



World Health
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Can people afford to pay for health care?

New evidence
on financial protection
in Finland

Jussi Tervola
Katri Aaltonen
Fanny Tallgren



Finland

WHO Barcelona Office for Health Systems Financing

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Can people afford to pay for health care? series

ISSN: 2789-5319 (print)
ISSN: 2789-5327 (online)

ISBN: 978-92-890-5600-7

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Suggested citation: Tervola J, Aaltonen K, Tallgren F. Can people afford to pay for health care? New evidence on financial protection in Finland. Copenhagen: WHO Regional Office for Europe; 2021. Licence: CCBY-NC-SA3.0 IGO.

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Design and typesetting by Aleix Artigal and Alex Prieto.

Abstract

This review is part of a series of country-based studies generating new evidence on financial protection in health systems in Europe. Financial protection is central to universal health coverage and a core dimension of health system performance. The incidence of catastrophic health spending in Finland is relatively high compared to other Nordic countries. It is driven mainly by out-of-pocket payments for outpatient medicines, followed by outpatient care and dental care. Unmet need for health and dental services is also more prevalent in Finland than in many other countries in western Europe. The factors that undermine access and financial protection, with a disproportionate impact on poorer and older households, include: long-standing issues in the governance of coverage policy – multiple and overlapping coverage schemes, combined with regional variation in waiting times and co-payments, favour people in work and wealthier households; complex and heavy co-payments for almost all health services, with inadequate protection mechanisms; gaps in coverage and weaknesses in purchasing outpatient medicines; and relatively low levels of public investment in health. To reduce unmet need and financial hardship, policy should focus on limiting co-payments for outpatient care, especially primary care; improving protection from all co-payments for poorer households and people with high need for health care; and strengthening supply-side policies to promote better prescribing, dispensing and use of medicines.

Keywords

FINLAND
HEALTHCARE FINANCING
HEALTH EXPENDITURES
HEALTH SERVICES ACCESSIBILITY
FINANCING, PERSONAL
POVERTY
UNIVERSAL COVERAGE

About the series

This series of country-based reviews monitors financial protection in European health systems by assessing the impact of out-of-pocket payments on household living standards. Financial protection is central to universal health coverage and a core dimension of health system performance.

What is the policy issue? People experience financial hardship when out-of-pocket payments – formal and informal payments made at the point of using any health care good or service – are large in relation to a household's ability to pay. Out-of-pocket payments may not be a problem if they are small or paid by people who can afford them, but even small out-of-pocket payments can cause financial hardship for poor people and those who have to pay for long-term treatment such as medicines for chronic illness. Where health systems fail to provide adequate financial protection, people may not have enough money to pay for health care or to meet other basic needs. As a result, lack of financial protection may reduce access to health care, undermine health status, deepen poverty and exacerbate health and socioeconomic inequalities. Because all health systems involve a degree of out-of-pocket payment, financial hardship can be a problem in any country.

How do country reviews assess financial protection? Each review is based on analysis of data from household budget surveys. Using household consumption as a proxy for living standards, it is possible to assess:

- how much households spend on health out of pocket in relation to their capacity to pay; out-of-pocket payments that exceed a threshold of a household's capacity to pay are considered to be *catastrophic*;
- household ability to meet basic needs after paying out of pocket for health; out-of-pocket payments that push households below a poverty line or basic needs line are considered to be *impoverishing*;
- how many households are affected, which households are most likely to be affected and the types of health care that result in financial hardship; and
- changes in any of the above over time.

Why is monitoring financial protection useful? The reviews identify the factors that strengthen and undermine financial protection; highlight implications for policy; and draw attention to areas that require further analysis. The overall aim of the series is to provide policy-makers and

others with robust, context-specific and actionable evidence that they can use to move towards universal health coverage. A limitation common to all analysis of financial protection is that it measures financial hardship among households who are using health services, and does not capture financial barriers to access that result in unmet need for health care. For this reason, the reviews systematically draw on evidence of unmet need, where available, to complement analysis of financial protection.

How are the reviews produced? Each review is produced by one or more country experts in collaboration with the WHO Barcelona Office for Health Systems Financing, part of the Division of Country Health Policies and Systems of the WHO Regional Office for Europe. To facilitate comparison across countries, the reviews follow a standard template, draw on similar sources of data (see Annex 1) and use the same methods (see Annex 2). Every review is subject to external peer review. Results are also shared with countries through a consultation process held jointly by WHO/Europe and WHO headquarters. The country consultation includes regional and global financial protection indicators (see Annex 3).

What is the basis for WHO's work on financial protection in Europe?

The Sustainable Development Goals adopted by the United Nations in 2015 call for monitoring of, and reporting on, financial protection as one of two indicators of universal health coverage. WHO support to Member States for monitoring financial protection in Europe is also underpinned by the European Programme of Work, 2020–2025 (United Action for Better Health in Europe), which includes moving towards universal health coverage as the first of three core priorities for the WHO European Region. Through the European Programme of Work, the WHO Regional Office for Europe will work to support national authorities to reduce financial hardship and unmet need for health services (including medicines) by identifying gaps in health coverage and redesigning coverage policy to address these gaps. The Tallinn Charter: Health Systems for Health and Wealth and resolution EUR/RC65/R5 on priorities for health systems strengthening in the WHO European Region include a commitment to work towards a Europe free of impoverishing out-of-pocket payments for health. A number of other regional and global resolutions call on WHO to provide Member States with tools and support for monitoring financial protection, including policy analysis and recommendations.

Comments and suggestions for improving the series are most welcome and can be sent to euhsf@who.int.

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Acknowledgements

This series of financial protection reviews is produced by the WHO Barcelona Office for Health Systems Financing (WHO Barcelona Office), which is part of the Division of Country Health Policies and Systems in the WHO Regional Office for Europe. The series editors are Sarah Thomson, Jonathan Cylus and Tamás Evetovits.

The review of financial protection in Finland was written by Jussi Tervola (Finnish Institute for Health and Welfare), Katri Aaltonen (University of Turku, The Social Insurance Institution of Finland) and Fanny Tallgren (Finnish Institute for Health and Welfare). It was edited by Marina Karanikolos and Sarah Thomson (WHO Barcelona Office).

The authors would like to thank Tarja Hatakka (Statistics Finland) and Ilmo Keskimäki (Finnish Institute for Health and Welfare) for providing information and comments.

The WHO Barcelona Office is grateful to Liina-Kaisa Tynkkynen (Tampere University, Finland) and Mika Gissler (Finnish Institute for Health and Welfare) for their feedback on the draft review.

Thanks are also extended to Statistics Finland for making the household budget survey data available to the authors.

Data on financial protection were shared with the Finnish Institute for Health and Welfare as part of a WHO consultation on universal health coverage indicators held in 2021.

WHO gratefully acknowledges funding from the Government of the Autonomous Community of Catalonia, Spain.

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Abbreviations

| | |
|----------------|---|
| EHIS | European Health Interview Survey |
| EU | European Union |
| EU27 | European Member States since 31 January 2020 |
| EU28 | European Member States before 31 January 2020 |
| EU-SILC | European Union Statistics on Income and Living Conditions |
| FSHS | Finnish Student Health Service |
| GDP | gross domestic product |
| GP | general practitioner |
| NHI | national health insurance |
| OECD | Organisation for Economic Co-operation and Development |
| OOPs | out-of-pocket (payments) |
| VHI | voluntary health insurance |

Executive summary

The Finnish health system is highly decentralized and fragmented, with complex coverage arrangements and long-standing inequalities in access to health care. Although the need for health system reform has garnered broad support for a long time, no major changes have taken place until recently due to challenges in the legislative process and in reaching political consensus. One of the main aims of the reform finally passed in June 2021 is to transfer responsibility for health service delivery from municipalities to regional authorities to increase efficiency and equity.

This review assesses the extent to which people in Finland experience financial hardship when they use health services, including medicines. It covers the period from 2006 to the present day (July 2021). Drawing on data from household budget surveys carried out between 2006 and 2016 (the latest year available), as well as data on unmet need for health services and information on coverage policy, it finds that:

- the incidence of catastrophic health spending in Finland is relatively high compared to other Nordic countries and countries in western Europe; in 2016 just over 3% of households were further impoverished, impoverished or at risk of impoverishment due to out-of-pocket payments and close to 4% experienced catastrophic health spending;
- catastrophic spending is heavily concentrated among poorer and older households;
- outpatient medicines account for the largest share of catastrophic spending, particularly in the poorer quintiles; outpatient care and dental care also account for a substantial share; and
- access to health services is weaker in Finland than in many other countries in western Europe; around 5% of the population report unmet need for health services and socioeconomic differences in unmet need are substantial.

The factors that undermine access and financial protection, with a disproportionate impact on poorer and older households, include the following.

- **Long-standing issues in the governance of coverage policy:** multiple and overlapping coverage schemes, combined with regional variation in waiting times and co-payments, favour people in work and wealthier households, exacerbating income- and age-based inequalities in access and financial protection.

- **Complex and heavy co-payments for almost all health services, with inadequate protection mechanisms:** there are very few exemptions from co-payments based on household income or health care needs; annual co-payment ceilings are fragmented, relatively high, do not apply to all co-payments and protect only a small share of households; and access to social assistance is limited.
- **Gaps in coverage and weaknesses in purchasing outpatient medicines:** a range of everyday medicines and medical supplies are not covered, which may result in financial hardship for poorer households, and municipalities have little financial incentive to strengthen the way in which covered medicines are prescribed and dispensed. These problems are compounded by the use of percentage co-payments for covered medicines.
- **Relatively low levels of public investment in health:** this reflects the low priority given to health when allocating the government budget in Finland compared to other Nordic countries and results in heavier reliance on out-of-pocket payments to finance the health system.

Between 2012 and 2016 public spending on health fell and co-payments were increased, especially in 2016. Household budget survey data from 2016 may not have captured the full effect of the policy change but show some evidence of higher out-of-pocket payments in areas where user charges were increased, such as outpatient municipal health care. There is also evidence of reduced use of privately provided dental care following reductions in national health insurance coverage of dental care.

New measures to reduce co-payments for municipal and dental care were introduced in 2021 and will be strengthened further in 2022. These are expected to address some gaps in coverage but will not focus on many of the factors that undermine financial protection. Additional changes are expected as part of major health and social care reforms to be implemented in 2023.

Further measures to reduce unmet need and financial hardship in Finland should consider:

- limiting co-payments for outpatient care, especially primary care;
- strengthening protection for poorer households and people with high need for health care through an integrated proactive exemption scheme building on the current system of means-tested social assistance and introducing exemptions based on health care need;

- ensuring automatic (digital) monitoring of all co-payments to alleviate the administrative burden on people using services and improve the information base on financial protection;
- improving the protective effect of ceilings – for example, by lowering and potentially merging the three co-payment ceilings into one ceiling that covers all co-payments for publicly financed health services and turning the ceiling into a genuine limit on co-payments so that no further co-payments are required once the ceiling has been reached; and
- reducing reliance on co-payments to contain public spending on outpatient prescribed medicines and instead strengthening supply-side policies to promote better prescribing, dispensing and use of medicines.

Efforts to address gaps in coverage will benefit from additional public investment in health. Increasing the priority given to health when allocating the government budget and using any new investment in health care to reduce access barriers for poor households and people with high health care needs will help to reduce unmet need and financial hardship.

1. Introduction

This review assesses the extent to which people in Finland experience financial hardship when they use health services, including medicines. It covers the period from 2006 to the present day (July 2021), drawing on data from household budget surveys carried out between 2006 and 2016, data on unmet need for health care up to 2020 and information on coverage policy up to 2021.

Research shows that financial hardship is more likely to occur when public spending on health is low relative to gross domestic product (GDP) and out-of-pocket payments account for a relatively high share of total spending on health (Xu et al., 2003; Xu et al., 2007; WHO, 2010; WHO Regional Office for Europe, 2019). Increases in public spending or reductions in out-of-pocket payments are not in themselves guarantees of better financial protection, however. Policy choices are also important.

Finland experienced a sharp drop in GDP in 2009, following the 2008 global financial crisis. Austerity measures adopted between 2008 and 2017 increased co-payments for publicly financed health services, including medicines, privately provided health services and health-related travel costs. Growth in public spending on health per person slowed significantly in comparison to the decade before the crisis and, at the same time, instances of people not paying health and social care co-payments (resulting in debt recovery proceedings) more than doubled. In 2018 public spending on health amounted to 7% of GDP (around 79% of current spending on health), above the European Union (EU) average of 6% but lower than in the other Nordic countries (7.1% in Iceland and over 8% in Denmark, Norway and Sweden); the out-of-pocket payment share of current health spending amounted to 18%, below the EU average of 21% but higher than in the other Nordic countries (14% in Denmark, Norway and Sweden and 16% in Iceland) (WHO, 2021).

The Finnish health system is highly decentralized and fragmented, with complex coverage arrangements and long-standing inequalities in access to health care. Although the need for health system reform – particularly the need for greater administrative centralization – has garnered broad support for a long time, no major changes have taken place until recently due to challenges in the legislative process and in reaching political consensus. One of the main aims of the reform, finally passed in June 2021, is to transfer responsibility for health service delivery from municipalities to regional authorities. The intention is that this will not only increase efficiency, but also ensure equal access to health care.

Research on financial protection in the Finnish health system has been carried out since the early 2000s using household budget surveys (Kapiainen & Klavus, 2007) and, more recently, data from administrative registries (Blomgren et al., 2015; Peltola & Vaalavuo, 2018; Tervola et al., 2018; Tervola et al., 2020). Recent studies have found that out-of-pocket payments increase the risk of poverty, especially among people aged 75 or older and people with disability pensions, and that the increase in user charges for municipal health care in 2016 increased the risk of poverty among older people by 0.2 percentage points (Tervola et al., 2018; 2020). This report adds to the evidence by providing an internationally comparable analysis drawing on household budget survey data and examining changes in financial protection over time.

The review is structured as follows. Section 2 sets out the analytical approach and sources of data used to measure financial protection. Section 3 provides a brief overview of health coverage and access to health care. Sections 4 and 5 present the results of the statistical analysis, with a focus on out-of-pocket payments in Section 4 and financial protection in Section 5. Section 6 provides a discussion of results of the financial protection analysis and identifies factors that strengthen and undermine financial protection: those that affect people's capacity to pay for health care and health system factors. Section 7 highlights implications for policy. Annex 1 provides information on household budget surveys, Annex 2 the methods used, Annex 3 regional and global financial protection indicators and Annex 4 a glossary of terms.

2. Methods

This section summarizes the review's analytical approach and main data sources. More detailed information can be found in Annexes 1–3.

2.1 Analytical approach

The analysis of financial protection in this review is based on an approach developed by the WHO Regional Office for Europe (Cylus et al., 2018; WHO Regional Office for Europe, 2019), building on established methods of measuring financial protection (Wagstaff & van Doorslaer, 2003; Xu et al., 2003). Financial protection is measured using two main indicators: catastrophic out-of-pocket payments and impoverishing out-of-pocket payments. Table 1 summarizes the key dimensions of each indicator. For more information on how these indicators are calculated and how they relate to global indicators, see Annexes 2 and 3.

Table 1. Key dimensions of catastrophic and impoverishing spending on health

Note: see Annex 4 for definitions of words in italics.

Source: WHO Regional Office for Europe (2019).

| Impoverishing health spending | |
|------------------------------------|--|
| Definition | The share of households <i>impoverished</i> or <i>further impoverished</i> after <i>out-of-pocket payments</i> |
| Poverty line | A <i>basic needs line</i> , calculated as the average amount spent on food, housing (rent) and <i>utilities</i> (water, electricity and fuel used for cooking and heating) by households between the 25th and 35th percentiles of the household <i>consumption</i> distribution who report any spending on each item, respectively, adjusted for household size and composition using Organisation for Economic Co-operation and Development (OECD) equivalence scales; these households are selected based on the assumption that they are able to meet, but not necessarily exceed, <i>basic needs</i> for food, housing and utilities; this standard amount is also used to define a household's <i>capacity to pay for health care</i> (see below) |
| Poverty dimensions captured | The share of households further impoverished, impoverished and at <i>risk of impoverishment after out-of-pocket payments</i> and the share of households not at risk of impoverishment after out-of-pocket payments; a household is impoverished if its total consumption falls below the basic needs line after out-of-pocket payments; further impoverished if its total consumption is below the basic needs line before out-of-pocket payments; and at risk of impoverishment if its total consumption after out-of-pocket payments comes within 120% of the basic needs line |
| Disaggregation | Results can be disaggregated into household <i>quintiles</i> by consumption and by other factors where relevant, as described above |
| Data source | Microdata from national <i>household budget surveys</i> |
| Catastrophic health spending | |
| Definition | The share of households with out-of-pocket payments that are greater than 40% of household <i>capacity to pay for health care</i> |
| Numerator | Out-of-pocket payments |
| Denominator | A household's <i>capacity to pay for health care</i> is defined as total household consumption minus a standard amount to cover basic needs; the standard amount is calculated as the average amount spent on food, housing and utilities by households between the 25th and 35th percentiles of the household consumption distribution, as described above; this standard amount is also used as a <i>poverty line</i> (basic needs line) to measure impoverishing health spending |
| Disaggregation | Results are disaggregated into household quintiles by consumption per person using OECD equivalence scales; disaggregation by place of residence (urban–rural), age of the head of the household, household composition and other factors is included where relevant |
| Data source | Microdata from national household budget surveys |

2.2 Data sources

The study analyses anonymized microdata from the household budget surveys conducted by Statistics Finland roughly every five years (2006, 2012 and 2016). In total 4007 households participated in the survey in 2006 (52% of contacted households), 3551 in 2012 (43% of contacted households) and 3673 in 2016 (46% of contacted households). The data were adjusted with weights to account for sampling, response and other possible biases.

The target population of the survey comprises private households permanently resident in Finland. It excludes people living in institutions. Data on household spending are collected using telephone and face-to-face interviews, household receipts (for daily spending such as groceries), consumption diaries (for other spending) and registers (for data on household income and education levels). Interviews are conducted evenly throughout the collection year.

Households are asked to report spending on health care that is not reimbursed by social assistance or voluntary health insurance. Health spending generally is collected for the previous three months, but for medicines is based on spending in the previous two weeks. As in all household budget surveys, these costs are extrapolated to cover the whole year – a procedure that may lead to health spending being both overstated and understated. For example, data collection does not take into account annual ceilings on user charges (co-payments); if interviews take place before the ceiling has been reached, health spending may be overstated; if they take place after the ceiling has been reached, it may be understated.

Annex 1 provides further information on household budget surveys in Europe.

All currency units in the study are presented in euros (€), with spending adjusted for inflation (converted to 2015 euros) where relevant.

3. Coverage and access to health care

This section briefly describes the governance and dimensions of publicly financed health coverage (population entitlement, the benefits package and user charges) in Finland in 2021, prior to the major reform due in 2023. It also reviews the role played by voluntary health insurance (VHI) and summarizes some key trends in rates of health service use, levels of unmet need for health care and inequalities in service use and unmet need.

3.1 Coverage

The Finnish health system is highly decentralized and fragmented, with complex coverage arrangements. At national level the Ministry of Social Affairs and Health is responsible for preparation of legislation and steering health policy. It works closely with a network of government expert agencies that support decision-making and regulatory processes.

Coverage operates through three main schemes: **municipal health care**, **national health insurance (NHI)** and **occupational health care**. Health services (including dental care) are delivered by municipal and private providers.

Municipal health care: municipalities (293 in 2021) are responsible for organizing primary care and specialist health services (including dental care) for their residents. For provision of specialist care municipalities form hospital districts (20 in 2021). Municipal health services, regulated by the Health Care Act (2010), are financed through municipal taxes, central government grants and user charges and can be provided by public or contracted private providers.

National health insurance (NHI): this scheme with two components – sickness and income insurance – is regulated by the Health Insurance Act (2004) and organized by the Social Insurance Institution (Kansaneläkelaitos (Kela)). NHI sickness insurance finances some outpatient prescription medicines, health-related travel costs and privately provided primary and specialist care (including dental care). NHI income insurance finances allowances for sickness, rehabilitation and parenthood and some occupational health care. NHI is financed by central government grants (47.9% in 2019), mandatory contributions from wage earners, self-employed people and social beneficiaries (36.5%) and mandatory contributions from employers (14.2%) (Kela, 2020a).

Student health care: student and school health care (including dental care) is regulated by the Health Care Act (2010) and organized as part of municipal health care. Prior to 2021 a foundation (the Finnish Student Health Service (FSHS)) organized student health care for university students with funding from NHI sickness insurance, the university municipalities, student contributions and user charges. In 2021 a new Act on Health Services for Higher Education Students (2019) shifted responsibility for organizing student health care for all students in higher education to Kela. Student health care is now provided nationally by the FSHS and financed by central government grants (77%) and mandatory contributions from students (23%).

Occupational health care: regulated by the Occupational Health Care Act (2001), this scheme provides health services for employed people. Employers

are legally obliged to offer preventive services such as the monitoring of working conditions, first aid and medical examinations. Over two thirds also provide additional ambulatory primary care and specialist services, the scope of which is determined by employers. Obligatory preventive and additional primary health care services are jointly financed by NHI income insurance (Health Insurance Act (2004)) and employers. Self-employed workers are also entitled to reimbursements for occupational health care through NHI income insurance.

3.1.1 Population entitlement

The main basis for entitlement to **municipal health care** is permanent residence. People covered by EU or other international social security regulations are also entitled to use municipal services. Asylum seekers are entitled to publicly financed treatment at reception centres; refugees are entitled to municipal care and, once place of residence has been granted, to the same level of coverage as other residents. Undocumented migrants are entitled to urgent health care (which is broadly defined) from public providers but have to pay out of pocket for all health care costs.

NHI sickness insurance covers all permanent residents, regardless of age, as well as non-resident employees. It provides reimbursement of prescribed medicines, regardless of whether the medicines were prescribed by public, private, student or occupational health care providers. It also provides reimbursement of privately provided health services and health-related travel costs. The privately provided health services covered by the NHI scheme are an alternative to municipal health care, but NHI is the only form of publicly financed coverage for health-related travel costs and outpatient prescription medicines.

Occupational health care is available to employed people (and to self-employed people on a voluntary basis). It does not extend to retired people or family members. In 2018 occupational health care covered 82% of the employed workforce and 91% of workers. This entirely parallel system has led to concerns about inequalities in access to health care among working-age people (Blomgren & Virta, 2020) because occupational health care often provides fast access to services that are free at the point of use, while municipal health care is subject to co-payments and much longer waiting times.

Student health care, provided by the FSHS, covers students in universities and, since 2021, students in all higher education institutions.

3.1.2 Service coverage

The Health Care Act (2010) specifies that **municipal health care** must include effective preventive, diagnostic, treatment and rehabilitation services, but does not define the benefits package in detail. Municipalities therefore have some freedom to determine the scope and content of service provision and there is some variation across the country (Keskimäki et al., 2019).

Municipal health centres provide a wide range of services, including prevention, maternity and child health services, general outpatient care,

inpatient ward care (mainly used for non-complex care for older patients), dental care, school health care, occupational health care, care for older people, family planning, physiotherapy, laboratory and imaging services and some ambulatory emergency services.

Since 2014 the Council for Choices in Health Care has monitored, defined and assessed the range of health services as a whole and issued general recommendations on which examination, treatment and rehabilitation methods should be used. These recommendations serve as the driver of a gradual revision in the range of publicly financed health services covered.

Access to non-emergency specialized care requires referral from an ambulatory care physician working in a municipal health centre, occupation health care or private practice.

Under the Health Insurance Act (2004), the Pharmaceutical Pricing Board, operating under the Ministry of Social Affairs and Health, evaluates wholesale prices and defines the coverage status of outpatient prescription medicines nationally. In 2019 the NHI scheme covered 80% of all prescription purchases in the electronic prescription register (Kari & Rättö, 2020).

Kela lists the range of **privately provided health services** that can be covered by the **NHI** scheme, as specified in the Health Insurance Act (2004) and Decree. The most commonly used NHI-reimbursed privately provided services are specialist ambulatory care (especially in ophthalmology and gynaecology), physiotherapy and dental care (Kela, 2020b).

