No. 130

Article 22 of the Constitution of the ILO

Report for the period 1 June 2017 to 31 May 2022, 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

Principal amendments to the Health Insurance Act (1224/2004)

- Act Amending and Temporarily Amending the Health Insurance Act (1100/2016): numerous changes to the medicine expenses reimbursement system, including conditional eligibility for reimbursement. Phased entry into force in 2016-2017, with provisions on conditional eligibility for reimbursement in interim effect until 31 December 2019.
- Act amending the Health Insurance Act (1135/2017). An increase in minimum daily allowances under the Health Insurance Act and a minimum rehabilitation allowance, amended conditions for the special care allowance and calculation of sickness allowance. Entry into force as of 1 January 2018.
- Act amending chapter 6 of the Health Insurance Act (1074/2018): Amendments in decision-making by the Pharmaceutical Pricing Board. Entry into force on 1 January 2019.
- Act Amending and Temporarily Amending the Health Insurance Act (1319/2018): several amendments, including to medicine expenses reimbursement and daily allowances. Phased entry into force in 2019.
- Act amending the Health Insurance Act (535/2019). The provisions of the Health Insurance Act governing earned income were updated and the criteria for determining daily allowance benefits were clarified and simplified. The reform incorporated a facility for using the National Incomes Register when granting daily allowance benefits. Entry into force on 1 January 2020.
- Act Amending Chapter 11, Section 10 of the Health Insurance Act (1216/2019). The minimum daily allowance benefits under the Health Insurance Act were increased by EUR 20. Entry into force as of 1 January 2020.
- Act Amending and Temporarily Amending the Health Insurance Act (1221/2019): prolonging conditional eligibility for reimbursement of medicine expenses until 2025. Entry into force as of 1 January 2020.
- Act Temporarily Amending the Health Insurance Act (1068/2020). Provisions on reimbursement for tests confirming COVID-19 infection were added to the Act. Entry into force as of 1 January 2021. The provisions will remain in force temporarily until 30 June 2022.

- Act Amending Chapter 4 of the Health Insurance Act (1156/2020). Amendments to travel costs of journeys to university student health care related to the treatment of illness. Entry into force as of 1 January 2021.

- Act Temporarily Amending the Health Insurance Act (225/2021). Provisions on compensation for COVID-19 vaccination measures were added to the Act. Entry into force as of 27 March 2021. The provisions will remain in force temporarily until 30 June 2022.

- Act Amending Chapter 8, Section 5a and Chapter 12, Section 6 of the Health Insurance Act (1075/2021). Provisions were added to the Act on the times for assessing the need for rehabilitation, remaining working capacity and the prospects for continuing at work during a prolonged sickness allowance period. Entry into force as of 1 January 2022.

- Act Amending Chapter 3, Section 8 of the Health Insurance Act (4/2022). The reimbursement rate for COVID-19 vaccination measures will be increased from the current EUR 10 to EUR 16. Entry into force as of 10 January 2022.

- Act Temporarily Amending the Health Insurance Act (139/2022). Amendments to regulations governing the infectious disease allowance when an insured person has been reliably diagnosed with COVID-19 and is accordingly prevented from engaging in gainful employment. Entry into force as of 28 February 2022. The provisions will remain in force temporarily until 30 June 2022.

2017

- The annual deductible (known as the medicine ceiling) fell to EUR 605.13 from EUR 610.37 in 2016. The annual deductible is tied to the cost of living index. No statutory amendment is accordingly required for the annual change in the medicine ceiling. The medicine ceiling has varied between EUR 572 and EUR 605.13 over the 2017-2022 reporting period.

- Diabetes medicines other than insulin products were transferred to a lower special reimbursement category. The Social Insurance Institution reimburses 65 per cent of their price following this change, meaning that the level of eligibility for reimbursement matches that of such illnesses as coronary artery disease and hypertension. Insulin therapy remains in the 100 per cent special reimbursement category.

