No. 130

Article 22 of the Constitution of the ILO

Report for the period 1 June 2012 to 31 May 2017, made by the **Government of Finland**

on the

MEDICAL CARE AND SICKNESS BENEFITS CONVENTION, 1969 (No. 130)

(ratification registered on 3 September 1974)

I LEGISLATION AND REGULATIONS

Employment Accidents Insurance Act

The new Occupational Accidents, Injuries and Diseases Act (459/2015) entered into force on 1 January 2016. It replaces the former Employment Accidents Insurance Act, Occupational Diseases Act and Act on Rehabilitation Compensable under the Employment Accidents Act. The new Act applies to accidents occurring on or after 1 January 2016. The legislation previously in force continues to apply to accidents that occurred prior to that date and occupational diseases that presented prior to that date.

The purpose of the new Act was to reform the structure of legislation regarding accident insurance and occupational diseases, bringing the provisions up to date and into compliance with current criteria for legislation. The new provisions are more detailed than before. The new Act did not change the essential content of the system of insurance cover for employment accidents and occupational diseases nor its fundamental structures such as the funding of the system, how it is implemented or who is entitled to claim compensation because of an occupational accident or disease. Also, no significant changes were enacted to the types of compensation or their amounts. A major change in the amounts of compensation apply to low-income workers. The minimum level for compensation for loss of income was raised by about 10%. If a worker's earned income is less than EUR 14,080 (at the 2017 level), compensation for loss of income will be determined on the basis of that minimum annual earned income. The reform was enacted on a cost-neutral basis as far as possible.

All employees in a private or public service employment relationship, without exception, are covered by statutory occupational accident and disease protection as before, and so are agricultural entrepreneurs under the separate Occupational Accident and Disease Act for Farmers (873/2015). Similar insurance cover for private entrepreneurs continues to be voluntary. Benefits for entrepreneurs and agricultural entrepreneurs continue to be commensurate with benefits for employees.

An unofficial translation of the new Occupational Accidents, Injuries and Diseases Act is appended (C 121 Annex I).

Health Insurance Act

1224/2004 Health Insurance Act Up-to-date statute (in Finnish)

The Health Insurance Act entered into force on 1 January 2005 (Chapter 11, section 4(5–7) on 1 December 2005). The following amendments have taken effect during the reporting period:

6/2017 Statute text; Entry into force: 1 March 2017
1524/2016 Statute text; Entry into force: 1 January 2017
1476/2016 Statute text; Entry into force: 1 January 2017
1343/2016 Statute text; Entry into force: 1 January 2017
1342/2016 Statute text; Entry into force: 1 April 2017
1275/2016 Statute text; Entry into force: 1 January 2017
1228/2016 Statute text; Entry into force: 1 March 2017
1100/2016 Statute text; Entry into force: 1 January 2017
943/2016 Statute text; Entry into force: 1 January 2018
925/2016 Statute text; Entry into force: 15 November 2016
184/2016 Statute text; Entry into force: 1 April 2016
91/2016 Statute text; Entry into force: 1 January 2017
1658/2015 Statute text; Entry into force: 1 January 2016
1656/2015 Statute text; Entry into force: 1 January 2016
1655/2015 Statute text; Entry into force: 1 January 2016
1029/2015 Statute text; Entry into force: 1 January 2016
880/2015 Statute text; Entry into force: 1 January 2016
252/2015 Statute text; Entry into force: 1 January 2016
1403/2014 Statute text; Entry into force: 1 January 2015
1257/2014 Statute text; Entry into force: 1 January 2015
1256/2014 Statute text; Entry into force: 1 January 2015
678/2014 Statute text; Entry into force: 1 January 2015
1204/2013 Statute text; Entry into force: 1 January 2014
1203/2013 Statute text; Entry into force: 1 January 2014
1197/2013 Statute text; Entry into force: 1 January 2014
980/2013 Statute text; Entry into force: 1 January 2014
974/2013 Statute text; Entry into force: 1 January 2014
972/2013 Statute text; Entry into force: 1 January 2014
888/2013 Statute text; Entry into force: 1 January 2014
739/2013 Statute text; Entry into force: 1 November 2013
953/2012 Statute text; Entry into force: 1 January 2013
936/2012 Statute text; Entry into force: 1 January 2013
903/2012 Statute text; Entry into force: 1 January 2013
622/2012 Statute text; Entry into force: 1 January 2013
19/2012 Statute text; Entry into force: 1 June 2012
911/2011 Statute text; entry into force: 1 August 2011 to 30 June 2015; Note: amends Chapter 13 section 11