Privately provided services are often used to bypass long **waiting times** for non-urgent municipal health care or to obtain a referral to municipal specialist care, especially in southern Finland. In 2019 42% of people could obtain a non-emergency general practitioner (GP) appointment in municipal primary care within a week, but it took longer than a month for 18%. By law, the waiting time for non-urgent care in municipal health centres should not be longer than three months. The limit was exceeded in 1% of cases in 2019 (Finnish Institute for Health and Welfare, 2020a). Waiting times also vary by municipality (Keskimäki et al., 2019).

In addition to preventive services through **occupational health care**, over two thirds of employers (71% in 2018 (Takala et al., 2018)), especially medium and large employers, choose to provide additional primary care services, mainly through private providers but also via municipal health centres and dedicated occupational care centres. Around a quarter of visits to a GP were made in occupational care centres in 2010 (Nguyen & Seppälä, 2014). The range of additional health services provided through occupational health care varies by employer.

The Health Care Act (2010) specifies that **student health care** should include preventive, primary and specialist care services, including mental health, substance abuse, sexual and reproductive health and dental care.

3.1.3 User charges (co-payments)

Co-payments, including for medicines, are applied widely in municipal health care and privately provided services but not in NHI-funded

occupational health services or, since 2021, in student health services (higher education).

User charges for **municipal health care** are regulated by the Act on User Fees in Social and Health Care (1992), which:

- specifies that visits to maternity and child welfare clinics, laboratory and X-ray examinations, primary care visits and (from 2021) nurse and ambulatory specialist care visits for children under 18, vaccines that are part of the national vaccination programme and inpatient medicines should be free at the point of use;
- determines the level of the annual co-payment ceiling (see Box 1) for municipal health care (€683 in 2021 for co-payments for outpatient care, excluding dental care); after this ceiling has been reached people no longer pay for outpatient care and pay-reduced co-payments for inpatient care; the annual ceiling for municipal care is per adult; children are covered by one of their parents' ceilings; and
- sets the maximum amount for individual co-payments, giving municipalities the freedom to charge less than these amounts and even abolish co-payments; since 2009 these maximum amounts have been updated every two years in line with the national pension index.

As a result, co-payments vary across municipalities, especially for primary care and home care (Haaga, 2019; Tervola et al., 2019). The most notable deviation is that primary care visits in Helsinki, the capital city, are free of charge. Some municipalities exempt groups of people such as war veterans, long-term unemployed people or those receiving the minimum pension from co-payments. For specialist, inpatient and dental care, however, most municipalities charge the maximum amounts.

Co-payments for **privately provided health services** are determined by unregulated market prices. NHI coverage (regulated by the Health Insurance Act (2004) and Decree) is based on fixed tariffs (the amount the NHI covers) with no annual ceiling. The real value of the non-indexed tariffs has decreased over time. In 2006 NHI covered on average 28% of the price of private doctor visits, 32% of the price of private examinations and treatments and 34% of the price of private dental care. In 2019 the respective shares were 15%, 13% and 14% (Kela, 2020b). Because of the high share of costs paid out of pocket, the use of privately provided services is heavily skewed towards people in higher socioeconomic groups (Blomgren et al., 2015; Blomgren & Virta, 2020; Tervola et al., 2020).

The NHI meets on average around 70% of the price of covered **outpatient prescribed medicines** (Kela, 2020b; Finnish Institute for Health and Welfare, 2020b). Covered medicines are subject to an annual deductible of €50 and, once the deductible has been reached, percentage co-payments for most medicines and fixed co-payments for medicines for selected conditions (see Table 2 for details). Children and young people under 19 are exempt from the annual deductible. Co-payments have an annual ceiling (€579.78 in 2021) after which people pay a fixed co-payment of €2.50 per item. Ceilings for medicines are individual and children are not included in those of their parents. There is also an internal reference price system in place, supported by generic substitution. If people opt for a product priced higher than the

reference price, they must pay the difference between the retail and the reference price out of pocket and this additional amount does not count towards the annual ceiling for medicines.

Health-related travel costs are covered by the NHI after people have paid a deductible of €25 per journey to a municipal or private health centre (including by ambulance) due to illness, pregnancy, childbirth or rehabilitation up to an annual co-payment ceiling (€300 in 2021), after which costs are fully covered. In 2019 the NHI covered 87% of travel costs for which people applied (Kela, 2020b).

There are two main ways in which people are protected against co-payments: annual ceilings on co-payments (see Box 1) and social assistance.

Box 1. The role of co-payment ceilings in the Finnish health system

Annual ceilings (maksukatto in Finnish) on co-payments for municipal health care, outpatient prescribed medicines and health-related travel expenses are in place to protect people from co-payments. The ceilings for municipal health care and outpatient prescriptions reduce rather than prevent further co-payments. In the case of travel, however, there are no further charges once the ceiling has been reached.

The ceilings are set to increase automatically in line with the national pension index. In total in 2021 they added up to €1562.78.

The ceiling for outpatient prescriptions was lowered from €720 to €670 in 2013, to €610 in 2014 and to €572 in 2019. The ceiling for travel costs was increased from €157 to €242 in 2013, to €272 in 2015 and to €300 in 2016.

People must monitor the annual ceiling for municipal health care themselves, but Kela monitors the ceilings for outpatient prescriptions and for travel costs and informs people once they have been reached. Since 2020 the outpatient prescriptions ceiling has been monitored automatically in pharmacies. Introducing automatized monitoring of the ceiling for municipal health care has been identified as a priority for reform.

Around 7.4% of the population reaches at least one of the annual ceilings, while less than 0.2% of the population reaches all three (Tervola & Heino, 2020).

Co-payments for municipal dental care and temporary home care and co-payments reimbursed through social assistance are to be included in the annual co-payment ceiling for municipal health care from 2022.

Residents who cannot afford their essential daily expenses can apply for **social assistance** that also covers out-of-pocket payments for outpatient prescribed medicines, municipal health care, dental care, eyeglasses and health-related travel costs (private services are covered only in exceptional

cases). In general terms, a household is eligible for social assistance if it has no assets and its total income after applicable housing and medical expenses is less than the basic amount (€504 a month for a person living alone in 2021) (Social Assistance Act (1997)). The assistance can cover out-of-pocket payments either in advance (and receive a voucher waiving co-payments), or retrospectively with proof of payment. Non-residents may be eligible only in emergency cases. Non-take-up of social assistance is prevalent (Tervola et al., 2021). In 2019 about 8% of the population received social assistance (298 000 households) (Finnish Institute for Health and Welfare, 2020c); according to a study from 2008 to 2010, over 65% of social assistance beneficiaries in Helsinki had at least some of their out-of-pocket payments covered (Aaltonen et al., 2013).

Co-payment policy has changed considerably over time (Table 3). Maximum co-payment amounts for municipal health care were increased substantially in 2015 and 2016. In 2018 there were about 430 000 debt recovery proceedings for unpaid municipal social and health care user charges, up from 180 000 in 2012 (Finnish Federation for Social Affairs and Health, 2019). Further changes are due to be implemented in July 2021 and January 2022, including exempting children under 18 from co-payments for specialist ambulatory care, abolishing co-payments for nurse visits and including dental care and temporary home care co-payments in the annual co-payment ceiling for municipal services. These changes are estimated to reduce co-payments for 30% of the population (Tervola, 2020).

Many policies have also addressed medicine prices and co-payments, including the introduction of generic substitution in 2003, the introduction of an internal reference price system in 2009, policies aiming to reduce prices introduced in 2013, 2014, 2016 and 2017, increases in co-payments in 2013, 2016 and 2017 and reductions in co-payments in 2013, 2014, 2016 and 2019 (Table 3).

3.1.4 The role of VHI

VHI plays a relatively small role in the health system, accounting for only 2% of current spending on health in 2018, up from 1.4% in 2006 (WHO, 2021). The number of people with VHI has risen by more than 50% since 2009, amounting to 23% of the population in 2020 (Finanssiala, 2021). Take-up is concentrated heavily in richer households: in 2016 30% of households in the highest income quintile had VHI, compared to only 8% in the lowest (Kajantie, 2019). The share of older people purchasing VHI is very low (Nguyen & Seppälä, 2014).

People purchase VHI to cover out-of-pocket payments for privately provided ambulatory care, which may be appealing to people wanting direct access to a specialist without referral or to bypass waiting lists. VHI also offers cover of co-payments for NHI-covered medicines or, in some cases, for non-covered medicines.

Because many working people have access to comprehensive occupational health care, reducing the appeal of VHI, VHI tends to be taken up mainly by families with younger children to cover dependants not yet eligible for occupational coverage (Nguyen & Seppälä, 2014; Kajantie, 2019; Keskimäki et al., 2019). This higher take-up among families with children is reflected in

the large share of private GP visits among children (Blomgren et al., 2017). However, the number of adult VHI policy holders has increased substantially in recent years, rising faster than the number of policies for children. This applies particularly to VHI policies paid for by employers, which rose by 170% between 2009 and 2020 (Finanssiala, 2021).

Table 4 highlights key issues in the governance of coverage, summarizes the main gaps in publicly financed coverage and indicates the role of VHI in filling these gaps.

Table 2. User charges for municipal health care, NHI-covered medicines and health-related travel costs, July 2021

NA: not applicable.
Source: authors.

| Type and level of user charge | Exemptions | Annual cap on user charges paid |
|--|---|---|
| Outpatient visits (municipal) | | |
| Primary care <ul style="list-style-type: none"> • GP visit: fixed co-payment of up to €20.60 per visit for up to three visits per year or an annual co-payment of up to €41.20 • Physiotherapy session: up to €11.40 per session | Children under 18 are exempt from co-payments for primary care, serial treatment and (from July 2021) ambulatory specialist care visits | Partially, with inpatient care: an annual calendar year ceiling of €683 per adult for outpatient care (excluding dental care) and short-term inpatient care; after the ceiling has been reached there are no co-payments for outpatient care and reduced co-payments for inpatient care |
| Specialist care <ul style="list-style-type: none"> • Ambulatory care visit: up to €41.20 per visit • Day surgery: up to €135.10 per surgery | Exempt services <ul style="list-style-type: none"> • Nurse visits (from July 2021) • Emergency care • Services in support centres for the victims of sexual violence and services for substance-abusing expectant mothers (from July 2021) | Children under 18 are included in their parents' ceiling |
| Other care <ul style="list-style-type: none"> • Serial treatments (radiotherapy, cytostatic treatment, physiotherapy etc.): up to €11.40 per session (for up to 45 sessions a year) • Medical certificate: up to €61 (when not related to the patient's care) • Emergency care: up to €28.30 per visit | <ul style="list-style-type: none"> • Treatment in outpatient psychiatric units • Treatment with life-supporting prolonged invasive ventilation support • Immunization when part of the national vaccination programme • Maternity and child welfare clinics • Testing and treatment (including outpatient medicines) for communicable diseases such as sexually transmitted infections, tuberculosis and hepatitis (also preventive medicines included from July 2021) | |
| Unused uncancelled visits <ul style="list-style-type: none"> • Up to €50.80 for people aged 15 or older | Low-income households can apply for co-payments to be covered by social assistance | |
| Outpatient prescription medicines (NHI) | | |
| Annual deductible: €50 per calendar year | Children under 18 are exempt from the €50 deductible | No, but there is an annual calendar year ceiling of €579.78 per adult and per child; after the ceiling has been reached, people no longer pay percentage co-payments and pay a reduced fixed co-payment of €2.50 per item instead |
| Percentage co-payment of 60% (basic rate) of the retail or reference price | Low-income households can apply for co-payments to be covered by social assistance | |
| People diagnosed with specific chronic or severe conditions (with a medical certificate) benefit from lower co-payments for that condition only <p>Based on the condition:</p> <ul style="list-style-type: none"> • percentage co-payment of 35% of the reference price (lower special rate) • percentage co-payment replaced with a fixed co-payment of €4.50 per item (upper special rate) | | |
| War veterans are eligible for a 10% discount on medicine prices | | |

Table 2 contd

| Type and level of user charge | Exemptions | Annual cap on user charges paid |
|--|--|--|
| Diagnostic tests (municipal) | | |
| None | NA | NA |
| Medical devices (municipal) | | |
| None: wheelchairs, prostheses, devices for diabetes and monitoring blood glucose, assistive devices for people with disabilities etc. Users pay the full price: eyeglasses and contact lenses, hearing aids, contraceptives, small care products (such as thermometers) | Low-income households can apply for eyeglasses to be covered by social assistance | No |
| Dental care (municipal) | | |
| Fixed co-payments: • €10.20 for oral hygienists • €13.10 for dentists • €19.20 for specialist dentists Additional fees for procedures: €8.40 to €222.70 Unused and uncancelled visits: up to €50.80 for people aged 15 or older | Children under 18 years of age Screening, preventive care and clinical work on prostheses for war veterans Low-income households can apply for co-payments to be covered by social assistance | No |
| Inpatient care (municipal) | | |
| Short-term (under three months): up to €48.90 per day in hospital or €22.50 per day in psychiatric hospital Long-term (more than three months): up to 85% of a person's monthly net income (if a person has a higher-income spouse, up to 42.5% of a couple's total monthly net income) | For children under 18 a maximum of seven inpatient days per year can be charged Low-income households can apply for co-payments to be covered by social assistance Municipalities are obliged to reduce or waive the payment for long-term care if people find it difficult to pay | No; with outpatient care: an annual calendar year ceiling of €683 per adult for outpatient care (excluding dental care) and short-term inpatient care; after the ceiling has been reached there are no co-payments for outpatient care and reduced co-payments for inpatient care (up to €22.50 per day) |
| Inpatient prescription medicines (municipal) | | |
| None | NA | NA |
| Home care (municipal) | | |
| Temporary: • Up to €18.90 per visit by a doctor or dentist • Up to €12.00 per visit by a nurse Long-term: for a person living alone up to 35% of gross income above €588 a month; the payment varies based on municipality, household size and the amount of care needed; the income of a spouse is also taken into account | Municipalities are obliged to reduce or waive the payment for long-term care if people find it difficult to pay | A monthly ceiling for long-term home care |
| Health-related travel costs (NHI) | | |
| Up to €25 per journey for illness, pregnancy, childbirth and rehabilitation, including by ambulance; costs above this are covered on the basis of the nearest applicable service provider and the cheapest applicable travel mode | Low-income households can apply for co-payments to be covered by social assistance | Annual (calendar year) ceiling of €300 per person |

Table 3. Main changes to coverage policy, 2007–2021

| Year | Change |
|------|---|
| 2008 | <p>Privately provided dental care: increase in NHI coverage of privately provided dental care costs with a target to raise the overall coverage rate from 32% to 40%</p> <p>Municipal health care: <i>maximum co-payments increase by 16.6%</i> <i>Introduction of an automatic adjustment (every two years based on the pension index) to maximum co-payments and annual co-payment ceilings</i></p> |
| 2009 | <p>Outpatient prescribed medicines: introduction of an internal reference price system</p> |
| 2010 | <p>Privately provided dental care: extension of NHI coverage of dental hygienist services prescribed by private dentists</p> <p>Municipal health care: the Health Care Act (2010) specifies the range of health services covered by municipalities and lists the services that should be organized by municipalities</p> |
| 2013 | <p>Outpatient prescribed medicines: <i>percentage co-payments increase from 58% to 65% (basic rate) and from 28% to 35% (lower special rate)</i> The annual co-payment ceiling is lowered from €720 to €670 Wholesale prices of covered medicines not included in the internal reference price system are cut by 5% <i>value-added tax on medicines is raised from 9% to 10%</i></p> <p>Privately provided services: NHI reimbursement rates and deductibles are replaced with reimbursement tariffs to facilitate the comparison of customer prices charged for private services</p> <p>Health-related travel costs: <i>the co-payment per journey increases from €9.25 to €14.25</i> <i>The annual ceiling increases from €157 to €242</i></p> |
| 2014 | <p>Outpatient prescribed medicines: the formula for calculating pharmacy margins is changed and, to counterbalance any higher out-of-pocket payments for medicines, the annual co-payment ceiling is lowered from €670 to €610</p> |
| 2015 | <p>Privately provided dental care: <i>NHI coverage of oral health examinations by dentist and dental hygienist is limited to once every two years, unless patient's health status requires more frequent examination (by dentist)</i></p> <p>Municipal health care: <i>maximum co-payments increase by 9.4% (excluding dental care)</i></p> <p>Health-related travel costs: <i>the co-payment per journey increases from €14 to €16</i> <i>The annual co-payment ceiling increases from €242 to €272</i></p> |
| 2016 | <p>Outpatient prescribed medicines: <i>introduction of an annual deductible of €50 per year for adults</i> The basic percentage co-payment rate is reduced from 65% to 60% <i>The fixed co-payment for medicines with a percentage co-payment of 0% rises from €3 to €4.50 and the fixed co-payment after reaching the annual co-payment ceiling rises from €1.50 to €2.50 per item</i> Maximum wholesale prices of originator products in the internal reference price system are reassessed and reduced The generic price link is strengthened (new generic maximum price of 50% of the price of the originator, down from 60%) Pharmacies are now obliged to inform people of the lowest cost alternative</p> <p>Privately provided services: <i>a reduction in NHI reimbursement tariffs for physician, dentist and dental hygienist visits and examinations and treatment prescribed by a physician or dentist increases co-payments for these services</i></p> <p>Municipal health care: <i>maximum co-payments increase by 27.5% (including dental care)</i></p> <p>Health-related travel costs: <i>co-payment per journey increases from €16 to €25</i> <i>The annual ceiling increases from €272 to €300</i></p> |
| 2017 | <p>Outpatient prescribed medicines: <i>diabetes medicines not containing insulin are switched from the upper to lower special category (co-payment switched from €4.50 per item to 35% of the retail or reference price)</i> The annual co-payment ceiling is lowered from €610 to €605 due to index change</p> |

Notes: index adjustments are not reported in the table. *Changes that increase out-of-pocket payments are in italics.*

Source: authors.

Table 3 contd

| Year | Change |
|-------------|--|
| 2019 | Outpatient prescribed medicines: the annual co-payment ceiling is lowered from €605 to €572 |
| 2021 (July) | Municipal health care: co-payments for nurse visits abolished Children under 18 are exempt from co-payments for specialist ambulatory care |
| 2022 | Municipal health care: co-payments for dental care and temporary home care and co-payments reimbursed through social assistance are to be included in the annual co-payment ceiling |

Table 4. Gaps in publicly financed health care and VHI coverage

Source: authors.

| Coverage dimension | Population entitlement | The benefits package | User charges |
|---|--|---|--|
| Issues in the governance of publicly financed coverage | Entitlement is based on residence but access depends on employment status | Differences in service availability and quality between municipalities in municipal health care and between employers in occupational health care | Co-payments are very widely applied |
| | Employed people have quicker and free-of-charge access to some health services via occupational health care | No overall assessment of the publicly financed benefits package for outpatient medicines | Large variation between municipalities in co-payments for primary care and home care |
| | People who can afford to pay for privately provided services are more likely to benefit from the NHI scheme | | No exemptions from co-payments based on household income or health status; exemptions are generally based on age (youth) |
| | | | Annual co-payment ceilings are separate, set at a high level, are not linked to financial status and, until January 2022, do not cover municipal dental care |
| | | | People have to keep track of co-payments themselves to benefit from the annual co-payment ceiling for municipal health care |
| | | | Social assistance is available only to residents with no assets and low income and non-take-up is common |
| Main gaps in publicly financed coverage | People who do not benefit from occupational health care and cannot afford to use the privately provided services partly covered by the NHI scheme | Long waiting lists for non-urgent publicly provided health and dental services | Co-payments for primary care, specialist outpatient care and inpatient care for adults and co-payments for outpatient prescribed medicines for children and adults |
| Are these gaps covered by VHI? | Partly; VHI covers 23% of individuals and accounts for 2% of current spending on health. Apart from covering the use of privately provided services, which may not be available in rural areas, VHI also covers municipal user charges. People who rely on publicly provided services are most likely to experience gaps in coverage and least likely to afford VHI. | | |

3.2 Access, use and unmet need

Unmet need for health services (Box 2) seems to be higher in Finland than the EU average for both health care and dental care and the gap has widened over time (Fig. 1). Income inequality in unmet need in Finland is substantial (Fig. 2). Breakdown of data from the EU Statistics on Income and Living Conditions (EU-SILC) on unmet need by reason indicates that waiting time (rather than cost or distance) is the single largest barrier to access.

Box 2. Unmet need for health care

Source: WHO Regional Office for Europe (2019).

Financial protection indicators capture financial hardship among people who incur out-of-pocket payments through the use of health services. They do not, however, indicate whether out-of-pocket payments create a barrier to access, resulting in unmet need for health care. Unmet need is an indicator of access, defined as instances in which people need health care but do not receive it because of access barriers.

Information on health care use or unmet need is not collected routinely in the household budget surveys used to analyse financial protection. These surveys indicate which households have not made out-of-pocket payments, but not why. Households with no out-of-pocket payments may have no need for health care, be exempt from user charges or face barriers to accessing the health services they need.

Financial protection analysis that does not account for unmet need could be misinterpreted. A country may have a relatively low incidence of catastrophic out-of-pocket payments because many people do not use health care, owing to limited availability of services or other barriers to access. Conversely, reforms that increase the use of services can increase people's out-of-pocket payments – through, for example, user charges – if protective policies are not in place. In such instances, reforms might improve access to health care but at the same time increase financial hardship.

This review uses data on unmet need to complement the analysis of financial protection. It also draws attention to changes in the share and distribution of households without out-of-pocket payments. If increases in the share of households without out-of-pocket payments cannot be explained by changes in the health system – for example, enhanced protection for certain households – they may be driven by increases in unmet need.

Every year, EU Member States collect data on unmet need for health and dental care through EU-SILC. These data can be disaggregated by age, gender, education level and income. Although this important source of data lacks explanatory power and is of limited value for comparative purposes because of differences in reporting by countries, it is useful for identifying trends over time within a country (Arora et al., 2015; European Commission Expert Panel on Effective Ways of Investing in Health, 2016; 2017).

EU Member States also collect data on unmet need through the European Health Interview Survey (EHIS) carried out every five years or so.

The second wave of this survey was conducted in 2014. A third wave was launched in 2019.

Whereas EU-SILC provides information on unmet need as a share of the population aged over 16 years, EHIS provides information on unmet need among those reporting a need for care. EHIS also asks people about unmet need for prescribed medicines.

