ESPN Thematic Report on Inequalities in access to healthcare

Finland

2018

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June *2018*

EUROPEAN COMMISSION

Directorate-General for Employment, Social Affairs and Inclusion
Directorate C — Social Affairs
Unit C.2 — Modernisation of social protection systems

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Summary/Highlights

Every resident in Finland is entitled to adequate healthcare, including primary and specialised healthcare and dental care. However, patients must pay part of the costs themselves for both services (client fees) and prescription medicine (partial reimbursement).

The Finnish healthcare system is threefold: National Health Insurance (NHI), a municipality-based healthcare service and occupational healthcare. The co-existence of these three models has resulted in a multichannel system for financing and for access to healthcare, and consequently in different levels of availability and access to care. The current efforts to carry out social and healthcare reform (SOTE) seek to simplify the system and improve equal access to care. Thus, the whole structure and logic of providing social and healthcare services will change, if the reform is passed.

Finnish healthcare is universal, as well as effective: the infant mortality and low birth weight rates are among the lowest in Europe, while survival rates from cancer and other severe diseases are very high. Consequently, Finns are very satisfied with their healthcare system. However, the share of people with unmet medical need in Finland is rather high, the main reason being the long waiting lists. Only 0.1% of Finns say that the reason for their unmet medical need is that care is too expensive. However, user fees may be too much for those people who live on minimum benefits. The government should consider whether it is possible to lower the annual cap of EUR 691.

The popularity of private health insurance is growing. More than half of families with children have a healthcare policy for their children and about one fifth of the adult population has a private policy to cover the costs of medical treatment.

One of the most severe challenges for the Finnish healthcare system is that it is socio-economically biased. Indeed, the OECD has classified the Finnish healthcare system as one of the most unequal in the industrial countries. The main reason for the observed inequality in access to healthcare stems from occupational healthcare, which is free and often more effective than public healthcare.

To improve access to, equality in and the quality of healthcare, a great reform, SOTE, is planned. The reform is also expected to cut costs. The final version of the reform was planned to be accepted by Parliament in summer 2018. However, it is unclear when and whether the reform will be passed at all. And even if it will be implemented in the present form, there are serious doubts whether it will succeed in achieving its goals.

When the SOTE reform is accomplished, the government should carefully follow developments in access to healthcare, and take rapid corrective measures if the reform does not produce the desired results. The government must keep records on how equal access is realised in urban and rural areas, in high- and low-resource groups, in groups in the labour market and groups that are inactive.

There are deficiencies in the access of immigrants to services and considerable variation in municipal practice; the danger is that this variation will remain even after the SOTE reform, when private providers have greater responsibility. Therefore, the central government and the 18 counties to be established must set out the obligations of private enterprises to tackle these problems. This should include preventive public health tasks, unless the government takes sole responsibility for those. Cream-skimming in private enterprises might also be a risk factor of the reform. The planned expansion of individual choice requires individuals to have enough information and knowledge to make rational choices between different care providers and different forms of services. The government must ensure adequate help for vulnerable groups – especially those without willing and able family members or friends.

1 Description of the functioning of the country's healthcare system for access

1.1 Three historical legacies and path dependencies

A cursory historical review is needed to understand the hybrid nature of the current Finnish healthcare system and the challenges it faces. There are three different historical legacies: insurance-based National Health Insurance (NHI), the municipality-based health service model and employment-related healthcare.