Legislation enacted under the Health Insurance Act (1224/2004):

101/2017 Government Decree amending Chapter 2 sections 1 and 3 of the Government Decree on the Implementation of the Health Insurance Act. Entry into force: 1 Mars 2017

1381/2016 Government Decree amending section 1 of the Government Decree on collecting the exceptional medicine-specific copayment. Entry into force: 1 January 2017

1007/2016 Government Decree on the rate of National Health Insurance premiums in 2017. Entry into force: 1 January 2017 to 31 December 2017

1343/2015 Government Decree on the rate of National Health Insurance premiums in 2016. Entry into force: 1 January 2016 to 31 December 2016

619/2015 Government Decree amending the Government Decree on the Implementation of the Health Insurance Act. Entry into force: 1 June 2015

337/2015 Government Decree on collecting the exceptional medicine-specific copayment. Entry into force: 1 April 2015

947/2014 Government Decree on the rate of National Health Insurance premiums in 2015. Entry into force: 1 January 2015 to 31 December 2015

808/2013 Government Decree on the rate of National Health Insurance premiums in 2014. Entry into force: 1 January 2014 to 31 December 2014

605/2013 Government Decree on the reimbursement tariff for patient transports. Entry into force: 1 September 2013

27/2013 Government Decree on reimbursements for clinical nutrition preparations. Entry into force: 1 February 2013

25/2013 Government Decree on reimbursements for the costs of medical treatment of serious and chronic illnesses. Entry into force: 1 February 2013

641/2012 Government Decree on the rate of National Health Insurance premiums in 2013. Entry into force: 1 January 2013 to 31 December 2013

267/2012 Government Decree on the reimbursement tariff for patient transports. Entry into force: 11 June 2012

1132/2011 Government Decree on the rate of National Health Insurance premiums in 2012
Entry into force: 1 January 2012 to 31 December 2012

566/2005 Act on the Rehabilitation Benefits and Rehabilitation Allowance Granted by the Social Insurance Institution Up-to-date statute

The Act on the Rehabilitation Benefits and Rehabilitation Allowance Granted by the Social Insurance Institution entered into force on 1 October 2005. The following amendments have entered into force during the reporting period:

1344/2016 Statute text; Entry into force**:** 1 January 2017
1309/2016 Statute text; Entry into force**:** 1 January 2017
1272/2016 Statute text; Entry into force**:** 1 January 2017
92/2016 Statute text; Entry into force**:** 1 January 2017
887/2015 Statute text; Entry into force**:** 1 January 2016
464/2015 Statute text; Entry into force**:** 1 January 2016
145/2015 Statute text; Entry into force**:** 1 January 2016

1258/2014 Statute text; Entry into force**:** 1 January 2015
1236/2014 Statute text; Entry into force**:** 1 October 2015
1229/2014 Statute text; Entry into force**:** 1 January 2015
679/2014 Statute text; Entry into force**:** 1 January 2015
973/2013 Statute text; Entry into force**:** 1 January 2014
741/2013 Statute text; Entry into force**:** 1 November 2013
935/2012 Statute text; Entry into force**:** 1 January 2013

In more detail, the main changes to health insurance benefits relevant to ILO Convention No. 130 during the reporting period 1 June 2012 to 31 May 2017 were as follows (some of which are also explained further in the report):

- 1 Jan 2013: A new system was introduced for reimbursing the costs of private medical care. The percentage-based reimbursement system was abandoned, and instead the Social Insurance Institution (KELA) now confirms a tariff for physicians' and dentists' fees, examinations and treatments, giving the patient exact reimbursement figures. At the same time, the fixed copayment of EUR 13.46 charged for examinations and treatments was abandoned. The level of reimbursement remains unchanged except for laboratory tests and radiological examinations.

- 1 Jan 2013: The per-trip copayment for travel expenses reimbursed by KELA increased from EUR 9.25 to EUR 14.25. The maximum total copayments per year for reimbursed travel (annual cap) increased from EUR 157.25 to EUR 242.25.

- 1 Jan 2013: The maximum total copayments per year for reimbursed pharmaceuticals (annual cap) decreased from EUR 700.92 to EUR 670. Beyond this, the client pays a copayment of EUR 1.50 for each reimbursed pharmaceutical.