- A delivery interval was applied to all products eligible for reimbursement. Compensation may henceforth be granted for a new batch of a medicine, clinical nutritional product and moisturiser after the previously purchased batch has been used almost entirely in accordance with the prescriber’s instructions.

- Expensive medicinal therapies costing more than EUR 1,000 per pack have been eligible for reimbursement according to need only one month at a time since 2017. Particularly expensive pharmaceutical products are used in the treatment of such illnesses as cancer, blood clotting disorders and rheumatism. Only to a small proportion of pharmaceutical product users are subject to a right of reimbursement limited to one month.

- The reference price of the pharmaceutical product is the highest reimbursed price. Since 2017, the reference price has been calculated by adding EUR 0.50 to the price of the most affordable product in the group. Reimbursement for pharmaceutical products that are cheaper than the reference price is paid at the sale price of the product. A client who declines to exchange a

medicine for a reference priced or more affordable product must pay the difference in excess of the reference price in addition to the deductible. This difference does not accrue to the annual deductible for pharmaceutical costs (the medicine ceiling). A prescriber may only prohibit the exchange of medicines on medical or therapeutic grounds.

- Conditional eligibility for reimbursement was introduced in Finland from the beginning of 2017, and is a way of managing uncertainty related to the total cost, cost-effectiveness and therapeutic value of using new medicines. The provisions on conditional reimbursement remain in force temporarily until the end of 2025. The Pharmaceutical Pricing Board assesses the prospects for initiating negotiations on conditional eligibility for reimbursement in each individual case. A decision on conditional eligibility for reimbursement involves an agreement between the pharmaceutical company and the Pharmaceutical Pricing Board, setting out the management and monitoring of uncertainty concerning the efficacy of the pharmaceutical product.

2018

- As of the beginning of 2018, a quantity of an expensive medicine exceeding the annual deductible for pharmaceutical costs (i.e. the medicine ceiling) may be acquired in a single purchase.

- The minimum daily allowances under the Health Insurance Act were increased to a net sum exceeding the basic element of social assistance, and so that their beneficiaries would essentially fall within the scope of the correct benefit system. This ensured the primacy of basic social security in relation to social assistance, and an appropriate allocation of support. The minimum sickness and parental allowances and special care allowance is EUR 22.89 per weekday. The increase also applied to the minimum rehabilitation allowance. The sum is also revised annually in line with the National Pension Index.

- A provision was added to the Health Insurance Act concerning the determination of sickness allowance when an insured person becomes incapacitated for work while working simultaneously in two or more employment relationships or in a self-employed capacity, and is incapacitated for only one of type of work, discontinues this work, and continues working in other respects. If an insured party is considered incapacitated for the discontinued type of work within the meaning of the Health Insurance Act, then the sickness allowance is determined on the basis of the loss of earnings from the work in question.

- The waiting period of a self-employed person for a daily allowance under the Health Insurance Act was shortened. Self-employed claimants were previously ineligible for the first four days of absence from work and loss of livelihood due to incapacity, which affected their ability to take sick leave. The self-employed will in future be paid sickness allowance in compensation for a period of incapacity for work over the waiting period, with the exception of the day on which the incapacity begins.

- Compensation may be granted for occupational health care costs as of the beginning of 2018, even if the self-employed person or entrepreneur in agriculture has no valid YEL or MYEL insurance while on rehabilitation allowance or temporary occupational accident pension.

- A special care allowance may be paid to both parents for the same period as of the beginning of 2018 in compensation for earnings lost during palliative care of a child at home. This is an

exception to the general rule that a special care allowance is not payable to both parents for the same period of care for a child at home.

2019

- The minimum daily allowances and minimum rehabilitation allowance payable under the Health Insurance Act were increased. The minimum sickness and parental allowances and special care allowance is EUR 25.88 per weekday.