Finland was the last European country to introduce legislated **sickness and health insurance (NHI)**. When the scheme was implemented in 1964, it was one of the most comprehensive health insurance programmes in the world. All residents became eligible for healthcare and all those over 16 years of age became eligible for a daily allowance that was paid on a flat-rate basis even to those who had no income (e.g. housewives, unpaid family workers, students). In addition, income-related benefits were paid to those who had earnings from employment.[1] The sickness insurance programme provided compensation for the costs of care and medicine. Thus, the 1964 law was solely an insurance model. The roots of the **municipal healthcare services**, however, go back much further – to 1939, when central government issued a recommendation on municipal medical doctors. The law was amended after the Second World War (1948) and every municipality was obliged to employ a general practitioner to widen access to healthcare. Universal, free healthcare in each municipality was established in 1972 by the Primary Healthcare Act.[2] The third path is **occupational healthcare**, which was institutionalised in 1978.[3] The NHI spends EUR 1.1 billion on private care (and a further EUR 1 billion on medicine); occupational healthcare expenditure is about EUR 1 billion; but in the public (municipal) sector the costs are much higher: EUR 2.8 billion for primary care, EUR 7.2 billion for specialist care and as much as EUR 4.9 billion for the long-term healthcare of the elderly and handicapped (data for 2016).[4]

The co-existence of these three models has resulted in a multichannel system for financing and access to healthcare, and consequently in different levels of availability and access to care. The current efforts to carry out social and healthcare reform seek to simplify the system and improve equal access to care. Thus, the whole structure and logic of providing social and healthcare services will change.

1.2 Current system characteristics

1.2.1 Municipal healthcare

Every resident is entitled to adequate social and health services (including dental care and medicine) under the Finnish Constitution. Thus, coverage is fully universal. At the moment, municipalities are responsible both for arranging healthcare and for funding it. Municipalities have the right to levy taxes, but they also qualify for state subsidies, which, in addition to user fees, are important in funding. The amount of the state subsidy depends on the municipality's demographic structure and morbidity, among other factors.

[1] Kangas (1992); Niemelä (2014).

[2] Act on Primary Healthcare. Act 66/1972.

[3] Act on Occupational Healthcare. Act 743/1978.

[4] National Institute for Health and Welfare, THL (2018a).

Certain population groups (undocumented migrants, tourists, temporary visitors from non-EU countries)[5] are excluded from coverage, but even they are entitled to essential emergency care. Reception centres provide basic healthcare for asylum seekers. Some municipalities, e.g. Helsinki, provide a larger set of healthcare services even to people who do not have permanent residence in the municipality, e.g. undocumented Roma coming from other EU Member States (indigenous Roma people are covered in the same way as all other native Finns).

Municipalities can organise the provision of primary healthcare services independently, or they can form joint municipal authorities. Local authorities can also outsource the provision of services to other local authorities, to non-governmental organisations or private service providers. The basic healthcare and specialised healthcare services that must be available are defined by law. Local authorities can, however, decide on the scale, scope and model of municipal service provision, so the services available may vary. The idea is to cater for the special needs and circumstances of each municipality.

Primary healthcare involves overseeing the health of the population, promoting health and various services. Primary healthcare services are provided at municipal health centres. Specialised medical care refers to specialist examinations and treatment. Most specialised medical care is performed in hospitals, and a referral is needed. Specialised healthcare services are organised by 21 federations of unicipalities and the country is divided into 21 hospital districts. In the present system, the NHI mostly provides pharmaceutical coverage and partially reimburses private services.[6]

Access to public healthcare services is guaranteed by legislation: there are set waiting times, which municipalities must report on regularly (Healthcare Act 1326/2010, Chapter 6).[7] For example, in non-emergency situations, assessment of the care needs of an adult must normally be carried out within 3 working days counted from the first contact with primary healthcare. According to the Act, any treatment deemed necessary on medical or dental grounds following assessment of the need for treatment must be provided within a 'reasonable' period of time, taking into consideration the health of the patient and the projected development of the condition – but in any case, within 3 months of the assessment. However, in practice these waiting times vary. For example, in October 2017 there were over 300 patients waiting more than 3 months in the counties of Uusimaa and Pohjois-Pohjamaa while in the counties of Kainuu, Keski-Pohjanmaa and Pohjois-Karjala, access to healthcare is good.[8] The Healthcare Act also provides freedom of choice – residents may choose their service provider from among the healthcare centres, as well as the provider of specialised healthcare (within certain limits).

1.2.2 National Health Insurance

The National Health Insurance (run by the Social Insurance Institution, Kela) provides reimbursement for the cost of prescription medicine, as well as for medical treatment by a private provider, if a patient chooses to use a private provider instead of public provision. All residents are covered.