- 1 Feb 2013: The basic reimbursement rate and lower special reimbursement rate for pharmaceuticals decreased. The basic reimbursement rate decreased from 42% to 35%, and the lower special reimbursement rate decreased from 72% to 65%. The higher special reimbursement rate remained unchanged at 100%. The reimbursement rate for the drug dose dispensing fee also decreased from 42% to 35%. Because the intention was not to reduce the reimbursement for the drug dose dispensing fee, the limit for accepting a fee as basis for reimbursement was raised from EUR 3 to EUR 3.60.

- 1 Feb 2013: The Pharmaceuticals Pricing Board decreased the wholesale prices of pharmaceuticals that have a sales authorisation and are reimbursed but are not included in the reference price system by 5%.

- 1 Jan 2014: The maximum total copayments per year for reimbursed pharmaceuticals (annual cap) decreased from EUR 670 to EUR 610. Beyond this, the client pays a copayment of EUR 1.50 for each reimbursed pharmaceutical purchased.

- 1 Jan 2014: The new Government Decree on the Price List of Drugs changed the basis for calculating the retail prices of prescription drugs. The highest-priced prescription drugs became cheaper, and the cheapest became more expensive. Also, the dispensing fee charged by the pharmacy increased from EUR 0.43 to EUR 2.39 (incl. VAT).

- 1 Jan 2014: The European medical prescription was introduced. Under the Patient Directive, prescriptions issued in another EU or EEA Member State or in Switzerland must be honoured if the medicine prescribed has a marketing authorisation in the country in which it is to be purchased.

- 1 Jan 2014: The Act on Cross-border Health Care entered into force. This Act implements the EU Patient Directive in Finland and also brings together provisions concerning cross-border health care regarding EU and EEA Member States and Switzerland (e.g. from the Health Insurance Act). The new Act introduced some changes to rights to medical care in Finland and abroad, to the grounds for reimbursing costs of medical care and to the application handling processes.

- 1 Jan 2014: Although clients were given the right to choose where to receive their medical treatment out of all health centres and specialist medical care units in Finland, KELA still only reimburses travel to the facility nearest to the client.

- 1 Jan 2015: As of this date, an oral and dental examination performed by a dentist is basically only reimbursed every other year. It may, however, be reimbursed every year as before if an annual examination is warranted because of the patient's medical condition. An oral health examination performed by a dental hygienist is only reimbursed every other calendar year.

- 1 Jan 2015: The per-trip (one way) copayment for travel costs reimbursed by KELA increased from EUR 14.25 to EUR 16. The maximum total copayments per year for reimbursed travel (annual cap) increased from EUR 242.50 to EUR 272. Two types of copayment were introduced for taxi rides. When a client orders a taxi using a dedicated regional phone number, the reimbursement is granted immediately, and the client only pays the copayment (EUR 16). When a client orders a taxi by other means, the client has to pay the entire cost of the taxi ride and then apply to KELA for reimbursement. In the latter case, the copayment is EUR 32, and this does not count towards the annual cap. The increased copayment rule does not apply in situations where a person entitled to travel cost reimbursement does not have health insurance in Finland. The same rule applies to taxi rides taken in EU and EEA Member States and in Switzerland.

- 1 Jan 2015: The maximum total copayments per year for reimbursed pharmaceuticals (annual cap) increased from EUR 610 to EUR 612.62. Beyond this, the client pays a copayment of EUR 1.50 for each reimbursed pharmaceutical.

- 1 Apr 2015: An extraordinary drug-specific copayment was introduced for the special higher reimbursement rate and additional reimbursements regarding pharmaceutical purchases for certain special groups for each treatment week or part thereof. The extraordinary drug-specific copayment is 1/12 of the drug-specific copayment for a treatment period of three months. The extraordinary drug-specific copayment may be charged if, for medical or therapeutic reasons or because of the pharmaceutical properties of the preparation, the quantity of a drug used for treating an illness for a period of no more than three months must be purchased in several batches, or if the drug in question is dispensed in doses.

- 1 May 2015: As of this date, the Act on Cross-border Health Care allowed Finland to charge actual costs for all patient groups in intergovernmental invoicing. New invoicing processes are waiting to be introduced, pending a similar provision to be enacted in EU legislation.

