

Health Care

in Finland



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Medicines

In Finland, only pharmacies have the right to sell medicines. This provision applies equally to prescription medicines and over-the-counter medicines. Licences to run a pharmacy are issued by the National Agency for Medicines, which operates under the Ministry of Social Affairs and Health. There are about 800 pharmacy branches in Finland.

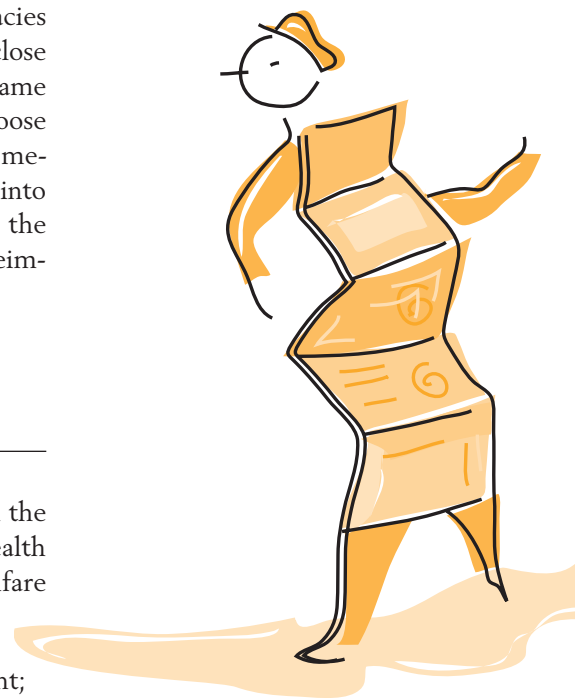
In 2003, the Social Insurance Institution reimbursed approximately 28 million prescriptions with a total value of EUR 1.4 billion. On average, a reimbursed drug prescription cost EUR 52.

The cost of medicinal products is rising continuously, although the trend has been curbed to some degree by generic substitution, which came into effect in 2003. Generic substitution means that pharmacies are required to offer clients a generic alternative with the lowest or close to the lowest price, which contains the same active substance in the same amount as the prescribed medicinal product. The client is free to choose whether he or she wishes to substitute a cheaper alternative for the medicinal product. Legislation concerning generic substitution entered into force in April 2003, resulting in savings of over EUR 63 million in the course of a year, i.e. just above four per cent of the total cost of reimbursed medicinal products.

The Rights of the Patient

Finland has legislation covering the rights of the patient. The Act on the Status and Rights of Patients applies to every part of the general health care system and also to health care services provided in social welfare institutions. Under the provisions of the Act:

- treatment cannot be given without the consent of the patient;
- the patient's agreement must also be obtained as to the forms of treatment;



- patients must, if they so request, be given information on their state of health, the extent of the proposed treatment, any risk factors, and possible alternative forms of treatment;
- the patients are entitled to see and correct the information entered in their own patient record;
- those on a waiting list for treatment must be told the reason for the delay and its estimated duration;
- patients dissatisfied with their treatment are entitled to lodge a complaint with the establishment concerned;
- establishments providing medical treatment must have a patient ombudsman, whose duty is to inform patients of their rights and assist them, if necessary, in submitting a complaint, appeal or claim for indemnity;
- the opinion of young patients must be taken into account if they have reached a stage of development at which they are able to express an opinion. The stage of development is assessed by a doctor or other health care professional;
- a child's parent or guardian is not entitled to refuse treatment that would avert a health risk or save the life of an underage person.

Time Limits for Accessing Medical Care

Legislation entered into force in 2005 defining the time frame in which a person must be ensured access to necessary medical care. The law refers to the small percentage of all treatments that are considered to be of a non-urgent nature. Working groups of experts representing various fields have defined the grounds for accessing medical care with respect to their specialist areas. In addition to this, doctors comply with Current Care guidelines regarding different diseases while assessing the necessary treatment. All of the guidelines are recommendations; in the final analysis it

is the doctor who decides independently on the necessary treatment for each patient.

Health centres must provide immediate contact by telephone, and the required treatment must be assessed at the health centre within three working days from the point of contact. An assessment does not necessarily require visiting the health centre in person; it can be provided over the telephone and may also be issued by some other health care professional besides a doctor. In primary health care, the treatment that has been assessed as necessary must be accessible within three months. The prescribed time frame may be exceeded by three months in oral health care and specialized medical care provided under primary health care, if the treatment can be postponed on justifiable grounds without jeopardizing the patient's state of health.