The cost of treatment by a doctor or dentist in private practice is reimbursed by the NHI according to a schedule of fees. The average reimbursement per private consultation (or a doctor's visit to home) is currently approximately one fifth of the fee charged. The reimbursement rate for travel to obtain healthcare is higher (about 90% of the cost).

[5] When we speak of immigrants, we specify whether these are immigrants who hold permanent residency in Finland, or are refugees or undocumented people (e.g. Roma from other EU countries; the native Roma people have the same rights to healthcare as any other group of native Finns).

[6] Hoitopaikan valinta (2018) https://www.hoitopaikanvalinta.fi/valitse-hoitopaikkasi/suomen-terveydenhuoltojarjestelma/julkinen-terveydenhuolto/

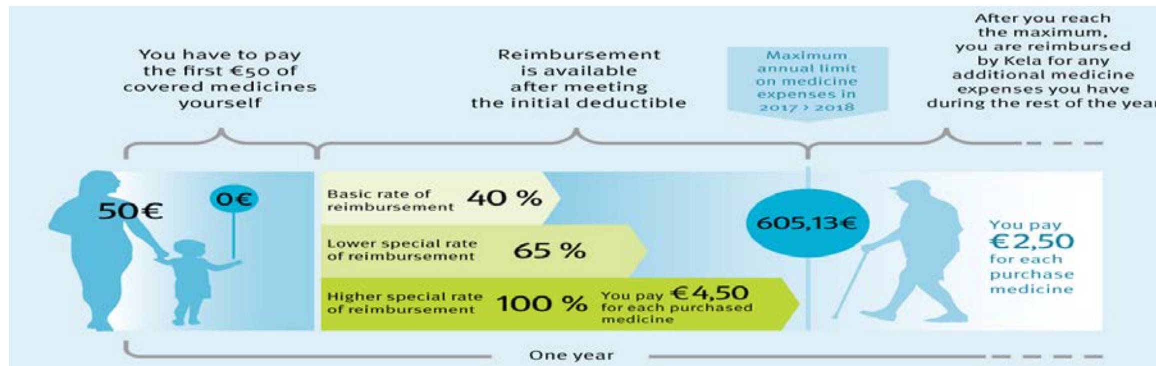
[7] The data on waiting times are collected by THL at https://thl.fi/en/web/thlfi-en/statistics/statistics-by-topic/primary-health-care-services

[8] https://thl.fi/fi/tilastot-ja-data/ohjeet-tietojen-toimittamiseen/hoitoonpaasy-perusterveydenhuollossa

Clients themselves pay any costs in excess of the statutory reimbursement rate. If the client has a private insurance policy, the policy will cover the extra costs.

The NHI reimbursements are also available for prescription medicines. The reimbursement is normally deducted from the price of the medicine at the pharmacy. The structure of the reimbursement system is depicted in Figure 1.

Figure 1. Reimbursement for medical costs in Finland, 2018[9]



The SOTE reform (see below) will bring to an end most NHI-based reimbursements. However, the occupational healthcare system – which also enjoys NHI reimbursements – will be left intact.

1.2.3 Occupational healthcare

The occupational healthcare system represents a third channel of healthcare provision. Approximately 90% of wage and salary earners have access to occupational healthcare. Employers are responsible for preventive healthcare for their employees (but not for family members); in addition, many big and medium-sized employers even provide basic outpatient treatment of common diseases for their employees. Employers can arrange the services by buying them from private providers (the most common option), or from public service providers. In this context there are no fees for consultation. The costs are covered by funds collected from employers (2/3) and employees (1/3).[10] The funding is channelled through the NHI. The SOTE reform will not change the structure of occupational healthcare.