- 1 Jan 2016: An initial copayment of EUR 50 per calendar year was introduced for pharmaceutical reimbursements for all persons aged 18 or over. This means that in each calendar year the client pays for prescription drugs in full until the initial copayment has been covered.

- 1 Jan 2016: The basic reimbursement rate for pharmaceuticals increased from 35% to 40%. The reimbursement rate for the drug dose dispensing fee also increased from 35% to 40%. Because the intention was not to reduce the reimbursement for the drug dose dispensing fee, the limit for accepting a fee as basis for reimbursement was lowered from EUR 3.60 to EUR 3.15.

- 1 Jan 2016: The drug-specific copayment under the higher special reimbursement rate increased from EUR 3 to EUR 4.50, and the drug-specific copayment under the additional reimbursement increased from EUR 1.50 to EUR 2.50. 1 Jan 2016: As of this date, the maximum total copayments per year for pharmaceuticals (annual cap) are EUR 610.37.

- 1 Jan 2016: Cuts were made to the procedure-specific reimbursement tariff for physicians, dentists and oral hygienists and to the reimbursement tariff for examinations and treatment ordered by physicians and dentists. The reimbursement for an oral examination performed by a dentist and for prosthesis procedures for war veterans remained at the 2015 level.

- 1 Jan 2016: The per-trip (one way) copayment for travel costs reimbursed by KELA increased from EUR 16 to EUR 25. The higher copayment type for taxi rides increased from EUR 32 to EUR 50. The maximum total copayments per year for reimbursed travel (annual cap) increased from EUR 272 to EUR 300.

- 1 Jul 2016: The Pharmaceuticals Pricing Board reduced the maximum wholesale prices of pharmaceutical products included in the reference price system. This applied to those pharmaceutical preparations included in the reference price system whose maximum wholesale prices are higher than the highest confirmed wholesale prices for equivalent generic products, i.e. mainly original preparations imported by direct or parallel importing.

Changes during the reporting period are also reported in the Statistical Yearbook of KELA (the most recent edition being for 2015), which can be found online:
http://www.kela.fi/tilastojulkaisut_kelan-tilastollinen-vuosikirja

II LEGISLATION AND ADMINISTRATIVE REGULATIONS FOR THE FOLLOWING ARTICLES

Articles 13, 17 and 30

According to Finnish legislation, the public health care sector bears the primary responsibility for arranging health care services. The organisation of public health care is not generally financed by statutory National Health Insurance. The purpose of the medical care insurance component of National Health Insurance is to complement public health care while taking account of the available funds. National Health Insurance is a relatively cost-efficient way for society to contribute to the funding of health care services and thus to alleviate the public sector's obligation to organise health care services.

National Health Insurance consists of earned income insurance and medical care insurance. Earned income insurance covers sickness, parenthood and rehabilitation allowances, as well as reimbursement paid to employers for occupational health care costs. Medical care insurance covers reimbursements for medical treatment costs and rehabilitation services. A minimum return of 8%, calculated to take account of costs, has been specified for the financial assets of the National Health Insurance Fund, plus a margin of four percentage points so as to permit financial assets to fluctuate without affecting the basis for health insurance premiums for the following year.

The funding reform of the National Health Insurance system has strengthened the realisation of the insurance principle. Increases in health insurance premiums have remained reasonable for both medical care insurance and earned income insurance.

Table 1: Health insurance premiums in 2013−2017:

Health Insurance Premiums	**2013**	**2014**	**2015**	**2016**	**2017**
Employers (% of payroll)	2.04	2.14	2.08	2.12	1.08
Pensioners and beneficiaries Health insurance (for medical care) (% of taxable pension and benefit income)	1.30	1.49	1.49	1.47	1.45
Employees and self-employed persons insured under the MYEL Act					
Health insurance total	2.04	2.16	2.10	2.12	1.58
For medical care (% of taxable income)	1.30	1.32	1.32	1.30	0.00
For earnings security (% of payroll)	0.74	0.84	0.78	0.82	1.58[1]
Self-employed persons insured under the YEL Act					
Health insurance total	2.18	2.29	2.23	2.25	1.64
For medical care (% of taxable income)	1.30	1.32	1.32	1.30	0.00
For earnings security (% of payroll)	0.88	0.97	0.91	0.95	1.64

The employer's health insurance contribution was reduced by 0.94 percentage points as of the beginning of 2017. This was implemented in practice by increasing the central government funding component towards health insurance expenditure by a like amount. The amount corresponding to the reduction in the employer's health insurance contribution was allocated to the medical care insurance component of National Health Insurance. Consequently, the wage earner's and entrepreneur's health care payment was reduced by an amount corresponding to the change in the central government component, and the wage earner's and entrepreneur's earned-income contribution payment was increased by a like amount.

