



“I KNOW I WON’T GET HELP”

INEQUALITY OF HEALTHCARE IN FINLAND

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CONTENTS

GLOSSARY	5
EXECUTIVE SUMMARY	6
1. METHODOLOGY	9
2. BACKGROUND	11
3. FINLAND'S HUMAN RIGHTS OBLIGATIONS	14
3.1 NON-DISCRIMINATION AND EQUALITY IN HEALTHCARE	15
3.2 AFFORDABILITY OF HEALTHCARE	15
3.3 HEALTH FUNDING, RESOURCE ALLOCATION AND AUSTERITY AS A HUMAN RIGHTS ISSUE	16
3.3.1 AUSTERITY AND THE RIGHT TO HEALTH	17
3.4 OBSERVATIONS ON FINLAND BY HUMAN RIGHTS MONITORING BODIES	17
4. EMPLOYMENT STATUS DETERMINES ACCESS TO SERVICES	19
4.1 PEOPLE EXCLUDED FROM OCCUPATIONAL HEALTHCARE	23
4.2 WIDE VARIATIONS IN OCCUPATIONAL HEALTHCARE PROVISION	24
5. INADEQUATE FUNDING FOR HEALTHCARE AND SHORTCOMINGS OF THE REFORM	26
5.1 FINLAND'S HEALTHCARE SPENDING PER CAPITA IS BELOW THE EU AVERAGE	26
5.1.1 IMPACT OF AUSTERITY MEASURES ON HEALTHCARE	28
5.2 FAILURE TO ENSURE ADEQUATE HUMAN RESOURCES IN PUBLIC HEALTHCARE SERVICES	29
5.3 LACK OF MEASURES IN SOCIAL AND HEALTHCARE REFORM TO TACKLE INEQUALITY	32
5.3.1 FRAGMENTED EFFORTS TO IMPROVE SERVICE PROVISION	33
5.4 IMPACT OF THE COVID-19 PANDEMIC AND COST-OF-LIVING CRISIS	34
6. MULTIPLE BARRIERS TO REALIZING THE RIGHT TO HEALTH	36
6.1 FINANCIAL BARRIERS	36
6.2 LONG WAITING TIMES IN PUBLIC HEALTHCARE	43

6.3 LIMITED AVAILABILITY AND AFFORDABILITY OF CERTAIN HEALTH SERVICES	47
6.3.1 DEEP SOCIOECONOMIC INEQUALITY IN ORAL HEALTHCARE	47
6.3.2 INADEQUATE MENTAL HEALTHCARE SERVICES	51
6.3.3 LACK OF SEXUAL AND REPRODUCTIVE HEALTH SERVICE PROVISION	53
6.4 THE DIGITAL DIVIDE – A BARRIER TO ACCESS	54
6.5 HEALTH CHECK-UPS: FAILURE TO REACH PEOPLE EXPERIENCING UNEMPLOYMENT AND TO INCORPORATE OCCUPATIONAL ISSUES	56
6.6 LACK OF TRUST IN PUBLIC HEALTHCARE	58
7. CONCLUSIONS AND RECOMMENDATIONS	60

GLOSSARY

CESCR	Un Committee on Economic, Social and Cultural Rights
Eurostat	European Statistical Office
HUS	Joint Authority of the Helsinki and Uusimaa Hospital District
ICESCR	International Covenant on Economic, Social and Cultural Rights
ILO	International Labour Organization
Kela	Social Insurance Institution of Finland
OECD	Organisation for Economic Co-operation and Development
OHC	occupational healthcare
OOP payment	out-of-pocket payment
PHC	primary healthcare
SHC	specialized healthcare
THL	Finnish Institute for Health and Welfare
UPR	Universal Periodic Review
WBSC	wellbeing services county
WHO	World Health Organization

EXECUTIVE SUMMARY

According to international evaluations, Finland has one of the most unequal healthcare systems among industrialized countries as regards the distribution and use of healthcare services and one of the highest income-related inequalities for unmet health needs. Human rights monitoring bodies have given Finland recommendations to reduce inequality in access to healthcare and to ensure the right to health for all.

This Amnesty International report illustrates how groups reliant on public primary healthcare services, such as people experiencing unemployment, older people, and people without private medical insurance, face greater and particular barriers in accessing and using healthcare services. These barriers in accessing and using services, that influence specific groups, are at odds with Finland's human rights obligations.

The report is based on extensive desk research and 117 interviews with service users, social and healthcare professionals, NGO representatives, authorities, and experts.

FINLAND HAS THE OBLIGATION TO GUARANTEE EVERYONE'S RIGHT TO HEALTH

Human rights norms ensure the right for all to enjoy the highest attainable standards of physical and mental health.

Unjust health inequality between different groups is the result of a multitude of social factors and conditions. Social and healthcare services alone cannot eradicate health inequality, but services play an important role, especially for those who are already marginalized or at risk of discrimination. Thus, healthcare systems play an important role in reducing – or entrenching – health inequality. The Finnish state has a poor record as regards reducing health inequality, despite it being a political goal for the past four decades.

The state has the obligation to ensure adequate, timely, affordable, and high-quality healthcare for all without discrimination based on one's socioeconomic status, gender or any other factor.

PEOPLE WHO RELY ON PUBLIC HEALTH CARE SERVICES FACE A MULTITUDE OF BARRIERS

People who do not have access to occupational healthcare through their employment or cannot afford private healthcare services face a number of obstacles in accessing the healthcare they need. These include inability to make contact with services, long waiting times, financial barriers, geographical inequality and digital barriers.

People experience notable difficulties in making contact with health centres in order to book appointments. In interviews with Amnesty International people reported calls going unanswered and never receiving call-backs. Often the health centres have no appointment times to give, and instead callers are asked to try again at another time. Appointment scheduling services became especially congested in many places during the Covid-19 pandemic. In some municipalities, call-back requests were even illegally deleted from appointment scheduling services.

Long waiting times for a doctor's appointment were the most mentioned problem in interviews conducted by Amnesty International. There are unreasonably long waiting times in primary-level services in different parts of the country. Several people interviewed by Amnesty International said that waiting causes them concern for their health and some felt that their health had deteriorated due to long waiting times. Long waiting times force people to manage with their symptoms and pain. Even after waiting for a long time an appointment can be cancelled or postponed.

Healthcare services and medicines are too expensive for many people. In 2022, almost 490 000 social and healthcare fees led to recovery proceedings, although recovery proceedings declined slightly after the 2021 Act on Client Charges reform. In interviews with Amnesty International people reported postponing seeking out healthcare services in fear of high costs, saving by taking medicine less often than prescribed by their physician or pulling out their own tooth due to not being able to afford the costs of oral healthcare.

The Covid-19 pandemic sped up the introduction of digital appointment scheduling and remote appointments services in healthcare. Digital services are not accessible for all equally. Some cannot afford smart phones or laptops. Some need more counselling and assistance to use digital services, and for some they are not accessible due to cognitive challenges. Steps to mitigate the particular impact on affected groups are lacking.

In interviews with service users and experts it was mentioned that problems in the availability and accessibility of services are present in especially oral health care services, sexual and reproductive healthcare services, and mental healthcare services. Problems were also experienced in services for drug users and in services for eye conditions.

According to Finnish legislation, wellbeing services counties must organise health check-ups for people experiencing unemployment, in order to monitor and promote their health. This requirement was introduced in the 2010 Health Care Act, in recognition of the unequal access to healthcare experienced by those without employment. However, the implementation of health check-ups for those experiencing unemployment is weak due to for instance lack of information, poor availability and long waiting times.

PARALLEL PRIMARY HEALTH CARE SYSTEMS AS A SOURCE OF HEALTH INEQUALITY

One of the reasons for inequalities in the Finnish healthcare service system are the multiple parallel primary healthcare services. People covered by comprehensive occupational health care schemes and those with the financial means to use private healthcare services have faster access to services than those dependent on public healthcare. Occupational healthcare services are also free of charge at the point of use whereas in public healthcare patients pay user fees for most services.

Unfortunately, the most recent reform of social and healthcare services does not address this key issue of structural inequality at all.

FINNISH HEALTH CARE FUNDING: STAGNATION AND AUSTERITY

In recent decades, Finnish healthcare funding has been characterized by stagnation and austerity. Since the 1990s, several austerity measures have hit public healthcare. Between periods of austerity, funding has grown modestly. Healthcare funding in Finland is below the Nordic and EU averages.

Long-term underfunding has consequences. The public healthcare sector suffers from a chronic understaffing and the staffing shortage of has risen rapidly in recent years. Staffing shortages result in lengthy waiting times and increased workloads and stress among health workers. In addition, increased competition between public and private healthcare bodies for qualified healthcare personnel has contributed to recruitment difficulties and staff shortages in public healthcare.

In an Amnesty International survey, wellbeing services counties reported that their funding is either inadequate or likely inadequate for them to be able to organize services required by law, let alone for them to improve access to healthcare services for those groups that experience obstacles in accessing the services they need. It is alarming that the social and healthcare funding model only considers 80 percent of the growth in service needs.

This report highlights the multiple challenges people face in accessing, using, and affording health care, and just how far Finland is from fulfilling its human rights obligations. Finland is failing to uphold the right to health for everyone, despite having a duty to do so.

KEY RECOMMENDATIONS TO THE GOVERNMENT AND PARLIAMENT OF FINLAND:

- Guarantee the right to health for all people and ensure Universal Health Coverage by ensuring available, accessible, and affordable healthcare for all, including for people on lower incomes without access to comprehensive occupational healthcare.
- Ensure that the public health system, and specifically primary healthcare, is strengthened and has adequate resources, by:
 - Considering concrete measures to allocate additional resources to primary healthcare, for example earmarking a progressively increasing share of funding to primary healthcare from the funds budgeted to wellbeing services counties.
 - Removing the automatic 20% cut to needs-based funding to wellbeing services counties.
 - Exploring alternative options for accessing the maximum available resources to fulfil human rights obligations, through, for example, taxation measures.
 - Considering further reductions in multi-channel health funding, including the reduction or removal of reimbursements for curative OHC, to promote universal access to healthcare for all.
 - Avoiding austerity measures targeted at public healthcare services and, if any austerity measures are considered, requiring that a human rights impact assessment be conducted to ensure that measures do not impact those who are marginalized or at risk of discrimination.
- Remove financial barriers to healthcare and reduce geographical inequality by reforming the Act on Client Charges in Healthcare and Social Welfare and changing the Regulation of Client Charges in Healthcare and Social Welfare. Reforms should include:
 - Revising user fees for primary healthcare, so healthcare is affordable to all.
 - Pending revision of user fees, expanding the responsibility of wellbeing services counties to waive and lower all user fees.
 - Combining all payment ceilings and transferring responsibility of assessing when the ceiling is reached from patients to the authorities.
- Carry out human rights impact assessments before any healthcare reform:
 - Human rights impact assessments should be comprehensive, including gender impact assessment, child impact assessment and give special consideration to the impact of decisions on those who are marginalized or at risk of discrimination.
 - State allocation of funds should be sufficient to ensure adequate human resources in state administration and sufficient expertise to conduct high-quality assessments.

1. METHODOLOGY

The report is based on extensive desk research including:

- (a) Analysing healthcare-related legislative and policy documents;
- (b) Reviewing secondary literature, including governmental and non-governmental studies on the accessibility, affordability, and use of healthcare services in Finland.
- (c) Examining public health expenditure and out-of-pocket (OOP) payments in Finland.
- (d) Reviewing statistical data on healthcare services and the use of services, including statistical data received from authorities through freedom of information requests. These include National Enforcement Authority Finland data on debt recovery proceedings for social and healthcare user fees and on Regional State Administrative Agency decisions on access to healthcare services.

Amnesty International conducted 117 interviews for this report between November 2022 and February 2023. These were:

- 1) Individual or small group interviews with 88 individuals who were either seeking or had sought healthcare through the public health system.

Based on consultations with civil society groups and public health experts, Amnesty International focused on groups that were identified as being particularly adversely affected in terms of access to and use of outpatient primary health care (PHC). These groups included people experiencing unemployment, especially long-term unemployment; people on low incomes without access to private healthcare services; young adults under the age of 25 not employed or in education; families with children; people with disabilities, and pensioners. Within these groups, people experiencing mental ill-health, people who use drugs, and those with chronic health conditions were further identified by health experts and NGOs as experiencing particular problems in accessing and using PHC. Interviewees included people from all the aforementioned groups, were aged between 20 and 90 and included parents with children.

Interviews were arranged through referrals from NGOs working on issues relevant to this report, for instance public health workers; organizations providing support for people experiencing unemployment, mental ill-health or who use drugs; community organizations; and religious organizations providing affordable meals and other services.

In-person interviews were conducted in eight cities in eight different wellbeing services counties (WBSCs)¹: Espoo (West Uusimaa WBSC), Helsinki (capital), Hämeenlinna (Kanta-Häme WBSC), Pori (Satakunta WBSC), Tampere (Pirkanmaa WBSC), Turku (Southwest Finland WBSC), Vaasa (Ostrobothnia WBSC), Vantaa (Vantaa and Kerava WBSC). The locations were chosen based on consultations with NGOs. Remote interviews were also conducted by phone and video call. Most interviews lasted between 45 minutes and 1.5 hours.

Before interviews were conducted, interviewees were informed about the research, how their interviews would be used and given the opportunity to ask questions. They were also informed that participation was voluntary and that they could withdraw their consent at any stage. Informed consent was a key consideration given that interviews often touched on personal topics such as health and interviewees included individuals from groups that are marginalized or at risk of discrimination. Names and identifying details of those quoted in this report have been withheld to protect interviewees' privacy and confidentiality; the names used are pseudonyms.

One of the interviewers has a healthcare degree and was able to provide general advice on how to seek out healthcare services when such needs were presented during interviews. The interviewers also provided information on various topics related to the interviews, such as the right to health check-ups for those experiencing unemployment and waivers or reductions of user fees.