Fig. 1. Self-reported unmet need for health care due to cost, distance and waiting time, Finland and EU

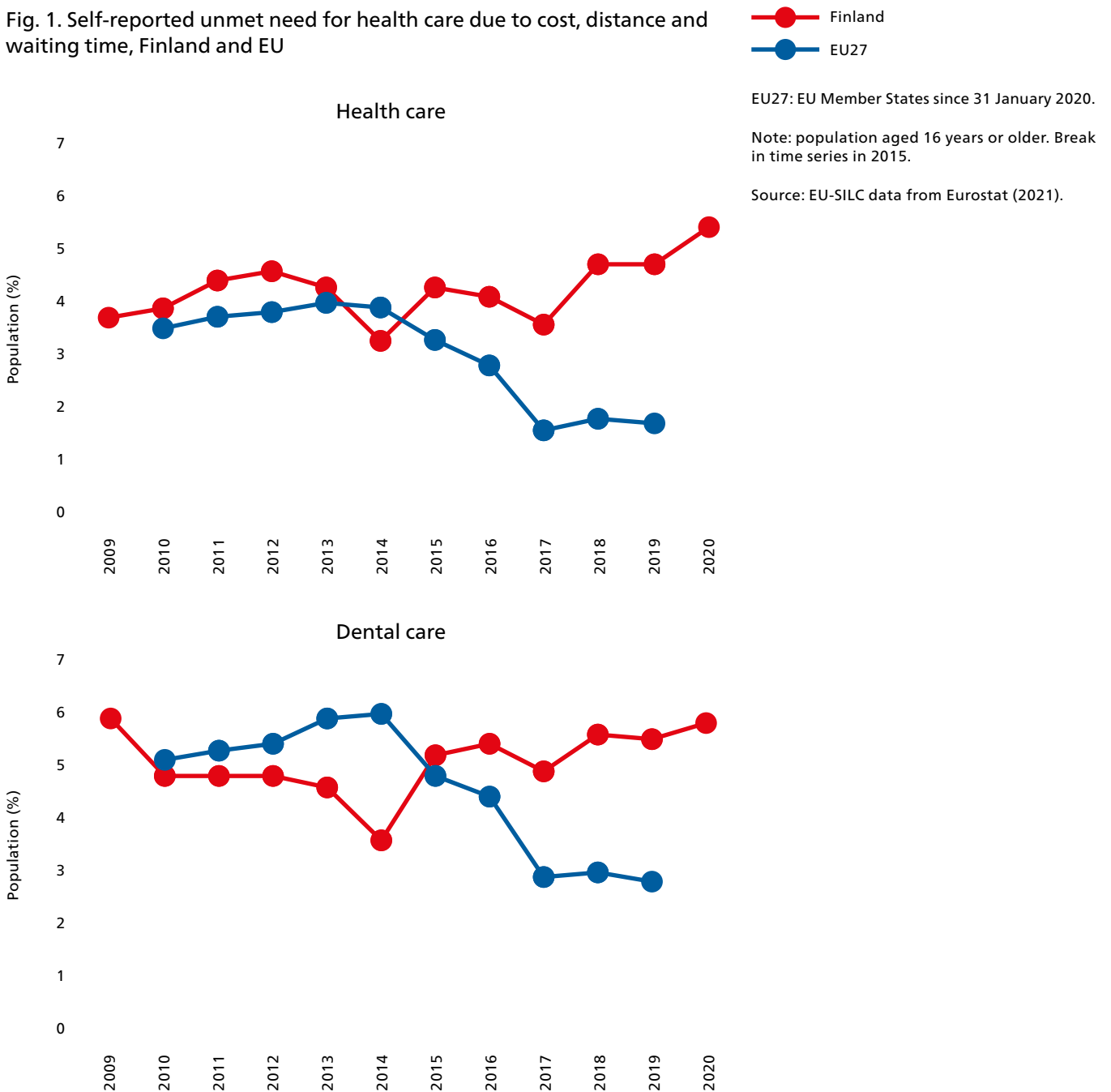
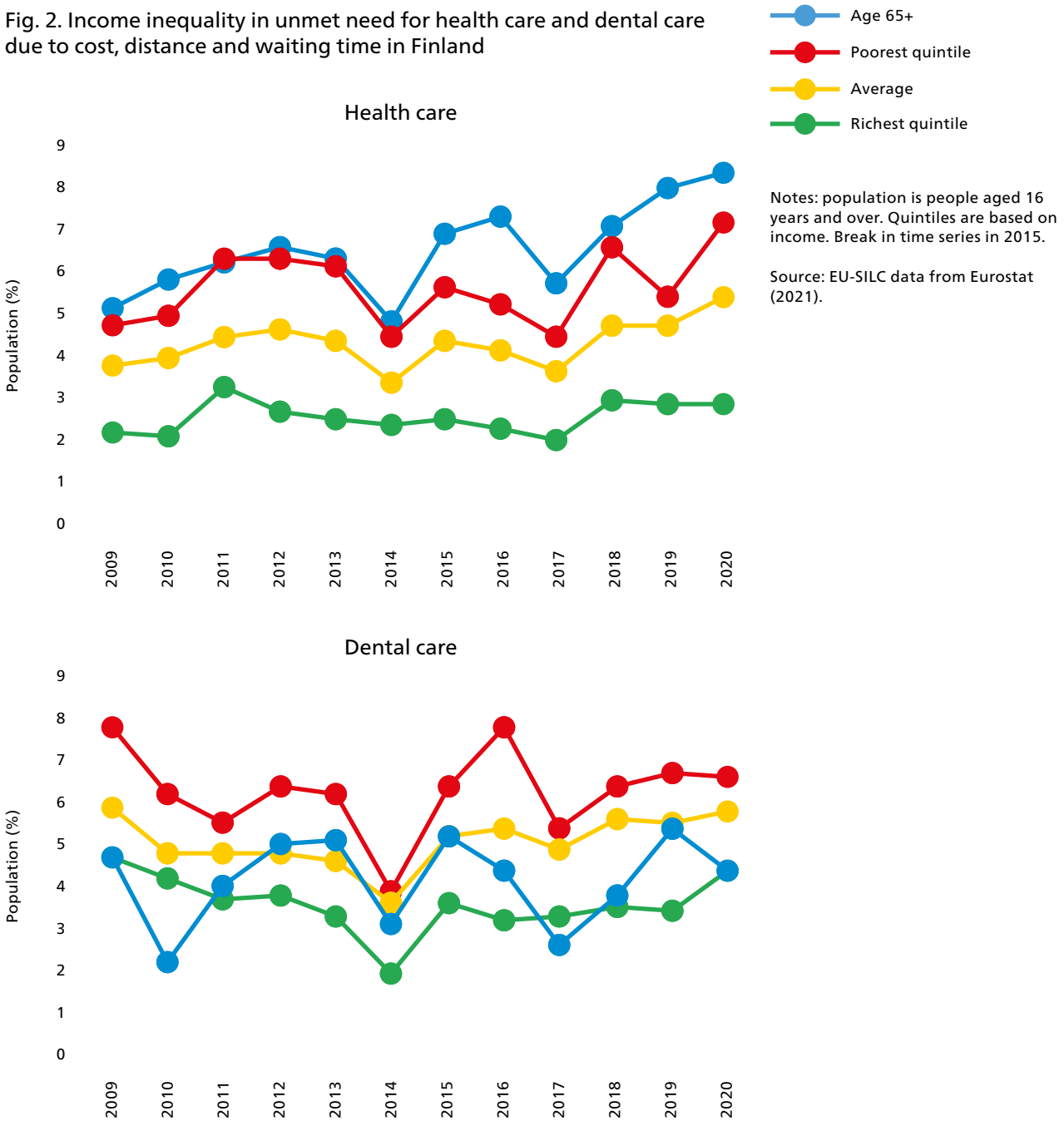
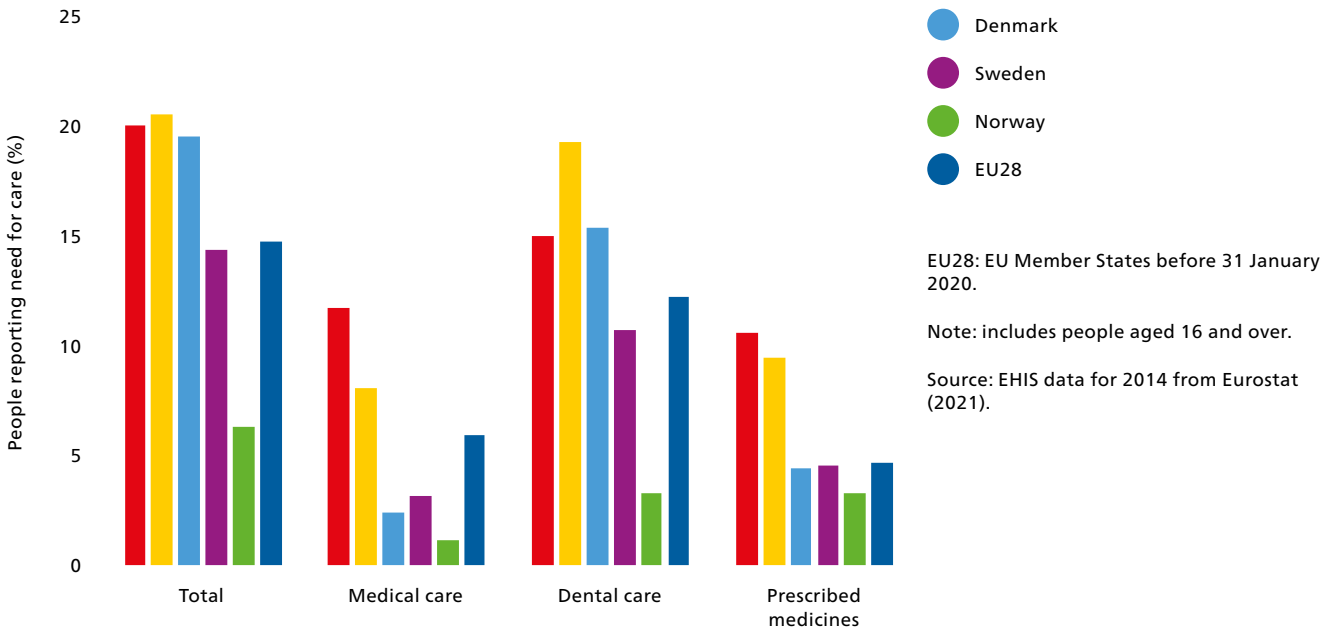


Fig. 2. Income inequality in unmet need for health care and dental care due to cost, distance and waiting time in Finland



EHIS data from 2014 (the latest year available) indicate that both waiting time and cost were key reasons for unmet need for health care, perhaps reflecting differences in survey design (see Box 2). In addition to unmet need for health care and dental care, EHIS also reports unmet need for prescribed medicines and mental health care. Unmet need due to cost in Finland was similar to Iceland and Denmark and higher than in Sweden, Norway and the EU average (Fig. 3). For medical care and prescribed medicines, it was the highest among the Nordic countries.

Fig. 3. Unmet need for health care due to cost in Finland and other Nordic countries, 2014



3.3 Summary

Coverage policy in Finland is highly complex, resulting in double coverage and faster access to health care for many employed people, gaps in coverage for non-employed people and people who cannot afford to pay for privately provided services, and socioeconomic and age-related inequalities in access to publicly financed health care.

All residents have access to municipal health care and the NHI scheme but this usually involves relatively high user charges and long waiting times. People with occupational health care or those able to pay for privately provided services enjoy faster access to health and dental care. Occupational health care is also free at the point of use. In contrast, with the exception of primary care for children under 18, preventive and diagnostic services and treatment of some conditions, user charges are applied to all municipal health and dental services. Co-payments range from €11 for a physiotherapy session to €135 for day surgery and a €50 annual deductible plus heavy percentage co-payments for most outpatient prescribed medicines.

Mechanisms to protect people from co-payments include three annual ceilings (for municipal care, outpatient medicines and travel costs), reduced co-payments for some services and some groups of people and social assistance for households with no assets and low income. These mechanisms are not always adequate, however, and sometimes are subject to bureaucratic procedures. As a result, not all people in vulnerable situations benefit from the annual ceilings or from social assistance.

VHI plays a minor but increasing role in the health system. It tends to exacerbate inequalities in access to health care, however, as take-up is concentrated among richer households and families with young children. Households with VHI benefit from faster access to privately provided health care and coverage of some out-of-pocket payments for private services and outpatient prescribed medicines.

EU-SILC data suggest Finland has higher levels of unmet need than the EU average, largely driven by waiting times, with significant income inequality in unmet need for health care and dental care. The gap between Finland and the EU average has increased in recent years.

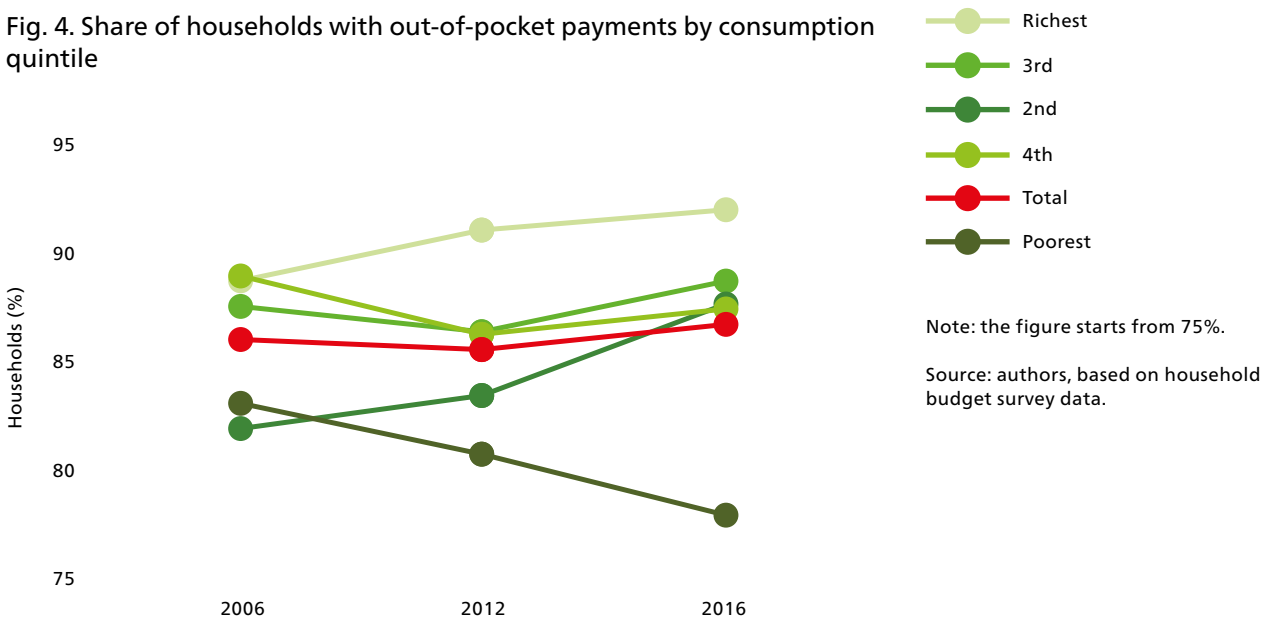
4. Household spending on health

The first part of this section uses data from the household budget survey to present trends in household spending on health – that is, out-of-pocket payments, the payments made by people at the time of using any good or service delivered in the health system. The second and third parts describe the role of informal payments and trends in public and private spending on health over time.

4.1 Out-of-pocket payments

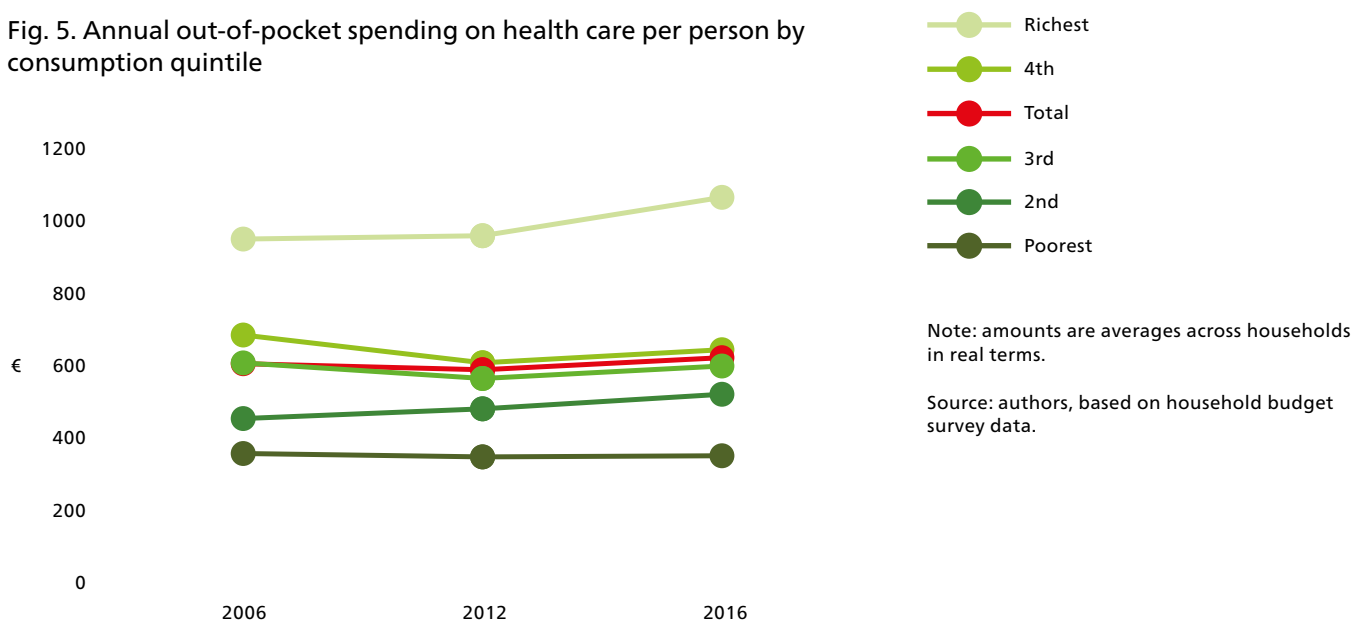
On average over 85% of households pay for health care out of pocket, a share that remained relatively stable during the study period (Fig. 4). Richer households generally are more likely to incur out-of-pocket payments than poorer households. In 2016 only 73% of households in the poorest quintile had out-of-pocket payments, compared to 92% in the richest. This may be because the poorest households are less able to pay for health care and more likely to experience unmet need. Conversely, it could reflect social assistance, which covers out-of-pocket payments for households with very low income who apply for help with health care costs or the fact that students, who are overrepresented in the poorest quintile, have access to a wider selection of health services that are free at the point of use than others. The share of households with out-of-pocket payments in the poorest quintile fell from 83% to 73% during the study period, which might reflect lower use of health services such as dental care.

Fig. 4. Share of households with out-of-pocket payments by consumption quintile



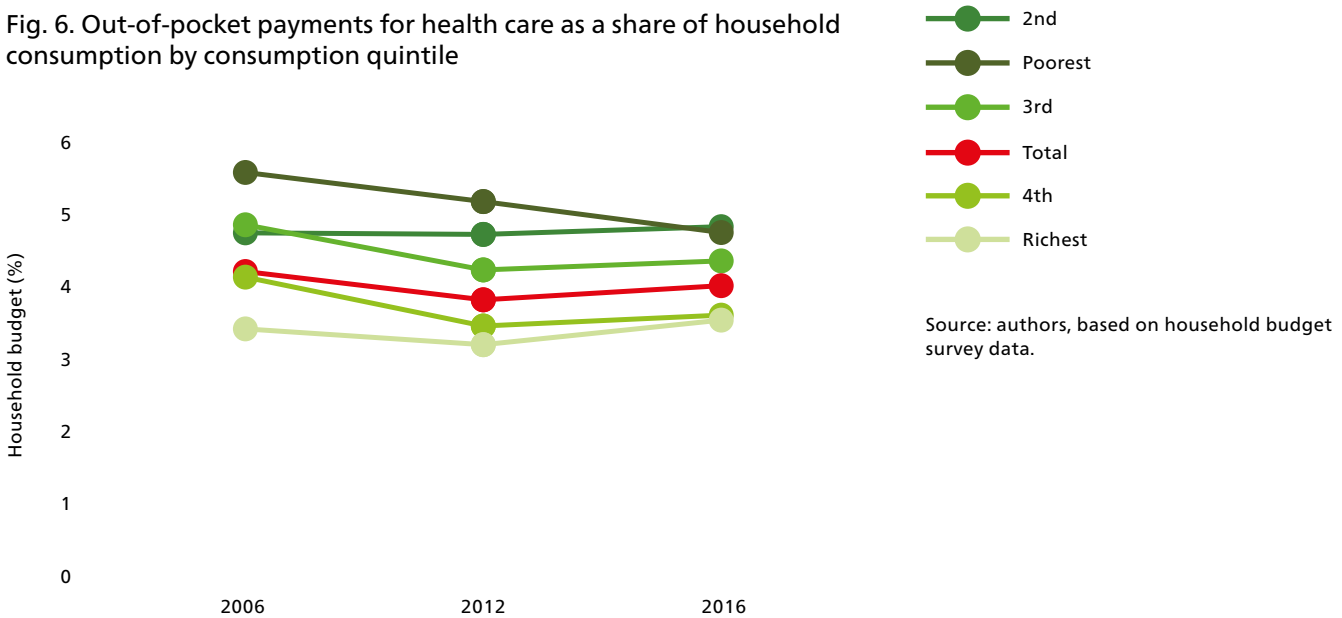
Household spending on health fell on average between 2006 and 2012 and grew between 2012 and 2016 (Fig. 5). The increase in out-of-pocket payments between 2012 and 2016, which was relatively modest in all except the richest quintile, may reflect increases in user charges in 2016. On average richer households spend substantially more out of pocket than poorer households.

Fig. 5. Annual out-of-pocket spending on health care per person by consumption quintile



The distribution of out-of-pocket payments as a share of total household consumption (the household budget) is highly regressive: out-of-pocket payments account for a larger share of the household budget in poorer than in richer quintiles, ranging from close to 5% on average in the two poorest quintiles to around 3.5% in the two richest (Fig. 6). However, the difference between quintiles has narrowed over time. The decrease in the out-of-pocket payment budget share in the poorest quintile partly is driven by a decrease in the share of households with out-of-pocket payments in this quintile (see Fig. 4) and partly by an increase in the overall budget of these households.

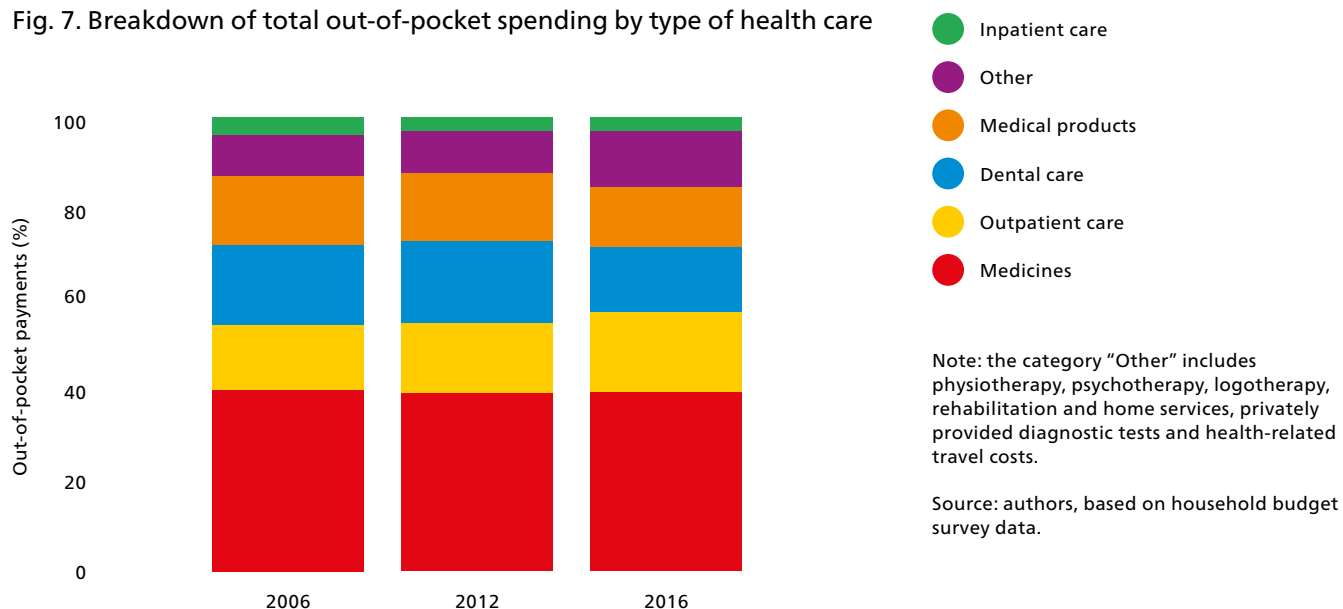
Fig. 6. Out-of-pocket payments for health care as a share of household consumption by consumption quintile



Throughout the study period, out-of-pocket payments were spent mainly on outpatient medicines (around 40% of all out-of-pocket payments) followed by outpatient care (18%), dental care and medical products (both at 14%), other services (12%) and inpatient care (3%) (Fig. 7). Over time, the share spent on dental care and medical products decreased and the share spent on outpatient care and other services increased.

In 2016: household spending on outpatient medicines included spending on prescribed medicines (45%), over-the-counter medicines (34%) and vitamins and other substances (21%); spending on outpatient care included user charges for private GPs (43%), municipal health centres (31%) and hospital outpatient visits (26%); spending on dental care included user charges for private services (73%) and municipal services (26%); and around 60–75% of services in the “Other” category were for privately provided services.