- The 55-day waiting period for the minimum daily allowance was abolished. Following this amendment a minimum sickness allowance may be paid immediately after the waiting period, meaning the nine working days following the date when incapacity for work begins. A corresponding amendment also applied to partial sickness allowance. The minimum sickness allowance was previously paid only after incapacity had lasted for a continuous period of not less than 55 days. A minimum sickness allowance was already exceptionally paid after the waiting period if it was evident at the onset of incapacity for work that the incapacity would continue for at least the maximum period of sickness allowance. Application of this regulation was discretionary, and the assessment of whether incapacity might last for the maximum period of sickness benefit was somewhat erratic. Other daily minimum allowance benefits and rehabilitation allowance under the Health Insurance Act were already paid with no waiting period. Following the abolition of the waiting period, claimants for a daily allowance receive their income from the primary benefit intended for their individual circumstances. The amendment also improved the situation of partial sickness allowance claimants, as the 55-day waiting period may have been a practical barrier to applying for partial sickness allowance. The amendment also put sickness allowance claimants on an equal footing with beneficiaries of other daily allowance benefits and rehabilitation allowance.

2020

- Since the beginning of 2020, clients have also received additional reimbursement at the point of sale for purchases exceeding the medicine ceiling at pharmacies. This means that a client no longer needs to seek additional compensation from the Social Insurance Institution for purchases exceeding the pharmaceutical ceiling, and the reimbursement is instead available immediately at the pharmacy.

- Following the "earned income reform" that took effect in 2020, the daily allowance benefit payable under the Health Insurance Act and the rehabilitation allowance payable under the Act on Rehabilitation Benefits and Rehabilitation Allowance Benefits of the Social Insurance Institution of Finland (566/2005) are determined on the basis of the insured person's annual income. Annual income corresponds more closely to an individual's income level when incapacity to work or entitlement to benefit begins. The daily allowance benefit of a self-employed person is determined on the basis of the confirmed YEL or MYEL income from working. The reform seeks to modernise the outdated income provisions of the Health Insurance Act and to clarify and simplify the basis for determining the daily allowance benefit and rehabilitation allowance. The aim is for the determining criteria to be intelligible to the claimant and for the daily allowance to be more in line with the loss of earnings suffered by the claimant when the benefit begins.

- To reduce inequality and emphasise the primary benefit, the minimum daily allowance benefits under the Health Insurance Act (i.e. sickness allowance, parental allowance and

special care allowance) were increased by EUR 20 per month. The increase also applied to the rehabilitation allowance.

2021

- Health insurance reimbursements began to cover the travel costs incurred by university students for the treatment of illness at student health care services.

- The compensation rate for COVID-19 testing was increased. The amendment enables a Government Decree to be enacted setting the reimbursement rate for PCR tests. A reimbursement rate of EUR 100 was set for PCR tests, whereas without the separate statutory amendments this rate would have been EUR 56 per test, as established by the Social Insurance Institution of Finland.

- A reimbursement rate for COVID-19 vaccination measures was temporarily added to health insurance reimbursements under the Health Insurance Act. The reimbursement rate was set at EUR 10 per vaccination measure. Vaccination measures have not previously been eligible for medical care reimbursement, as they do not constitute treatment but prevention of disease. Reimbursement for COVID-19 vaccination measures provides an alternative to vaccination in public health care by reimbursing part of the costs of vaccination in private health care. Adding reimbursements for COVID-19 vaccination measures to medical care reimbursements under the Health Insurance Act also brought travel for such vaccinations within the scope of travel expense reimbursement under medical insurance.

2022

- The reimbursement rate for COVID-19 vaccination measures was increased from EUR 10 to EUR 16.

- Provisions were added to the Health Insurance Act on the times for assessing remaining working capacity, the prospects for continuing at work, and the need for rehabilitation. The aim was to provide for new checkpoints supporting a person's return to work, continued work and working capacity, and the timeliness of access to rehabilitation during a prolonged sickness allowance period. Legislation already previously in force required an employer to notify the occupational health care service after an employee's absence from work due to illness has lasted for 30 days. A person must seek sickness benefit from the Social Insurance Institution within two months of the beginning of an incapacity for work. The Social Insurance Institution must determine the insured person's rehabilitation needs by no later than when the number of days of sickness allowance and partial sickness allowance exceeds 60 days. The occupational health care service is responsible for preparing a statement on the employee's remaining working capacity and prospects for continuing to work, and the employee must forward that statement to the Social Insurance Institution within 90 days of sickness allowance. The amendment added provisions to the Health Insurance Act concerning assessment, within no more than 150 and 230 sickness allowance days, of the prospects for working capacity and continued working, and of the need for rehabilitation on a means-tested basis.