1.2.4 The role of private providers and private health insurance policies is expanding in Finland

Private service providers – like enterprises, non-governmental organisations and foundations – can sell their services to municipalities, joint municipal authorities or direct to clients. Users of private healthcare pay the fees themselves, but they receive a partial reimbursement through the obligatory NHI.[11] Throughout the 2000s, the number of private service providers has increased steadily and they now supply a quarter of all health services.[12] There is a growing trend also toward private health insurance policies. More than half of families with children have a healthcare policy for their children and about one fifth of the adult population has a private policy to cover the costs of medical treatment: two thirds are taken out by individuals themselves and one third by employers for their employees.[13] Private insurance policies help people avoid queues in the public sector and allow them to choose a private provider, while the policy offers

[9] Kela (2018a).

[10] ASISP Country Document 2013 Finland; Kela (2018b)

[11] Kela (2018c).

[12] Ministry of Social Affairs and Health (2015).

[13] Kela (2014).

compensation for the share that is not paid by the NHI. The policies are not subsidised by any tax exemptions.

1.2.5 Level and structure of financing

Total health spending in Finland corresponds to 9.3% of GDP (figure for 2016). The lion's share (7.3%) is consumed by the public health sector.[14] Whereas in the total healthcare budget, private out-of-pocket payments comprise as much as 20% of total revenue, they cover 7-9% of the costs of the public health and welfare services. A cap of EUR 691 per person per year applies to user charges for public health services. In a European perspective, the Finnish out-of-pocket share is close to the EU-28 average (21%), but is much higher than, for example, in the Netherlands or the UK (6% and 9%, respectively).

Some services are free of charge (e.g. outpatient primary and dental care for children, visits to maternal and child health clinics, occupational healthcare services), and people with certain diseases and disabilities are also exempt from payments. But otherwise, clients pay part of the costs of healthcare. The maximum fees charged for municipal social and health services are stipulated in the Act and Decree on Social and Healthcare Client Fees (734/1992).[15] Municipalities may opt to use lower rates or to provide the relevant service free of charge.

Because long waiting lists were generating high levels of unmet medical need, in 2004 the government adopted an Act on Healthcare Guarantee to eliminate queues in care.[16] The Act stipulates that in acute cases, primary care in health care centre must be immediately available, and in other cases within 3 days; if the patient needs hospital care, it must be started within three months from the assessment of the need for treatment. In order to get access to specialized care, the patient must first get an admission report from the 'gate keeping' health care center (or private doctor). The evaluation of the need for special care ought to be initiated within three weeks from the arrival of the admission report and the treatment must be started in six months.[17]

The care guarantee shortened waiting lists, but they are still far too long, as indicated by the share of people reporting unmet medical need.

2 Analysis of the challenges in inequalities in access to healthcare in the country and the way they are tackled

2.1 Health outputs and outcomes

The share of people with unmet medical need in Finland is rather high by European standards. The main reason is the long waiting times. Comparisons within the country show that there is substantial variation between low-income (5.2%), middle-income (1.5%) and high-income (0.9%) earners reporting healthcare needs. The elderly (7.3%) and young people (4.1%) suffer from unmet medical need more than people of working age (3.1%). Furthermore, the inactive – i.e. the retired (7.2%) and the unemployed (6.5%) – have more problems than the employed (1.9%). Only 0.1% say that the reason for their unmet medical need is unreasonably expensive care. However, there are real differences. As mentioned above, municipalities may choose not to levy fees. Usually rich towns in the southern part of the country use lower fees, while poorer municipalities are

[14] OECD (2017), p. 135.

[15] The Act is expected to be renewed to guarantee access to services to all. The new act is due to be in force by 2020, see http://alueuudistus.fi/asiakasmaksut

[16] Act on Healthcare Guarantee. Act 1019/2004.

[17] STM, Ministry of Social and Health Affairs (2018).

compelled to apply higher fees for economic reasons; this widens the gap on health outcomes between regions and municipalities.