- 2) Individual interviews with 29 healthcare workers, social workers, representatives of health worker organizations, public health experts and academics working on public health issues, health economists, representatives of NGOs, a representative of the

¹ A wellbeing services county is a body governed by public law with autonomy in its territory that is distinct from the municipalities and the state. Wellbeing services counties are responsible for organizing health, social and rescue services in Finland.

National Employment Services Agency and a representative of the Regional State Administrative Agency, who provided background and context on the Finnish health system. Interviews were conducted both in-person and by video call.

In November and December 2022, Amnesty International conducted an online survey of officials from the 21 WBSCs that are responsible for organizing public healthcare in Finland. A total of 14 officials from 11 WBSCs responded to the survey. The questionnaire covered several issues including: county strategies for reducing health inequality; county decisions on the level of user fees for social and healthcare services; the provision of mandatory health check-ups for those experiencing unemployment; and whether government funding for WBSCs was seen as sufficient to cover the minimum service provision mandated by law.

The conclusions in this report have been drawn from the quantitative data, secondary literature, interviews, and the questionnaire described above. The qualitative interviews were analysed to identify and highlight emerging themes that were verified against secondary literature, statistics, and other data.

Quotes from interviewees sharing their own experiences of the public healthcare system that appear in this report illustrate how inequalities in the accessibility, affordability and use of health services have impacted people's lives.

Amnesty International is profoundly grateful to the people who shared their stories. It also thanks the numerous NGOs who assisted the organization in this research, as well as the civil society representatives, officials and experts who were interviewed for this report.

2. BACKGROUND

“This was all foreseeable. I graduated as a nurse at the turn of the millennium. Even though the situation was better than it is now, I already noticed at that time that public healthcare is a sinking ship. There is no way it will last when the waiting lists just grow longer and longer and longer.”

Nurse working in the public healthcare system

Finland is a wealthy country². Yet, the Organisation for Economic Co-operation and Development (OECD) has labelled Finland’s healthcare system one of the most unequal among industrialized countries as regards the distribution and use of healthcare services.³

Healthcare systems are important factors in reducing or perpetuating overall health inequality, which is the result of a multitude of social factors and conditions. According to World Health Organization (WHO), health inequality refers to “unfair differences in health status or the distribution of health resources between different population groups”.⁴

The Finnish PHC system is unique in that services are made available through a complex multi-channelled funding system.⁵ Outpatient PHC is available through: 1. Public PHC; 2. Occupational healthcare (OHC); 3. Student healthcare services; and 4. Private healthcare services.

The existence of multiple parallel healthcare services is one of the reasons for inequalities in the Finnish healthcare service system.⁶ For example, people covered by comprehensive OHC schemes have same-day access to a health provider and services are free of charge at the point of use.⁷ In contrast, those dependent on public healthcare services experience long waiting times and pay user fees for most services.⁸ Those on higher incomes use more health services in general than those on lower incomes, when service needs are

² Based on GDP per capita, Finland usually ranks among the top 30 countries in the world.

³ Based on the average rank of each country’s inequality index across seven services (GP visit, specialist visit, dentist visit, hospitalisation, as well as cervical, breast and colorectal cancer screenings), countries are clustered into groups reflecting the overall level of inequalities in the utilisation of services. Finland is ranked in the group with the highest levels of inequalities, along with Bulgaria, Croatia, Cyprus, Greece, Italy, Latvia, Poland, Romania, Slovenia, Spain, and the United States. Organisation for Economic Co-operation and Development (OECD), *Health for Everyone?: Social inequalities in health and health systems*, 2019, oecd-ilibrary.org/docserver/3c8385d0en.pdf?expires=1674135849&id=id&accname=guest&checksum=051308FB0740BD84BE85F970C73FE1D7, pp. 25-26.

⁴ World Health Organization (WHO), “Health inequities and their causes”, 22 February 2018, who.int/news-room/facts-in-pictures/detail/health-inequities-and-their-causes.

⁵ Tuukka Holster et al., “The role of occupational healthcare in ambulatory healthcare in Finland”, 2022, *Nordic Journal of Health Economics – Early view*, journals.uio.no/NJHE/article/view/8561/8121, p. 1.

⁶ See, for example, Olli Kangas and Laura Kallioma-Puha, *ESPN Thematic report on inequalities in access to healthcare Finland 2018*, 2018, ec.europa.eu/social/BlobServlet?docId=20367&langId=lv, p. 4; OECD, *State of Health in the EU: Finland - Country Health Profile 2019*, 2019, oecd-ilibrary.org/docserver/20656739en.pdf?expires=1671538813&id=id&accname=guest&checksum=F92E5E413958CBF90B4ED35CE1E63B25, p. 22; Ilmo Keskimäki et al., *Finland: Health system review*, 2019, apps.who.int/iris/bitstream/handle/10665/327538/HiT-21-2-2019-eng.pdf?sequence=7&isAllowed=y, p. 153; Kristiina Manderbacka et al., “Eriarvoisuus somaattisissa terveyspalveluissa”, 2017, *Suomen sosiaalinen tila 2/2017*, julkari.fi/bitstream/handle/10024/132346/SST2_2017_15062017.pdf?sequence=3&isAllowed=y, p. 1.

⁷ OECD, *State of Health in the EU: Finland - Country Health Profile 2019*, 2019, oecd-ilibrary.org/docserver/20656739-en.pdf?expires=1671538813&id=id&accname=guest&checksum=F92E5E413958CBF90B4ED35CE1E63B25, p. 17.

⁸ OECD, *State of Health in the EU: Finland - Country Health Profile 2019*, 2019, oecd-ilibrary.org/docserver/20656739-en.pdf?expires=1671538813&id=id&accname=guest&checksum=F92E5E413958CBF90B4ED35CE1E63B25, p. 12.

considered.⁹ This means that even when health needs have been recorded as being the same, people on higher incomes tend to access services more than people on lower incomes.

The state has a poor record as regards reducing health inequality – although reducing health inequality has been a prominent public health goal in Finland for nearly four decades.¹⁰ The state's previous public health programme for the years 2001-2015 failed to reduce stark socioeconomic health inequality.¹¹ Indeed, health inequality increased during this period.¹²

In 2021, major social and healthcare reform legislation was enacted to create 21 new WBSCs to take over responsibility from municipalities for organizing social and healthcare and rescue services.¹³ The WBSCs officially started operating in January 2023. The long-term aim of the reform is to balance resource allocation and reduce waiting times by centralizing health and social care at the regional level.¹⁴

However, the reform and healthcare policies do not address persistent inequalities in access to healthcare created by the existence of multiple schemes, despite repeated efforts by health experts to draw attention to this problem.¹⁵

The WBSCs started implementing the reforms in an especially challenging situation given the intense strain placed on the healthcare sector by the Covid-19 pandemic; chronic personnel shortages in social care and healthcare;¹⁶ nurse strikes and labour disputes in 2022;¹⁷ the energy crisis due to Russia's war of aggression in Ukraine; high inflation and rising operating costs; and accumulated long waiting times for treatment.

The crisis in the healthcare system became a regular media headline in 2022, when for months emergency care services across the country struggled with an influx of patients, staff shortages and delays in transferring patients from the emergency care services to other health and social service units.¹⁸ Low capacity in care services for older people meant that emergency care services were not able to discharge older patients, since they had nowhere to go, and as a result emergency care units were full of patients waiting to be transferred to follow-up treatment facilities.¹⁹ In late December 2022, the Head of Services of the Hospital District of Helsinki and Uusimaa stated that following media reports on these problems, people had started to avoid going to emergency care units.²⁰

“When you see on the news what kind of backlogs they are talking about, it makes me consider very carefully whether to go there to wait in line. I’m trying to postpone going to the doctor and surely that’s not a good thing.”

Kari, a 79-year-old pensioner

⁹ Kristiina Manderbacka et al., “Eriarvoisuus somaattisissa terveystalveissa”, 2017, Suomen sosiaalinen tila 2/2017, julkari.fi/bitstream/handle/10024/132346/SST2_2017_15062017.pdf?sequence=3&isAllowed=y, p. 3.

¹⁰ Hannele Palosuo et al. (editors), *Health inequalities in Finland: trends in socioeconomic health differences 1980-2005*, 2009, julkaisut.valtioneuvosto.fi/bitstream/handle/10024/72254/URN%3aNB%3afi-fe201504224334.pdf?sequence=1&isAllowed=y, p. 4.

¹¹ Tuulia Rotko and Tapani Kauppinen, *Terveys 2015 –kansanterveysohjelman loppuarviointi*, 2016, julkari.fi/bitstream/handle/10024/130313/TY%3c%962016_8_Terveys%202015_WEB_korjattu%20ja%20linkitetty_6.4.16%20%283%29.pdf?sequence=1&isAllowed=y, p. 6.

¹² The programme aimed at reducing health inequality measured as socioeconomic differences in mortality. Tuulia Rotko and Tapani Kauppinen, *Terveys 2015 –kansanterveysohjelman loppuarviointi*, 2016, julkari.fi/bitstream/handle/10024/130313/TY%3c%962016_8_Terveys%202015_WEB_korjattu%20ja%20linkitetty_6.4.16%20%283%29.pdf?sequence=1&isAllowed=y, p. 35.

¹³ In addition to the 21 WBSCs, services are also organised by the city of Helsinki and the Hospital District of Helsinki and Uusimaa. Rescue services include a range of operations from emergency services, fire brigades, rescuing accident victims and issuing warnings to the public on any hazards to public health and safety.

¹⁴ OECD, *State of Health in the EU: Finland - Country Health Profile 2021*, 2021, oecd-ilibrary.org/docserver/2e74e317-en.pdf?expires=1667402156&id=id&accname=guest&checksum=488ECBE68D339786CA93B152EF522D1A, p. 16.

¹⁵ Paula Saikkonen et al., “Monimuotoinen hyvinvointi ja muuttuva hyvinvointivaltio”, in Sakari Karvonen et al. (editors), *Suomalaisten hyvinvointi 2022*, 2022, julkari.fi/bitstream/handle/10024/145692/Suomalaisten%20hyvinvointi%202022%20verkko.pdf?sequence=4&isAllowed=y, p. 359.

¹⁶ Terhi Tevameri, *Toimialaraportit: Katsaus sote-alan työvoimaan - Toimintaympäristön ajankohtaisten muutosten ja pidemmän aikavälin tarkastelua*, 2021, julkaisut.valtioneuvosto.fi/bitstream/handle/10024/162852/TEM_2021_02_t.pdf, p. 49.

¹⁷ Yle News, “Possible resolution of nurses’ strike on the horizon”, 3 October 2022, yle.fi/a/3-12647333.

¹⁸ See, for example, Helsingin Sanomat (HS), “Työntekijät kertovat, mistä Husin katastrofaaliset ruuhkat johtuvat: ‘Koko terveydenhoitojärjestelmä on sakkautunut’”, 8 August 2022, hs.fi/kaupunki/art-2000008990790.html; Yle Uutiset, “Päivystykset ovat tukossa koko Suomessa, selvisi Ylen kyselyssä – Joensuussa potilas odotti jopa 65 tuntia jatkohoitoa”, 7 August 2022, yle.fi/a/3-12566516; MTV Uutiset, “HUS:n päivystyksessä joutuu odottamaan jopa vuorokausia – johtaja: ‘Potilaat tulevat tänne, kun he eivät saa muualta apua’”, 4 August 2022, mtvuutiset.fi/artikkeli/hus-n-paivystyksessa-joutuu-odottamaan-jopa-vuorokausia-johtaja-potilaat-tulevat-tanne-kun-he-eivat-saa-muualta-apua/8482316#gs.7sf58z; Länsiväylä, “Jorvin päivystys jälleen pahasti tukossa – ambulansseja on ohjattu Meilahteen”, 11 October 2022, lansivayla.fi/paikalliset/5408871.

¹⁹ HS, “Päivystyslääkäri: Vanhusten vaiva hoidetaan päivystyksessä puolessa tunnissa mutta hän jää sinne päiviksi makaamaan”, 10 August 2022, hs.fi/kotimaa/art-2000008991336.html.

²⁰ MTV Uutiset, “Päivystysten ruuhkat HUSin alueella iskevät kovimmin vanhuksiin – ‘Pisimmillään odotusaika on ollut yli sata tuntia’”, 22 December 2022, mtvuutiset.fi/artikkeli/paivystysten-ruuhkat-husin-alueella-iskevät-kovimmin-vanhuksiin-pisimmillaan-odotusaika-on-ollut-yli-sata-tuntia/8597458.

Faced with these challenges, WBSCs have repeatedly stated that government funding is inadequate to enable them to provide even the minimum services required by law.²¹ The backdrop to the funding challenges in social care and healthcare systems is the country's aging population – Finland's population is in fact among the oldest in the world.²² As life expectancy rises, the healthcare system will need to be able to provide services for a growing population of older people.

Before the 2023 parliamentary elections, political parties in Finland campaigned on the need to curb public spending, which had increased during the Covid-19 pandemic and led to increased state debt.²³ Social and healthcare services were also used as an example of a sector where considerable savings could be made.²⁴ Public health experts have noted that as the implementation of the reform advances, it will be necessary to further develop and fix the social care and healthcare systems.²⁵

This report seeks to illustrate current human rights gaps in the health system, that is inequality in the accessibility, affordability, and use of healthcare services in Finland, with a focus on outpatient PHC (healthcare that does not involve admission to a hospital). It also sets out recommendations to various authorities for addressing gaps in the state's measures to ensure the right to health of the population, both within and beyond the current reform.

²¹ See, for example, Yle Uutiset, "Ylen selvitys: Hyvinvointialueet kertovat tarvitsevansa jopa 1,5 miljardia lisää rahaa ensi vuodelle", 5 September 2022, yle.fi/a/3-12609206; Turun Sanomat (TS), "Rahat eivät riitä edes pakollisiin sote-palkkojen nostoihin, arvioivat hyvinvointialueiden johtajat laajassa kyselyssämme – edessä miljardiluokan lisälasku", 11 June 2022, ts.fi/teemat/5681889.