- A provision was added to the Health Insurance Act whereby an insured person is also entitled to an infectious disease allowance if the insured person has been reliably diagnosed with a COVID-19 infection and participation in gainful employment is not recommended due to the risk of spreading the infection. The guardian of a child under the age of 16 years is similarly

entitled if the child has been reliably diagnosed with a COVID-19 infection, attendance at early childhood education and care or an educational institution is not advisable due to the risk of spreading the infection, and the guardian is accordingly prevented from engaging in gainful employment. Application of this provision accordingly does not require a decision taken under the Communicable Diseases Act concerning absence from work, early childhood education and care or an educational institution, or a quarantine or isolation order. The sickness allowance for infectious diseases granted under the new provision is determined in the same way as the sickness allowance granted during quarantine or isolation under the Communicable Diseases Act. The retroactive application period for an infectious disease allowance was extended from two months to six months.

Health and social services reform and amendments concerning occupational health care reimbursements

Principal responsibility for arranging public health care in Finland remains with municipalities (of which there are approximately 300) until 31 December 2022. The restructuring of health and social services arrangements (*health and social services reform*) transfers responsibility for arranging health and social care, rescue services and other separately prescribed services and functions from municipalities to new wellbeing services counties from the beginning of 2023 (21 wellbeing services counties and the City of Helsinki, with certain services also arranged by a public legal entity called the HUS Joint Authority in Finland's most populous region of Uusimaa). Five health and social care co-operation areas will also be formed for regional coordination, development and cooperation in health and social care arranged by wellbeing services counties. This is a very important societal reform with respect to the organisation of health and social services.

All local residents and certain other individuals prescribed by law are entitled to use municipal public health care services. Even though people in work enjoy services through occupational health care, they may also use public health care services.

The aim of restructuring health and social services is to ensure that these services are coordinated, that care chains are smooth, and that people receive appropriate and effective services in a timely manner. The focus of the healthcare and social welfare system will shift towards basic-level services and prevention. The reform seeks to improve the effectiveness and productivity of health and social services, to curb the rise in service costs, and to make services more open and transparent.

The health and social services reform seeks to address the challenges posed by such aspects as Finland's fragmented municipal and service structure, its decentralised legislation governing responsibility for arranging health and social care, the deficient financial position of its municipalities, and the changing age structure of its population. The reform also aims to ensure the long-term availability and quality of health and social care in a uniform and equal manner throughout the country.

The Occupational Health Care Act (1383/2001) obliges employers to provide preventative occupational health care for their employees. Employers must arrange occupational healthcare at their own expense to prevent and control health hazards and risks related to work and working conditions, and to protect and promote the safety, health and working capacity of employees. Occupational health care functions are discharged through such measures as health inspections

and workplace surveys. Employers must arrange and implement occupational health care to the extent required by the need arising from the work, working arrangements, staff, workplace conditions and changes therein. Besides preventative measures, employers may also arrange medical care and other health care services for their employees. The organisation of such services is voluntary.

Employers have largely included GP-level medical care services in their occupational health care contracts, which vary in scope from employer to employer. According to the 2019 Occupational Health Care Statistics of the Social Insurance Institution, some 1,936,900 employees were covered by employer-arranged occupational health care in 2019, which is 87.3 per cent of wage and salary earners. Employers may arrange occupational health care services in-house, or purchase them from a health centre, a private medical clinic or another service provider. Private medical centres are by far the most important provider of occupational health care services. These centres provided occupational health care services to 1.7 million people, or 85 per cent of those covered by occupational health care in 2019.