There are several ways to measure health outputs and outcomes. One of the most frequently used output measures is healthcare spending. As indicated above, Finland spends 9.6% of its GDP on total healthcare – close to the OECD average The other output measures are related to the number of healthcare personnel. Finland has 3.3 doctors per 1,000 inhabitants (the EU average is 3.4). The figure for nurses in Finland (14.1 nurses per 1,000 residents) is the second highest in Europe (after Denmark). Finns deviate from other Europeans in terms of their low utilisation of doctors: the average Finn visits a doctor only three times a year. After Cyprus, that is the lowest figure in the EU (the EU average is seven visits).[18]

Health outcomes can also be measured in various ways. Finnish healthcare is universal and effective: the infant mortality and low birth weight rates are among the lowest in Europe, survival rates from cancer and other severe diseases are very high. Consequently, Finns are very satisfied with their healthcare system; according to the European Social Survey,[19] only Belgians and Luxembourgers express a higher degree of satisfaction with their healthcare.

Against this background it may be somewhat surprising that the self-evaluated health status in Finland is not particularly good: 67% of Finns rate their health as good or very good (the EU-28 average is 65%, with the highest figures – in Ireland and Sweden – topping 80%). While the self-rated general health status in Finland is close to the EU average, the share of those who say that they have a long-standing illness is the highest in the EU, at 47%.[20]

2.2 Reasons for inequalities

One of the most severe challenges for the Finnish healthcare system is its socio-economic bias. Indeed, the OECD has classified the Finnish healthcare system as one of the most unequal in the industrial countries.[21]

The main reason for the inequality observed in access to healthcare stems from the fact that while those with low financial resources and in difficult labour market positions depend mainly on municipal healthcare, those who are in work and with higher resources benefit from the other two care sectors. As stated above, universal public services are available to all, either free of charge or with low co-payments; but they are not always easily accessible because of the long waiting times. However, for most employed people, rapid and free access to primary healthcare is often guaranteed through occupational healthcare, which is free of charge. In addition, those on higher incomes may top up the care provided by the other two sectors with private care, and thus trade off high co-payments for easy access to care. In sum, those with the lowest resources and the greatest need may have difficulty in accessing healthcare; while the better-off in society have rapid access, despite their smaller need.[22] One of the central aims of the SOTE reform is to improve equity in access to healthcare.

When (or if) the SOTE reform is accomplished, the government should carefully follow developments in access to healthcare and take rapid corrective measures if the reform does not produce the expected equal results.

[18] OECD (2014).

[19] European Social Survey (2015).

[20] Kangas and Blomgren (2014).

[21] OECD (2017).

[22] See for example Rotko and Manderbacka (2015).

2.3 Vulnerable groups and access to healthcare

In principle, all residents, regardless of background (native or immigrant), should have the same rights to healthcare. There are special regulations for refugees, asylum seekers and undocumented migrants. Whereas refugees have the same rights to social and health services as municipal residents, adult asylum seekers are only entitled to urgent and necessary healthcare. The rights to healthcare of undocumented migrants vary from municipality to municipality (see section 1.2.1), but in principle they should be entitled to urgent healthcare.[23]

Despite the high degree of universalism, some groups have better access to healthcare than others. The most privileged are those with extensive occupational healthcare arrangements that offer a wide variety of health and dental care services without waiting lists and without out-of-pocket payments. This divide will persist even after the SOTE reform.

According to data from the EU Statistics on Income and Living Conditions (EU-SILC), only 0.5% of Finns say that they have unmet medical need because care is too expensive. However, the problem with registers is that the most vulnerable groups may be under-represented, or the number of people in these specific groups is so small that it is impossible to draw definite conclusions. National surveys focusing on vulnerable groups paint a gloomier picture than, for example, the EU-SILC: 2% of the total population say that they have not obtained medicine or have forgone medical care (also 2%) because of lack of money. The corresponding shares among basic unemployment benefit recipients are 8% and 6%, respectively.[24] Some 10% of pensioners who only have a minimum pension say that they have had to forgo medical treatment because of their low income.[25]

An examination of the statistics on unmet medical need shows that the biggest problems are among those outside the labour market, whether unemployed, elderly or inactive. Unfortunately, it is not possible to separate the incidence of unmet medical need according to immigrant status. However, in its 2014 report the State Audit Office[26] complained that municipalities had not responded properly to the specific needs of immigrants. There were complaints about the lack of interpreters, problems with advice and guidance, and access to mental healthcare services. There were also substantial differences between municipal practices.