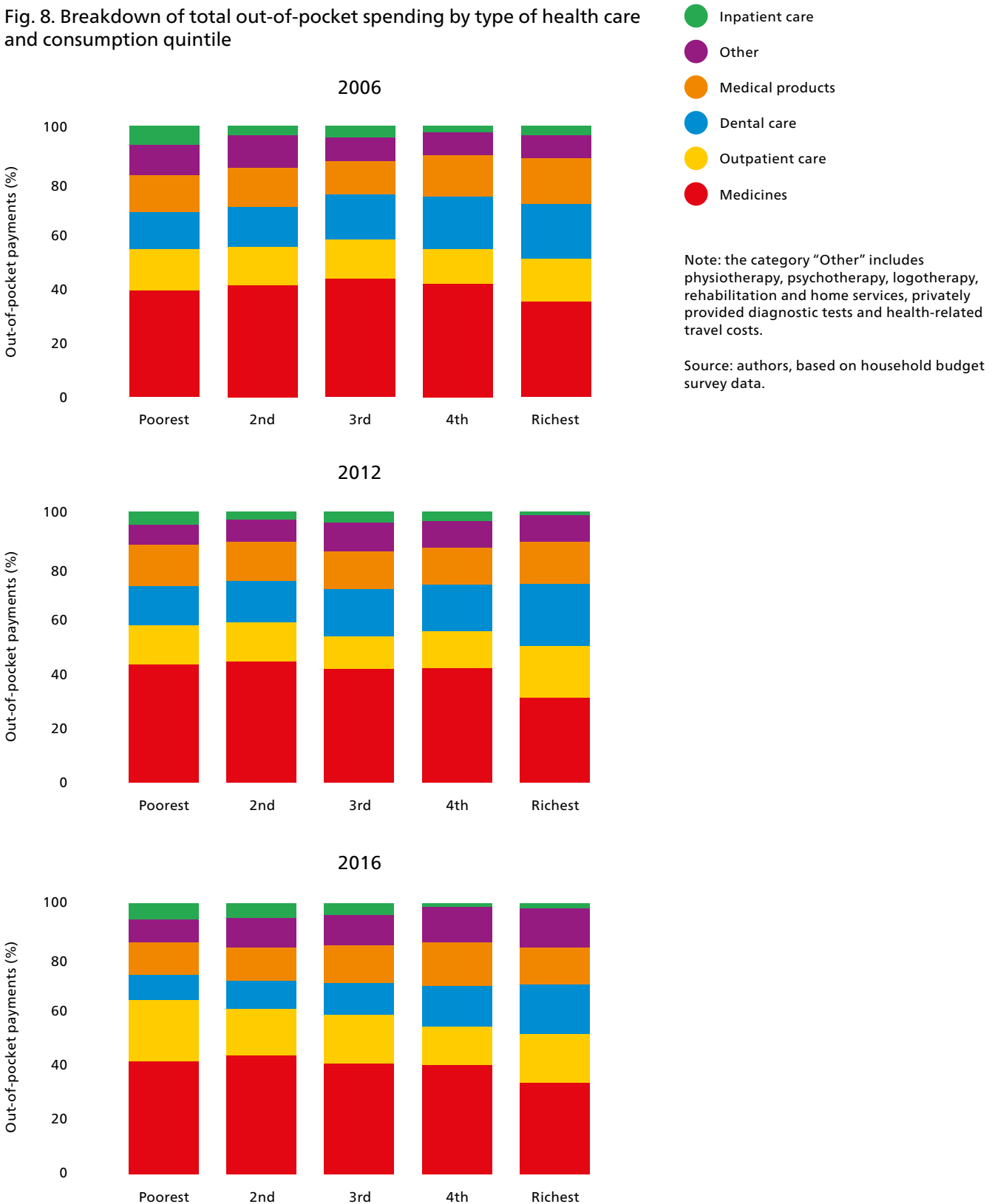
Fig. 7. Breakdown of total out-of-pocket spending by type of health care



In 2016 the share of spending on outpatient and inpatient care was more pronounced among the poorer quintiles, while the share of spending on dental care, medical products and other services was higher in richer households (Fig. 8). Nineteen per cent of households in the richest quintile reported spending on dental care, compared to only 9% in the poorest. The outpatient medicines' share was similar across all but the richest quintile, a finding that echoes other studies (Blomgren et al., 2015; Tervola et al., 2018). Poorer households were more likely to spend on prescribed medicines than richer households.

Spending patterns were relatively stable over time. The most notable shift was in the poorest quintile, where the dental care share fell and the outpatient care share increased between 2012 and 2016.

Fig. 8. Breakdown of total out-of-pocket spending by type of health care and consumption quintile



Household spending on different types of health care remained stable between 2006 and 2012 (Fig. 9). Between 2012 and 2016 spending on medicines, outpatient care and other services increased, while spending on dental care decreased and spending on medical products and inpatient care did not change (Fig. 9). Further breakdown of the household budget survey data (not shown) suggests that:

- the increase in spending on **outpatient medicines** was due largely to higher use of vitamins and over-the-counter medicines, a finding that may reflect multiple efforts to reduce the price of covered outpatient medicines during this period, which offset some of the increase in co-payments for outpatient prescribed medicines (see Table 3 and the discussion in Section 6);
- the increase in spending on **outpatient care** was driven mainly by spending on user charges for municipal health centres rather than for private GP or hospital outpatient visits; this could be attributed to the increase in maximum user charges for municipal health care introduced in 2015 and 2016; and
- the decrease in spending on **dental care** was due to a reduction in the number of households spending on dental care, especially privately provided dental services; studies have attributed this to a reduction in the use of dental care linked to NHI dental care coverage restrictions introduced in 2015 (Blomgren et al., 2017; Linden & Nolvi, 2019).

Fig. 9. Annual out-of-pocket spending on health care per person by type of health care

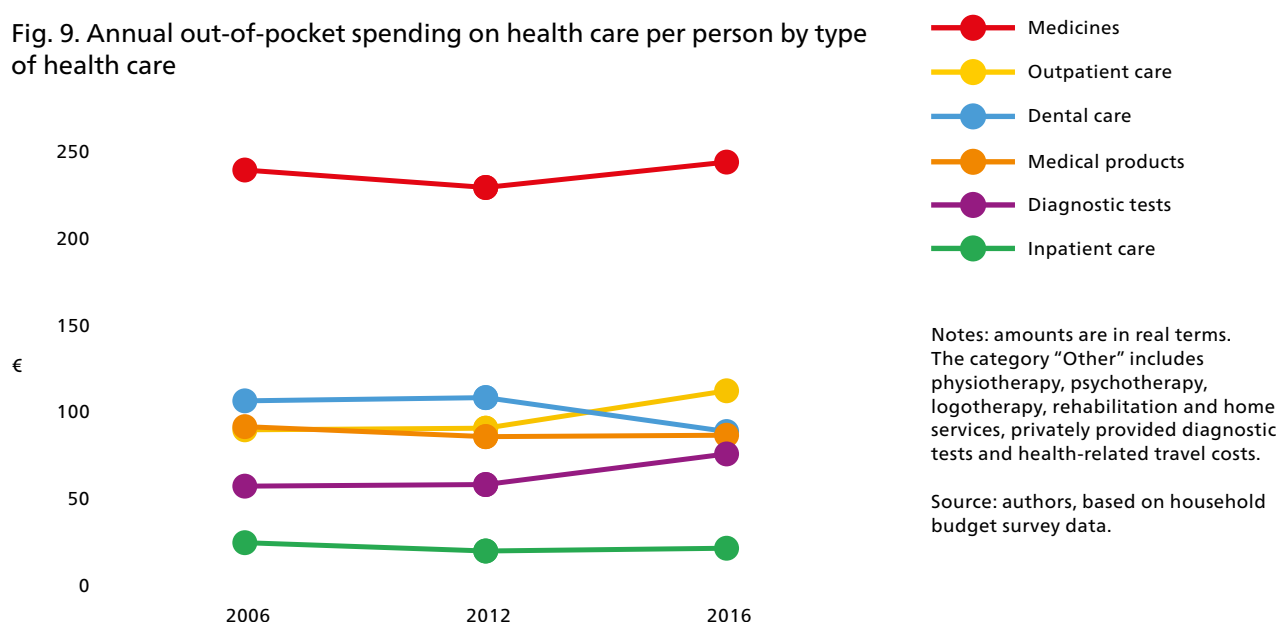
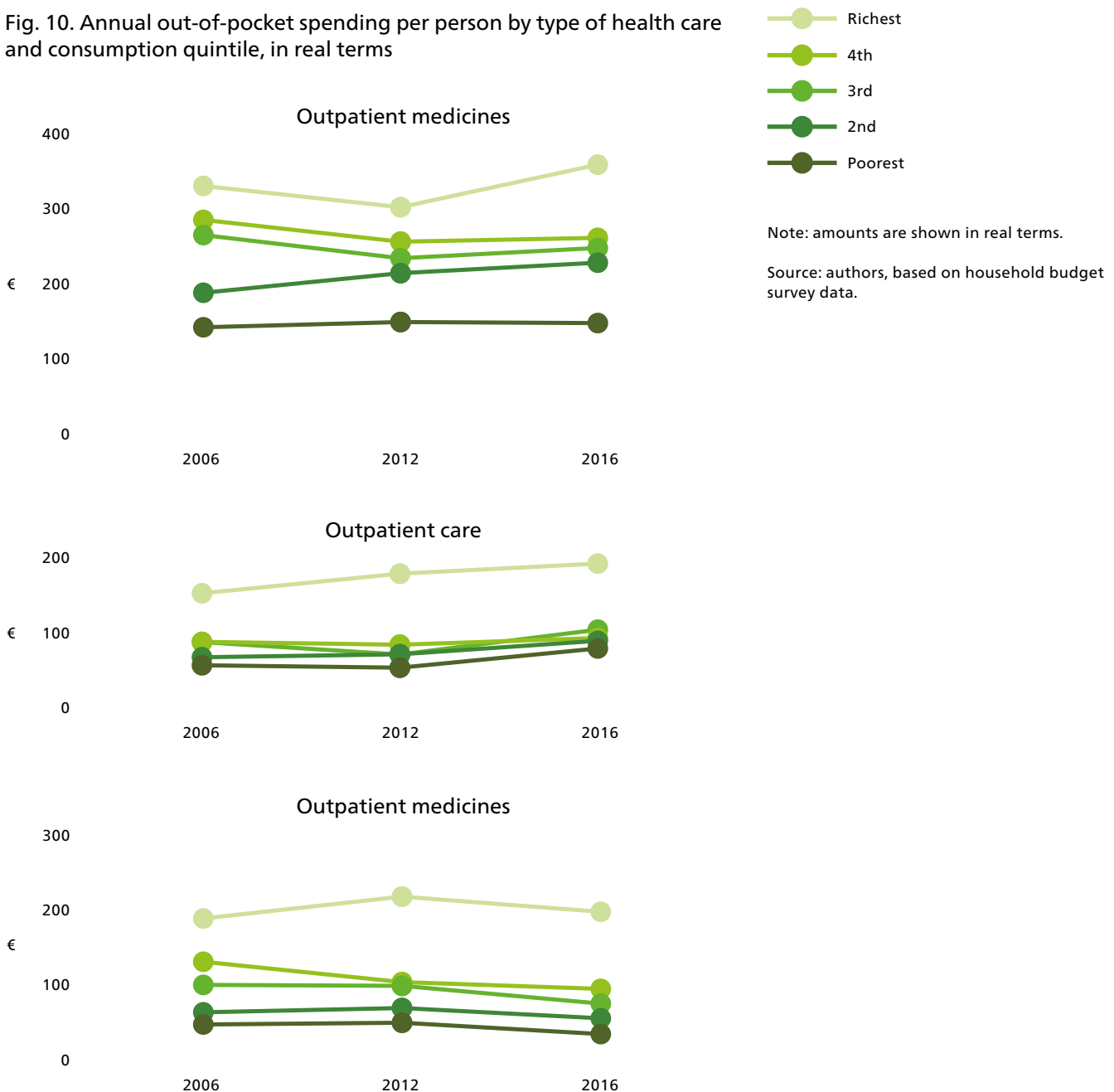


Fig. 10 shows the change in household spending on health by type of health care and consumption quintile for medicines, outpatient care and dental care. While increases in spending on outpatient medicines were

most marked for the richest quintile between 2012 and 2016, spending on outpatient care rose across all quintiles, with the largest increase in the poorest households. This shows that although there was only a small overall increase in out-of-pocket payments between 2012 and 2016 (as seen in Fig. 5), the increase in user charges disproportionately affected certain types of health care and people with lower income. The decrease in spending on dental care, caused by a reduction in the number of households spending on dental care, occurred in all quintiles.

Fig. 10. Annual out-of-pocket spending per person by type of health care and consumption quintile, in real terms



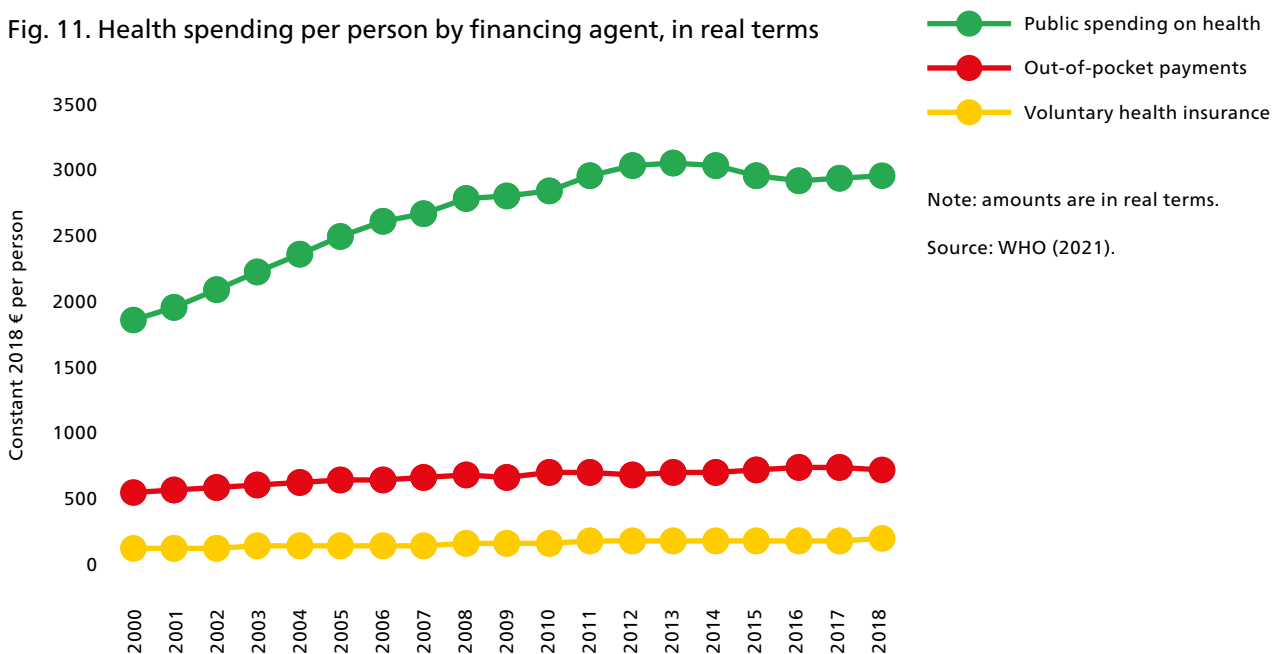
4.2 Informal payments

Informal payments do not play a significant role in the Finnish health system. In 2020 a special Eurobarometer report on corruption found that 1% of survey respondents in Finland who had visited a health care provider in the previous 12 months reported having had to make an extra payment, do a favour or give a gift for health services. This was below the EU average of 3% (European Commission, 2020).

4.3 Trends in public and private spending on health

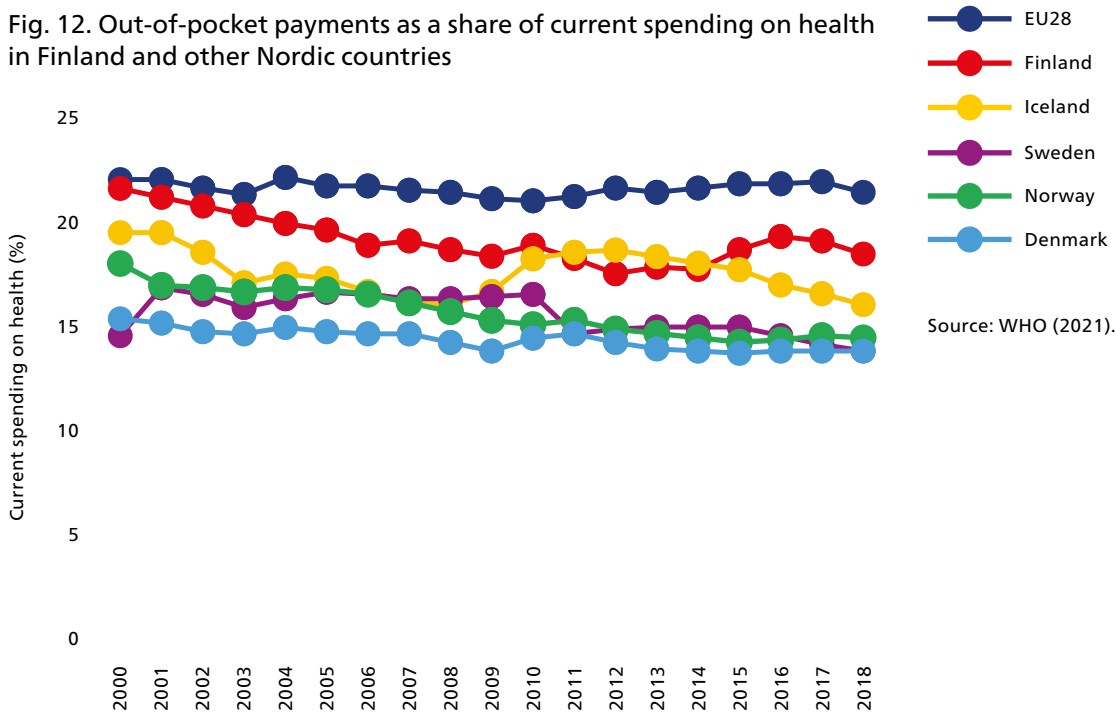
Public spending on health per person grew rapidly between 2000 and 2006, grew more slowly between 2006 and 2013 and has fallen since then (Fig. 11). In 2018 it was at the same level as it had been in 2011. Out-of-pocket payments followed a similar pattern initially, but growth largely continued until 2016, with falls seen in 2017 and 2018. Spending on VHI remains low but has grown over time.

Fig. 11. Health spending per person by financing agent, in real terms



In 2018 out-of-pocket payments accounted for 18% of current spending on health (Fig. 12). This is below the EU28 average of 21% but substantially higher than in other Nordic countries. The out-of-pocket payment share largely fell between 2000 and 2012, increased until 2016 and has decreased slightly since then.

Fig. 12. Out-of-pocket payments as a share of current spending on health in Finland and other Nordic countries



4.4 Summary

Over 85% of Finnish households pay for health care out of pocket, with average annual spending amounting to €621 per person in 2016. Out-of-pocket payments impose a heavier financial burden on poorer households than richer, accounting for around 5% of household budgets in the two poorest quintiles in 2016, compared to around 3.5% in the two richest.

Average household spending on health decreased slightly between 2006 and 2012 but increased in 2016, mainly driven by an increase in spending in the richest quintile.

In 2016 nearly 40% of out-of-pocket payments were spent on outpatient medicines, followed by 18% on outpatient care. The medicines share has remained stable over time but the outpatient care share has grown, particularly for the poorest quintile.

The overall increase in out-of-pocket payments between 2012 and 2016 was relatively small considering the substantial increase in user charges in 2016, although the effect of higher user charges for municipal health care can be seen in the increase in household spending on outpatient care. Increases in co-payments for outpatient prescribed medicines are likely to have been at least partly counterbalanced by a reduction in prices achieved through several policy measures targeting the supply side.

Following many years of growth, public spending on health per person has fallen in real terms since 2012, whereas out-of-pocket payments per person have increased slightly. Although the out-of-pocket payment share of current spending on health in Finland is below the EU average, it is substantially higher than in other Nordic countries.

5. Financial protection

This section uses data from the Finnish household budget survey to assess the extent to which out-of-pocket payments result in financial hardship for households that use health services. The section shows the relationship between out-of-pocket spending on health and risk of impoverishment, and presents estimates of the incidence, distribution and drivers of catastrophic out-of-pocket payments.

1. The basic needs line varies between renters (equivalized €614 per month in 2016) and non-renters (equivalized €336). It does not include other housing costs for non-renters, such as maintenance fees.

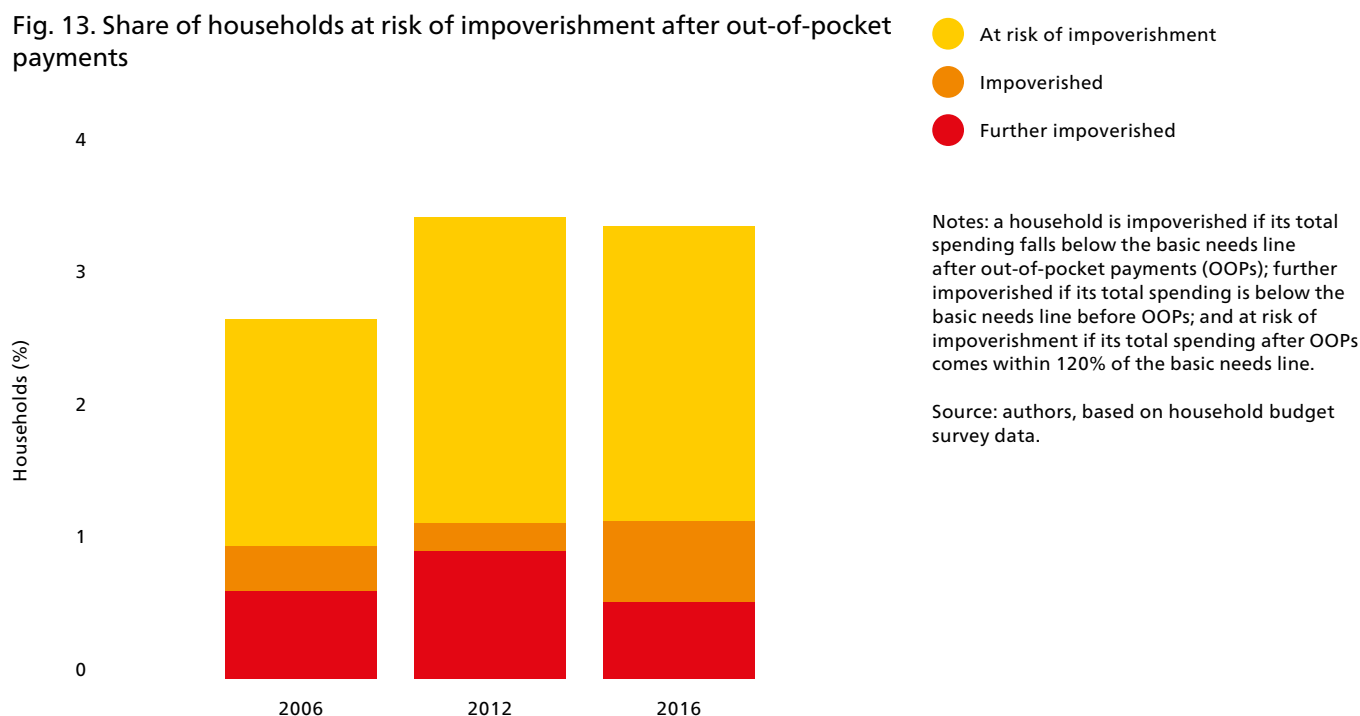
5.1 How many households experience financial hardship?

5.1.1 Out-of-pocket payments and risk of impoverishment

Fig. 13 shows the share of households at risk of impoverishment after out-of-pocket spending on health. The poverty line reflects the cost of spending on basic needs (food, rent and utilities) among a relatively poor part of the Finnish population (households between the 25th and 35th percentiles of the consumption distribution, adjusted for household size and composition). The monthly cost of meeting these basic needs in Finland – the basic needs line – was €772.50 per household on average in 2016.¹ This is very low compared to the at-risk-of-poverty line, defined as 60% of equivalized median income, which was €1752 per household in 2016. As a result, only around 1% of households were living below the basic needs line during the study period, compared to around 11% living below the at-risk-of-poverty line.