[1] The earnings-related contribution payment was alleviated for low-income employees: the payment is not collected from those earning less than EUR 14,000 per year. The funding shortfall caused by this was covered partly by raising the earnings-related contribution payment by 0.04 percentage points for those earning EUR 14,000 or more per year and partly by increasing the central government contribution to earnings security insurance by 3.34 percentage points.

The level of minimum daily allowance, which forms part of the statutory benefits included in the earned income insurance component of National Health Insurance, has been increased since the funding reform was implemented. The minimum daily allowance is financed by the central government.

Medicine reimbursements

In Finland, medicine reimbursements form part of the statutory National Health Insurance. The key goal of the medicine reimbursement system under National Health Insurance is to provide financial security for patients in case of illness. The medicine reimbursement system is intended to guarantee that persons covered by Finnish social security can obtain the medicines they need for treatment of illness in outpatient care at a reasonable cost. The medicine reimbursement system also determines the public funding contribution to the costs of medical treatment deemed necessary.

Under the Health Insurance Act (1224/2004), reimbursement is available for the costs of medicines prescribed for treatment of an illness by a physician, a dentist or a nurse with a limited or fixed-term right to prescribe medication. Reimbursement is available for prescription medicines intended for internal or external use for the purpose of treating or alleviating an illness or its symptoms. Only medical treatment costs that are deemed necessary are eligible for reimbursement. Treatment in accordance with generally accepted current care practice may be deemed necessary.

For a pharmaceutical preparation to be reimbursed, the Pharmaceuticals Pricing Board must accept it as reimbursable and confirm the wholesale price used as the basis for reimbursement. A pharmaceutical preparation may only be confirmed as reimbursable to the extent specified in the summary of product characteristics confirmed for the product by the marketing authorisation authority and for the accepted indications of use given therein. The above also applies, as applicable, to clinical nutrition preparations and basic ointments. Over-the-counter medicines that are medically necessary and prescribed by a prescription are also reimbursable if their reimbursability status is valid. Patients are also entitled to reimbursement for any generic replacement medicine exchanged by a pharmacy for the prescribed medicine.

Reimbursement is paid after the initial copayment has been made. The initial copayment is EUR 50 per calendar year. The initial copayment does not apply to children and adolescents; it begins to apply from the beginning of the year of the individual’s 19th birthday. There are three reimbursement categories: basic reimbursement rate 40%, lower special reimbursement rate 65% and higher special reimbursement rate 100%. In all cases, the copayment is EUR 4.50 per medicine per purchase.

Reimbursement expenditure has grown in recent years, and means for curbing this growth have had to be sought during the reporting period.

Article 27

The funeral allowance provided for by Article 27 is not paid on the basis of the Health Insurance Act (1224/2004).

As regards the personal scope of application, see the appendix ‘Personal coverage’.

Under section 25 of the Employment Accidents Insurance Act, a funeral allowance as referred to section 16 of the Act is paid to the estate of the deceased if the funeral costs were paid out of the

estate. Otherwise, the parties that arrange the funeral are reimbursed for its costs, though not exceeding the amount that would been payable to the estate. In 2012, the funeral allowance was EUR 4,570. The funeral allowance is subject to annual index-based adjustment and used to reimburse reasonable funeral costs.

Funeral costs are also reimbursed under the Military Accidents Act (1211/1990), the Military Injuries Act (404/1948) and the Seamen's Pensions Act (1290/2006), and also under the Tort Liability Act (412/1974) in the case of traffic accidents.

The key labour market organisations have agreed on group life insurance security for employees. With certain minor exceptions, the insurance security covers employees to whom employment pensions legislation applies. The obligation to insure applies to all organised employers who are bound by a collective agreement that includes provisions concerning group life insurance. Unorganised employers whose field is regulated by a general national collective agreement which is in force and contains corresponding provisions also have an obligation to insure. The insurance is valid at work and in leisure time, and beneficiaries are reimbursed on the basis of these insurance policies. The reimbursement was EUR 4,370 to EUR 15,760 in 2012, depending on the insured person's age. In addition, a child increase (EUR 7,100 in 2012) is paid for every child who is a beneficiary.