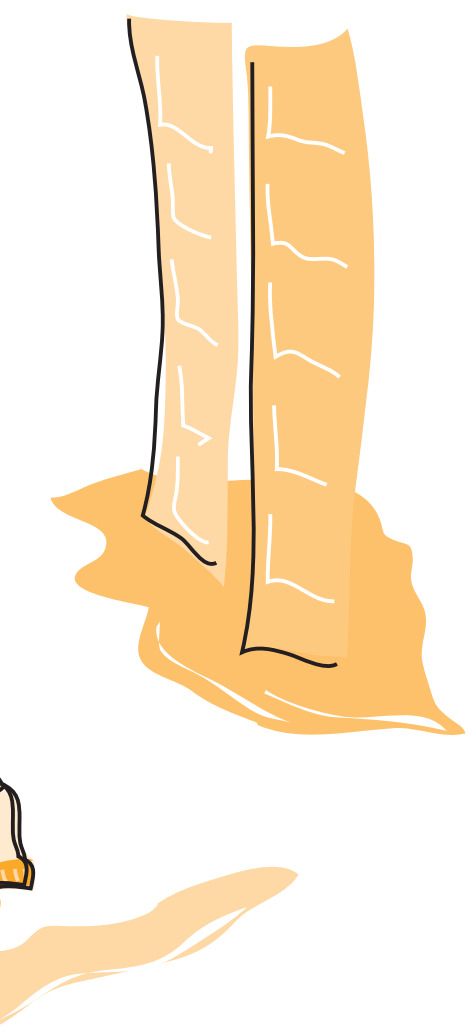
In specialized medical care, an assessment of the required treatment must be arranged within three weeks from the date that the referral has arrived at a health care unit, such as a hospital outpatient department. The necessary hospital treatment must be accessible within six months. If unable to arrange examinations and treatment within the time frame, the local authority or joint municipal board is responsible for arranging for the treatment of the patient at some other hospital without a change to the client fee.

In mental health care services for children and young people, treatment must be arranged within three months, unless related medical or treatment issues require otherwise.

Patient Insurance

Health and medical care establishments and practitioners must be insured against the risk of injury to patients. Patients are covered for bodily injury incurred in the course of health care or medical treatment. Pay-



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ment of compensation is not dependent on an error, carelessness or negligence on the part of health care staff. Compensation is not paid for an injury in connection with a procedure known to involve the risk of such an injury, nor is compensation paid for a medically minor injury.

Health Care Professionals

The work of health care staff is regulated by the Act on Health Care Professionals. The purpose of the Act is to promote the safety of patients and the provision of high-quality health care services by ensuring that health care staff receive proper professional training and are generally qualified and competent to perform their duties.

Responsibility for professional training in health care lies with the Ministry of Education, while overall supervision of health care staff comes within the remit of the Ministry of Social Affairs and Health. The National Authority for Medicolegal Affairs and the State Provincial Offices also supervise and monitor the work of health care professionals by, for example, handling complaints regarding health care professionals.

In addition to professional training, certain categories of health care professionals also require official authorization or a license to practice their profession. Authorization and licenses for health care professionals are granted by the National Authority for Medicolegal Affairs.

Although some categories of health care professionals do not require official authorization to practice their profession, in the interests of patient safety and consumer protection it is reasonable that clients should be able to confirm the status and competence of the person treating them. Such professional groups are defined by decree, and their members are entitled to use a legally protected occupational title as conferred by diploma.

Health Insurance

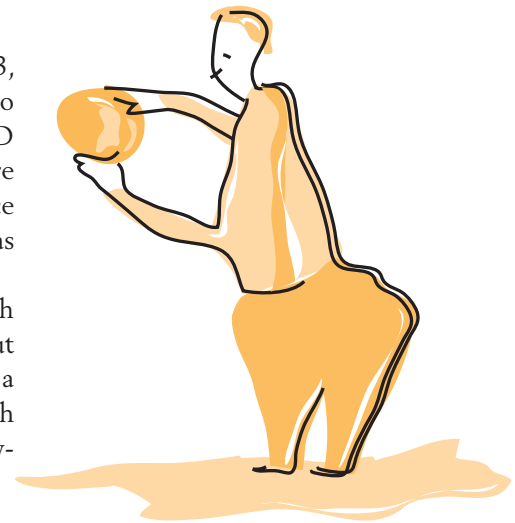
The system of national health insurance administered by the Social Insurance Institution supplements the public health care system by refunding some of the costs incurred by the client in using private health care services and of medicines used in outpatient care. It also reimburses rehabilitation and travel costs. A daily allowance is payable in compensation for sickness that continues for a maximum of twelve months and is causing a loss of income. The level of the daily allowance is determined by the applicant's taxable yearly income.