In 2016 3.3% of households were at risk of impoverishment, impoverished or further impoverished, up from 2.7% in 2006 (Fig. 13). The overall share of households with impoverishing health spending (households impoverished and further impoverished by out-of-pocket payments) has remained stable over time. The share of further impoverished households increased in 2012 and fell in 2016, while the share of impoverished households fell in 2012 and increased substantially in 2016.

Fig. 13. Share of households at risk of impoverishment after out-of-pocket payments



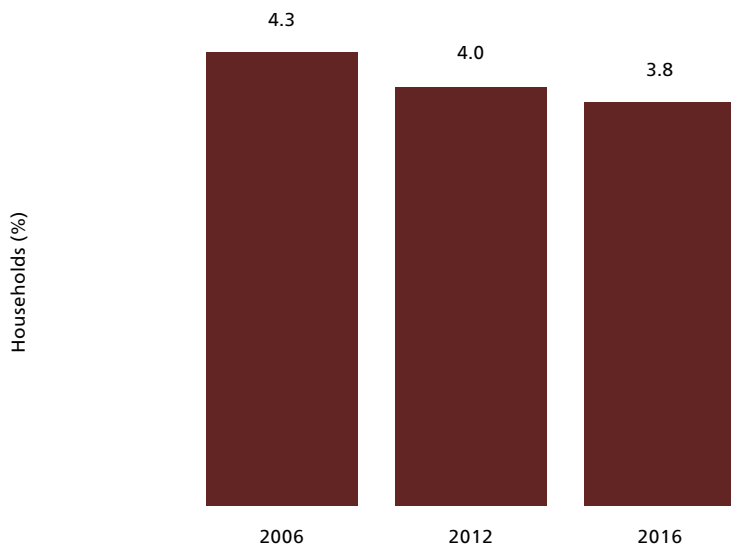
5.1.2 Catastrophic out-of-pocket payments

Households with catastrophic levels of out-of-pocket spending are defined here as those who spend more than 40% of their capacity to pay for health care. This includes households that are impoverished after out-of-pocket payments (because they no longer have any capacity to pay) and further impoverished (because they had no capacity to pay before paying out of pocket for health care).

In 2016 3.8% of households experienced catastrophic levels of spending on health care, down from 4.3% in 2006 (Fig. 14).

Fig. 14. Share of households with catastrophic out-of-pocket payments

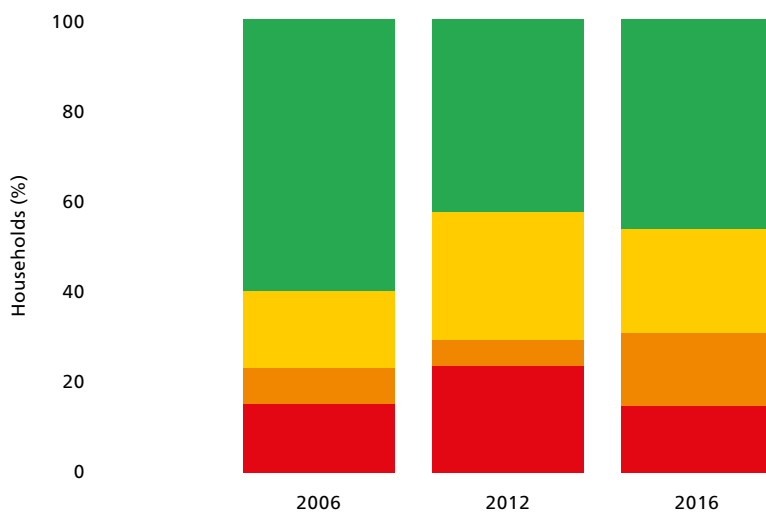
Source: authors, based on household budget survey data.



Catastrophic health spending is concentrated among households at risk of impoverishment and households who are impoverished or further impoverished (Fig. 15). Their share increased in 2012.

Fig. 15. Breakdown of households with catastrophic spending by risk of impoverishment

- Not at risk of impoverishment
- At risk of impoverishment
- Impoverished
- Further impoverished

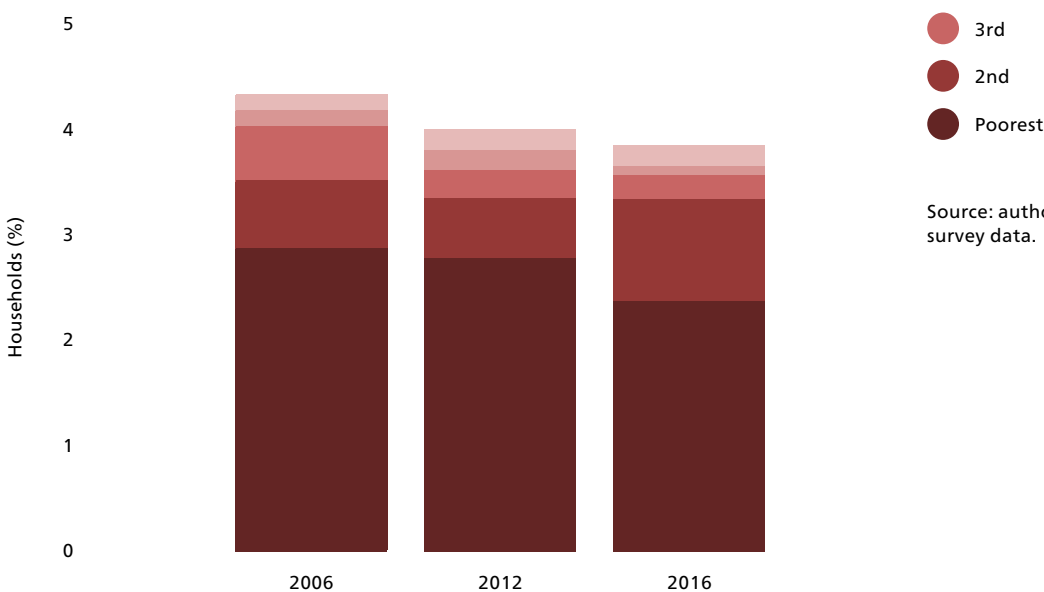


Source: authors, based on household budget survey data.

5.2 Who experiences financial hardship?

Catastrophic spending is highly concentrated in the two poorest quintiles (Fig. 16). Together, these quintiles accounted for 85% of households with catastrophic spending in 2016. Between 2012 and 2016 the incidence of catastrophic spending fell slightly in the poorest quintile and increased in the second poorest. In 2016 around 12% of households in the poorest quintile experienced catastrophic spending compared to around 5% in the second and less than 1% in the richest.

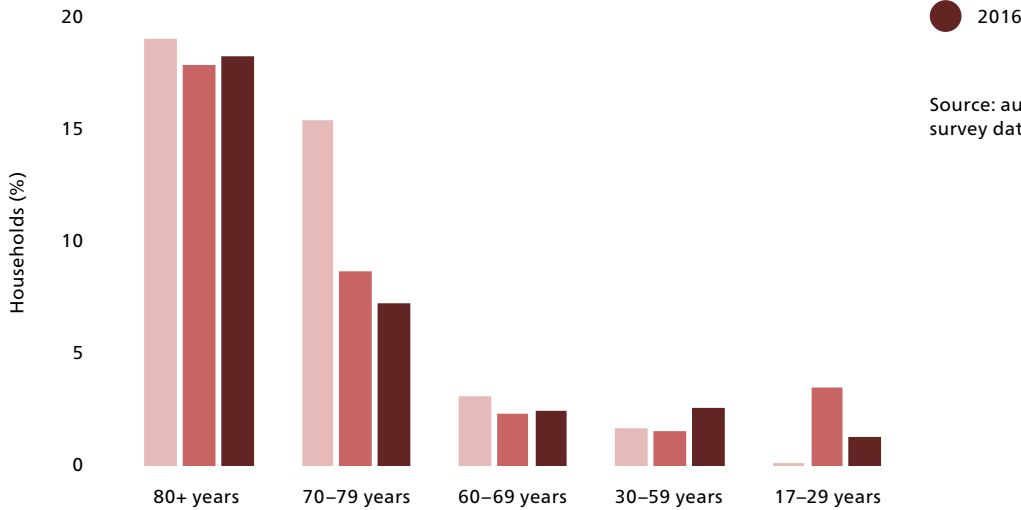
Fig. 16. Share of households with catastrophic spending by consumption quintile



Source: authors, based on household budget survey data.

The incidence of catastrophic spending rises with the age of the head of the household. It is higher than average in households headed by people aged 70–79 (7% in 2016) and particularly high in households headed by people aged over 80 (18%) (Fig. 17). Catastrophic incidence fell sharply among households headed by 70–79-year-olds between 2006 and 2012 but remained fairly stable among households headed by people aged over 80. This can be explained by a cohort effect: people who recently have retired generally are wealthier and this was particularly evident in 2012. In 2016 people aged over 80 were slightly wealthier than in 2012, but this is not reflected in lower incidence of catastrophic spending because their spending on health was also higher in 2016 than in 2012.

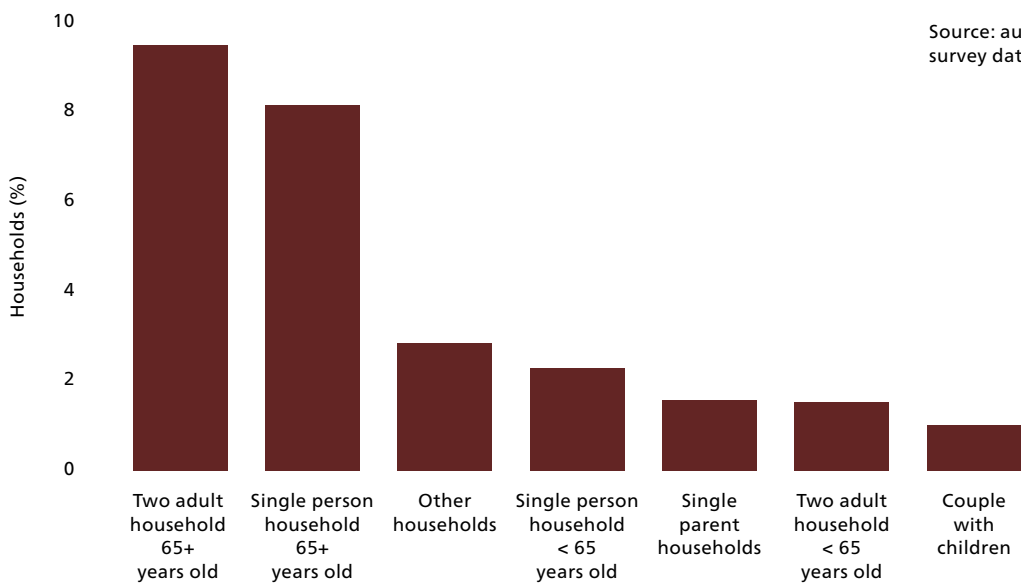
Fig. 17. Share of households with catastrophic spending by age of the head of the household



Source: authors, based on household budget survey data.

Fig. 18 confirms the pattern of the incidence of catastrophic spending being higher among older households.

Fig. 18. Share of households with catastrophic spending by household type in 2016



Notes: data available only for 2016. Children are defined as those younger than 18 years. Households with older children are included in other households.

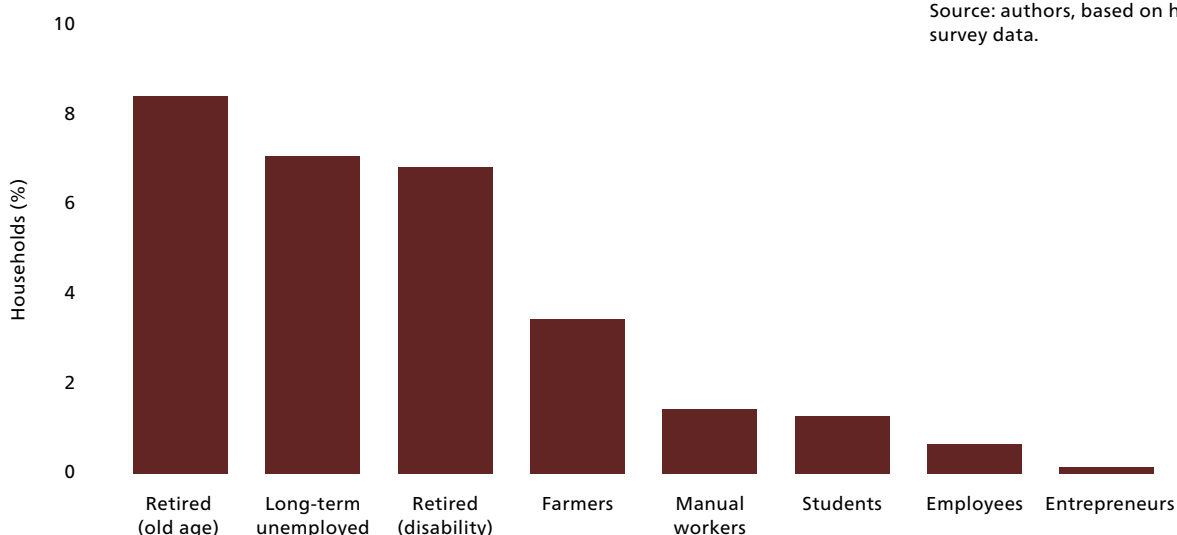
Source: authors, based on household budget survey data.

Looked at by socioeconomic status, in 2016 the incidence of catastrophic spending was much higher than average among people receiving pensions and those who were long-term unemployed (Fig. 19). The high incidence among long-term unemployed people reflects their low income and poor health status. For example: long-term unemployed people generally are older; people with rejected applications for disability pensions often remain on low-level unemployment benefits (Perhoniemi et al., 2020); and unemployed people experience relatively high levels of unmet need for health care due to waiting times (Keskimäki et al., 2019).

Fig. 19. Catastrophic health spending by the socioeconomic status of the head of the household, 2016

Note: retirement due to old age/disability is approximated from age, disability pensioners being those aged 61 years or less.

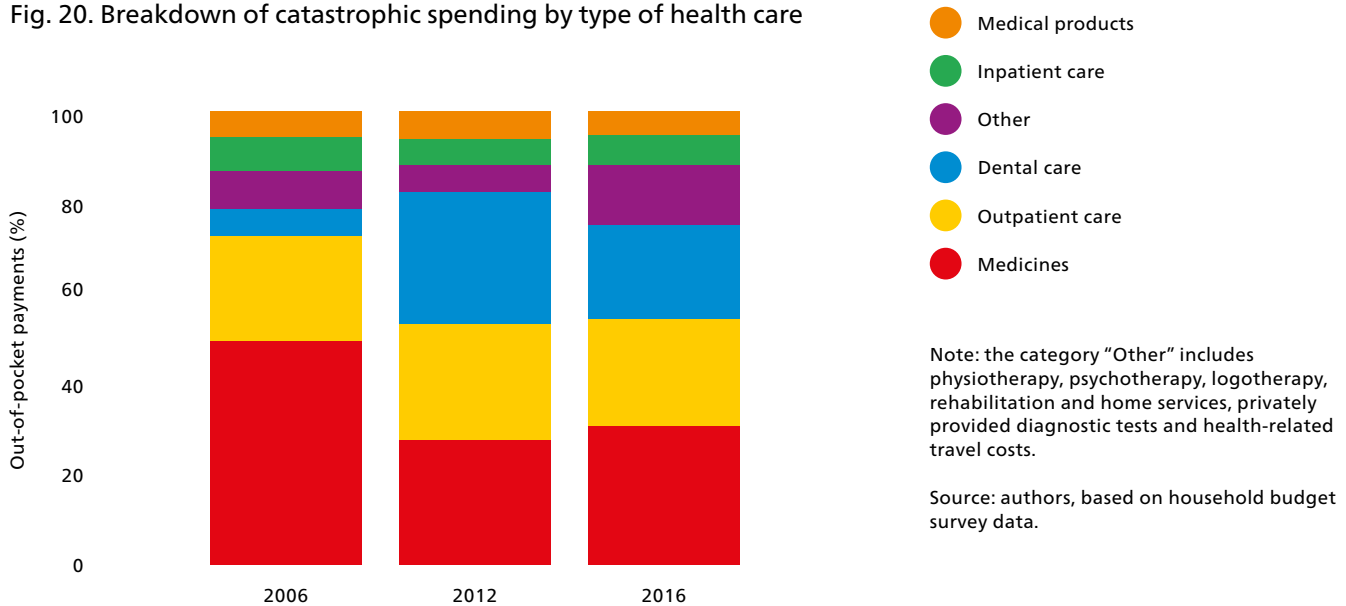
Source: authors, based on household budget survey data.



5.3 Which health services are responsible for financial hardship?

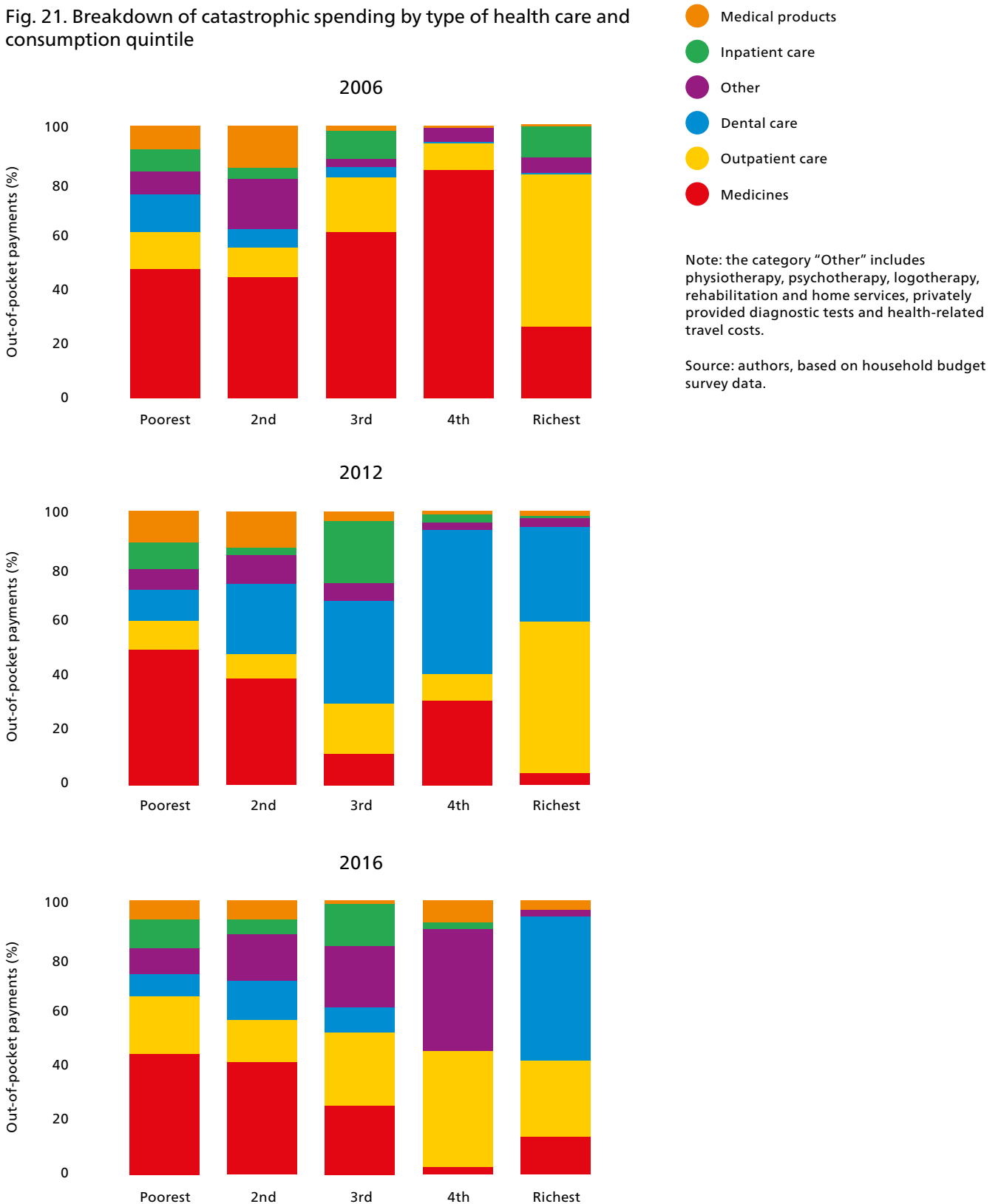
In 2016 the three main drivers of out-of-pocket payments among households with catastrophic spending were outpatient medicines (31%), outpatient care (23%) and dental care (21%) (Fig. 20). In comparison to all out-of-pocket payments, however (see Fig. 7), the inpatient care, dental care and outpatient care shares are larger among households with catastrophic spending, while the medical products and outpatient medicines shares are smaller. The outpatient medicines share of catastrophic out-of-pocket payments fell between 2006 and 2012 and that for dental care increased markedly then fell slightly between 2012 and 2016.

Fig. 20. Breakdown of catastrophic spending by type of health care



The breakdown of catastrophic out-of-pocket payments by type of health care varies across quintiles (Fig. 21). Among the poorer quintiles catastrophic out-of-pocket payments are spent mainly on outpatient medicines (over 40% in the first and second quintiles in all three years), but dental care is the main driver in the richest quintile (53% in 2016). However, the small sample size of households with catastrophic spending may cause random variation between the years, so the results for richer quintiles should be interpreted with caution.

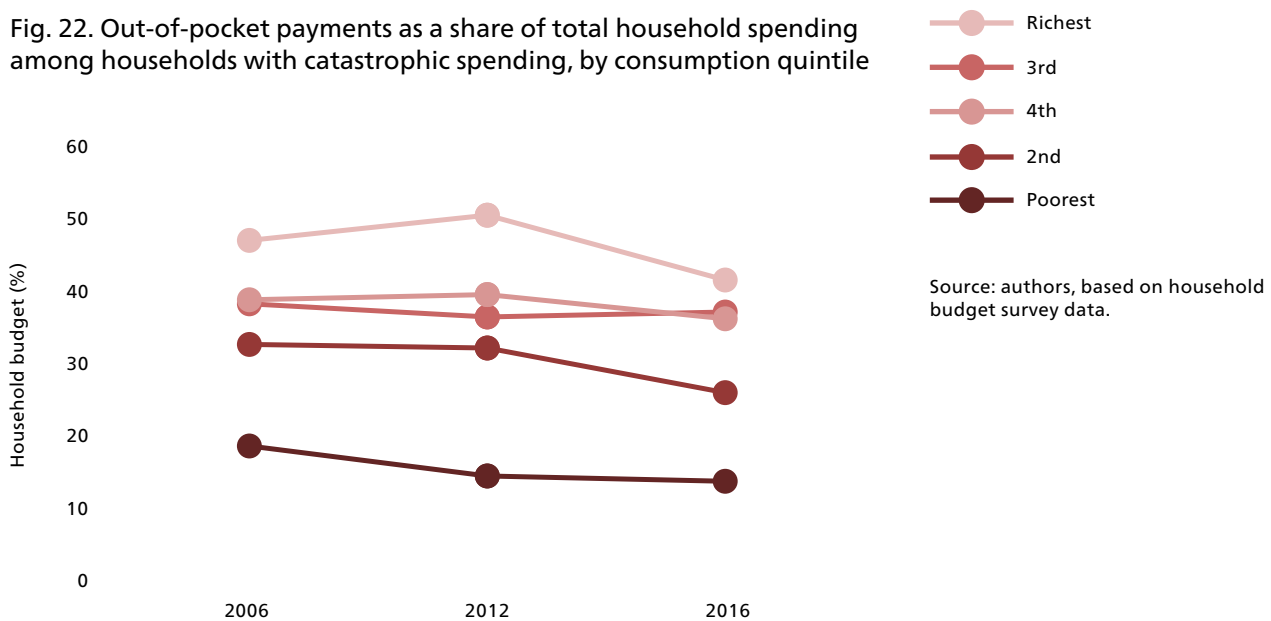
Fig. 21. Breakdown of catastrophic spending by type of health care and consumption quintile



5.4 How much financial hardship?

Among households with catastrophic spending, the amount spent on health as a share of total household spending rises progressively with income (Fig. 22). The magnitude of out-of-pocket payments among households with catastrophic spending has decreased over time in almost all quintiles.