A specific study on the health and well-being of immigrants[27] showed that immigrants of Somali and Kurdish origin used primary health services more than the Russian or Finnish population. Mostly the visits were emergency visits to municipal healthcare centres. All the immigrant groups used private or occupational healthcare services less than the rest of the population. The study summarises the reasons for the lower level of utilisation: 'The most common obstacles to receiving care were waiting for appointments, excessively high prices and language difficulties. The perceived need for rehabilitation was especially common among persons of Russian and Kurdish origin, with one in five reporting that they needed rehabilitation in their opinion.'

In sum, there are differences in the utilisation of various healthcare services between immigrants and the native population; however, neither immigrants nor the rest of the population are homogeneous groupings. There are differences between immigrants from different countries, as well as between socio-economic groups, age groups, income quintiles and people living in urban areas and the countryside. People whose income

[23] THL (2018b).
[24] Ylikännö (2014).
[25] Airio et al. (2014).
[26] State Audit Office (2014).
[27] Castaneda et al. (2012).

consists of minimum pensions or minimum unemployment benefits report unmet medical need due to lack of money.

As the State Audit Office complained, there are deficiencies in services for immigrants and considerable variation in municipal practices. The danger is that this variation will remain even after the SOTE reform, when private providers have more responsibility. Therefore, the central government and the 18 counties to be established must set out the obligations of these private enterprises to take better account of the specific demands of the growing immigrant population. Furthermore, user fees may be too expensive for those people living on minimum benefits. The government should consider whether it is possible to lower the annual cap of EUR 691.

2.4 Planned reforms: social and healthcare reform (SOTE) will solve some problems but new problems will emerge[28]

The current centre-right government led by Mr Juha Sipilä is trying to launch the largest social policy reform ever in Finland. The social and healthcare reform (SOTE) will introduce 18 new administrative domains – counties – between central government and the municipalities. According to the government's[29] SOTE plan, healthcare and social services – including long-term care – will be transferred to these counties. The aim is to create seamless service chains for the provision of key social welfare and healthcare services. The government's plan is to have SOTE implemented by 2020.

It is still too early to evaluate all the consequences of these reforms. Much is expected of the SOTE reform: there are hopes that it will make the system more equal, effective and economical. Even though many doubt the outcome, all agree on the importance of finally completing the reform. SOTE will abolish one of the historical legacies, i.e. the National Health Insurance will be severely circumscribed – or maybe even closed – and private actors will become more important vis-à-vis public providers in healthcare delivery.

SOTE will transfer responsibility for organising healthcare from the municipalities to the counties, and often private enterprises will be healthcare providers. The critical question is then what will happen to public health. Private enterprises do not have any incentive to take care of it, and municipalities may not have the resources to take responsibility for preventive public health measures. Therefore, central government must be active in coordinating these activities.

2.5 Universal coverage with unequal outcomes: main strengths and weaknesses of the Finnish healthcare system

The main strength of the Finnish healthcare system is its universal coverage. In principle, all residents are covered and, according to the OECD, the quality of care is good and effective. Specialised care, in particular, is not only cost effective, but also produces very good care results.[30] In Finland, good results are obtained at reasonable cost. However, there are severe weaknesses as well. There are good outcomes, e.g. infant mortality is among the lowest in the world and public health is improving; but not all outcome indicators display positive trends – e.g. there are still huge differences between socio-economic groups and genders in health and life expectancy.

Those differences are partly due to lifestyle and partly to inequalities in access to care. Long waiting lists cause problems for weak socio-economic groups. Most probably the SOTE reform will solve some of those problems; but there are many critical voices saying that the socio-economic and regional cleavages in access to healthcare will remain. The increasing private/public division might lead to dual healthcare markets. The

[28] Kangas and Kalliomaa-Puha (2016).

[29] Government of Finland (2017).