²² In 2021, 22.9 % of the Finnish population was above the age of 65. Laura Kestilä and Ilmo Keskimäki, "Katsaus Suomen väestöön ja väestön hyvinvointiin tilastojen valossa" in Sakari Karvonen et al. (editors), *Suomalaisten hyvinvointi 2022*, 2022, julkari.fi/bitstream/handle/10024/145692/Suomalaisten%20hyvinvointi%202022%20verkko.pdf?sequence=4&isAllowed=y, p. 20.

²³ Yle Uutiset, "Ylen vaalikysely: Puoluejohtajat kertovat, mihin ensi vaalikaudella panostetaan ja mistä leikataan – vertaile ja tutki puolueiden lupauksia", 31 January 2023, yle.fi/a/74-20014938.

²⁴ HS, "Orpo lupaa vaikeiden päätösten aikaa – Kokoomus tasapainottaa julkista taloutta ensi vaalikaudella kuudella miljardilla eurolla", 29 January 2023, hs.fi/politiikka/art-2000009357891.html.

²⁵ This was brought up repeatedly by public health experts in interviews conducted for this report. See also Sakari Karvonen et al., "Johdanto", in Sakari Karvonen et al. (editors), *Suomalaisten hyvinvointi 2022*, 2022, julkari.fi/bitstream/handle/10024/145692/Suomalaisten%20hyvinvointi%202022%20verkko.pdf?sequence=4&isAllowed=y, p. 13; Markku Satokangas and Ilmo Keskimäki, "Sote-uudistus tarjoaa mahdollisuuden parantaa palvelujärjestelmän oikeudenmukaisuutta", 14 October 2022, stnipro.fi/yleinen/sote-uudistus-tarjoaa-mahdollisuuden-parantaa-palvelujarjestelman-oikeudenmukaisuutta/.

3. FINLAND'S HUMAN RIGHTS OBLIGATIONS

“The right to health for all people means that everyone should have access to the health services they need, when and where they need them, without suffering financial hardship.”

Dr Tedros Adhanom Ghebreyesus, Director-General of the World Health Organization (WHO)²⁶

International human rights treaties guarantee the right to health without discrimination. Finland has ratified a range of such treaties, thereby undertaking to respect, protect and fulfil this right. These treaties include the International Covenant on Economic, Social and Cultural Rights (ICESCR) and its Optional Protocol; the Convention on the Elimination of All Forms of Discrimination against Women; the International Convention on the Elimination of All Forms of Racial Discrimination; the Convention on the Rights of the Child; and the Convention on the Rights of Persons with Disabilities.

Finland also has obligations under regional instruments that protect the right to health. It has ratified the European Social Charter (Revised), which states that everyone has the right to benefit from any measures enabling them to enjoy the highest possible standard of health attainable.²⁷ Finland has committed to delivering on the rights and principles contained in the European Pillar of Social Rights, which includes Principle 16 on healthcare: “Everyone has the right to timely access to affordable, preventive and curative health care of good quality.”²⁸

The Finnish Constitution protects the right to health and obliges public authorities to guarantee adequate social, health and medical services and promote the health of the population.²⁹ It also states that public authorities must ensure the realization of Constitutional and human rights.³⁰ The grounds for evaluating the adequacy of healthcare services that were set in the government proposal for reforming the Bill of Rights, is that the service level “should create the prerequisites for each person to function as a full member of the society.”³¹

²⁶ WHO, “Health is a fundamental human right”, 10 December 2017, apps.who.int/mediacentre/news/statements/fundamental-human-right/en/index.html.

²⁷ European Social Charter (Revised), <https://rm.coe.int/168007cf93>, Article 11.

²⁸ European Commission, The European Pillar of Social Rights in 20 principles, ec.europa.eu/commission/priorities/deeper-and-fairer-economic-and-monetary-union/european-pillar-social-rights/european-pillar-social-rights-20-principles_en#chapter-iii-social-protection-and-inclusion.

²⁹ Constitution of Finland, 1999, finlex.fi/en/laki/kaannokset/1999/en19990731, Section 19.

³⁰ Constitution of Finland, 1999, finlex.fi/en/laki/kaannokset/1999/en19990731, Section 22.

³¹ 1993 vp – HE 309, eduskunta.fi/FI/vaski/HallituksenEsitys/Documents/he_309+1993.pdf, p. 71.

3.1 NON-DISCRIMINATION AND EQUALITY IN HEALTHCARE

Non-discrimination and equality are fundamental components of international human rights norms and essential to the enjoyment of economic, social, and cultural rights.³² Discrimination of any kind on grounds of race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth, or other status is prohibited.³³

The UN Committee on Economic, Social and Cultural Rights (CESCR) has asserted that realization of the right to health requires that healthcare services be accessible to everyone in law and in fact, especially the most vulnerable or marginalized sections of the population, without discrimination.³⁴ The CESCR has stated that “the right of access to health facilities, goods and services on a non-discriminatory basis, especially for vulnerable or marginalized groups” is a minimum core obligation of the state.³⁵ A state cannot, under any circumstances, justify non-compliance with its core obligations.³⁶

3.2 AFFORDABILITY OF HEALTHCARE

Finland has an obligation to ensure that healthcare is affordable for all. According to the CESCR, a person’s social or economic situation should not lead to unequal access to healthcare.³⁷

OOP payments must be based on the principle of equality, ensuring that health services, whether privately or publicly provided, are affordable for all, including socially disadvantaged groups.³⁸ The CESCR has stated that: “equity demands that poorer households should not be disproportionately burdened with heavy expenses as compared to richer households”.³⁹

The state must ensure that the ability to pay does not affect an individual’s decision on whether to access necessary health goods and services.⁴⁰ The WHO Commission on Social Determinants of Health emphasizes that states should ensure universal access to care regardless of ability to pay and notes that it is vital to minimize OOP payments for healthcare.⁴¹ The Constitutional Law Committee of Finland has also stated that user fees must not create a barrier to access to healthcare services.⁴²

Regarding private healthcare providers, the CESCR has noted that state obligations to protect health include, among other things, the duties of states to take other measures to ensure that privatization of healthcare services does not constitute a threat to the availability, accessibility, acceptability and quality of health facilities, goods, and services.⁴³

OCCUPATIONAL HEALTHCARE AND INTERNATIONAL LABOUR ORGANIZATION STANDARDS

The right to OHC is set out in the Occupational Health Services Convention No. 161 of the International Labour Organization (ILO) and the ICESCR.⁴⁴ According to Article 1 of ILO Convention 161 “the term occupational health services means services entrusted with essentially preventive functions and responsible for advising the employer, the workers, and their representatives in the undertaking on the requirements for establishing and maintaining a safe and healthy working environment which will facilitate optimal physical and mental health in relation to work; and the adaptation of work to the capabilities of workers in the light of their state of physical and mental health”.⁴⁵ In other words, the *raison d’être* of OHC, according to ILO standards, is the protection of the health of workers in relation to their work and working environment, not the provision of a parallel PHC system for workers.

³² Committee on Economic, Social and Cultural Rights (CESCR), General Comment No. 20: Non-discrimination in economic, social and cultural rights (art. 2, Para. 2, of the International Covenant on Economic, Social and Cultural Rights), E/C.12/GC/20, 2 July 2009 [“CESCR General Comment 20”], Para 2.

³³ CESCR General Comment 20, Para 2.

³⁴ CESCR, General Comment No. 14: The Right to the Highest Attainable Standard of Health, E/C.12/2000/4, 11 August 2000 [“CESCR General Comment 14”], Para 12b.

³⁵ CESCR, General Comment 14, Para 43a.

³⁶ CESCR, General Comment 14, Para 47.

³⁷ CESCR General Comment 20, Para 35.

³⁸ CESCR, General Comment 14, Para 12b.

³⁹ CESCR General Comment 14.

⁴⁰ Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, *Interim report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health*, A/67/302, 2012, [Special Rapporteur on the Right to Health, 2012], Para 34.

⁴¹ 1993 vp – HE 309, apps.who.int/iris/rest/bitstreams/65985/retrieve, p. 12-13.

⁴² Perustuslakivaliokunta, PeVL 39/1996 vp – HE 208/1996 vp, eduskunta.fi/FI/vaski/Lausunto/Documents/pevl_39+1996.pdf, p. 2.

⁴³ CESCR, General Comment 14, Para 35.

⁴⁴ C161 - Occupational Health Services Convention, 1985 (No. 161).

ilo.org/dyn/normlex/en/f?p=NORMLEXPUB:55:0::NO::P55_TYPE,P55_LANG,P55_DOCUMENT,P55_NODE:CON,en,C161./Document; Article 12, International Covenant on Economic, Social and Cultural Rights.

⁴⁵ C161 - Occupational Health Services Convention, 1985 (No. 161).

ilo.org/dyn/normlex/en/f?p=NORMLEXPUB:55:0::NO::P55_TYPE,P55_LANG,P55_DOCUMENT,P55_NODE:CON,en,C161./Document.

3.3 HEALTH FUNDING, RESOURCE ALLOCATION AND AUSTERITY AS HUMAN RIGHTS ISSUES

Finland has an obligation to progressively realize the right to health, with deliberate, concrete and targeted steps towards the full realization of this right.⁴⁶ These obligations require Finland to adopt legislative, administrative, budgetary, judicial, promotional and other appropriate measures.⁴⁷ Health financing is a central component of realizing the right to health.⁴⁸

States must make use of maximum available resources by taking all necessary steps to raise adequate revenue, mobilizing adequate resources for health, and ensuring that health financing is prioritized in national budgets.⁴⁹ The right to health approach to health financing requires that taxation to fund healthcare be levied progressively to ensure equitable revenue generation.⁵⁰

OPTIONS FOR STATE MOBILIZATION OF MAXIMUM AVAILABLE RESOURCES FOR HEALTHCARE

There are many ways in which the state can mobilize resources in a manner consistent with its human rights obligations. For example, according to estimates, Finland loses hundreds of millions of euros annually to tax evasion and tax fraud.⁵¹ Effectively addressing tax evasion and tax fraud can be used to accrue resources to fulfil the right to health.

According to the State Treasury of Finland, reducing the dividend tax relief for non-listed companies, due to which dividend taxation of non-listed companies is lower than for listed companies, could increase tax revenue by EUR 430 million annually.⁵² The vast majority of this additional revenue, EUR 400 million, would be collected from those in the highest income decile.⁵³

The government proposal for reforming the Bill of Rights in the Constitution in 1993 stated that the Bill of Rights has notable significance for state resource allocation.⁵⁴ The Constitutional Law Committee has stated that the Bill of Rights must be considered when the Parliament exercises budgetary power.⁵⁵

When a state fails to take all necessary steps to ensure the realization of the right to health, it is in breach of its human rights obligations. According to the CESCR, examples of this include failing to implement a national health policy designed to ensure the right to health for everyone; insufficient expenditure or misallocation of public resources which result in the non-enjoyment of the right to health by individuals or groups, particularly the vulnerable or marginalized; and the failure to take measures to reduce the unequal distribution of health facilities, goods and services.⁵⁶

How healthcare services are prioritized in resource allocation is also a human rights issue. The CESCR has noted that health investments “should not disproportionately favour expensive curative health services which are often accessible only to a small, privileged fraction of the population, rather than primary and preventive health care benefiting a far larger part of the population”.⁵⁷ PHC is generally less costly than specialized health care (SHC), which requires, for instance, sophisticated equipment.⁵⁸ Investment in PHC is thus more cost-efficient in the long run because it prevents illness and promotes general health, which reduces the need for more costly care.⁵⁹ The right to health thus requires an efficient allocation of health resources between PHC and SHC, with an emphasis on PHC.⁶⁰

⁴⁶ CESCR General Comment 14.

⁴⁷ CESCR General Comment 14.

⁴⁸ Special Rapporteur on the Right to Health, 2012, Para 5.

⁴⁹ Special Rapporteur on the Right to Health, 2012, Para 6-7.

⁵⁰ Special Rapporteur on the Right to Health, 2012, Para 16.

⁵¹ See for example, Mikko Lumme & Olli Ropponen, *Monikansallisten yritysten voiton siirto ja yhteisöveropohjan rapautuminen – kokoluokan arviointia kansainvälisen kirjallisuuden valossa*, 2020, doria.fi/bitstream/handle/10024/177488/vatt-muistiot-58.pdf?sequence=1&isAllowed=y, p. 3; Website Missing profits, “Close to 40% of multinational profits are shifted to tax havens each year”, missingprofits.world/.

⁵² State Treasury of Finland, *Verokartoitus 2023*, julkaisut.valtioneuvosto.fi/bitstream/handle/10024/164690/2023_VM_15.pdf?sequence=1&isAllowed=y, pp. 67-68. This has also been noted by the Economic Policy Council in its 2022 report: talouspolitiikanarviointineuvosto.fi/wp-content/uploads/2023/02/Full-report-2022.pdf, p. 11.

⁵³ State Treasury of Finland, *Verokartoitus 2023*, julkaisut.valtioneuvosto.fi/bitstream/handle/10024/164690/2023_VM_15.pdf?sequence=1&isAllowed=y, p. 68.

⁵⁴ 1993 vp – HE 309, eduskunta.fi/Fi/vaski/HallituksenEsitys/Documents/he_309+1993.pdf, p. 28.

⁵⁵ Perustuslakivaliokunnan mietintö n:o 25 hallituksen esityksestä perustuslakien perusoikeussäännösten muuttamisesta (1994 vp – PeVM 25 – HE 309/1993 vp), eduskunta.fi/Fi/vaski/mietinto/Documents/pevm_25+1994.pdf, p. 3.