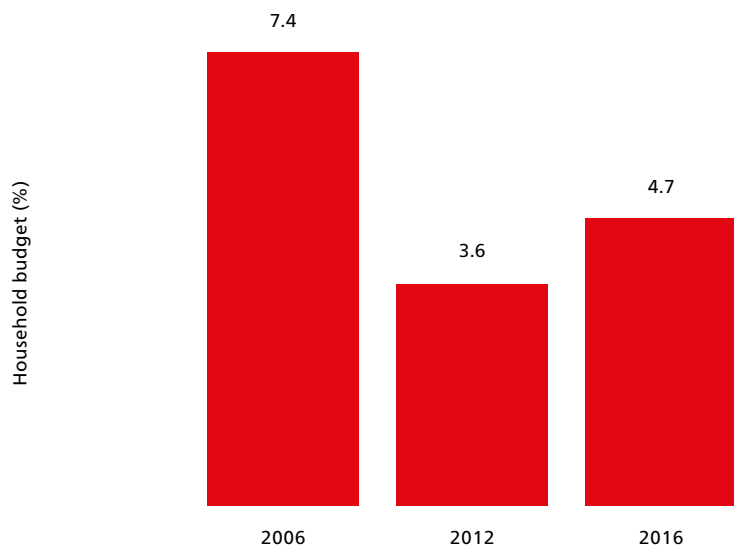
Fig. 22. Out-of-pocket payments as a share of total household spending among households with catastrophic spending, by consumption quintile



Among further impoverished households, the out-of-pocket payment share of total household spending has fluctuated during the study period, falling from 7.4% in 2006 to 3.6% in 2012, and increasing to 4.7% in 2016 (Fig. 23). The shares in 2006 and 2016 are higher than for the average household, which is approximately 4% (see Fig. 6).

Fig. 23. Out-of-pocket payments as a share of total household spending among further impoverished households

Source: authors, based on household budget survey data.



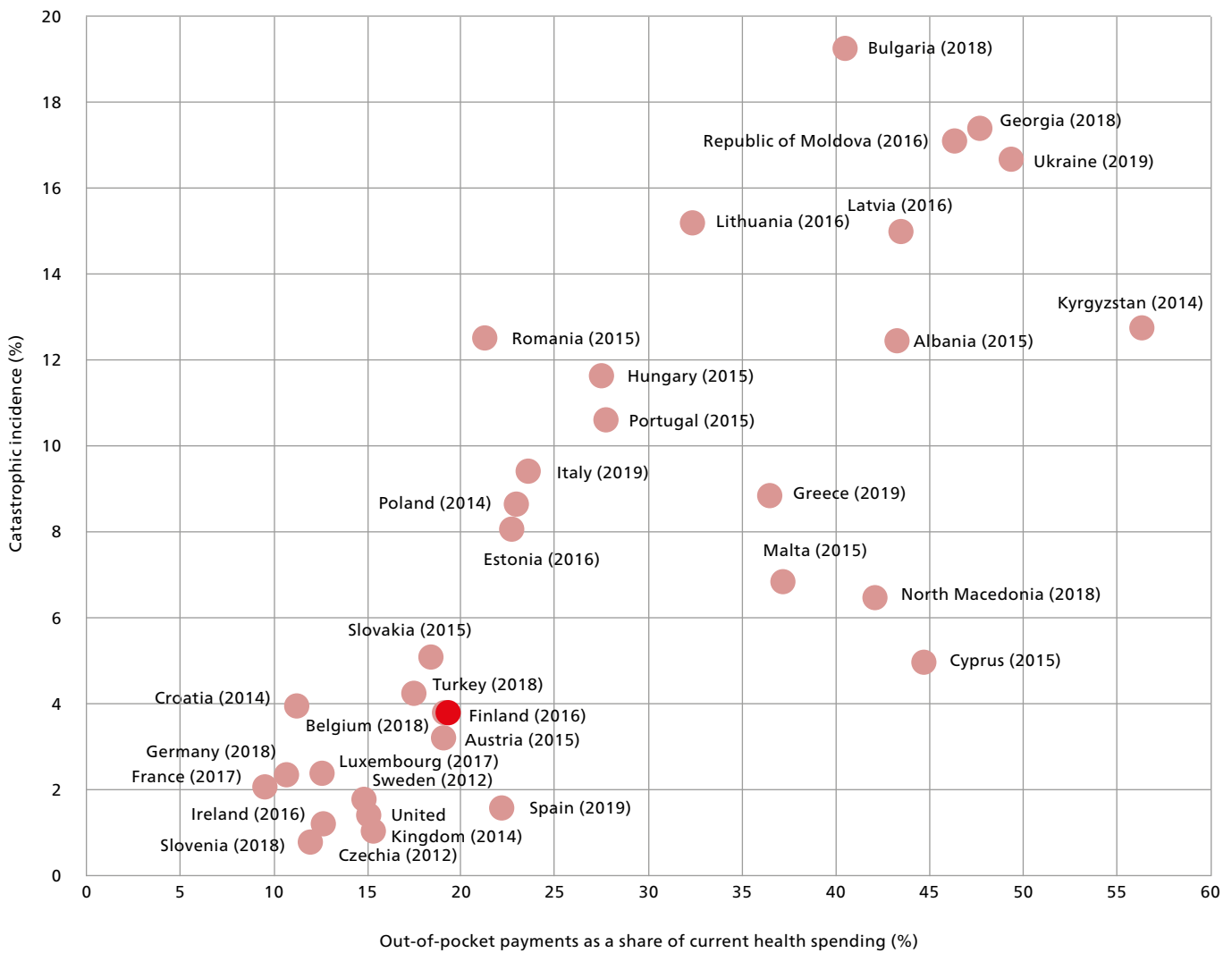
5.5 International comparison

The incidence of catastrophic health spending is relatively high in Finland compared to many other Nordic or western European countries (Fig. 24).

Fig. 24. Incidence of catastrophic health spending and the out-of-pocket payment share of current spending on health in selected European countries, latest year available.

Notes: data on out-of-pocket payments are for the same year as data on catastrophic health spending.

Source: WHO Barcelona Office for Health Systems Financing (catastrophic incidence) and WHO Global Health Expenditure Database (out-of-pocket payments).



5.6 Summary

In 2016 3.3% of households were further impoverished, impoverished or at risk of impoverishment due to out-of-pocket payments, up from 2.7% in 2006.

The share of households with catastrophic health spending was 3.8% in 2016, down from 4.3% in 2006.

The incidence of catastrophic health spending in Finland is relatively high compared to other Nordic countries and countries in western Europe.

Catastrophic spending is heavily concentrated among poorer and older households. In 2016 catastrophic spending was much higher than average (4%) in households in the poorest quintile (12%), households headed by or comprising older people (7% to 18%) and households headed by long-term unemployed people (7%) or disability pension recipients (7%).

Medicines account for the largest share of catastrophic spending, particularly in the poorer quintiles. Outpatient care and dental care also account for a substantial share. The dental care share fell between 2012 and 2016.

6. Factors that strengthen and undermine financial protection

This section considers the factors that may be responsible for financial hardship caused by out-of-pocket payments in Finland and could explain the trend over time. It begins by looking at factors outside the health system affecting people's capacity to pay for health care – for example, changes in income and the cost of living – and then looks at factors in the health system.

6.1 Factors affecting people's capacity to pay for health care

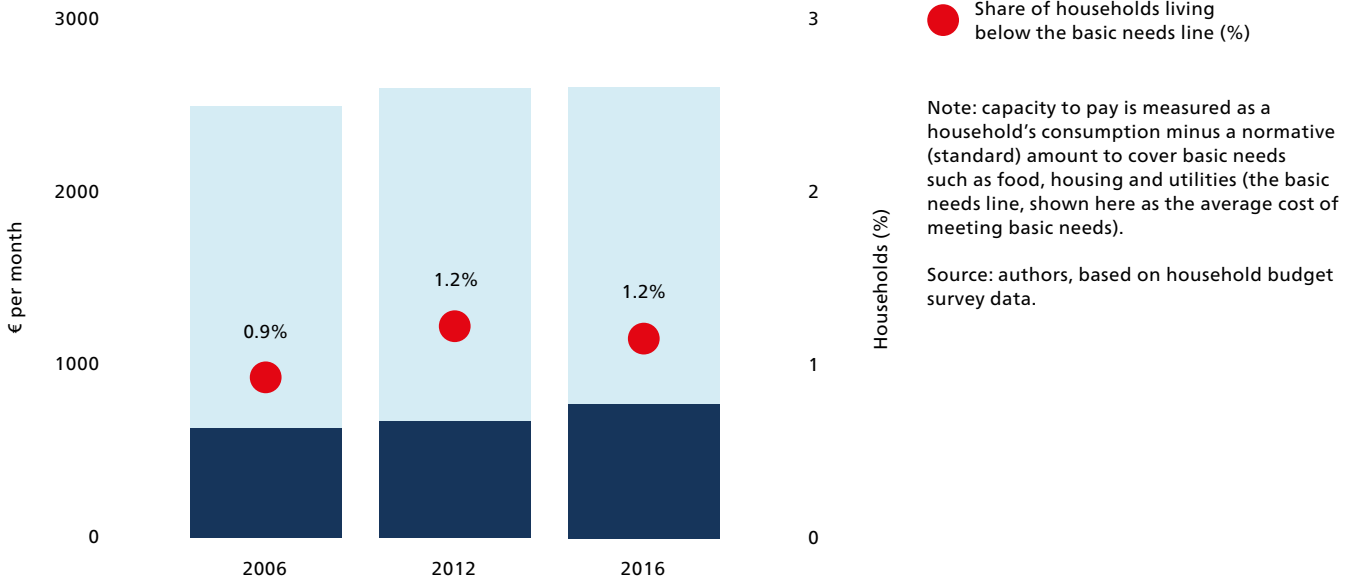
The following paragraphs draw on data from the household budget survey and other national sources to review changes in people's capacity to pay for health care.

Finland was hit hard by the 2008 global financial crisis. GDP fell by nearly 9% in 2009 and unemployment rose from 6.4% in 2008 to 8.4% in 2010 (Eurostat, 2021). By 2012, however, the economic situation had improved substantially. In addition, many social benefits increased between 2011 and 2015.

Household budget survey data indicate that average spending on basic needs (food, housing and utilities) increased steadily during the study period; average household capacity to pay grew between 2006 and 2012 but fell between 2012 and 2016. The share of households living below the basic needs line used in the study increased between 2006 and 2012. The increase in 2012 is reflected in an increase in the incidence of further impoverished households, but the incidence of further impoverished households fell again in 2016 (see Fig. 13), even though the share of households living below the basic needs line did not really change.

Once again, it should be stressed that the basic needs line used in this review is very low compared to the at-risk-of-poverty line (60% of median income). This partly reflects the fact that it does not include significant housing costs (maintenance fees) and partly Finland's protective system of social assistance, including a relatively generous minimum income scheme and non-contributory minimum benefits for some groups of people, such as those receiving pensions and long-term unemployed people. For example, only 1.2% of households were living below the basic needs line in 2016 (Fig. 25) compared to 2.4% of the population with severe material deprivation or 11.5% of the population living below the at-risk-of-poverty line (data not shown). When people with material deprivation and people in households with very low work intensity are combined with people below the at-risk-of-poverty line, the share rises to 15.7% in 2016, as shown in Fig. 26. This explains why a previous study (Tervola et al., 2020) found a slightly higher incidence of impoverishing health spending.

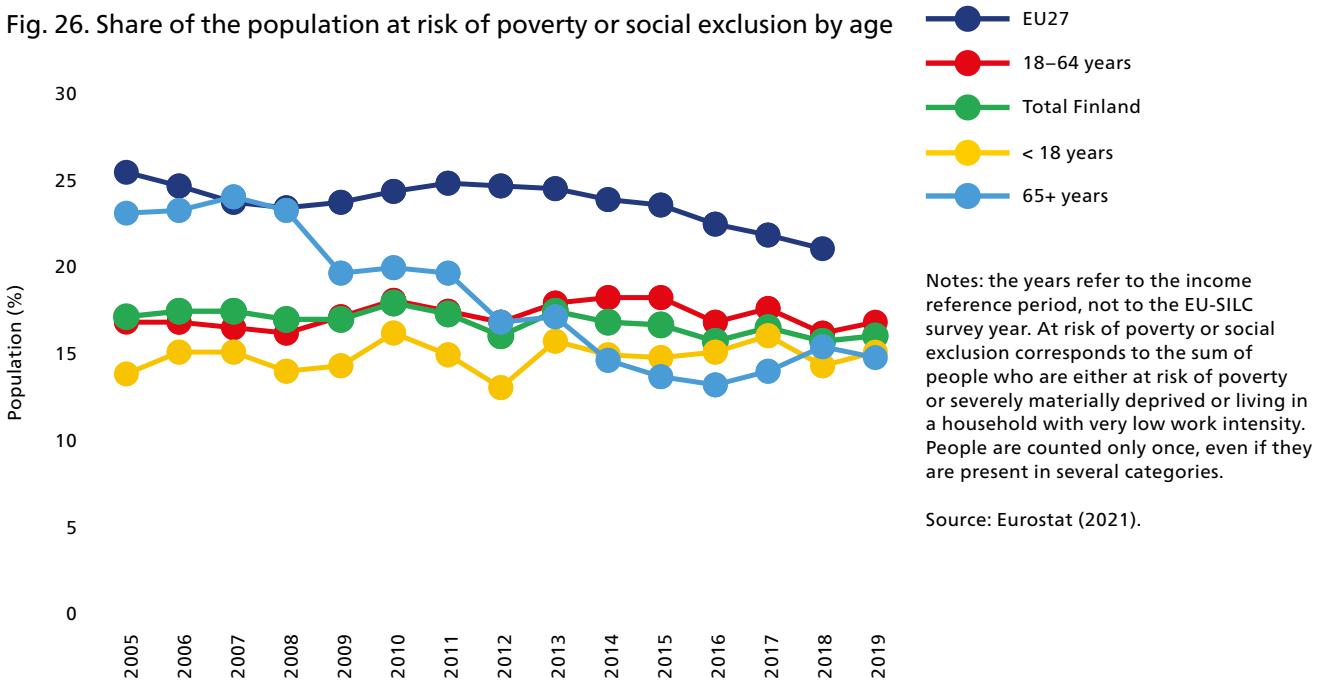
Fig. 25. Changes in the cost of meeting basic needs, capacity to pay and the share of households living below the basic needs line



The most visible impact of the economic crisis in national poverty data is in the reduction in relative poverty among older people between 2007 and 2012, reflecting a fall in median income that was mainly due to an increase in the unemployment rate; this had more of an impact on income among younger people (Fig. 26).

Taken together, these data suggest that relative stability in the incidence of impoverishing and catastrophic health spending between 2012 and 2016, despite policy changes that increased user charges (co-payments) for health care, reflects the protective effect of social assistance and increases in the minimum income scheme, which buffered the impact of higher user charges.

Fig. 26. Share of the population at risk of poverty or social exclusion by age



6.2 Health system factors

The following paragraphs consider spending on health, coverage policy and the health services that drive financial hardship.

6.2.1 Health spending

Public spending on health as a share of GDP was lower in Finland than in other Nordic countries in 2018 (Fig. 27). One reason for this is the low priority given to health when allocating the government budget in Finland in comparison to the other Nordic countries: just over 13% in Finland in 2018, compared to 17% in Denmark and Norway and nearly 19% in Sweden (Fig. 28). The health share of the government budget in Finland grew steadily between 2000 and 2006, fluctuated between 2006 and 2012 and fell steadily between 2012 and 2016. It was slightly lower in 2018 than it had been in 2006. As a result, public spending on health per person also fell during this period (see Fig. 11).

Fig. 27. Public spending on health and GDP per person in the EU, Iceland and Norway, 2018

Note: the figure excludes Ireland and Luxembourg.

Source: WHO (2021).

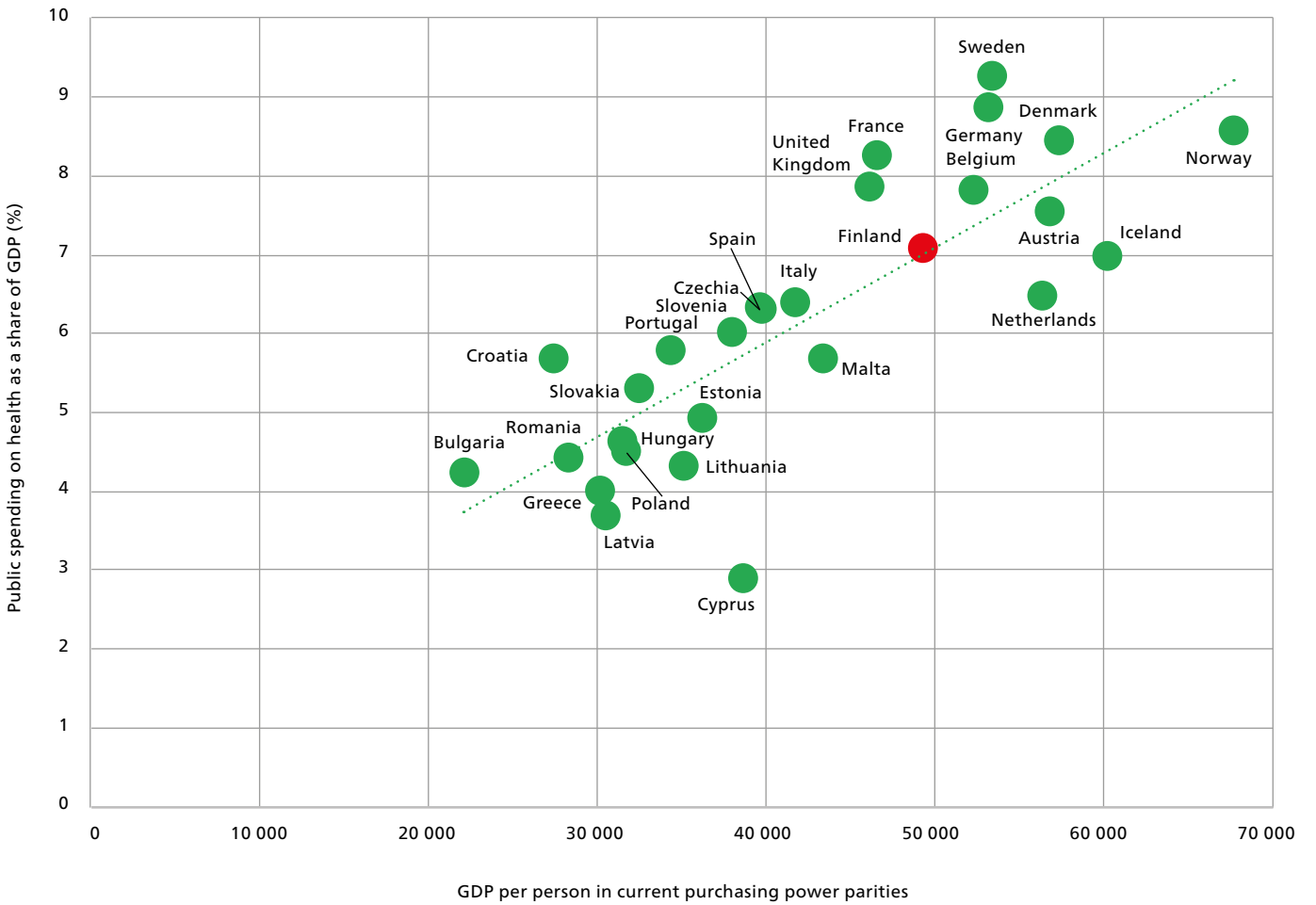


Fig. 28. Share of the government budget allocated to health in Finland and other Nordic countries

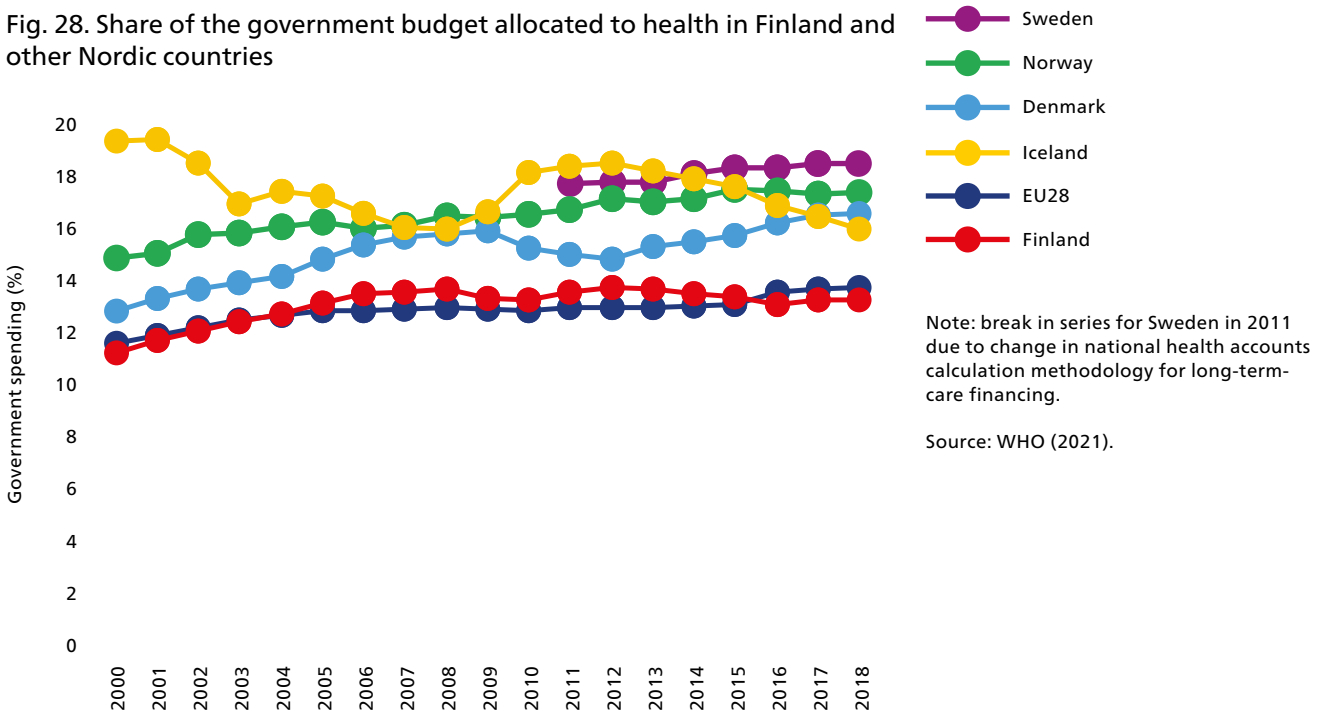
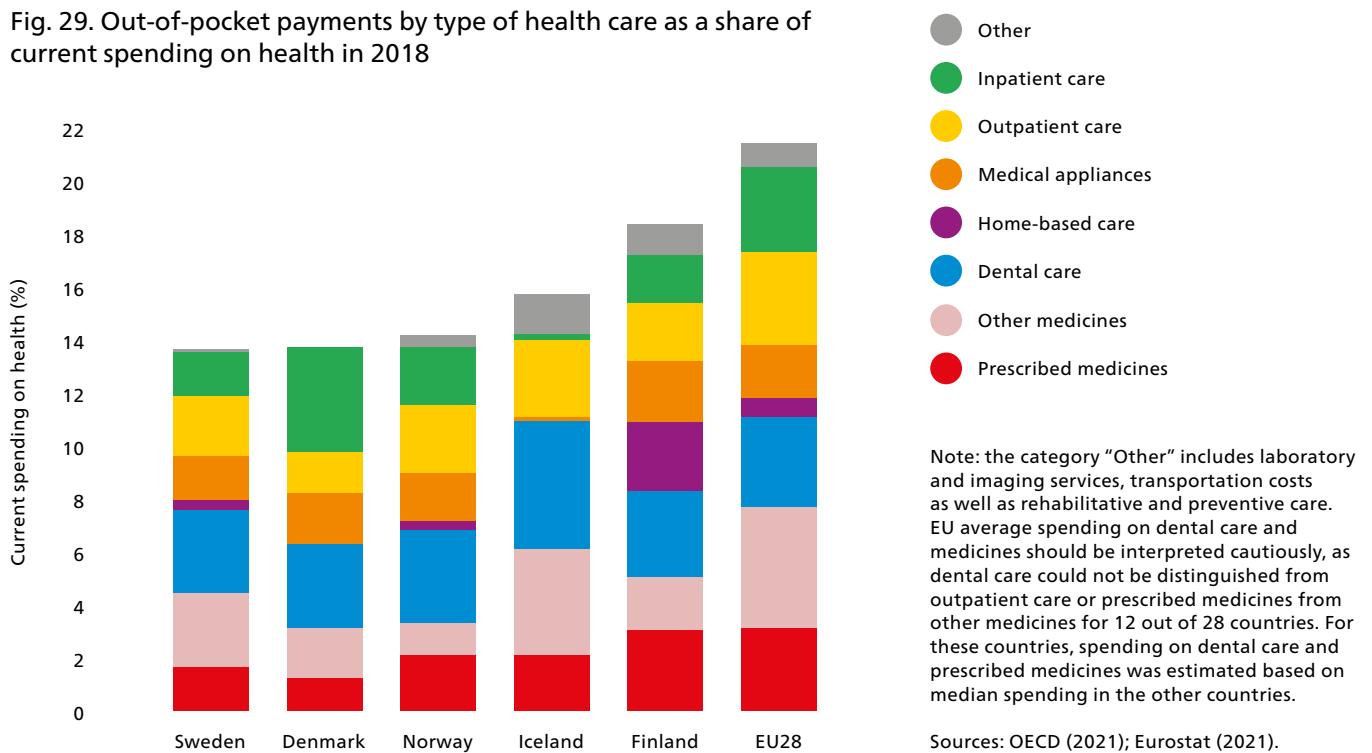


Fig. 29 shows that Finland’s higher reliance on out-of-pocket payments than that of other Nordic countries is largely driven by out-of-pocket payments for home-based care (including assisted housing) and prescribed medicines. Further analysis (data not shown) indicates that the high level of out-of-pocket payments for prescribed medicines is due to higher overall spending on prescribed medicines rather than a lower rate of coverage, whereas the higher level of out-of-pocket payments for home-based care is linked to the rate of coverage rather than overall spending on home care.