Employers, entrepreneurs and other self-employed persons are entitled under the Occupational Health Care Act to reimbursement of the costs incurred in arranging occupational health care and other health care as provided in the Health Insurance Act (1224/2004). An amendment to the Health Insurance Act that took effect at the beginning of 2020 revised these reimbursements. The change was prompted by a policy of then Prime Minister Juha Sipilä's Government, shifting the focus of occupational health care services towards preventative measures. The impact assessments of this policy proposal noted that while current occupational health care clients may be transferred to public health care, it is difficult to estimate the number of such transferring clients.

Prior to the legislative reform, 50 per cent of eligible costs up to a calculated maximum were generally reimbursed for both mandatory preventative occupational health care and voluntary medical care costs, with 60 per cent of mandatory preventative occupational health care costs reimbursed in certain circumstances. The reform reimburses 60 per cent of eligible preventative occupational health care costs and 50 per cent of eligible voluntary costs up to a maximum calculated ceiling. The compensation system was also revised by specifying a single ceiling for occupational health care services arranged by the employer and specifying that the costs of medical care would not exceed 40 per cent of the common maximum for occupational health care services. One exception to this is that the entire common maximum compensation may be used for preventative measures.

The eligible costs of occupational health care arranged by employers in 2019 amounted to EUR 875 million. Some EUR 424 million of these costs was incurred for preventative occupational health care services, with EUR 451 million spent on medical and other health care services. Compensation paid to employers by the Social Insurance Institution for occupational health care amounted to EUR 367 million. A total of 4.3 million medical visits were made. Some 3 million of these visits were made to physicians, 860,000 to nurses, 200,000 to physiotherapists and 200,000 to other specialists. An average of two medical visits were made per employee. A total of 4.3 million laboratory tests and 400,000 imaging examinations were conducted for purposes of medical care. The medical practices of occupational health care services in respect of access to surgeries, the division of labour between occupational groups (physician-oriented) and examination practices differ to some extent from those of primary public health care.

The primary health care services arranged by the municipality of residence and future wellbeing services county are for the population as a whole. Most people of working age may also use medical care provided free of charge by an employer to employees. Client fees are charged for using public primary health care in accordance with the Act and Decree on Client Charges in Healthcare and Social Welfare.

II Direct Request 2019

"The Committee requests the Government to indicate the measures taken to ensure that the participation of protected persons in the costs of pharmaceutical supplies does not entail financial hardship nor prejudice the effectiveness of medical and social protection."

- Prescription medicine reimbursements under the Health Insurance Act were revised at the beginning of 2016. An initial deductible of EUR 50 was incurred by persons aged 18 years and over, the basic reimbursement level increased from 35 to 40 per cent, and fixed deductibles increased. Several other measures were also taken with a view to influencing the prices and reimbursement costs of medicines.

- The effects of the 2016 amendments have been monitored by microsimulation. The simulation suggests that the changes in reimbursements in 2016 reduced health insurance reimbursement costs by EUR 44 million (3 per cent). This amount was transferred to the patients' contribution. The average patients' deductible increased from EUR 147 to EUR 159 (an increase of EUR 12).

- The aim of reforming the pharmaceutical medicines system was to ensure that heavy medicine users would benefit from reimbursements and that costs would not become an obstacle to accessing the necessary pharmacotherapy for people on low incomes.

- In line with these objectives, the introduction of an initial deductible shifted the focus of the reimbursement system to completely exclude individuals with the lowest medicine expenditures. Increasing the level of basic reimbursement also benefited some patients with moderately high initial deductibles. On the other hand, the increases in fixed deductibles for medicines reduced this effect by increasing the deductibles of those paying a great deal for their medicines in particular, and reducing the benefits arising from lowering the medicine ceiling.