⁵⁶ CESCR, General Comment 14, Para 52.

⁵⁷ CESCR General Comment 14.

⁵⁸ Special Rapporteur on the Right to Health, 2012, Para 12.

⁵⁹ Special Rapporteur on the Right to Health, 2012, Para 12.

⁶⁰ Special Rapporteur on the Right to Health, 2012, Para 12.

Human resources are a vital component of all health systems. The CESCR has stated that ensuring the availability of healthcare requires trained healthcare personnel who receive domestically competitive salaries.⁶¹ This is echoed by the WHO Commission on Social Determinants of Health, which urges states to invest in national health workforces to ensure equitable healthcare for all.⁶²

3.3.1 AUSTERITY AND THE RIGHT TO HEALTH

There is a strong presumption in the ICESCR against deliberately retrogressive measures.⁶³ Austerity measures usually involve reductions in public spending and structural changes in welfare systems to save costs. These often have the effect of causing a retrogression in the enjoyment of economic and social rights.⁶⁴

Human rights monitoring bodies have noted the human rights risks associated with austerity programmes and that states continue to have human rights obligations in times of economic crisis.⁶⁵ The CESCR has underlined that, even in times of severe resources constraints, vulnerable members of society must be protected.⁶⁶

If any deliberately retrogressive measures are taken, the state must show that “they have been introduced after the most careful consideration of all alternatives and that they are duly justified by reference to the totality of the rights provided for in the Covenant in the context of the full use of the State party’s maximum available resources.”⁶⁷

3.4 OBSERVATIONS ON FINLAND BY HUMAN RIGHTS MONITORING BODIES

In 2021, the CESCR expressed concern that certain groups experience greater difficulties in accessing healthcare services in Finland.⁶⁸ It also noted that PHC is not sufficiently available and accessible throughout the country⁶⁹ and recommended that the social and healthcare reform address the barriers to services experienced by different groups such as people experiencing unemployment and older people.⁷⁰

Regarding mental health, the CESCR stated that there is a mental healthcare deficit in Finland, with unequal access to appropriate services for disadvantaged groups.⁷¹ It urged Finland to improve the availability of affordable mental healthcare, including targeted measures for households on low incomes.⁷²

⁶¹ CESCR General Comment 14.

⁶² WHO, *Closing the gap in a generation: Health equity through action on the social determinants of health*, 2008, apps.who.int/iris/rest/bitstreams/65985/retrieve, pp. 12-13.

⁶³ CESCR General Comment 14, Para 30.

⁶⁴ Amnesty International, “Spain: Wrong prescription: The impact of austerity measures on the right to health in Spain”, 24 April 2018, www.amnesty.org/en/documents/eur41/8136/2018/en/, p. 50.

⁶⁵ CESCR Letter, 16 May 2012, www2.ohchr.org/english/bodies/cescr/docs/Lettercescrtosp16.05.12.pdf.

⁶⁶ CESCR, General Comment No. 3: The nature of States parties’ obligations (art. 2, par. 1), E/1991/23, 14 December 1990, Para 12.

⁶⁷ CESCR General Comment 14.

⁶⁸ CESCR, Concluding observations: Finland, E/C.12/FIN/CO/7, 30 March 2021, Para 41.

⁶⁹ CESCR, Concluding observations: Finland, E/C.12/FIN/CO/7, 30 March 2021, Para 41.

⁷⁰ CESCR, Concluding observations: Finland, E/C.12/FIN/CO/7, 30 March 2021, Para 42.

⁷¹ CESCR, Concluding observations: Finland, E/C.12/FIN/CO/7, 30 March 2021, Para 43.

⁷² CESCR, Concluding observations: Finland, E/C.12/FIN/CO/7, 30 March 2021, Paras 44, 45.

HEALTH-RELATED RECOMMENDATIONS TO FINLAND AT THE 2022 UN UNIVERSAL PERIODIC REVIEW

The Universal Periodic Review (UPR) is a state-driven process under the Human Rights Council in which the human rights situation in UN member states is assessed. Finland's human rights record was last reviewed in 2022. Recommendations to Finland by UN member states included:

- Ensure access to health services for everyone without discrimination.
- Ensure access for everyone, without distinction, to appropriate care.
- Consider strengthening PHC to enhance availability and accessibility throughout the country, with a view to ensuring equal access to all groups.
- Provide accessible, affordable, and equitable access to PHC, thus achieving universal health coverage,⁷³ in line with recommendations of the CESCR.

There were also several recommendations regarding specific healthcare services, including mental healthcare, care for older people and care for vulnerable groups.⁷⁴

⁷³ According to WHO, universal health coverage means that all people have access to the full range of quality health services they need, when and where they need them, without financial hardship.

⁷⁴ United Nations Human Rights Council, *Draft report of the Working Group on the Universal Periodic Review: Finland, 2022*, uprmeetings.OHCHR.org/Sessions/41/Finland/Documents/Finland%20-%20Draft%20report%20after%20adoption.docx.

4. EMPLOYMENT STATUS DETERMINES ACCESS TO SERVICES

“[P]eople living in different social classes receive different healthcare in Finland. Roughly, for those who would need healthcare the most, it is the hardest to access it. People on higher incomes have comprehensive occupational healthcare in Finland, while people on lower incomes queue up for public services. People on higher incomes can also afford to buy the medicines they need, which may not be possible for people on lower incomes.”

Satu Jokela et al. in *Health inequalities in Finland – Proposal for the development of a health inequality monitoring system in Finland*, 2021.⁷⁵

Finland has an obligation to ensure that its national health policy is designed to progressively realize the right to health for everyone and reduce the unequal distribution of health facilities, goods, and services.⁷⁶ However, the reality today is inequalities in access to adequate healthcare are being perpetuated and entrenched by systems that differentiate on the basis of employment status and income levels.

The level of unmet need for healthcare and oral healthcare services is higher in Finland than the EU average.⁷⁷ It has been gradually increasing over time.⁷⁸ There are significant differences between lower and higher income quintiles as regards unmet needs for

⁷⁵ Satu Jokela et al. (editors), *Terveysten eriarvoisuus Suomessa: Ehdotus seurantajärjestelmän kehittämiseen*, 2021, julkari.fi/bitstream/handle/10024/142576/RAP2021_005_Terveysten_eri-arvoisuus_Suomessa_s_korj2.pdf?sequence=10&isAllowed=y, p. 14.

⁷⁶ CESCR, General Comment 14, Para 52.

⁷⁷ Jussi Tervola et al., *Can people afford to pay for health care?: New evidence on financial protection in Finland*, 2021, apps.who.int/iris/bitstream/handle/10665/346170/9789289056007-eng.pdf?sequence=1, p. 21.

⁷⁸ Jussi Tervola et al., *Can people afford to pay for health care?: New evidence on financial protection in Finland*, 2021, apps.who.int/iris/bitstream/handle/10665/346170/9789289056007-eng.pdf?sequence=1 p. 21.

healthcare and oral healthcare (see figures 1 and 2 below).⁷⁹ There are also unmet needs for prescription medicines.⁸⁰ Socio-economic inequality in access to and use of healthcare services in Finland is most pronounced in outpatient PHC.⁸¹

Figure 1. Self-reported unmet needs for medical examination by income quintiles in Finland, 2012-2021.⁸²

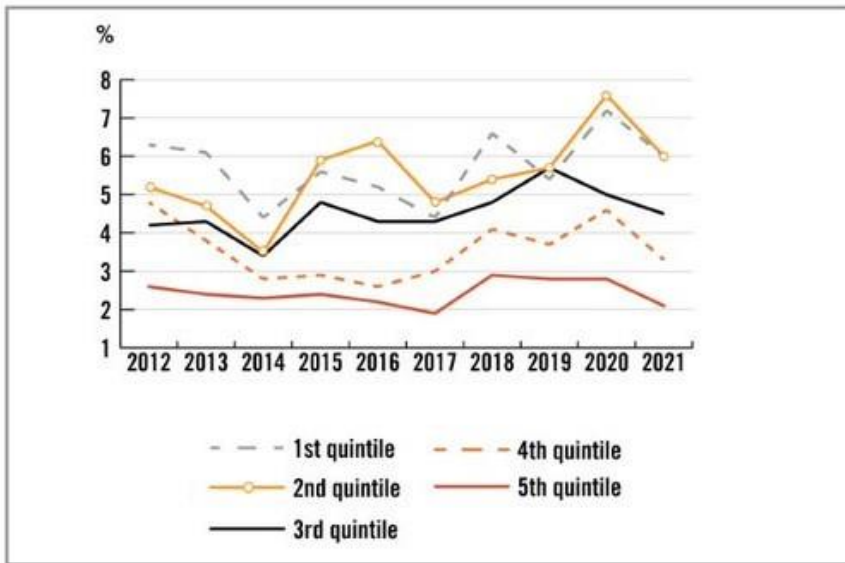
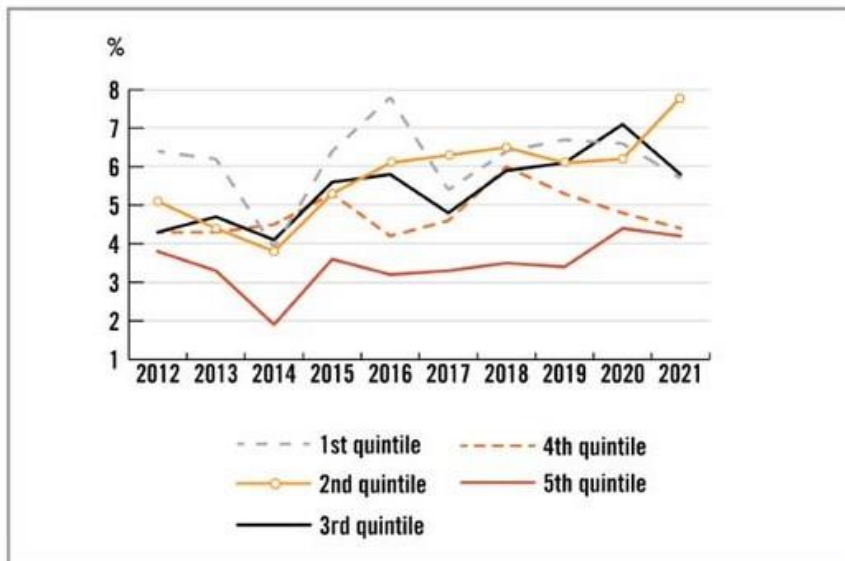


Figure 2. Self-reported unmet needs for dental examination by income quintile in Finland, 2012-2021.⁸³



⁷⁹ Jussi Tervola et al., *Can people afford to pay for health care?: New evidence on financial protection in Finland, 2021*, apps.who.int/iris/bitstream/handle/10665/346170/9789289056007-eng.pdf?sequence=1, p. 22.

⁸⁰ Jussi Tervola et al., *Can people afford to pay for health care?: New evidence on financial protection in Finland, 2021*, apps.who.int/iris/bitstream/handle/10665/346170/9789289056007-eng.pdf?sequence=1, p. 23.

⁸¹ Kristiina Manderbacka et al., "Eriarvoisuus somaattisten terveysten palvelujen saatavuudessa", in Laura Kestilä and Sakari Karvonen (editors), *Suomalaisten hyvinvointi 2018, 2019*, julkari.fi/bitstream/handle/10024/137498/THL_Suomalaisten%20hyvinvointi%202018.pdf?sequence=1&isAllowed=y, p. 213.

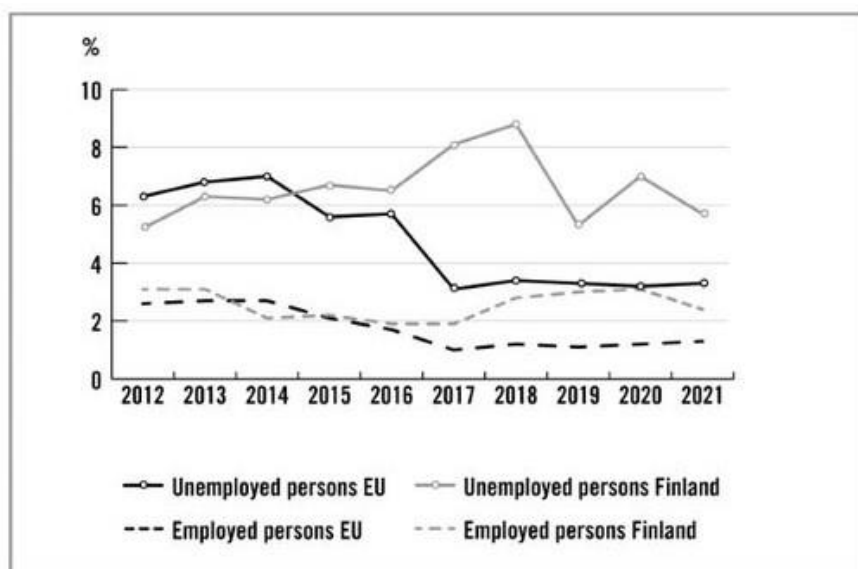
⁸² Reasons for unmet needs include: too expensive, too far to travel, waiting list. Eurostat, "Self-reported unmet needs for medical examination by sex, age, main reason declared and income quintile", ec.europa.eu/eurostat/databrowser/product/page/HLTH_SILC_08_custom_3748553.

⁸³ Reasons for unmet needs include: too expensive, too far to travel, waiting list. Eurostat, "Self-reported unmet needs for dental examination by sex, age, main reason declared and income quintile", ec.europa.eu/eurostat/databrowser/product/page/HLTH_SILC_09_custom_4939904.