Fig. 29. Out-of-pocket payments by type of health care as a share of current spending on health in 2018



Note: the category "Other" includes laboratory and imaging services, transportation costs as well as rehabilitative and preventive care. EU average spending on dental care and medicines should be interpreted cautiously, as dental care could not be distinguished from outpatient care or prescribed medicines from other medicines for 12 out of 28 countries. For these countries, spending on dental care and prescribed medicines was estimated based on median spending in the other countries.

Sources: OECD (2021); Eurostat (2021).

6.2.2 Coverage policy

Coverage policy in Finland is unusually complex and has been subject to multiple increases in user charges (co-payments) in recent years.

A large part of the complexity comes from the existence of multiple coverage schemes with differences in **population entitlement**. Although all residents are entitled to publicly financed health services covered by municipal health care and the NHI scheme, most workers benefit from additional coverage through occupational health care (see Section 3). This double coverage exacerbates inequalities in access and financial protection in two main ways.

- People covered by occupational health care generally benefit from access to primary care services that are free at the point of use and faster access to primary and specialist care. Among people of working age,

those with higher income are more likely to use occupational health care, either exclusively or in combination with municipal and privately provided services (Blomgren & Virta, 2020). Conversely, working-age adults with lower income are more likely not to use any primary care services, leading to socioeconomic differences in health care use and unmet need (see Fig. 2).

- The NHI scheme offers some coverage of privately provided services, but because this coverage is limited, it mainly benefits people who are able to afford to pay out of pocket for privately provided care.

Publicly financed benefits packages are relatively broad in scope and include coverage of dental care. The main issues with **service coverage** are long waiting times for municipal health and dental care, with some regional variation, and gaps in the coverage of outpatient medicines.

- Municipalities have considerable autonomy in shaping the services they provide. As a result, their ability to meet population health needs and provide timely access to health services varies based on their financial situation: municipalities with wealthier and healthier residents and higher tax revenues are able to provide better service coverage than those with poorer and less healthy residents (Keskimäki et al., 2019).
- Although the range of covered outpatient medicines is quite broad, many prescribed medicines are not covered. About 20% of all prescriptions in the electronic prescription register in 2019 were for non-covered medicines (Kari & Rättö, 2020) and these medicines accounted for 28% of out-of-pocket payments for outpatient prescribed medicines in 2018 (Finnish Institute for Health and Welfare, 2020b). There is no comprehensive list of non-covered products, but a recent report identified topical and systemic medicines for pain, contraceptives, hypnotics, anxiolytics, tricyclic antidepressants, medicines for constipation and nasal decongestants as the most common non-covered products used by people receiving social assistance (Kari et al., 2020).

Widespread and heavy **user charges (co-payments)** are a major gap in coverage and play a large role in driving financial hardship. The following design aspects of Finland's complex co-payment policy are worth highlighting as areas of concern.

- User charges apply to almost all publicly financed health services, including primary care visits, emergency care and use of ambulance services.
- There is regional variation in people's exposure to co-payments, as municipalities have autonomy to determine their own co-payment policy, subject to maximum amounts defined in law. Municipalities with wealthier residents and higher tax revenues are able to offer people lower user charges – for example, Helsinki abolished co-payments for GP visits in 2013 but most other municipalities charge the maximum amount of €20.60 per visit (or €41.20 per year).
- Co-payments for outpatient prescribed medicines are mostly in the form of percentage co-payments, where people pay a share of the price, and the basic co-payment rate is high (60%). Percentage co-payments means

that people's exposure to out-of-pocket payments depends on the price and quantity of services they require. Unless the price is clearly known in advance, people may face uncertainty about how much they have to pay out of pocket. The negative effect of percentage co-payments is magnified for people with chronic conditions or a condition that requires higher-cost treatment when prices are relatively high or subject to fluctuation, and when physicians and pharmacists are not required, or do not have incentives, to prescribe and dispense cheaper alternatives (WHO Regional Office for Europe, 2019). The use of fixed co-payments instead of percentage co-payments for some medicines used to treat chronic or severe illness suggests that Finnish health authorities already recognize the negative effects percentage co-payments can have on people.

- Very few services or people are exempt from **co-payments**. **Exemptions** are almost always based on age (youth) rather than household income or health care need. For example, children under 18 years are exempt from co-payments for primary care visits, serial treatment and dental care. People with low income and no assets can apply for **social assistance** to cover co-payments for publicly financed health care, but social assistance is characterized by high levels of bureaucracy and low take-up rates (Tervola et al., 2021).
- The **annual co-payment ceilings** (see also Box 1) are fragmented and set at a high level: €683 per adult (which includes children's co-payments) for outpatient and inpatient municipal health care; €580 per individual for outpatient prescribed medicines; and €300 per individual for health-related travel. Together they amount to €1563 in 2021. The ceilings are limited in many other ways: co-payments for inpatient care and outpatient prescribed medicines continue beyond the ceilings, even if at a reduced rate; the ceiling for municipal health care does not apply to co-payments for dental care (although this is set to change in 2022); the outpatient prescribed medicines ceiling does not apply to co-payments for non-covered medicines; the ceilings place a financial burden on people at the beginning of each year; and while Kela automatically keeps track of people's co-payments and informs them once they have reached the ceilings for outpatient prescribed medicines or health-related travel costs, people have to keep track of their co-payments for municipal health care.

The mechanisms in place to protect people from co-payments do not seem to be enough to prevent financial hardship among disabled, long-term unemployed and older people. Household budget survey data indicate that these groups are disproportionately affected by out-of-pocket payments. In contrast, wealthier households mainly incur out-of-pocket payments linked to the use of supplementary and privately provided health services.

6.2.3 Health services

Household budget survey data indicate that out-of-pocket payments on average and in households with catastrophic health spending are spent mainly on outpatient medicines, outpatient care (especially municipal health care) and dental care (see Fig. 7 and Fig. 20). The role of outpatient medicines in driving financial hardship declined in 2012 for the richer quintiles as the role of dental care increased. In 2016 the role of outpatient care increased among the poorer quintiles.

The extent of out-of-pocket spending on **outpatient medicines** reflects heavy co-payments for covered medicines (an annual deductible of €50 plus percentage co-payments of 65% or 35%, or a fixed fee of €4.50), the absence of efforts to improve prescribing and relatively high use of non-covered medicines.

Between 2012 and 2016 there were multiple policy changes that aimed not only to increase co-payments but also to reduce the price of medicines, increase the range of generic alternatives (Koskinen, 2018) and enhance protection against co-payments (Aaltonen et al., 2017). As a result of this mix of policies pulling in different directions, average household spending on outpatient medicines increased only slightly during the study period. Recent studies have shown that people are sensitive to co-payment increases, however, with negative effects extending to people with chronic conditions (Hamina et al., 2020; Lavikainen et al., 2020; Rättö & Aaltonen, 2021).

Because the NHI covers outpatient prescribed medicines, municipalities have little financial incentive to strengthen prescribing. Clinical guidelines generally have not focused on cost-effectiveness, meaning that prescribers have considerable prescribing autonomy (Järvinen et al., 2016; Soppi et al., 2018). Strengthening prescribing guidance at all levels and increasing municipalities' responsibility for the cost of outpatient medicines would be a more effective way of controlling public spending on medicines than shifting costs onto households (Ministry of Social Affairs and Health, 2018; 2019).

During the study period, the balance of household spending on outpatient medicines shifted towards non-covered medicines, which are not subject to price regulation. Non-covered prescribed medicines, over-the-counter medicines and vitamins account for a substantial share of household spending on medicines but have not been subject to much policy debate, partly because they do not involve public budgets and partly due to limited data on their use. While most high-cost medicines and medicines for chronic conditions are covered, a range of everyday medicines and medical supplies are not covered and may result in financial hardship for poorer households.

Out-of-pocket payments for **outpatient care** reflect heavy co-payments, especially for municipal health services. Co-payments for municipal health care did not change much between 2006 and 2014 but were subject to a rise in 2015 and a further large rise in 2016. Co-payments for GP visits – €20.60 per visit for adults in 2021 – are higher than in most Nordic countries and among the highest in Europe.

These policy changes are clearly visible in household budget survey data, which show that out-of-pocket spending on outpatient care increased in real terms between 2012 and 2016, particularly for poorer quintiles. As a result, the outpatient care share of out-of-pocket payments among households with catastrophic spending also increased for all except the richest quintile, doubling among households in the two poorest quintiles. The effect might have been even stronger if some of the household budget survey data collection had not preceded the introduction of the higher co-payments; part of the survey took place in 2015 and some municipalities did not introduce the 2016 increase until later in the year (Haaga, 2019).

Out-of-pocket payments for **dental care** also reflect heavy co-payments for adults, without any annual co-payment ceiling (although this is set to change in 2022). These co-payments are not only a source of financial hardship, but also present a barrier to access and result in unmet need, particularly for poorer households (see Fig. 2). Household budget survey data indicate that in 2016 only 15% of households in the poorest quintile had spending on dental care, compared to 27% in the richest quintile. Restrictions to NHI coverage of privately provided health services in 2016, including dental care, reduced the use of privately provided dental care – an effect that can be seen in the household budget survey data used in this review (Blomgren et al., 2017; Linden & Nolvi, 2018).

In July 2021 some aspects of financial protection in municipal health care were strengthened and will be strengthened further from January 2022. Co-payments for nurse visits (charged in some municipalities) were abolished in July 2021, as were all co-payments for ambulatory care for children (people under 18 years). From January 2022 the ceiling on co-payments for municipal health care will be extended to include co-payments for municipal dental care and temporary home care and any co-payments reimbursed through social assistance.

6.3 Summary

The factors that undermine access and financial protection, with a disproportionate impact on poorer and older households, include the following:

- **long-standing issues in the governance of coverage policy:** multiple and overlapping coverage schemes, combined with regional variation in waiting times and co-payments, favour people in work and wealthier households, exacerbating income- and age-based inequalities in access and financial protection;
- **complex and heavy co-payments** for almost all health services, with inadequate protection mechanisms: there are very few exemptions from co-payments based on household income or health care needs; annual co-payment ceilings are fragmented, relatively high, do not apply to all co-payments and protect only a small share of households; and access to social assistance is limited;

- **gaps in the coverage of and weaknesses in purchasing outpatient medicines:** a range of everyday medicines and medical supplies are not covered, which may result in financial hardship for poorer households, and municipalities have little financial incentive to strengthen the way in which covered medicines are prescribed and dispensed; these problems are compounded by the use of percentage co-payments for covered medicines; and
- **relatively low levels of public investment in health:** this reflects the low priority given to health when allocating the government budget in Finland compared to other Nordic countries and results in heavier reliance on out-of-pocket payments to finance the health system.

Between 2012 and 2016 public spending on health fell and co-payments were increased, especially in 2016. Higher co-payments did not lead to higher incidence of impoverishing or catastrophic spending, perhaps due to social assistance, which protected poorer households, and improvement in the social benefits available to the poorest households. In addition, part of the 2016 household budget survey was carried out before the 2016 increase in user charges was implemented, so it may not have captured the full effect of the policy change.

Household budget survey data nevertheless do show some evidence of the impact of higher co-payments on households. First, health care costs were shifted on to households: out-of-pocket payments rose in areas where user charges were increased, such as outpatient municipal health care. Second, there is evidence of reduced use of privately provided dental care in 2016, indicating a potential increase in unmet need following reductions in NHI coverage of dental care. This is supported by EU-SILC data showing an increase in unmet need for dental care among poorer households in 2016.

New measures to reduce co-payments for municipal and dental care were introduced in July 2021 and will be strengthened further from January 2022. These measures are expected to address some gaps in coverage but will not focus on many of the factors that undermine financial protection.

7. Implications for policy

Financial protection is weaker in Finland than in other Nordic countries.

Close to 4% of Finnish households experience catastrophic health spending. Catastrophic spending is most likely to affect poorer people and households headed by people who are older, disabled or long-term unemployed.

Medicines account for the largest share of catastrophic spending, particularly among poorer households. Outpatient care and dental care also account for a substantial share.

Access to health services is weaker in Finland than in many other countries in western Europe. Around 5% of the population report unmet need for health services. Socioeconomic differences in unmet need are large.

Relatively high levels of unmet need and financial hardship are outcomes of Finland's complex and fragmented coverage policy. Due to the presence of multiple and overlapping publicly financed coverage schemes, regional variation in waiting times, co-payments for municipal health care and subsidies for privately provided services through the NHI scheme, access to health and dental care varies by employment status, employer, place of residence and ability to pay. Employed people, people living in wealthier parts of the country and people able to afford to pay for privately provided services benefit from faster access to primary and specialist care and face fewer co-payments than those who are unemployed, retired or self-employed. This not only undermines equity and efficiency but may also undermine public support for financing municipal health care.

Financial hardship is driven mainly by co-payments, which are applied to almost all publicly financed health services, including primary care, with relatively weak protection mechanisms. Co-payments generally are relatively high in Finland compared to other Nordic countries. During the study period there were multiple increases in co-payments for outpatient prescribed medicines and municipal health care, which increased out-of-pocket payments but did not increase the incidence of catastrophic health spending, perhaps due to social assistance. Despite efforts to strengthen protection from co-payments, protection mechanisms continue to be weak.

With the exception of long-term care, there are no legal co-payment exemptions based on household income or health care needs. Most exemptions are based on being young (under 18 years), even though the greatest health care need and catastrophic health spending are heavily concentrated among poorer and older people.

Social assistance covers co-payments for publicly financed care, but it is only available to the poorest households and non-take-up is common. Although Finland's robust social protection mechanisms have mitigated the impact of co-payment increases, the social assistance scheme covering co-payments is limited to residents with no assets and low income. People need to apply for protection from co-payments (it is not automatic) and the scheme is organized through a separate institution, which may cause low take-up.

Annual co-payment ceilings are fragmented, set at a high level, do not apply to all co-payments and protect only a small share of households.

Three separate annual co-payment ceilings (for municipal health care, covered outpatient medicines and health-related travel costs) together amount to €1563 in 2021. The ceilings for municipal health care and medicines are not actually a cap: once they have been reached people still have to pay co-payments, just at a reduced rate. In addition to these shortcomings, people have to keep track of how much they spend out of pocket on municipal health care and apply for protection once they reach the ceiling. As a result, only 7% of the population reach at least one ceiling and only 0.2% reach all three.

Gaps in coverage are exacerbated by weaknesses in the purchasing of outpatient medicines. The role of medicines in driving financial hardship, particularly among poorer households, reflects three main factors. First, there are substantial co-payments for covered medicines (an annual deductible of €50 plus percentage co-payments of 65% or 35%), with no exemptions from co-payments for anyone and a high ceiling of €580 a year per person. Second, non-covered medicines, including a range of everyday medicines and medical supplies, account for a growing share of out-of-pocket payments. Third, municipalities lack financial incentives to strengthen medicines policy, which has in the past relied relatively heavily on co-payments to curb public spending on health. More recently, the Ministry of Social Affairs and Health has recognized that paying more attention to improving the quality of prescribing and dispensing and increasing municipal responsibility for spending on outpatient medicines would help to control spending growth without shifting costs on to households (Ministry of Social Affairs and Health, 2018; 2019).

Inadequate coverage of dental care is a growing barrier to access. Heavy co-payments and waiting times for municipal dental care are sources of financial hardship for some households and increasingly present barriers to access. Between 2012 and 2016 reduced use of dental care led to a decline in out-of-pocket payments but was also associated with a sharp rise in unmet need.

There are several policy options to reduce unmet need and financial hardship linked to out-of-pocket payments. New measures to reduce co-payments for municipal health services, including dental care, were introduced in July 2021 and will be strengthened further from January 2022. These measures are expected to address some gaps in coverage but will not focus on many of the factors that undermine financial protection. Additional changes are expected as part of major health and social care reforms to be implemented in 2023; the content of these measures is still unknown, however.

In June 2021 an expert group appointed to consider the abolition of multiple funding streams in the health system published evaluations of potential reforms, such as the abolition of NHI reimbursement of privately provided health services (Ministry of Social Affairs and Health, 2021); no political decisions have yet been made in any direction.

Further measures to reduce unmet need and financial hardship should consider:

- limiting co-payments for outpatient care, especially primary care;
- strengthening protection for poorer households and people with high need for health care through an integrated proactive exemption scheme building on the current system of means-tested social assistance and introducing exemptions based on health care need;
- ensuring automatic (digital) monitoring of all co-payments to alleviate the administrative burden on people using services and improve the information base on financial protection;
- improving protective effects of ceilings by, for example, lowering and potentially merging the three co-payment ceilings into one ceiling that covers all co-payments for publicly financed health services and turning the ceiling into a genuine limit on co-payments, so that no further co-payments are required once the ceiling has been reached; and
- reducing reliance on co-payments to contain public spending on outpatient prescribed medicines and instead strengthening supply-side policies to promote better prescribing, dispensing and use of medicines.

Efforts to address gaps in coverage will benefit from additional public investment in health. Finland has low levels of public spending on health in comparison to other Nordic countries, resulting in relatively high levels of out-of-pocket payments. Increasing the priority given to health when allocating the government budget and using any new investment in health care to reduce access barriers for poor households and people with high health care needs will help to reduce unmet need and financial hardship.

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Annex 1. Household budget surveys in Europe

What is a household budget survey? Household budget surveys are national sample surveys that aim to measure household consumption of goods and services over a given period of time. In addition to information about consumption expenditure, they include information about household characteristics.

Why are they carried out? Household budget surveys provide valuable information on how societies and people use goods and services to meet their needs and preferences. In many countries, the main purpose of a household budget survey is to calculate weights for the Consumer Price Index, which measures the rate of price inflation as experienced and perceived by households (Eurostat, 2015). Household budget surveys are also used by governments, research entities and private firms wanting to understand household living conditions and consumption patterns.

Who is responsible for them? Responsibility for household budget surveys usually lies with national statistical offices.

Are they carried out in all countries? Almost every country in Europe conducts a household budget survey (Yerramilli et al., 2018).

How often are they performed? EU countries conduct a household budget survey at least once every five years, on a voluntary basis, following an informal agreement reached in 1989 (Eurostat, 2015). Many countries in Europe conduct them at more frequent intervals (Yerramilli et al., 2018).

What health-related information do they contain? Information on household consumption expenditure is gathered in a structured way, usually using the United Nations Classification of Individual Consumption According to Purpose (COICOP) (United Nations Statistics Division, 2018). A new European version of COICOP known as ECOICOP, intended to encourage further harmonization across countries, was introduced in 2016 (Eurostat, 2016).

Information on health-related consumption comes under COICOP code 6, which is further divided into three groups, as shown in Table A1.1. In this study, health-related information from household budget surveys is divided into six groups (with corresponding COICOP codes): medicines (06.1.1), medical products (06.1.2 and 06.1.3), outpatient care (06.2.1), dental care (06.2.2), diagnostic tests (06.2.3) and inpatient care (06.3).

In a very small minority of countries in Europe (Belgium, France, Luxembourg and Switzerland), people entitled to publicly financed health care may pay for treatment themselves, then claim or receive reimbursement from their publicly financed health insurance fund (OECD, 2019). In a wider range of countries, people may also be reimbursed by entities offering voluntary health insurance – for example, private insurance companies or occupational health schemes.

To avoid households reporting payments that are subsequently reimbursed, many household budget surveys in Europe specify that household spending on health should be net of any reimbursement from a third party such as the government, a health insurance fund or a private insurance company (Heijink et al., 2011).

Some surveys ask households about spending on voluntary health insurance. This is reported under a different COICOP code (12.5.3 Insurance connected with health, which covers "Service charges for private sickness and accident insurance") (United Nations Statistics Division, 2018).

Are household budget surveys comparable across countries?

Classification tools such as COICOP (and ECOICOP in Europe) support standardization, but they do not address variation in the instruments used to capture data (e.g. diaries, questionnaires, interviews, registers), response rates and unobservable differences such as whether the survey sample is truly nationally representative. Cross-national variation in survey instruments can affect levels of spending and the distribution of spending across households. It is important to note, however, that its effect on spending on health in relation to total consumption – which is what financial protection indicators measure – may not be so great.

An important methodological difference in quantitative terms is **owner-occupier imputed rent**. Not all countries impute rent and, among those that do, the methods used to impute rent vary substantially (Eurostat, 2015). In this series, imputed rent is excluded when measuring total household consumption.

Table A1.1. Health-related consumption expenditure in household budget surveys

Source: United Nations Statistics Division (2018).

| COICOP codes | Includes | Excludes |
|--|---|--|
| 06.1 Medical products, appliances and equipment 06.1.1 Pharmaceutical products 06.1.2 Other medical products 06.1.3 Therapeutic appliances and equipment | This covers medicaments, prostheses, medical appliances and equipment and other health-related products purchased by individuals or households, either with or without a prescription, usually from dispensing chemists, pharmacists or medical equipment suppliers. They are intended for consumption or use outside a health facility or institution. | Products supplied directly to outpatients by medical, dental and paramedical practitioners or to inpatients by hospitals and the like are included in outpatient services (06.2) or hospital services (06.3). |
| 06.2 Outpatient services 06.2.1 Medical services 06.2.2 Dental services 06.2.3 Paramedical services | This covers medical, dental and paramedical services delivered to outpatients by medical, dental and paramedical practitioners and auxiliaries. The services may be delivered at home or in individual or group consulting facilities, dispensaries and the outpatient clinics of hospitals and the like. Outpatient services include the medicaments, prostheses, medical appliances and equipment and other health-related products supplied directly to outpatients by medical, dental and paramedical practitioners and auxiliaries. | Medical, dental and paramedical services provided to inpatients by hospitals and the like are included in hospital services (06.3). |
| 06.3 Hospital services | Hospitalization is defined as occurring when a patient is accommodated in a hospital for the duration of the treatment. Hospital day care and home-based hospital treatment are included, as are hospices for terminally ill persons. This group covers the services of general and specialist hospitals; the services of medical centres, maternity centres, nursing homes and convalescent homes that chiefly provide inpatient health care; the services of institutions serving older people in which medical monitoring is an essential component; and the services of rehabilitation centres providing inpatient health care and rehabilitative therapy where the objective is to treat the patient rather than to provide long-term support. Hospitals are defined as institutions that offer inpatient care under the direct supervision of qualified medical doctors. Medical centres, maternity centres, nursing homes and convalescent homes also provide inpatient care, but their services are supervised and frequently delivered by staff of lower qualification than medical doctors. | This group does not cover the services of facilities (such as surgeries, clinics and dispensaries) devoted exclusively to outpatient care (06.2). Nor does it include the services of retirement homes for older people, institutions for disabled people and rehabilitation centres providing primarily long-term support (12.4). |

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Annex 2. Methods used to measure financial protection in Europe

Background

The indicators used for monitoring financial protection in Europe are adapted from the approach set out in Xu et al. (2003, 2007). They also draw on elements of the approach set out in Wagstaff & Eozenou (2014). For further information on the rationale for developing a refined indicator for Europe, see Thomson et al. (2016) and WHO Regional Office for Europe (2019).