All farmers and people with grants and scholarships who have the statutory farmers' pension insurance (MYEL) also have group life insurance security.

The most important reforms concerning National Health Insurance benefits during the reporting period 2012−2017:

Articles 8 to 17

a) Reimbursements for medical treatments

A new reimbursement system for private medical care costs was introduced with an amendment to the Health Insurance Act as of 1 January 2013 (622/2012). The percentage-based reimbursement system was abandoned, and instead the Social Insurance Institution (KELA) now confirms a tariff for physicians' and dentists' fees, examinations and treatments, giving the patient exact reimbursement figures.

The copayments for travel costs reimbursed under National Health Insurance were changed by amendments to the Health Insurance Act that entered into force on 1 January 2013 and 1 January 2016 (622/2012 and 1655/2015, respectively).

Reimbursements for medical costs were changed by amendments that entered into force on 1 January 2013, 1 January 2014, 1 January 2016 and 1 April 2017 (622/2012, 974/2013, 1656/2015 and 1100/2016, respectively).

The European medical prescription was introduced with an amendment to the Health Insurance Act that entered into force on 1 January 2014 (1203/2013). Under the Patient Directive, prescriptions issued in another EU or EEA Member State or in Switzerland must be honoured if the medicine prescribed has a marketing authorisation in the country in which it is to be purchased.

The Act on Cross-border Health Care (1201/2013) entered into force at the beginning of 2014. This Act implements the EU Patient Directive in Finland and also brings together provisions concerning

cross-border health care regarding EU and EEA Member States and Switzerland (e.g. from the Health Insurance Act). The new Act introduced some changes to rights to medical care in Finland and abroad, to the grounds for reimbursing costs of medical care and to the application handling processes.

Under the amendment to the Health Insurance Act that entered into force on 1 January 2015, an oral and dental examination performed by a dentist is basically only reimbursed every other year. It may, however, be reimbursed every year as before if an annual examination is warranted because of the patient's medical condition. An oral health examination performed by a dental hygienist is only reimbursed every other calendar year.

Articles 18 to 27

b) Daily allowances

By an amendment (804/2008) to the Health Insurance Act, the minimum amounts of sickness, parenthood (maternity, paternity and parental) and special care allowances were increased from EUR 15.20 per day to EUR 22.04 per day. The increase also applied to the minimum amount of rehabilitation allowance referred to in the Act on the Rehabilitation Benefits and Rehabilitation Allowance Granted by the Social Insurance Institution (566/2005). Increases in the level of minimum daily allowances entered into force at the beginning of 2009.

In addition, the minimum daily allowances (sickness, parenthood, special care and rehabilitation allowances) were linked to a national pension index that corresponds to changes in consumer prices, starting from 1 March 2011. On that date, the minimum daily allowances increased to EUR 22.13 per day. *The minimum daily allowances will not be adjusted to the national pension index in the years 2017 to 2019 (1082/2016).*

In 2017, the amount of minimum daily allowances is EUR 23.73 per day. A daily allowance is paid for weekdays, i.e. days other than Sundays, public holidays and midweek holidays. This means that it is generally paid for six days per week, computationally 25 days per month. In 2017, the computational amount of minimum daily allowances is therefore EUR 593 per month.

The provisions of the Health Insurance Act (1224/2004) on partial sickness allowance were amended by an Act (532/2009) that entered into force at the beginning of 2010. An opportunity was laid down for insured persons to work part-time while receiving partial sickness allowance, starting from the beginning of his/her incapacity to work after the waiting period laid down in the Health Insurance Act. An uninterrupted sickness allowance period of 60 days immediately preceding the partial sickness allowance period is no longer a requirement for granting the partial sickness allowance. In addition, the partial sickness allowance can be granted immediately after a sickness allowance period or a rehabilitation allowance period; a rehabilitation allowance can also be granted immediately after a partial sickness allowance period. This reform promotes the recovery of a person unable to work, and helps him/her remain in work and return to full-time work. *The maximum payment period for the partial sickness allowance was extended from the previous 72 weekdays to 120 weekdays as of the beginning of 2014 (972/2013).*

The partial sickness allowance is always half of the sickness allowance that immediately precedes it or half of that sickness allowance to which the insured person would have been entitled at the moment when his/her right to receive partial sickness allowance began. The partial sickness allowance is always at least half of the minimum sickness allowance if incapacity for work due to

illness has lasted for 55 consecutive days. In 2017, the minimum amount of the partial sickness allowance is EUR 11.87 per day.