The Finnish health system is highly fragmented with PHC coverage available through four different funding schemes: public PHC, OHC, student healthcare and private healthcare. The fragmentation of the health system, and especially the OHC system which operates in parallel to the public PHC system, contributes to inequalities in access to and use of healthcare services in Finland.⁸⁴

Employed people can use OHC, private healthcare and public healthcare, while those experiencing unemployment and without the financial means to use private services are dependent on public health services alone.⁸⁵ Inequality was also highlighted in interviews Amnesty International conducted for this report. As Oskari, a 76-year-old pensioner, put it: “It’s true that employed people have it better. There is inequality. If you have money, you can get services. If not, you play second fiddle.” Suvi, a 62-year-old woman experiencing unemployment, said: “If you are in public health care, you don’t have access to occupational health care. All those who use [public health care] are automatically lower caste.”

Figure 3. Self-reported unmet needs for medical examination by employment status in Finland and EU countries, 2012-2021.⁸⁶



PHC (FUNDED BY THE STATE AND PATIENTS)	OHC (FUNDED BY EMPLOYERS AND EMPLOYEES)
<p>WBSCs are responsible for organizing PHC, SHC and social services. Service providers include public and contracted private providers.</p> <p>Services are available for permanent residents. Some services are available for other groups as well, for instance from 2023 onwards, health services considered “necessary” healthcare are also available for irregular migrants.</p> <p>Services are financed by central government grants and OOP payments (16.4% of costs were covered by OOP payments in 2020).⁸⁷</p>	<p>The OHC scheme covers 88.6% of employed people in Finland.⁸⁸ It does not cover family members or pensioners. The Occupational Health Care Act requires employers to offer certain, mostly preventative, work-related health services.⁸⁹ Additionally employers can offer a range of curative services (that is, treatment for illnesses).</p> <p>Obligatory preventive OHC is financed through the national health insurance income scheme (60% of costs) and employers. Of acceptable curative service costs that the employer may choose to provide, 50% can be financed through the national health insurance scheme,</p>

⁸⁴ Jenni Blomgren and Lauri J. Virta, “Socioeconomic differences in use of public, occupational and private health care: A register-linkage study of a working-age population in Finland”, 2020, PLoS ONE, Volume 15, journals.plos.org/plosone/article/file?id=10.1371/journal.pone.0231792&type=printable, p. 16.

⁸⁵ Jenni Blomgren and Lauri J. Virta, “Socioeconomic differences in use of public, occupational and private health care: A register-linkage study of a working-age population in Finland”, 2020, PLoS ONE, Volume 15, journals.plos.org/plosone/article/file?id=10.1371/journal.pone.0231792&type=printable, p. 16.

⁸⁶ Reasons for unmet needs include: too expensive, too far to travel, waiting list. Eurostat, “Self-reported unmet needs for medical examination by sex, age, main reason declared and labour status”, ec.europa.eu/eurostat/databrowser/product/page/HLTH_SILC_13_custom_3748500.

⁸⁷ THL, “Terveystieteiden tutkimuskeskuksen rahoitus 2000–2020, % käyttömenoista”, thl.fi/documents/10531/0/Terveystieteiden_tutkimuskeskuksen_rahoitus_2000-2020_%_kayttomenoista*/thl_v09_2022.xlsx/e21a307b-f4ce-deb3-ab52-78ca13d29d5a?t=1664360130176, Table 6b.

⁸⁸ Figure from 2020. Tuomas Sarparanta (editor), *Kelan työterveyshuoltotilasto 2020*, 2020, helda.helsinki.fi/bitstream/handle/10138/344595/Kelan_tyoterveyshuoltotilasto_2020.pdf?sequence=1&isAllowed=y, p. 7.

⁸⁹ Työterveyshuoltolaki – Occupational Health Care Act, 21.12.2001/1383, finlex.fi/fi/laki/ajantasa/2001/20011383.

	<p>up to a pre-specified limit.⁹⁰ Self-employed workers are entitled to reimbursements for using OHC through the national health insurance income scheme.</p> <p>Services are free of charge at the point of use.</p>
<p>STUDENT HEALTHCARE (FUNDED BY THE STATE AND STUDENTS)</p> <p>Student healthcare is provided by the Finnish Student Health Service and covers students in higher education institutions. Student healthcare includes health and medical services, excluding some SHC and emergency care.⁹¹</p> <p>Student healthcare is financed by government grants and mandatory annual contributions from students.</p> <p>Services are free of charge at the point of use.</p>	<p>NATIONAL HEALTH INSURANCE</p> <p>National health insurance includes sickness and income insurance.</p> <p>Sickness insurance covers permanent residents and non-resident employees. It provides reimbursement of outpatient prescription medicines as well as some health-related travel costs and privately provided health services. The income insurance also covers several allowances – sickness, rehabilitation, and parenthood – and finances aspects of OHC.</p> <p>National health insurance is financed by government grants, as well as mandatory contributions from employers, employees, self-employed people, and social security beneficiaries.</p>

EXPANDING OCCUPATIONAL HEALTHCARE AND STARK INCREASE OF PRIVATE MEDICAL EXPENSE INSURANCES

The Occupational Health Care Act obliges employers to organize OHC for employees. By law, OHC is meant to promote the prevention of work-related health risks and help ensure a healthy and safe working environment.⁹² However, over time OHC has expanded from preventive and strictly work-related healthcare services to include a wide range of different healthcare services that are not necessarily work-related, such as curative healthcare services,⁹³ which are services given to treat a condition or illness.⁹⁴ In 2020, preventive OHC costs were EUR 417 million, while the curative and other OHC costs were EUR 463 million.⁹⁵ In 2020, employers had 42.2% of their total OHC costs reimbursed.⁹⁶

Private medical insurance has increased drastically in Finland in recent decades. Between 2009 and 2022, private medical insurance policies bought by companies for their employees almost tripled from 98,359 to 278,339.⁹⁷ Private medical insurance by companies complement OHC and typically covers a range of costs for privately provided healthcare services and prescription medicines. The sharp increase in companies' provision of private medical insurance for employees reflects the expansion of OHC. Another related phenomenon is oral healthcare provided through OHC. It is difficult to estimate how many employers offer this as a tax-free benefit, but most private OHC providers advertise these services. In certain situations, such as the requirement to provide the same coverage to all employees, private medical insurance by employers are tax-free benefits.⁹⁸ They can also be tax-free benefits when provided for retiring employees.⁹⁹

⁹⁰ Of the total annual OHC costs per employer, a maximum of 50 % of costs can be reimbursed and of total reimbursements, a maximum of 40 % can be accrued from curative and other than preventive services. Sairausvakuutuslaki – Health Insurance Act, 21.12.2004/1224, finlex.fi/fi/laki/ajantasa/2004/20041224, Chapter 13, sections 1-7.

⁹¹ Wellbeing services counties are responsible for organizing services not included in the student healthcare.

⁹² Työterveyshuoltolaki (1383/2001), Section 1.

⁹³ Ilmo Keskimäki, *Development of Primary Health Care in Finland, 2022*, ishtm.ac.uk/media/62361, p. 15.

⁹⁴ Tuukka Holster et al., "The role of occupational healthcare in ambulatory healthcare in Finland", 2022, *Nordic Journal of Health Economics – Early view*, <https://journals.uio.no/NJHE/article/view/8561/8121>, p. 3.

⁹⁵ Tuomas Sarparanta (editor), *Kelan työterveyshuoltotilasto 2020, 2020*, helda.helsinki.fi/bitstream/handle/10138/344595/Kelan_tyoterveyshuoltotilasto_2020.pdf?sequence=1&isAllowed=y, p. 9.

⁹⁶ Tuomas Sarparanta (editor), *Kelan työterveyshuoltotilasto 2020, 2020*, helda.helsinki.fi/bitstream/handle/10138/344595/Kelan_tyoterveyshuoltotilasto_2020.pdf?sequence=1&isAllowed=y, p. 9.

⁹⁷ During the same period 2009-2022, private medical insurances for adults increased by 69% (from 327,763 to 552,667) and private medical expense insurances for children increased by 16% (from 398,439 to 460,838). Number of insurances for 2022: Finanssiala, Sairauskuluvakuutus, finanssiala.fi/wp-content/uploads/2023/04/fa-tilasto-sairauskuluvakuutus-2012-2022.pdf; Number of insurances for 2009: Finanssiala, Sairauskuluvakuutus 2009-2020, finanssiala.fi/wp-content/uploads/2021/04/FA-tilasto-sairauskuluvakuutus-2009-2020.pdf.

⁹⁸ However, it should be noted that for instance non-regular employees or those employees who have been employed for less than six months can be excluded. Janne Myllymäki, "Työnantajan ottaman sairauskuluvakuutuksen verotus", 26 November 2020, tilisanomat.fi/palkka-ja-henkilostohallinto/tyonantajan-ottaman-sairauskuluvakuutuksen-verotus; Finnish Tax Administration, "Työnantajan ottaman sairauskuluvakuutuksen verotus", 15 December 2014, vero.fi/syventavat-vero-ohjeet/ohje-hakusivu/48347/tyonantajan-ottaman-sairauskuluvakuutus/.

⁹⁹ Janne Myllymäki, "Työnantajan ottaman sairauskuluvakuutuksen verotus", 26 November 2020, tilisanomat.fi/palkka-ja-henkilostohallinto/tyonantajan-ottaman-sairauskuluvakuutuksen-verotus.

4.1 PEOPLE EXCLUDED FROM OCCUPATIONAL HEALTHCARE

The largest group of working-age people excluded from OHC are people experiencing unemployment. At the end of 2022, there were over 260,000 people experiencing unemployment in Finland.¹⁰⁰ This is a heterogeneous group and includes people experiencing both short-term and long-term unemployment lasting for more than a year.¹⁰¹

People who are unable to work due to impaired health are in some instances categorized as “unemployed”. A study commissioned by the Ministry of Social Affairs and Health estimated that in 2018 there were 27,000 people whose health status was such that they would be unable to work if offered a job but who were nevertheless in receipt of unemployment benefits.

Employers are not required to provide OHC for those on work try outs or rehabilitative work activities of six to 12 months designed to reintegrate people back into the workforce.¹⁰² Stiina, aged 47 and who has experienced unemployment, told Amnesty International about the consequences of not having access to OHC: “If you are unemployed and participate in rehabilitative work activities and get paid EUR 9 per day, and you get sick, many places require that you get a sick leave certificate from the very first day. For example, [a large third sector employer] had this requirement when I was working there. It causes people to come to work when they are sick and then infect others, because they cannot afford to spend EUR 20 to get a [sick leave] certificate. If they have a terrible headache, diarrhoea, or something and they can't go to work, they can't self-certificate for absence from work. Paid staff can usually self-certificate for absences from work for three days. They don't have to pay for a certificate. It's a terrible burden for people who can barely make ends meet to get a sick leave certificate every day just because of their employer's lack of trust. And they must pay for it every time.”

In Finland, people experiencing unemployment generally have worse health than those who are employed.¹⁰³ Those outside of working life report having worse self-reported health and more commonly experience chronic illness compared to the general population.¹⁰⁴ According to some estimates, about half of the people who experience long-term unemployment have a work-related disability, and one third are considered “unfit for work”.¹⁰⁵ The reasons behind this are two-fold: those in better health find employment more easily and on the other hand unemployment can have a negative impact on one's health.¹⁰⁶ The OECD has estimated that health problems are the most common barriers to employment in Finland.¹⁰⁷

According to a 2022 study, most people who are unemployed in Finland either did not use or only made limited use of social and healthcare services during a one-year observation period.¹⁰⁸ Service use is concentrated among relatively small percentage of those experiencing unemployment: 10% of those experiencing unemployment accounted for 60% of the total health costs of those experiencing unemployment.¹⁰⁹ Long-term unemployment in particular is associated with non-use of healthcare services.¹¹⁰ There are indications that some people who experience unemployment use emergency health services more frequently due to inadequate access to other health services.¹¹¹

Non-working-age people are also excluded from OHC, as family members are not generally included in OHC schemes. This means that children and young people are excluded. Those young adults who are enrolled in higher education have access to student healthcare services, but not those who are enrolled in upper secondary education or not enrolled in studies. Pensioners are also excluded from OHC, as are people with disabilities who are not employed in the formal sector.

¹⁰⁰ Ministry of Economic Affairs and Employment of Finland, “Työttömiä työnhakijoita tammikuussa 258 000”, 21 February 2023, temtyollisyyskatsaus.fi/TextBase/Tkat/Prs/Tkat_fi.htm.

¹⁰¹ In December 2022, there were 86 200 persons in Finland who had been unemployed for more than a year. Ministry of Economic Affairs and Employment of Finland, “Työttömiä työnhakijoita tammikuussa 258 000”, 21 February 2023, temtyollisyyskatsaus.fi/TextBase/Tkat/Prs/Tkat_fi.htm.

¹⁰² The purpose of a work try out is to support a person's employment for example when they do not have vocational education or have been outside the job market for a long time. Rehabilitative work activities are intended for people who are unable to participate in employment or employment services because of limitations in their working and functional capacity. National Employment Services Agency, “Työkokeilun käytännöt ja säännökset”, 6 September 2022, toimistot.te-palvelut.fi/tyokokeilun-kaytannot-ja-saannokset.

¹⁰³ Tuija Oivo and Raija Kerätär, *Osatyökykyisten reitit työllisyyteen - etuudet, palvelut, tukitoimet: Selvityshenkilöiden raportti*, 2018, julkaisut.valtioneuvosto.fi/bitstream/handle/10024/161151/STM%20rap%2043%202018%20Osatyökykyisten%20reitit%20työllisyyteen.pdf?sequence=4&isAllowed=y, p. 87.

¹⁰⁴ “Outside of working life” refers to those who are neither employed nor have an unemployed status. Lars Leemann et al., *Työelämän ulkopuolella olevien osallisuus ja hyvinvointi: Kyselytutkimuksen tuloksia*, 2018, julkari.fi/bitstream/handle/10024/136551/URN_ISBN_978-952-343-119-5.pdf?sequence=1&isAllowed=y, p. 51.