Data sources and requirements

Preparing country-level estimates for indicators of financial protection requires nationally representative household survey data that includes information on household composition or the number of household members.

The following variables are required at household level:

- total household consumption expenditure;
- food expenditure (excluding tobacco and alcohol if possible);
- housing expenditure, disaggregated by rent and utilities (such as water, gas, electricity and heating); and
- health expenditure (out-of-pocket payments), disaggregated by type of health care good and service.

Information on household consumption expenditure is gathered in a structured way, usually using the United Nations Classification of Individual Consumption According to Purpose (COICOP) (United National Statistics Division, 2018).

If the survey includes a household sampling weight variable, calculations should consider the weight in all instances. Information on household or individual-level characteristics such as age, sex, education and location are useful for additional equity analysis.

Defining household consumption expenditure variables

Survey data come in various time units, often depending on whether the reporting period is 7 days, 2 weeks, 1 month, 3 months, 6 months or 1 year. It is important to convert all variables related to household consumption expenditure to a common time unit. To facilitate comparison with other national-level indicators, it may be most useful to annualize all survey data. If annualizing survey data, it is important not to report the average level of out-of-pocket payments only among households with out-of-pocket payments, as this will produce inaccurate figures.

Total household consumption expenditure not including imputed rent

Household consumption expenditure comprises both monetary and in-kind payment for all goods and services (including out-of-pocket payments) and the money value of the consumption of home-made products. Many household budget surveys do not calculate imputed rent. To maintain cross-country comparability with surveys that do not calculate imputed rent, imputed rent (COICOP code 04.2) should be subtracted from total consumption if the survey includes it.

Food expenditure

Household food expenditure is the amount spent on all foodstuffs by the household plus the value of the family's own food production consumed within the household. It should exclude expenditure on alcoholic beverages and tobacco. Food expenditure corresponds to COICOP code 01.

Housing expenditure on rent and utilities

Expenditure on rent and utilities is the amount spent by households on rent (only among households who report paying rent) and on utilities (only among households who report paying utilities) including electricity, heating and water. These data should be disaggregated to correspond to COICOP codes 04.1 (for rent) and 04.4 and 04.5 (for utilities). Care should be taken to exclude spending on secondary dwellings. Imputed rent (COICOP code 04.2) is not available in all household budget surveys and should not be used in this analysis.

Health expenditure (out-of-pocket payments)

Out-of-pocket payments refer to formal and informal payments made by people at the time of using any health service provided by any type of provider (COICOP code 06). Health services are any good or service delivered in the health system. These typically include consultation fees, payment for medications and other medical supplies, payment for diagnostic and laboratory tests and payments occurring during hospitalization. The latter may include a number of distinct payments such as to the hospital, to health workers (doctors, nurses, anaesthesiologists etc.) and for tests. Both cash and in-kind payments should be included if the latter are quantified in monetary value. Both formal and informal payments should also be included. Although out-of-pocket payments include spending on alternative or traditional medicine, they do not include spending on health-related transportation and special nutrition. It is also important to note that out-of-pocket payments are net of any reimbursement to households from the government, health insurance funds or private insurance companies.

Estimating spending on basic needs and capacity to pay for health care

Basic needs expenditure is a socially recognized minimum level of spending considered necessary to ensure sustenance and other basic personal needs. This report calculates household-specific levels of basic needs expenditure to estimate a household's capacity to pay for health care.

Households whose total consumption expenditure is less than the basic needs expenditure level generated by the basic needs line are deemed to be poor.

Defining a basic needs line

Basic needs can be defined in different ways. This report considers food, utilities and rent to be basic needs and distinguishes between:

- households that do not report any utilities or rent expenses; their basic needs include food;
- households that do not report rent expenses (households that own their home outright or make mortgage payments, which are not included in consumption expenditure data), but do report utilities expenses; their basic needs include food and utilities;
- households that pay rent, but do not report utilities expenditure (for example, if the reporting period is so short that it does not overlap with billing for utilities and there is no alternative reporting of irregular purchases); their basic needs include food and rent;
- households that report paying both utilities and rent, so that their basic needs include food, utilities and rent.

Adjusting households' capacity to pay for rent (among renters) is important. Household budget surveys consider mortgages to be investments, not consumption expenditure. For this reason most do not collect household spending on mortgages. Without subtracting some measure of rent expenditure from those who rent, renters will appear to be systematically wealthier (and have greater capacity to pay) than identical households with mortgages.

To estimate standard (normative) levels of basic needs expenditure, all households are ranked based on their per (equivalent) person total consumption expenditure. Households between the 25th and 35th percentiles of the total sample are referred to as the representative sample for estimating basic needs expenditure. It is assumed that they are able to meet, but not necessarily exceed, basic needs for food, utilities and rent.

In some countries it is common to finance out-of-pocket payments from savings or borrowing, which might artificially inflate a household's consumption and affect household ranking. Where this is an issue, it may be preferable to rank households by per equivalent person non-out-of-pocket payment consumption expenditure.

Calculating the basic needs line

To begin to calculate basic needs, a household equivalence scale should be used to reflect the economy scale of household consumption. The Organisation for Economic Co-operation and Development equivalence scale (the Oxford scale) is used to generate the equivalent household size for each household:

$$\text{equivalent household size} = 1 + 0.7 * (\text{number of adults} - 1) + 0.5 * (\text{number of children under 13 years of age})$$

Each household's total consumption expenditure (less imputed rent), food expenditure, utilities expenditure and rent expenditure is divided by the equivalent household size to obtain respective equivalized expenditure levels.

Households whose equivalized total consumption expenditure is between the 25th and 35th percentile across the whole weighted sample are the representative households used to calculate normative basic needs levels. Using survey weights, the weighted average of spending on food, utilities and rent among representative households that report positive values for food, utilities and rent expenditure, respectively, gives the basic needs expenditure per (equivalent) person for food, utilities and rent.

Note again that households that do not report food expenditure are excluded as this may reflect reporting errors. For households that do not report any rent or utilities expenses, only the sample-weighted food basic needs expenditure is used to represent total basic needs expenditure per (equivalent) person. For households that report utilities expenditures but do not report any rent expenses, the two basic needs expenditure sample-weighted averages for food and utilities are added to calculate total basic needs expenditure per (equivalent) person. For households that report rent expenditures but do not report any utilities expenses, the two basic needs expenditure sample-weighted averages for food and rent are added to calculate total basic needs expenditure per (equivalent) person. For households that report both rent and utilities, the three basic needs expenditure sample-weighted averages for food, utilities and rent are added to calculate total basic needs expenditure per (equivalent) person.

Calculating basic needs expenditure levels for each household

Calculate the basic needs expenditure specific to each household by multiplying the total basic needs expenditure per (equivalent) person level calculated above by each household's equivalence scale. Note that a household is regarded as being poor when its total consumption expenditure is less than its basic needs expenditure.

Capacity to pay for health care

This is defined as non-basic needs resources used for consumption expenditure. Some households may report total consumption expenditure that is lower than basic needs expenditure, which defines them as being poor. Note that if a household is poor, capacity to pay will be negative after subtracting the basic needs level.

Estimating impoverishing out-of-pocket payments

Measures of impoverishing health spending aim to quantify the impact of out-of-pocket payments on poverty. For this indicator, households are divided into five categories based on their level of out-of-pocket spending on health in relation to the poverty line (the basic needs line):

- no out-of-pocket payments: households that report no out-of-pocket payments;
- not at risk of impoverishment after out-of-pocket payments: non-poor households (those whose equivalent person total consumption exceeds the poverty line) with out-of-pocket payments that do not push them below 120% of the poverty line (i.e. households whose per equivalent person consumption net of out-of-pocket payments is at or above 120% of the poverty line);
- at risk of impoverishment after out-of-pocket payments: non-poor households with out-of-pocket payments that push them below 120% of the poverty line; this review uses a multiple of 120%, but estimates were also prepared using 105% and 110%;
- impoverished after out-of-pocket payments: households who were non-poor before out-of-pocket payments, but are pushed below the poverty line after out-of-pocket payments; in the exceptional case that capacity to pay is zero and out-of-pocket payments are greater than zero, a household would be considered to be impoverished by out-of-pocket payments; and
- further impoverished after out-of-pocket payments: poor households (those whose equivalent person total consumption is below the poverty line) who incur out-of-pocket payments.

Estimating catastrophic out-of-pocket payments

Catastrophic out-of-pocket payments are measured as out-of-pocket payments that equal or exceed some threshold of a household's capacity to pay for health care. Thresholds are arbitrary. The threshold used most often with capacity to pay measures is 40%. This review uses 40% for reporting purposes, but estimates were also prepared using thresholds of 20%, 25% and 30%.

Households with catastrophic out-of-pocket payments are defined as:

- those with out-of-pocket payments greater than 40% of their capacity to pay; i.e. all households who are impoverished after out-of-pocket payments, because their out-of-pocket payments are greater than their capacity to pay for health care; and
- those with out-of-pocket payments whose ratio of out-of-pocket payments to capacity to pay is less than zero (negative); i.e. all households who are further impoverished after out-of-pocket payments, because they do not have any capacity to pay for health care.

Households with non-catastrophic out-of-pocket payments are defined as those with out-of-pocket payments that are less than the pre-defined catastrophic spending threshold.

For policy purposes it is useful to identify which groups of people are more or less affected by catastrophic out-of-pocket payments (equity) and

which health services are more or less responsible for catastrophic out-of-pocket payments.

4. All weblinks accessed 19 July 2021.

Distribution of catastrophic out-of-pocket payments

The first equity dimension is expenditure quintile. Expenditure quintiles are determined based on equivalized per person household expenditure. Household weights should be used when grouping the population by quintile. Countries may find it relevant to analyse other equity dimensions such as differences between urban and rural populations, regions, men and women, age groups and types of household.

In some countries it is common to finance out-of-pocket payments from savings or borrowing, which might artificially inflate a household's consumption and affect household ranking. Where this is an issue, it may be preferable to calculate quintiles based on non-health equivalized per person household expenditure.

Structure of catastrophic out-of-pocket payments

For households in each financial protection category, the percentage of out-of-pocket payments on different types of health goods and services should be reported, if the sample size allows, using the following categories, with their corresponding COICOP categorization: medicines (06.1.1), medical products (06.1.2 and 06.1.3), outpatient care (06.2.1), dental care (06.2.2), diagnostic tests (06.2.3) and inpatient care (06.3). Where possible, a distinction should be made between prescription and over-the-counter medicines.

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Annex 3. Regional and global financial protection indicators

WHO uses regional and global indicators to monitor financial protection in the European Region, as shown in Table A3.1.

Table A3.1. Regional and global financial protection indicators in the European Region

| Regional indicators | + | Global indicators |
|---|---|---|
| Impoverishing out-of-pocket payments | | |
| Risk of poverty due to out-of-pocket payments: the proportion of households further impoverished, impoverished, at risk of impoverishment or not at risk of impoverishment after out-of-pocket payments using a country-specific line based on household spending to meet basic needs (food, housing and utilities) | | Changes in the incidence and severity of poverty due to household expenditure on health using: <ul style="list-style-type: none"> • an extreme poverty line of PPP-adjusted US\$ 1.90 per person per day • a poverty line of PPP-adjusted US\$ 3.10 per person per day • a relative poverty line of 60% of median consumption or income per person per day |
| Catastrophic out-of-pocket payments | | |
| The proportion of households with out-of-pocket payments greater than 40% of household capacity to pay for health care | | The proportion of the population with large household expenditure on health as a share of total household consumption or income (greater than 10% or 25% of total household consumption or income) |

Note: PPP: purchasing power parity.

Sources: WHO headquarters and WHO Regional Office for Europe.

Regional indicators

The regional indicators reflect a commitment to the needs of European Member States. They were developed by the WHO Barcelona Office for Health Systems Financing (part of the Division of Country Health Policies and Systems in the WHO Regional Office for Europe), at the request of the WHO Regional Director for Europe, to meet demand from Member States for performance measures more suited to high- and middle-income countries and with a stronger focus on pro-poor policies, in line with Regional Committee resolutions (see Annex 2).

At the regional level, WHO's support for monitoring financial protection is underpinned by the Tallinn Charter: Health Systems for Health and Wealth, Health 2020 and resolution EUR/RC65/R5 on priorities for health systems strengthening in the WHO European Region 2015–2020, all of which include the commitment to work towards a Europe free of impoverishing payments for health.

Global indicators

The global indicators reflect a commitment to global monitoring. They enable the performance of Member States in the European Region to be

easily compared to the performance of Member States in the rest of the world.

At the global level, support by WHO for the monitoring of financial protection is underpinned by World Health Assembly resolution WHA64.9 on sustainable health financing structures and universal coverage, which was adopted by Member States in May 2011. More recently, with the adoption of the 2030 Agenda for Sustainable Development and its concomitant Sustainable Development Goals (SDGs) in 2015, the United Nations has recognized WHO as the custodian agency for SDG3 (Good health and well-being: ensure healthy lives and promote well-being for all at all ages) and specifically for target 3.8 on achieving universal health coverage, including financial risk protection, access to quality essential health care services and access to safe, effective, quality and affordable essential medicines and vaccines for all. Target 3.8 has two indicators: 3.8.1 on coverage of essential health services and 3.8.2 on financial protection when using health services.

The choice of global or regional indicator has implications for policy

Global and regional indicators provide insights into the incidence and magnitude of financial hardship associated with out-of-pocket payments for health, but they do so in different ways. As a result, they may have different implications for policy and suggest different policy responses.

For example, the global indicator defines out-of-pocket payments as catastrophic when they exceed a fixed percentage of a household's consumption or income (its budget). Applying the same fixed percentage threshold to all households, regardless of wealth, implies that very poor households and very rich households spending the same share of their budget on health will experience the same degree of financial hardship.

Global studies find that this approach results in the incidence of catastrophic out-of-pocket payments being more concentrated among richer households (or less concentrated among poorer households) (WHO & World Bank 2015; 2017). With this type of distribution, the implication for policy is that richer households are more likely to experience financial hardship than poorer households. The appropriate policy response to such a finding is not clear.

In contrast, to identify households with catastrophic out-of-pocket payments, the regional indicator deducts a standard amount representing spending on three basic needs – food, housing (rent) and utilities – from each household's consumption expenditure. It then applies the same fixed percentage threshold to the remaining amount (which is referred to as the household's capacity to pay for health care). As a result, although the same threshold is applied to all households, the amount to which it is applied is now significantly less than total household consumption for poorer households but closer to total household consumption for richer households. This implies that very poor households spending small amounts on out-of-pocket payments, which constitute a relatively small share of their total budget, may experience financial hardship, while wealthier households are assumed to not experience hardship until they

have spent a comparatively greater share of their budget on out-of-pocket payments.

The approach used in the European Region results in the incidence of catastrophic out-of-pocket payments being highly concentrated among poor households in all countries (Cylus et al., 2018). For countries seeking to improve financial protection, the appropriate response to this type of distribution is clear: design policies that protect poorer households more than richer households.

Recent global studies most commonly report impoverishing out-of-pocket payments using absolute poverty lines set at US\$ 1.90 or US\$ 3.10 a day in purchasing power parity (WHO & World Bank 2015; 2017). These poverty lines are found to be too low to be useful in Europe, even among middle-income countries. For example, the most recent global monitoring report suggests that in 2010 only 0.1% of the population in the WHO European Region was impoverished after out-of-pocket payments using the US\$ 1.90 a day poverty line (0.2% at the US\$ 3.10 a day poverty line) (WHO & World Bank, 2017).

European studies make greater use of national poverty lines or poverty lines constructed to reflect national patterns of consumption (Yerramilli et al., 2018). While national poverty lines vary across countries, making international comparison difficult, poverty lines constructed to reflect national patterns of consumption – such as that which is used as the poverty line for the regional indicator – facilitate international comparison (Saksena et al., 2014).

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Annex 4. Glossary of terms

Ability to pay for health care: Ability to pay refers to all the financial resources at a household's disposal. When monitoring financial protection, an ability to pay approach assumes that all of a household's resources are available to pay for health care, in contrast to a capacity to pay approach (see below), which assumes that some of a household's resources must go towards meeting basic needs. In practice, measures of ability to pay are often derived from household survey data on reported levels of consumption expenditure or income over a given time period. The available data rarely capture all of the financial resources available to a household – for example, resources in the form of savings and investments.

Basic needs: The minimum resources needed for sustenance, often understood as the consumption of goods such as food, clothing and shelter.

Basic needs line: A measure of the level of personal or household income or consumption required to meet basic needs such as food, housing and utilities. Basic needs lines, like poverty lines, can be defined in different ways. They are used to measure impoverishing out-of-pocket payments. In this study the basic needs line is defined as the average amount spent on food, housing and utilities by households between the 25th and 35th percentiles of the household consumption distribution, adjusted for household size and composition. Basic needs line and poverty line are used interchangeably. See poverty line.

Budget: See household budget.

Cap on benefits: A mechanism to protect third-party payers such as the government, a health insurance fund or a private insurance company. A cap on benefits is a maximum amount a third-party payer is required to cover per item or service or in a given period of time. It is usually defined as an absolute amount. After the amount is reached, the user must pay all remaining costs. Sometimes referred to as a benefit maximum or ceiling.

Cap on user charges (co-payments): A mechanism to protect people from out-of-pocket payments. A cap on user charges is a maximum amount a person or household is required to pay out of pocket through user charges per item or service or in a given period of time. It can be defined as an absolute amount or as a share of a person's income. Sometimes referred to as an out-of-pocket maximum or ceiling.

Capacity to pay for health care: In this study capacity to pay is measured as a household's consumption minus a normative (standard) amount to cover basic needs such as food, housing and utilities. This amount is deducted consistently for all households. It is referred to as a poverty line or basic needs line.

Catastrophic out-of-pocket payments: Also referred to as catastrophic health spending. An indicator of financial protection. Catastrophic out-of-pocket payments can be measured in different ways. This study defines them as out-of-pocket payments that exceed 40% of a household's

capacity to pay for health care. The incidence of catastrophic health spending includes households who are impoverished and households who are further impoverished.

Consumption: Also referred to as consumption expenditure. Total household consumption is the monetary value of all items consumed by a household during a given period. It includes the imputed value of items that are not purchased but are procured for consumption in other ways (for example, home-grown produce).

Co-payments (user charges or user fees): Money people are required to pay at the point of using health services covered by a third party such as the government, a health insurance fund or a private insurance company. *Fixed co-payments* are a flat amount per good or service; *percentage co-payments* (also referred to as co-insurance) require the user to pay a share of the good or service price; *deductibles* require users to pay up to a fixed amount first, before the third party will cover any costs. Other types of user charges include *balance billing* (a system in which providers are allowed to charge patients more than the price or tariff determined by the third-party payer), *extra billing* (billing for services that are not included in the benefits package) and *reference pricing* (a system in which people are required to pay any difference between the price or tariff determined by the third-party payer – the reference price – and the retail price).

Equivalent person: To ensure comparisons of household spending account for differences in household size and composition, equivalence scales are used to calculate spending levels per equivalent adult in a household. This review uses the Oxford scale (also known as the Organisation for Economic Co-operation and Development equivalence scale), in which the first adult in a household counts as one equivalent adult, subsequent household members aged 13 years or over count as 0.7 equivalent adults and children under 13 count as 0.5 equivalent adults.

Exemption from user charges (co-payments): A mechanism to protect people from out-of-pocket payments. Exemptions can apply to groups of people, conditions, diseases, goods or services.

Financial hardship: People experience financial hardship when out-of-pocket payments are large in relation to their ability to pay for health care.

Financial protection: The absence of financial hardship when using health services. Where health systems fail to provide adequate financial protection, households may not have enough money to pay for health care or to meet other basic needs. Lack of financial protection can lead to a range of negative health and economic consequences, potentially reducing access to health care, undermining health status, deepening poverty and exacerbating health and socioeconomic inequalities.

Further impoverished households: Poor households (those whose equivalent person total consumption is below the poverty line or basic needs line) who incur out-of-pocket payments.

Health services: Any good or service delivered in the health system, including medicines, medical products, diagnostic tests, dental care, outpatient care and inpatient care. Used interchangeably with health care.

Household budget: Also referred to as total household consumption. The sum of the monetary value of all items consumed by the household during a given period and the imputed value of items that are not purchased but are procured for consumption in other ways.

Household budget survey: Usually national sample surveys, often carried out by national statistical offices, to measure household consumption over a given period of time. Sometimes referred to as household consumption expenditure or household expenditure surveys. European Union countries are required to carry out a household budget survey at least once every five years.

Impoverished households: Households who were non-poor before out-of-pocket payments, but are pushed below the poverty line or basic needs line after out-of-pocket payments.

Impoverishing out-of-pocket payments: Also referred to as impoverishing health spending. An indicator of financial protection. Out-of-pocket payments that push people into poverty or deepen their poverty. A household is measured as being impoverished if its total consumption was above the national or international poverty line or basic needs line before out-of-pocket payments and falls below the line after out-of-pocket payments.

Informal payment: a direct contribution made in addition to any contribution determined by the terms of entitlement, in cash or in kind, by patients or others acting on their behalf, to health care providers for services to which patients are entitled.

Out-of-pocket payments: Also referred to as household expenditure (spending) on health. Any payment made by people at the time of using any health good or service provided by any type of provider. Out-of-pocket payments include: formal co-payments (user charges or user fees) for covered goods and services; formal payments for the private purchase of goods and services; and informal payments for covered or privately purchased goods and services. They exclude pre-payment (for example, taxes, contributions or premiums) and reimbursement of the household by a third party such as the government, a health insurance fund or a private insurance company.

Poverty line: A level of personal or household income or consumption below which a person or household is classified as poor. Poverty lines are defined in different ways. This study uses basic needs line and poverty line interchangeably. See basic needs line.

Quintile: One of five equal groups (fifths) of a population. This study commonly divides households into quintiles based on per equivalent person household consumption. The first quintile is the fifth of households with the lowest consumption, referred to in the study as the poorest quintile; the fifth quintile has the highest consumption, referred to in the study as the richest quintile.

Risk of impoverishment after out-of-pocket payments: After paying out of pocket for health care, a household may be further impoverished, impoverished, at risk of impoverishment or not at risk of impoverishment. A household is at risk of impoverishment (or not at risk of impoverishment) if its total spending after out-of-pocket payments comes close to (or does not come close to) the poverty line or basic needs line.

Universal health coverage: Everyone can use the quality health services they need without experiencing financial hardship.

Unmet need for health care: An indicator of access to health care. Instances in which people need health care but do not receive it due to access barriers.

User charges: Also referred to as user fees. See co-payments.

Utilities: Water, electricity and fuels used for cooking and heating.

The WHO Regional Office for Europe

The World Health Organization (WHO) is a specialized agency of the United Nations created in 1948 with the primary responsibility for international health matters and public health. The WHO Regional Office for Europe is one of six regional offices throughout the world, each with its own programme geared to the particular health conditions of the countries it serves.

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ISBN 978-92-890-5600-7



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