability varies greatly by region. Access to quality services is limited, and the systematic development of community-based mental health services in Estonia is still in its early stages (15). The

situation analysis (SANA) and SWOT analysis have revealed the areas that should be addressed as well as potential success factors. The prioritized implementation measures are presented in Box 1.

Box 1. Prioritized measures for pilot implementation (ref)

- **A model for patient management** is being prepared, which describes the roles of various stakeholders from the legal system, healthcare system, and social welfare sectors, as well as the compulsory treatment patient and their close ones. The model also addresses the organization of information exchange between different stakeholders. One part of the model is also the description of providing mobile outpatient compulsory treatment service. If necessary, proposals for the establishment of relevant legal regulations will be submitted to the Ministry of Justice and the Ministry of Social Affairs.
- **Pilot the mobile outpatient compulsory treatment service** by multidisciplinary team from Psychiatric Clinic of Viljandi Hospital.
- **Find funding for the mobile outpatient service** to ensure the sustainability of the service.

POTENTIAL SUCCESS FACTORS

- ✓ **A model has been created** to describe a community-based mobile psychiatric service based on the example of the mobile outpatient compulsory treatment service provided by Compulsory treatment department in Psychiatric Clinic of Viljandi Hospital.
- ✓ The mobile outpatient psychiatric compulsory treatment **service has been piloted** in geographically diverse regions of Estonia.
- ✓ The mobile outpatient service **has funding** to ensure sustainability and continuity.

4 Priorities & Next steps

- Pilot mobile outpatient compulsory treatment service by multidisciplinary team from Psychiatric Clinic of Viljandi Hospital's compulsory department.
- Conduct network meetings in different regions of Estonia to identify support options for compulsory treatment patients and promote collaboration between the treatment team and network members.
- Prepare a model for patient management, which describes the roles of various stakeholders from the legal system, healthcare system, and social welfare sectors, as well as the compulsory treatment patient and their close ones. The model also addresses the organization of information exchange between different stakeholders. One part of the model is also the description of providing mobile outpatient compulsory treatment service.
- Provide trainings to mobile multidisciplinary teams about the outreach service.
- If necessary, proposals for the establishment of relevant legal regulations will be submitted to the Ministry of Justice and the Ministry of Social Affairs.

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