¹⁰⁵ Tuija Oivo and Raija Kerätär, *Osatyökykyisten reitit työllisyyteen - etuudet, palvelut, tukitoimet: Selvityshenkilöiden raportti*, 2018, julkaisut.valtioneuvosto.fi/bitstream/handle/10024/161151/STM%20rap%2043%202018%20Osatyökykyisten%20reitit%20työllisyyteen.pdf?sequence=4&isAllowed=y, p. 20.

¹⁰⁶ Tuija Oivo and Raija Kerätär, *Osatyökykyisten reitit työllisyyteen - etuudet, palvelut, tukitoimet: Selvityshenkilöiden raportti*, 2018, julkaisut.valtioneuvosto.fi/bitstream/handle/10024/161151/STM%20rap%2043%202018%20Osatyökykyisten%20reitit%20työllisyyteen.pdf?sequence=4&isAllowed=y, p. 19.

¹⁰⁷ OECD, *A People-centred Perspective on Employment Barriers and Policies: Faces of joblessness in Finland*, 2020, oecd.org/els/soc/OECD-2020-FoJ-Finland.pdf, p. 41.

¹⁰⁸ Peppi Saikku et al., “Työttömien sosiaali- ja terveystalouden käyttö ja kustannukset”, in Sakari Karvonen et al. (editors), *Suomalaisten hyvinvointi 2022, 2022*, julkari.fi/bitstream/handle/10024/145692/Suomalaisten%20hyvinvointi%202022%20verkko.pdf?sequence=4&isAllowed=y, p. 218.

¹⁰⁹ Peppi Saikku et al., “Työttömien sosiaali- ja terveystalouden käyttö ja kustannukset”, in Sakari Karvonen et al. (editors), *Suomalaisten hyvinvointi 2022, 2022*, julkari.fi/bitstream/handle/10024/145692/Suomalaisten%20hyvinvointi%202022%20verkko.pdf?sequence=4&isAllowed=y, p. 218.

¹¹⁰ Kirsi Lappalainen et al., “Pisimpään työttömänä olleet käyttävät vähiten terveyskeskuksen palveluja”, 2018, laakarilehti.fi/tieteessa/alkuperäistutkimukset/pisimpään-työttömänä-olleet-kayttavat-vahiten-terveyskeskuksen-palveluja/.

¹¹¹ Peppi Saikku et al., “Työttömien sosiaali- ja terveystalouden käyttö ja kustannukset”, in Sakari Karvonen et al. (editors), *Suomalaisten hyvinvointi 2022, 2022*, julkari.fi/bitstream/handle/10024/145692/Suomalaisten%20hyvinvointi%202022%20verkko.pdf?sequence=4&isAllowed=y, p. 220; Jenni Blomgren et al., “Avosairaanhoidon palvelujen käyttö on vahvasti eriytynyt työmarkkina-aseman mukaan”, 2022, laakarilehti.fi/tieteessa/alkuperäistutkimukset/avosairaanhoidon-palvelujen-kaytto-on-vahvasti-eriytynyt-tyomarkkina-aseman-mukaan/#reference-10.

People working in the informal sector, on short-term contracts and those in the “gig” economy, are commonly not covered by OHC. For instance, only about one in eight of those working in agriculture and less than 5,000 self-employed people are covered by OHC.¹¹² Couriers working for platform delivery companies such as Wolt and Foodora are also not covered by OHC, even though the Regional State Administrative Agency for Southern Finland has issued a ruling that the couriers are employees, not self-employed as the company claimed.¹¹³

4.2 WIDE VARIATIONS IN OCCUPATIONAL HEALTHCARE PROVISION

“Occupational healthcare is extremely unequal. It is the employer who decides what it includes.”

Jyrjö Mattila, Chairperson, Finnish Society of Social Rights

OHC coverage for employees depends on the contracts employers agree with providers.¹¹⁴ Employees working for the same employer are generally provided with the same services, but services vary between employers.¹¹⁵ Some employers offer curative services and even SHC, while others only provide the minimum services mandated by law, namely services for strictly work-related health issues.¹¹⁶ The little data available on the coverage of OHC contracts indicates that about a third of employers do not offer curative healthcare services as a part of OHC.¹¹⁷

All employees and employers must contribute to funding curative OHC through compulsory tax-based payments, although curative services are not mandated by law and the coverage of OHC contracts vary. For employers, the payment in 2023 is 1.53% of paid salaries.¹¹⁸ For employees and the self-employed, it is 1.36% of paid salaries or incomes over EUR 15,703.¹¹⁹ Those employees on low incomes are exempt from payments.

Research indicates that OHC is important for people on lower incomes as they may have a greater need for healthcare services¹²⁰ and that frequent use of OHC may be associated, for instance, with working in the social care and healthcare sector, manufacturing industry or public administration, as well as being employed in a medium or large company.¹²¹ Higher use may also be associated with diagnoses related to the musculoskeletal system, mental and behavioural disorders and the female gender.¹²² Employees in lower status occupational positions have more sickness absences than those in higher status occupational positions and physical working conditions play a large role in explaining these differences.¹²³ People in lower status occupational positions often have more physically demanding jobs.

¹¹² Esa-Pekka Takala et al., *Työterveyshuollon toiminta ja laatu Suomessa 2018, 2019*, julkari.fi/bitstream/handle/10024/138566/TTL-978-952-261-891-7.pdf?sequence=6&isAllowed=y, p. 3.

¹¹³ The Wolt case will likely be later resolved in administrative court. See, for example, Helsinki News, “Wolt’s couriers are employees, rules authority; Wolt to defy ruling”, 3 November 2021, helsinkitimes.fi/finland/finland-news/domestic/20285-wolt-s-couriers-are-employees-rules-authority-wolt-to-defy-ruling.html.

¹¹⁴ OHC can, depending on the contract, in addition to common outpatient PHC, such as doctor’s and nurse’s appointments and examinations, also include consultations with specialist doctors, physiotherapy, psychotherapy, and oral medicine. Emergency services, inpatient care and specialised medical treatments are not included. Tuukka Holster et al., “The role of occupational healthcare in ambulatory healthcare in Finland”, 2022, *Nordic Journal of Health Economics – Early view*, journals.uio.no/NJHE/article/view/8561/8121, p. 3.

¹¹⁵ If the provided range of services vary between employees working for the same employer, the extra services not provided for all are not eligible for tax deductions.

¹¹⁶ Tuukka Holster et al., “The role of occupational healthcare in ambulatory healthcare in Finland”, 2022, *Nordic Journal of Health Economics – Early view*, journals.uio.no/NJHE/article/view/8561/8121, p. 3.

¹¹⁷ Liina-Kaisa Tynkkynen et al., “Pohdinta ja johtopäätökset” in Päivikki Koponen and Liina-Kaisa Tynkkynen (editors) *Työterveyshuollon sairaanhoitopalvelut – näkökulmia suomalaisen terveydenhuoltojärjestelmän oikeudenmukaisuuteen*, 2023, julkari.fi/bitstream/handle/10024/146227/TY%c3%962023_008_Ty%c3%b6terveyshuollon%20sairaanhoitopalvelut_s_korjattu%20150323.pdf?sequence=4&isAllowed=y, p. 113.

¹¹⁸ Ministry of Social Affairs and Health, “Sairausvakuutusmaksut vahvistettu vuodelle 2023”, 17 November 2022, valtioneuvosto.fi/-/1271139/sairausvakuutusmaksut-vahvistettu-vuodelle-2023.

¹¹⁹ Ministry of Social Affairs and Health, “Sairausvakuutusmaksut vahvistettu vuodelle 2023”, 17 November 2022, valtioneuvosto.fi/-/1271139/sairausvakuutusmaksut-vahvistettu-vuodelle-2023.

¹²⁰ Hilla Sumanen et al., “Association between socioeconomic position and occupational health service utilisation trajectories among young municipal employees in Finland”, 2019, *BMJ Open*, Volume 9, bmjopen.bmj.com/content/9/11/e028742.long.

¹²¹ Tiia T.M. Reho et al., “Frequent attenders in occupational health primary care: A cross-sectional study”, 2019, *Scandinavian Journal of Public Health*, Volume 47, journals.sagepub.com/doi/pdf/10.1177/1403494818777436.

¹²² Tiia T.M. Reho et al., “Frequent attenders in occupational health primary care: A cross-sectional study”, 2019, *Scandinavian Journal of Public Health*, Volume 47, journals.sagepub.com/doi/pdf/10.1177/1403494818777436.

¹²³ Mikko Laaksonen et al., “Explaining occupational class differences in sickness absence: results from middle-aged municipal employees”, 2010, *Journal of Epidemiology & Community Health*, Volume 64, researchgate.net/profile/Mikko-Laaksonen/publication/26835893_Explaining_occupational_class_differences_in_sickness_absence_Results_from_middle-aged_municipal_employees/links/5f92a466458515b7cf96c557/Explaining-occupational-class-differences-in-sickness-absence-Results-from-middle-aged-municipal-employees.pdf.

Karl Bang Christensen et al., “Explaining the social gradient in long-term sickness absence: a prospective study of Danish employees”, 2008, *Journal of Epidemiology & Community Health*, Volume 62, discovery.ucl.ac.uk/id/eprint/5328/1/5328.pdf.

However, socio-economic differences have also been found in the use of OHC. Employees in the higher income quintiles contact OHC more often than people in the lowest income quintile.¹²⁴ The reasons for this remain unclear but could be related to those on higher incomes more commonly working for employers who offer curative OHC.¹²⁵

In interviews with healthcare personnel, unequal coverage depending on employers was highlighted by a nurse working for the Joint Authority of the Helsinki and Uusimaa Hospital District HUS who explained: “I used to work for the City of Helsinki and thought that the OHC in HUS must be better. I quickly realized that it only includes the minimum required by law. It only includes a pre-employment physical examination and treatment for things related to the job. There aren’t any curative services... Now I don’t even try to access my OHC. Then when I call the health centre, the first thing they ask is ‘Why don’t you go to OHC?’”

¹²⁴ Tuukka Holster et al., “The role of occupational healthcare in ambulatory healthcare in Finland”, 2022, Nordic Journal of Health Economics – Early view, journals.uio.no/NJHE/article/view/8561/8121, p. 11.

¹²⁵ Tuukka Holster et al., “The role of occupational healthcare in ambulatory healthcare in Finland”, 2022, Nordic Journal of Health Economics – Early view, journals.uio.no/NJHE/article/view/8561/8121, p. 11.

5. INADEQUATE FUNDING FOR HEALTHCARE AND SHORTCOMINGS OF THE REFORM

A key aspect of states' obligation to progressively realize the right to health is the adoption of budgetary measures that would enable progress towards this ultimate aim.¹²⁶ This requires states to make use of maximum available resources by mobilizing adequate resources for health and ensuring that health financing is prioritized in national budgets.¹²⁷ This chapter shows how the policies implemented in Finland in recent years have in fact seen funding for public health remain stagnant or decrease resulting in backward steps in terms of realizing the right to health.

5.1 FINLAND'S HEALTHCARE SPENDING PER CAPITA IS BELOW THE EU AVERAGE

Health spending per capita in Finland was 10% lower than the EU average and notably lower than in other Nordic countries before the Covid-19 pandemic in 2019.¹²⁸ In the 2010s, health spending per capita increased at a very slow rate in Finland, when compared to the average of other EU countries.¹²⁹ In 2020, health expenditure as a share of GDP in Finland was 9.6%, that is below the 10.9% EU average and the 9.7% OECD country average.¹³⁰

¹²⁶ Special Rapporteur on the Right to Health, 2012, Para 5.

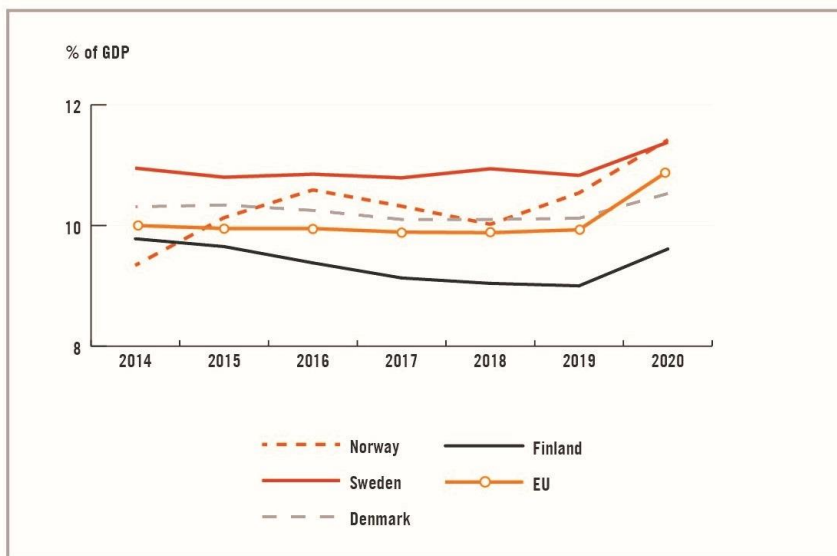
¹²⁷ Special Rapporteur on the Right to Health, 2012, Paras 6, 7.

¹²⁸ In 2019, health spending per capita was EUR 3,150, when the EU average was EUR 3,520. OECD, *State of Health in the EU: Finland - Country Health Profile 2021*, 2021, oecd-ilibrary.org/docserver/2e74e317-en.pdf?expires=1667402156&id=id&accname=guest&checksum=488ECBE68D339786CA93B152EF522D1A, pp. 3, 8.

¹²⁹ OECD, *State of Health in the EU: Finland - Country Health Profile 2021*, 2021, oecd-ilibrary.org/docserver/2e74e317-en.pdf?expires=1667402156&id=id&accname=guest&checksum=488ECBE68D339786CA93B152EF522D1A, p. 3.