[30] For example, OECD (2017).

government's hope is that the SOTE reform will save EUR 3 billion. Many experts regard this figure as unrealistic. There will be the extra costs of establishing a totally new bureaucratic organisation between the state and the municipalities. There are also fears that the competition between private and public providers for medical doctors and other personnel will lead to a wage drift at all occupational levels, which will gradually increase the costs. The merger of municipal employees with county employees may also mean growing wage costs: the wage level is varied in municipalities, and since those employees on better wages understandably do not want to see them cut, the principle of equal pay for equal jobs implies wage rises. According to this scenario, future governments must seek cost containment by reducing service delivery and increasing out-of-pocket payments – which in turn will lead to unequal access to care and negative health outcomes.

In the present system, the most privileged are those – mainly public sector employees and employees in bigger enterprises – that have access to good-quality occupational healthcare. However, there are also differences within the occupational healthcare systems, and usually the self-employed do not have such extensive coverage as many other employee categories. The long waiting lists are problematic for low-income groups, the elderly and those outside the labour force. Immigrants often have language difficulties and suffer from lack of access to proper interpreters. It is believed that the SOTE reform will improve the situation and resolve at least some of the problems.

The SOTE reform has great potential to create more equal access to healthcare. However, there are plenty of risks as well. The government must keep records of how equal access is realised between urban and rural areas, between high- and low-resource groups, between those in the labour market and those who are inactive. The government must create measures to prevent cream-skimming and the development of dual markets: a private one for 'good' clients and the public one for 'bad' clients. The wide variety in individual choice requires individuals to have enough information and knowledge to make rational choices between different care providers and different forms of services. Since this is not possible for all clients, more informal and formal help is needed than is available at present. The government must ensure the sufficient provision of help for vulnerable groups – especially those without willing and able family members or friends.

2.6 National Archive of Health Information as an example of good practice

Finland has had a National Archive of Health Information (Kanta) in use since April 2014.[31] The national data system provides for electronic prescriptions, a pharmaceutical database, clients' own pages ('My Kanta') and a patient data repository. Most healthcare units are already using it. However, the aim is also to store social welfare information on the same database. The work is ongoing. The plan is in line with the idea of integrating all the social welfare and healthcare services presented in the social welfare and healthcare reform (SOTE). The idea is also in line with the use of e-health to improve an individual's own opportunities to use electronic services to enhance self-care. Here one crucial aspect to achieving equality in care is guidance and advice, so that the weakest groups in society can also benefit from digital medicine.

3 Discussion of the measurement of inequalities in access to healthcare in the country

Inequalities in access to healthcare can be measured directly and indirectly. Direct measures include the question of unmet medical need – available, for example, from EU-SILC. In the Finnish case, the comparative data make it possible to trace the main

[31] See http://www.kanta.fi/en/

reasons for the inequalities: in Finland these are related to excessively long waiting lists, whereas in other countries the reasons are related to cost. Also, various OECD measures provide useful information, such as the OECD horizontal inequity index (HII).[32] The HII is used to examine the extent to which the use of health services based on standardised needs differs across different income groups in various countries. The HII indicates that the present Finnish healthcare system is one of the most unequal in the western hemisphere. Consequently, differences in health between socio-economic groups are large in Finland.[33] Also some modules in the European Social Survey (ESS) offer direct measures and the possibility of comparative analysis.

Finnish registers are rich in content and, by combining various registers (on income, education, socio-economic status, language (but not ethnicity), diagnoses, the utilisation of healthcare services and the use of medicine), they open up possibilities to directly evaluate the state of health and the utilisation of services in terms of coverage, availability or affordability, for example. However, only a few countries have similar opportunities. Therefore, the possibilities for comparative studies are limited.

The access to healthcare can also be evaluated indirectly by looking at health outcomes, as is done by the OECD Health at a Glance publications, which provide useful information on inputs, outputs and outcomes in national healthcare schemes.

[32] Doorslaer et al. (2004).

[33] Kangas and Blomgren (2014).

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