National health insurance is funded through contributions by employers and insured employees. The government is responsible for ensuring the adequacy of the health insurance funds.

Health Care Economics

Health care in Finland is primarily funded from tax revenue. In 2003, total health care expenditure was almost EUR 11 billion, amounting to 7.6 per cent of GDP, which is still below the average for the OECD countries. In 2002, municipalities funded 43 per cent of total health care expenditure, while the government funded 17 per cent, health insurance 16 per cent, households 20 per cent and other private bodies (such as insurance companies) 4 per cent.

In 2002, the share of client fees in the funding of municipal health care services was approximately 8 per cent, while municipalities paid out 67 per cent and the government 25 per cent. Local authorities receive a government grant for social welfare and health care, the level of which depends on the municipality's population, age distribution, unemployment rate and other related factors.



Client Fees in Public Health Care

(in 2005)

Preventive health care, such as the services of maternity and child health clinics, are free of charge. Under-18s do not have to pay for health centre outpatient services, such as an appointment with a doctor or dentist, but may be required to pay a daily charge for up to 7 days for treatment on a ward of a health centre or hospital.

Health Centre Client Fees

Visiting the maternity or child health clinic, appointments with a public nurse, and laboratory and X-ray examinations are free of charge at a health centre.

A health centre may charge a single or annual payment for doctor's appointments. A single payment is EUR 11, which can be charged for a maximum of three appointments, i.e. EUR 33 per calendar year. An annual payment is a maximum of EUR 22 per calendar year.

A fee of EUR 15 can be charged for a visit to the health centre emergency clinic on weekdays between 8 p.m. and 8 a.m., on Saturdays, on Sundays and on bank holidays.

Clients aged 15 and above may be required to pay a penalty charge of EUR 27 for unattended appointments.

The basic fee for dental care is a maximum of EUR 7. On top of this, a fee can be charged for the treatment administered, such as EUR 5–45 for a filling. The applicable fees are listed in a chart of procedures.

Hospital Fees

Hospitals may charge for a visit to an outpatient department, an outpatient surgery procedure, a daily hospital fee, a series of treatment and rehabilitation.

A hospital outpatient department fee is a maximum of EUR 22 per visit, while the fee for an outpatient surgery procedure is a maximum of EUR 72. The daily charge is EUR 26 in a hospital and EUR 12 in a psychiatric hospital, covering examinations, treatment, medicine and meals. A maximum of EUR 12 is charged for day or night care at hospital.

A maximum of 80 per cent of a patient's monthly income is charged for long-term hospital or institutional care, ensuring that at least EUR 80 remains available for the patient's personal use.

With regard to a series of treatments, EUR 6 is charged for each appointment up to 45 appointments a year. A series of treatments may comprise dialysis treatment, radiographic or cytostatic treatment and medical rehabilitation.

A daily fee of EUR 9 can be incurred by an establishment for the rehabilitation of a disabled or mentally handicapped person.

A maximum fee of EUR 27 can be charged for a medical certificate depending on the type of certificate.

Home Nursing Fees

The fees for nursing provided at home depend on whether the care is occasional or continual. A maximum of EUR 11 per visit is charged for occasional treatment by a doctor or a dentist, while EUR 7 is charged for a visit by some other health care professional.

A monthly fee is incurred for continual treatment, which depends on the quality and extent of the service, as well as the patient's monthly income and family size.

Ceiling for Health Care Fees

Within public health care, client fees have an annual ceiling of EUR 590, after which clients principally receive outpatient services free of charge. The daily charge for short-term institutional care is reduced to EUR 12.

The payment ceiling for parents covers the fees of their under-18-year-old children.

The payment ceiling applies to health centre outpatient doctor's appointments, physiotherapy, a series of treatment, hospital outpatient department fees, outpatient surgery fees and fees for short-term institutional care in both social welfare and health care institutions.

Health care service users are responsible for monitoring whether the payment ceiling is met. Clients may be asked to present the original receipts before issuing a certificate to prove that the payment ceiling has been met. A certificate is always issued by a health centre or other public health care establishment.