¹³⁰ OECD figures: OECD, 'Health Statistics 2022', 2022, [oecd.org/health/OECD-Health-Statistics-2022-Frequently-Requested-Data.xls](https://ec.europa.eu/eurostat/databrowser/view/HLTH_SHA11_HF_custom_4139406/default/table?lang=en); EU and Finnish figures: Eurostat, 'Health care expenditure by financing scheme', 2023, https://ec.europa.eu/eurostat/databrowser/view/HLTH_SHA11_HF_custom_4139406/default/table?lang=en.

Figure 4. Health expenditure in Nordic countries and the EU, 2014-2020.¹³¹



Public healthcare funding also accounts for a lower share of all health expenditure in Finland, when compared to the EU average.¹³² OOP payments account for most of the private health expenditure (for more on OOP payments, see section 6.1).¹³³

Resources for PHC have not increased in the past two decades.¹³⁴ Funding for PHC in fact declined in absolute terms in the 2010s, increasing slightly only in 2020, when the Covid-19 pandemic started.¹³⁵ PHC's share of total healthcare expenditure has also declined steadily in recent decades. In 1995, PHC's percentage share of total healthcare expenditure was 19.4%, by 2019, before the pandemic, this had fallen to 13%,¹³⁶ rising slightly to 13.6% in 2020.¹³⁷ Of all social and healthcare costs, 11.5% was allocated to outpatient PHC in 2020.¹³⁸ In contrast, during the period 1995-2020 the share of healthcare expenditure allocated to SHC rose from 32.6% to 36.9%.¹³⁹

Nearly all the health experts interviewed for this report stated that public funding for healthcare services, especially PHC, should be increased and that this should be a long-term commitment in national health policy. A doctor interviewed by Amnesty International noted that the low level of funding for PHC in comparison to SHC is clearly visible in public health centres, where "vacancies for physicians haven't increased, while at the same time vacancies in hospitals have increased by a lot".

¹³¹ Eurostat, "Health care expenditure by financing scheme", ec.europa.eu/eurostat/databrowser/view/HLTH_SHA11_HF_custom_4139406/default/table?lang=en//hlth_sha11_hf_custom_4139406_page_spreadsheet.xlsx.

¹³² Public funding accounts for 78 % of all health spending in Finland, when the EU average is 80 %. OECD, *State of Health in the EU: Finland - Country Health Profile 2021*, 2021, oecd-ilibrary.org/docserver/2e74e317-en.pdf?expires=1667402156&id=id&accname=guest&checksum=488ECBE68D339786CA93B152EF522D1A, p. 3.

¹³³ OECD, *State of Health in the EU: Finland - Country Health Profile 2021*, 2021, oecd-ilibrary.org/docserver/2e74e317-en.pdf?expires=1667402156&id=id&accname=guest&checksum=488ECBE68D339786CA93B152EF522D1A, 8.

¹³⁴ Pasi Eskola et al., *Hoidon jatkuvuusmalli: Omalääkäri 2.0 -selvityksen loppuraportti*, 2022, julkaisut.valtioneuvosto.fi/bitstream/handle/10024/164291/STM_2022_17_rap.pdf, p. 64.

¹³⁵ THL, Liitetaulukko 2. Terveystuotomenot toiminnoittain 2000–2020, milj. euroa vuoden 2020 hinnoin, thl.fi/documents/10531/0/Terveystuotomenot+menot+ja+rahoitus+2020%2C+ennakkotiedot%2C+THL_v09_2022.xlsx/e21a307b-f4ce-deb3-ab52-78ca13d29d5a?t=1664360130176, table 2.

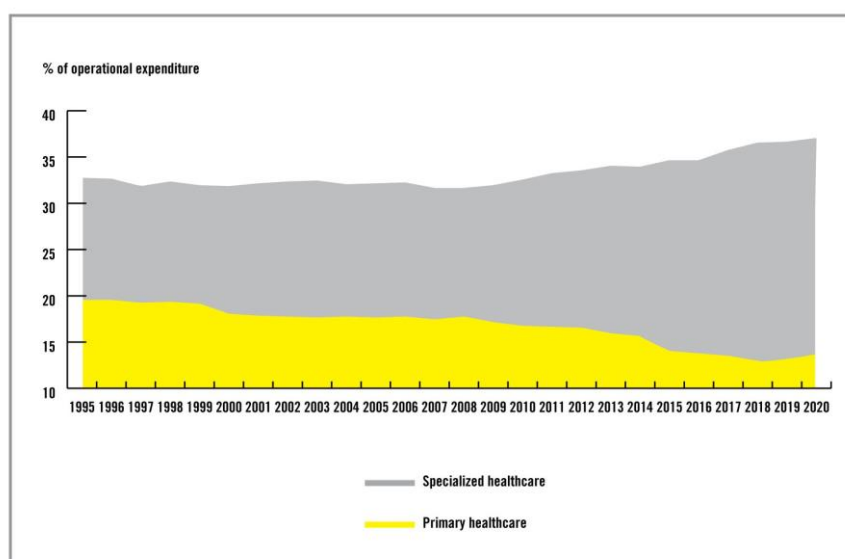
¹³⁶ Figure for 1995: Official Statistics of Finland, *Health expenditure and financing 2013*, 2015, julkari.fi/bitstream/handle/10024/125775/Tr06_2015_Terveystuotomenot%20menot%20ja%20rahoitus%202013.pdf?sequence=4&isAllowed=y, p. 16; Figure for 2019: THL, Terveystuotomenojen rakenne toiminnoittain 2000–2020, % käypähintaisista käyttömeneista, thl.fi/documents/10531/0/Terveystuotomenot+menot+ja+rahoitus+2020%2C+ennakkotiedot%2C+THL_v09_2022.xlsx/e21a307b-f4ce-deb3-ab52-78ca13d29d5a?t=1664360130176, table 3.

¹³⁷ THL, Terveystuotomenojen rakenne toiminnoittain 2000–2020, % käypähintaisista käyttömeneista, thl.fi/documents/10531/0/Terveystuotomenot+menot+ja+rahoitus+2020%2C+ennakkotiedot%2C+THL_v09_2022.xlsx/e21a307b-f4ce-deb3-ab52-78ca13d29d5a?t=1664360130176, table 3.

¹³⁸ Tiina Hetemaa et al., *Tiedosta arviointiin – tavoitteena paremmat palvelut: Sosiaali- ja terveyspalvelut Suomessa 2020*, 2022, julkari.fi/bitstream/handle/10024/144240/PT2022_003%20verkko%20k.pdf?sequence=4&isAllowed=y, p. 17.

¹³⁹ Figure for 1995: Official Statistics of Finland, *Health expenditure and financing 2013*, 2015, julkari.fi/bitstream/handle/10024/125775/Tr06_2015_Terveystuotomenot%20menot%20ja%20rahoitus%202013.pdf?sequence=4&isAllowed=y, p. 16; Figure for 2019: THL, Terveystuotomenojen rakenne toiminnoittain 2000–2020, % käypähintaisista käyttömeneista, thl.fi/documents/10531/0/Terveystuotomenot+menot+ja+rahoitus+2020%2C+ennakkotiedot%2C+THL_v09_2022.xlsx/e21a307b-f4ce-deb3-ab52-78ca13d29d5a?t=1664360130176, table 3.

Figure 5. Health expenditure in Finland, 1989-2020.¹⁴⁰



5.1.1 IMPACT OF AUSTERITY MEASURES ON HEALTHCARE

Austerity measures have had a significant impact on the Finnish health sector. The decline of funding for PHC can be traced back to the economic depression of the early 1990s and the austerity measures that followed.¹⁴¹ At the time, municipalities were responsible for organizing PHC, and they cut health centre budgets by 8-9% between 1991 and 1992.¹⁴² Reform of state funding for services also took place at this time, which further encouraged municipalities to cut healthcare budget allocation.¹⁴³ In 1992, municipalities were allowed to raise user fees up to a maximum level regulated by the state.¹⁴⁴

As Finland recovered from the economic depression, healthcare funding rose very slowly in the 1990s and 2000s, staying mostly below 8% of the GDP.¹⁴⁵ From 2009 onwards, funding started to increase, reaching 9.8% of GDP in 2013.¹⁴⁶ The government of Prime Ministers Jyrki Katainen and Alexander Stubb, in office between 2011 and 2015, introduced spending cuts and increased the costs incurred by users for medicines, health-related travel and the use of private healthcare services.¹⁴⁷

The government of Prime Minister Juha Sipilä, in office between 2015 and 2019, introduced wide-ranging austerity measures, including significant cuts to social and healthcare services and social security benefits.¹⁴⁸ Healthcare funding, in relation to GDP,

¹⁴⁰ Statistics of operational health costs for years 1995-1999: THL, *Terveydenhuollon menot ja rahoitus 2013, 2015*, Liitetaulukko 3. *Terveydenhuoltomenojen rakenne toiminnoittain 1995-2013, % käypähintaisista kokonaismenoista*, julkari.fi/bitstream/handle/10024/125775/Tr06_2015_Terveydenhuollon_menot_ja_rahointus_2013.pdf?sequence=4&isAllowed=y; Statistics for operational health costs for years 2000-2020 (the figures for these years do not include investment costs): THL, *Terveydenhuollon menot ja rahoitus 2020*, Liitetaulukko 3. *Terveydenhuoltomenojen rakenne toiminnoittain 2000-2020, % käypähintaisista käyttömenoista*, julkari.fi/bitstream/handle/10024/146539/Tr18_23.pdf?sequence=1&isAllowed=y.

¹⁴¹ Pasi Eskola et al., *Hoidon jatkuvuusmalli: Omalääkäri 2.0 -selvityksen loppuraportti, 2022*, julkaisut.valtioneuvosto.fi/bitstream/handle/10024/164291/STM_2022_17_rap.pdf, p. 34.

¹⁴² Pasi Eskola et al., *Hoidon jatkuvuusmalli: Omalääkäri 2.0 -selvityksen loppuraportti, 2022*, julkaisut.valtioneuvosto.fi/bitstream/handle/10024/164291/STM_2022_17_rap.pdf, p. 34.

¹⁴³ Pasi Eskola et al., *Hoidon jatkuvuusmalli: Omalääkäri 2.0 -selvityksen loppuraportti, 2022*, julkaisut.valtioneuvosto.fi/bitstream/handle/10024/164291/STM_2022_17_rap.pdf, pp. 34-35.

¹⁴⁴ Pasi Eskola et al., *Hoidon jatkuvuusmalli: Omalääkäri 2.0 -selvityksen loppuraportti, 2022*, julkaisut.valtioneuvosto.fi/bitstream/handle/10024/164291/STM_2022_17_rap.pdf, p. 35.

¹⁴⁵ Official Statistics of Finland, *Health expenditure and financing 2013, 2015*, julkari.fi/bitstream/handle/10024/125775/Tr06_2015_Terveydenhuollon%20menot%20ja%20rahointus%202013.pdf?sequence=4&isAllowed=y, p. 13.

¹⁴⁶ THL, *Terveydenhuoltomenot toiminnoittain 2000-2020*, milj. euroa käyvin hinnoin, thl.fi/documents/10531/0/Terveydenhuollon+menot+ja+rahointus+2020%2C+ennakkotiedot%2C+THL_v09_2022.xlsx/e21a307b-f4ce-deb3-ab52-78ca13d29d5a?t=1664360130176, table 1.

¹⁴⁷ Katri Aaltonen et al., "Analysing the Effects of Healthcare Payment Policies on Poverty: A Microsimulation Study with Real-World Healthcare Data", 2023, *International Journal of Microsimulation*, pp. 92-94.

¹⁴⁸ Olli Kangas and Laura Kallioma-Puha, "Austerity measures in Finland", 2017, *ESPN Flash Report 2017/28*; Katri Aaltonen, "Austerity, economic hardship and access to medications: a repeated cross-sectional population survey study, 2013-2020", 2023, *J Epidemiol Community Health*, Volume 77, jech.bmj.com/content/jech/early/2023/01/23/jech-2022-219706.full.pdf.

declined during this administration.¹⁴⁹ The maximum allowed level of user fees was raised by 27.5%.¹⁵⁰ As a result, financial hardship, including problems affording medication, increased especially among women experiencing unemployment, male pensioners, people with disabilities or illnesses, and men with part-time jobs.¹⁵¹ Socioeconomic inequalities were exacerbated as these groups experienced significantly greater financial hardship than those with full-time jobs.¹⁵²

PREVIOUS AMNESTY INTERNATIONAL RESEARCH ON THE EFFECTS OF AUSTERITY ON THE RIGHT TO HEALTH

Amnesty International has previously examined the impact of austerity measures on the right to health. It published reports on the effects of austerity on the Spanish health system (2018) and on the Greek health system (2020).¹⁵³ Both countries introduced austerity measures affecting their healthcare systems following the economic and financial crisis of 2008.¹⁵⁴

Amnesty International found that in both countries austerity measures resulted in a deterioration in the accessibility, affordability, and quality of healthcare. Austerity measures in Spain had a particular and disproportionate impact on people on lower incomes, especially people with chronic health conditions, people with disabilities, older persons and people accessing mental healthcare.¹⁵⁵ In Greece, austerity measures eroded the accessibility and affordability of healthcare and greatly increased the burden on health workers.¹⁵⁶

5.2 FAILURE TO ENSURE ADEQUATE HUMAN RESOURCES IN PUBLIC HEALTHCARE SERVICES

The public healthcare sector suffers from a chronic understaffing.¹⁵⁷ In October 2022, as many as 8% of doctors' positions in health centres were unfilled.¹⁵⁸ Medical directors have estimated that on top of the unfilled vacancies, an additional 300 doctors' posts are needed.¹⁵⁹ The ratio of doctors per inhabitant is lower than in most other Nordic countries¹⁶⁰ and the EU average.¹⁶¹

There are also significant regional differences in health worker resources. The number of doctors is much greater in major cities than in more sparsely populated regions.¹⁶² This is because most hospitals and SHC units are concentrated in urban areas.¹⁶³ In addition,

¹⁴⁹ THL, Terveystalouden toiminnoittain 2000–2020, milj. euroa käyvin hinnoin, thl.fi/documents/10531/0/Terveystalouden+menot+ja+rahoitus+2020%2C+ennakkotiedot%2C+THL_v09_2022.xlsx/e21a307b-f4ce-deb3-ab52-78ca13d29d5a?t=1664360130176, table 1.