Statistics

The annual deductible for travel reimbursements covered by the National Health Insurance is EUR 300, and the annual deductible for medicines is EUR 605.13 in 2017.

In 2016, 3.49 million physician's appointments were reimbursed for 1.6 million insured people, and 2.5 million dentist's appointments were reimbursed for 1.0 million insured people. Reimbursements for examination and treatment were paid to 1.1 million insured people. Travel covered by the National Health Insurance was reimbursed for 576.000 insured people. In 2017, the average rates of reimbursement were as follows: 16.7% for the costs of private medical treatment, 15.7% for the costs of private dental care, 14.7% for examinations and treatment, 76.9% for travel, 37.8% for medicines approved for basic reimbursement, 63.2% for medicines approved for lower special reimbursement and 96.6% for medicines approved for higher special reimbursement.[2]

III – V.

Nothing new to report.

VI.

A copy of this report has been sent to the following labour market organisations:

1. The Confederation of Finnish Industries (EK)
2. The Central Organisation of Finnish Trade Unions (SAK)
3. The Finnish Confederation of Professionals (STTK)
4. The Confederation of Unions for Professional and Managerial Staff in Finland (Akava)
5. Local Government Employers (KT)
6. The Office for the Government as Employer (VTML)
7. The Federation of Finnish Enterprises

Statements of the labour market organisations

The Central Organisation of Finnish Trade Unions (SAK), the Finnish Confederation of Professionals (STTK) and the Confederation of Unions for Professional and Managerial Staff in Finland (Akava) note that health differentials in Finland are still considerable. Using the life expectancy for people aged 25 as an indicator, we find that there is a difference of 9.9 years between the highest and lowest income groups for men and 4.9 years for women. Considering educational attainment, we find that the difference in life expectancy between the highest and lowest educated population groups is 7.3 years for men and 5.0 years for women.

Looking at mortality, we find that avoidable mortality is more common in low-income population groups. According to a study conducted by the National Institute for Health and Welfare, there are clear differences in the use of services attributable to differences in socioeconomic backgrounds: relative to their need for services, high-income groups use the services more than low-income

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[2] Statistical database Kelasto, produced by Kansaneläkelaitos (Kela), the Social Insurance Institution of Finland: **http://www.kela.fi/in/internet/english.nsf/alias/kelasto**

groups. This is partly explained by the use of private medical services and occupational health services.

Although access to care at health centres has improved lately, there are still considerable regional differences in the waiting time to see a physician. Finland has a care guarantee in place, meaning that there are maximum times defined by law within which a patient must be able to make contact with a health care unit, be admitted to a care needs assessment in primary health care and be admitted to an appointment with a professional. This also applies to specialist medical care. The introduction of the care guarantee has made access to care faster, but there are still failures to meet the care guarantee deadlines.

Medical care for employees organised under occupational health care, jointly funded by employers and employees, has largely compensated for the accessibility problem in public health care.

Since 2012, the copayments for purchases of medicines have been increased in Finland on several occasions, which means that sick people have to pay more for their medicines. As a result, many low-income people have to compromise on the purchase of medicines and abandon treatment because of not being able to afford it.

The purpose of the sickness allowance paid by KELA is to compensate for the financial loss caused by illness, such as loss of wages or loss of business income. The compensation level of the sickness allowance was cut back as of the beginning of 2017, and the allowance now compensates less well for loss of income due to illness.

In cases of occupational accidents and illnesses, the daily allowance paid out by insurance companies is more consistent with the income of the recipient than the sickness allowance paid by KELA. However, insurance companies are also now clearly increasingly reluctant to pay daily allowances or to compensate for costs beyond the immediate treatment of an occupational accident or illness. For instance, if a broken leg is put in a plaster cast, the insurance company is unwilling to compensate for the treatment of thrombosis caused by the plaster cast. This follows from a new interpretation of medical cause and effect on the part of insurance companies, for which they cite the Occupational Accidents, Injuries and Diseases Act that entered into force at the beginning of 2016.

According to SAK, STTK and Akava, health differentials and economic inequality have been augmented by the increases in client fees, the increases in copayments for medicines and the cuts to the sickness allowance. This is also reflected in the use of vital medical care services.