- The Ministry of Social Affairs and Health has launched a comprehensive reform of pharmacotherapy, which will also involve reviewing the medicine reimbursement system. The reform of medicine issues is a comprehensive exercise that will continue over several government terms. One component of the overall reform will examine the guidance and financing systems, simultaneous development of which seeks to strengthen national guidance by comprehensively supporting pharmacotherapies and services that help to maintain the working and functional capacity of the population and enable the provision of high-quality, affordable, appropriate and effective care on an equitable and comprehensively economical basis to people who need them.

"The Committee requests the Government to provide information on progress made in the implementation of the National Health Care Guarantee with a view to ensuring the due provision of medical care benefits to protected persons, in line with Article 30(1) of the Convention."

- The Ministry of Social Affairs and Health has prepared an amendment to the Health Care Act to tighten the guarantee of primary health care in non-urgent cases. Implementation of the reform will ensure that patients must in future be admitted to treatment within seven days of assessing the need for treatment. Government Proposal HE 74/2022 for an Act Amending the Health Care Act and Related Acts was submitted to Parliament on 12 May 2022. The proposal seeks to reinforce basic health care services and improve access to services. Strengthening basic services will reduce disparities in individual well-being and health, and improve equality within the population.

- The care guarantee would also promote the ability of insured individuals to claim sickness-related benefits without delay when the required health care certificate or opinion could be secured from the health care service within a reasonable time.

- Time limits for accessing treatment are governed by the Health Care Act currently in force (1326/2010), and have applied to both primary and specialised health care from the outset. Assessment of a need for non-urgent treatment must be completed in public health care by no later than the third working day after the patient contacts a health centre. Any treatment deemed necessary on medical or dental grounds in the course of assessing the need for treatment must be provided within a reasonable time, having regard to the health and prognosis of the patient, and in any case within three months of the assessment. This three-month period may be exceeded by a maximum of three months in oral health care if, for medical, therapeutic or other similarly justified reasons, treatment can be postponed without jeopardising the health of the patient (six-month care guarantee). Assessment of a referral to specialised medical care must begin within three months of its arrival, and treatment must begin within a reasonable period, having regard to the urgency thereof, and within six months of the date on which the need for treatment was established.

- According to the National Institute for Health and Welfare, approximately 60 per cent of visitors were admitted to non-urgent physician outpatient surgeries in primary health care within one week of assessing the need for treatment in October 2021. In virtually no cases was the maximum statutory period of three months exceeded. Approximately 90 per cent of visitors secured non-urgent dental appointments within three months, and approximately two per cent of visitors within more than six months of assessing the need for treatment. There are regional variations in access to treatment.

- Statistics of the Institute of Health and Welfare indicate that 6.8 per cent of patients awaiting treatment in specialised hospital care had waited for longer than the statutory six-month maximum period at the end of December 2021. The average waiting time of patients requiring non-urgent medical care was 1-2 months on 31 December 2021.

- The Government has submitted a proposal to Parliament seeking to reduce the deadlines for access to treatment in non-urgent primary health care so that treatment would be available within 14 days in outpatient care and within four months in oral health care during a transition period beginning on 1 September 2023. Shorter standard deadlines would take effect as of 1 November 2024, with treatment available within seven days in outpatient care and within three months in oral health care. Reducing the time limits for access to treatment would improve access to treatment more rapidly, and accordingly improve equality in relation to such patients as those for whom occupational health care does not include medical services. The Government proposal is supported by a package of discretionary government transfer project grants called the Centre for Health and Social Services of the

Future, which allocates more than EUR 200 million to regional development projects seeking to improve access to care.

III APPLICATION OF THE ARTICLES IN FINLAND

Please see the parts I-II of this report.

IV

A copy of this report has been sent to the following labour market organisations:
1. The Confederation of Finnish Industries (EK)
2. The Central Organization of Finnish Trade Unions (SAK)
3. The Finnish Confederation of Professionals (STTK)
4. The Confederation of Unions for Academic Professionals in Finland (AKAVA)
5. Local Government and County Employers (KT)
6. The State Employers' Office (VTML)
7. The Federation of Finnish enterprises

Statements of the labour market organisations

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