¹⁵⁰ THL, Uusi tutkimus: Asiakasmaksujen korotukset ja lääkekorvausten leikkaukset köyhdyttivät etenkin ikääntyneitä, 4 April 2023, thl.fi/fi/-/uusi-tutkimus-asiakasmaksujen-korotukset-ja-laaekorvausten-leikkaukset-koyhdyttivat-etenkin-ikaantyneita?redirect=%2Ffi%2F

¹⁵¹ Katri Aaltonen, "Austerity, economic hardship and access to medications: a repeated cross-sectional population survey study, 2013–2020", 2023, *J Epidemiol Community Health*, Volume 77, jech.bmj.com/content/jech/early/2023/01/23/jech-2022-219706.full.pdf.

¹⁵² Katri Aaltonen, "Austerity, economic hardship and access to medications: a repeated cross-sectional population survey study, 2013–2020", 2023, *J Epidemiol Community Health*, Volume 77, jech.bmj.com/content/jech/early/2023/01/23/jech-2022-219706.full.pdf.

¹⁵³ Amnesty International, "Greece: Resuscitation required – The Greek health system after a decade of austerity", 28 April 2020,

[amnesty.org/en/documents/eur25/2176/2020/en/](https://www.amnesty.org/en/documents/eur25/2176/2020/en/); Amnesty International, "Spain: Wrong prescription: The impact of austerity measures on the right to health in Spain", 24 April 2018, [amnesty.org/en/documents/eur41/8136/2018/en/](https://www.amnesty.org/en/documents/eur41/8136/2018/en/).

¹⁵⁴ Amnesty International, "Greece: Resuscitation required – The Greek health system after a decade of austerity", 28 April 2020,

[amnesty.org/en/documents/eur25/2176/2020/en/](https://www.amnesty.org/en/documents/eur25/2176/2020/en/); Amnesty International, "Spain: Wrong prescription: The impact of austerity measures on the right to health in Spain", 24 April 2018, [amnesty.org/en/documents/eur41/8136/2018/en/](https://www.amnesty.org/en/documents/eur41/8136/2018/en/).

¹⁵⁵ Amnesty International, "Spain: Wrong prescription: The impact of austerity measures on the right to health in Spain", 24 April 2018,

[amnesty.org/en/documents/eur41/8136/2018/en/](https://www.amnesty.org/en/documents/eur41/8136/2018/en/).

¹⁵⁶ Amnesty International, "Greece: Resuscitation required – The Greek health system after a decade of austerity", 28 April 2020,

[amnesty.org/en/documents/eur25/2176/2020/en/](https://www.amnesty.org/en/documents/eur25/2176/2020/en/).

¹⁵⁷ Terhi Tevameri, *Toimialaraportit: Katsaus sote-alan työvoimaan – Toimintaympäristön ajankohtaisten muutosten ja pidemmän aikavälin tarkastelua*, 2021, julkaisut.valtioneuvosto.fi/bitstream/handle/10024/162852/TEM_2021_02_t.pdf, pp. 49–50.

¹⁵⁸ There were 325 positions that the health centres were unable to fill. In addition, there were 97,5 positions that were not filled, but for which no recruitment had been opened. Peppiina Saastamoinen, "Terveyskeskusten lääkäritilanne 2022", 2023, laakariliitto.fi/site/assets/files/5223/2022_terveyskeskusten_laakaritilanne_final3.pdf, p. 25.

¹⁵⁹ Peppiina Saastamoinen, "Terveyskeskusten lääkäritilanne 2022", 2023, https://www.laakariliitto.fi/site/assets/files/5223/2022_terveyskeskusten_laakaritilanne_final3.pdf, p. 26.

¹⁶⁰ OECD, *Health at a Glance: Europe 2020: State of health in the EU cycle*, 2020, oecd-ilibrary.org/docserver/82129230-en.pdf?expires=1669106624&id=id&accname=guest&checksum=2266CD5E22F801F118108ABD608C5796 p. 213.

¹⁶¹ OECD, *Health at a Glance: Europe 2020: State of health in the EU cycle*, 2020, oecd-ilibrary.org/docserver/82129230-en.pdf?expires=1669106624&id=id&accname=guest&checksum=2266CD5E22F801F118108ABD608C5796 p. 213.

¹⁶² OECD, *State of Health in the EU: Finland - Country Health Profile 2021*, 2021, oecd-ilibrary.org/docserver/2e74e317-en.pdf?expires=1667898441&id=id&accname=guest&checksum=BB94A78D61BC40195F7DFF19E2FAC143, p. 15.

¹⁶³ OECD, *State of Health in the EU: Finland - Country Health Profile 2021*, 2021, oecd-ilibrary.org/docserver/2e74e317-en.pdf?expires=1667898441&id=id&accname=guest&checksum=BB94A78D61BC40195F7DFF19E2FAC143, p. 15.

access to private medical services is better in big cities than in rural municipalities.¹⁶⁴ A survey conducted by the Finnish Medical Association in 2022 found that the shortage of doctors was more than 10% in eight hospital districts.¹⁶⁵

There is also a notable shortage of dentists. The shortage of dentists in public health centres has become worse in recent years, rising from 5% in 2019 to 9.3% in 2022.¹⁶⁶ In October 2022, there were 184 dentist vacancies in health centres.¹⁶⁷ Again, there were large geographical differences, with the shortage of dentists most severe in the following WBSCs: Southern Savonia (25.9%) and Central Ostrobothnia (24.6%), where about one in four vacancies were unfilled.¹⁶⁸ In a 2022 survey of directors of oral health in health centres, more than one in two respondents estimated that more dentist vacancies were needed in health centres.¹⁶⁹ In the same survey, the majority of directors estimated the availability of dental hygienists and dental nurses to be either rather or very bad.¹⁷⁰ The Finnish Dental Association estimated in 2022 that the unused capacity of private dentists was equivalent to nearly 80% of the unmet need nationally, although it doesn't match the need geographically.¹⁷¹ In other words, most of the shortage could be covered by improved distribution of resources. Despite the mismatch of capacity in the private and public sectors, only 27% of privately employed dentists were contracted to provide services to health centres.¹⁷²

Shortages of nursing staff has also become a constant in public healthcare. The Covid-19 pandemic and increase in care needs in the population have further increased shortages of nursing staff.¹⁷³ There are shortages of registered nurses and public health nurses nearly everywhere in the country.¹⁷⁴ According to the local government pensions institution Keva, nursing staff shortages have increased rapidly in recent years – in 2023, there was a shortage of 16,600 registered nurses and 8,800 practical nurses¹⁷⁵; the equivalent figures in 2021 were 8,000 registered nurses and 738 practical nurses.¹⁷⁶

“The shortage of nurses is so enormous that it affects the functioning and availability of healthcare services. Waiting for treatment affects the person’s ability to work, their family life and wellbeing. It would benefit everyone to resolve the shortage of nurses.”

Anne Pauna, Executive Director, Finnish Nurses Association

¹⁶⁴ Kristiina Manderbacka et al., "Terveyspalvelujen oikeudenmukaisuus edellyttää paikkatietoista politiikkaa", 2019, Suomen sosiaalinen tila 1/2019, julkari.fi/bitstream/handle/10024/138484/URN_ISBN_978-952-343-371-7.pdf?sequence=1, p. 8.

¹⁶⁵ Until 2022, Hospital districts were administrative units in the Finnish healthcare system, which were responsible for providing residents of their member municipalities with SHC. In 2023 hospital districts were merged with WBSCs. The districts with over 10% shortage were Southern Ostrobothnia, Vaasa, Southern Savonia, Kainuu, Central Ostrobothnia, Eastern Savonia, Southern Karelia, and Northern Karelia. Peppiina Saastamoinen, "Terveyskeskusten lääkäritilanne 2022", 2023, laakariliitto.fi/site/assets/files/5223/2022_terveyskeskusten_laakaritilanne_final3.pdf, p. 26.

¹⁶⁶ Finnish Dental Association, "Työvoimaselvitys 2022: Terveyskeskusten hammaslääkäritilanne lokakuussa", 2022, hammaslaakariliitto.fi/sites/default/files/mediafiles/tyovoimaselvitys_2022_-_terveyskeskukset.pdf, p. 10.

¹⁶⁷ Finnish Dental Association, "Työvoimaselvitys 2022: Terveyskeskusten hammaslääkäritilanne lokakuussa", 2022, hammaslaakariliitto.fi/sites/default/files/mediafiles/tyovoimaselvitys_2022_-_terveyskeskukset.pdf, p. 7.

¹⁶⁸ The shortage was smallest in Northern Savonia (1%), Vantaa and Kerava (1.7%) and East Uusimaa (2.7%). Finnish Dental Association, "Työvoimaselvitys 2022: Terveyskeskusten hammaslääkäritilanne lokakuussa", 2022, hammaslaakariliitto.fi/sites/default/files/mediafiles/tyovoimaselvitys_2022_-_terveyskeskukset.pdf, p. 16.

¹⁶⁹ Finnish Dental Association, "Työvoimaselvitys 2022: Terveyskeskusten hammaslääkäritilanne lokakuussa", 2022, hammaslaakariliitto.fi/sites/default/files/mediafiles/tyovoimaselvitys_2022_-_terveyskeskukset.pdf, p. 22.

¹⁷⁰ 72% for dental hygienists and 74.1% for dental nurses. Finnish Dental Association, "Työvoimaselvitys 2022: Terveyskeskusten hammaslääkäritilanne lokakuussa", 2022, hammaslaakariliitto.fi/sites/default/files/mediafiles/tyovoimaselvitys_2022_-_terveyskeskukset.pdf, p. 27.

¹⁷¹ Finnish Dental Association, "Yksityisen sektorin työvoimaselvitys 2022", 2022, hammaslaakariliitto.fi/sites/default/files/mediafiles/tyovoimaselvitys_2022_-_yksityinen_sektori.pdf, p. 16.

¹⁷² Finnish Dental Association, "Yksityisen sektorin työvoimaselvitys 2022", 2022, hammaslaakariliitto.fi/sites/default/files/mediafiles/tyovoimaselvitys_2022_-_yksityinen_sektori.pdf, p. 13.

¹⁷³ Terhi Tevameri, *Toimialaraportit: Katsaus sote-alan työvoimaan – Toimintaympäristön ajankohtaisten muutosten ja pidemmän aikavälin tarkastelua*, 2021, julkaisut.valtioneuvosto.fi/bitstream/handle/10024/162852/TEM_2021_02_t.pdf?sequence=1&isAllowed=y, p. 54.

¹⁷⁴ Terhi Tevameri, *Toimialaraportit: Katsaus sote-alan työvoimaan – Toimintaympäristön ajankohtaisten muutosten ja pidemmän aikavälin tarkastelua*, 2021, julkaisut.valtioneuvosto.fi/bitstream/handle/10024/162852/TEM_2021_02_t.pdf?sequence=1&isAllowed=y, p. 56.

¹⁷⁵ Registered nurses have completed a Bachelor degree of health care in a university of applied sciences, while practical nurses have completed a shorter upper secondary level qualification.

¹⁷⁶ Keva, "Kuntien työvoimaennuste: Hoitajapula kaksinkertaistui kahdessa vuodessa", 1 March 2023, keva.fi/uutiset-ja-artikkelit/kuntien-tyovoimaennuste-hoitajapula-kaksinkertaistui-kahdessa-vuodessa/.

NURSES' WAGES AND WORKING CONDITIONS IN 2022

Nurses in Finland earned less than the average wage of all workers in 2020, while on average across EU countries, nurses earn slightly above the average wage of all workers.¹⁷⁷

A 2020 survey commissioned by the nurses' labour union found that nearly 90% of nurses and public health nurses had considered a career change, with as many as 95% under the age of 30 considering a career change.¹⁷⁸ The reasons for discontent included low wages, personnel shortages, lack of appreciation and high levels of emotional stress.¹⁷⁹

In 2022, nurses made a demand for higher wages. A strike in support of this demand in April 2022 was followed by plans for mass resignations when the government threatened to restrict nurses' right to strike, on the stated grounds of protecting patient safety.¹⁸⁰ Almost a thousand nurses removed their names from the national register of health professionals in 2022 and hundreds more were set to follow in early 2023.¹⁸¹ The labour dispute was finally settled in October 2022 when salary increases were agreed.¹⁸²

The parallel and overlapping PHC systems – that is public PHC and OHC – have increased competition between public and private healthcare bodies for qualified healthcare personnel, including doctors and nurses.¹⁸³ This has contributed to recruitment difficulties and staff shortages in public healthcare.¹⁸⁴

“The OHC system affects the availability of labour in the public sector. Human resources are also not very effectively in use in OHC.”

Lauri Vuorenkoski, Health Policy Advisor, Finnish Medical Association

The impact of parallel PHC systems on working conditions in public health facilities has also affected those who work in and those who access public healthcare centres, who are usually people experiencing unemployment and older people.¹⁸⁵ Healthcare workers interviewed by Amnesty International stated that the workload has increased, and the case work has become more complex. Patients in health centres are more likely to have chronic conditions and need several different services.¹⁸⁶

According to a survey by the Finnish Institute for Health and Welfare (THL), the Finnish Medical Association and the University of Helsinki, burnout is more than twice as common among doctors working in health centres compared to those working in private practices.¹⁸⁷ Similarly a doctor interviewed by Amnesty International said: “In occupational healthcare, work is an awful lot simpler than in public healthcare. There aren't grandmothers with 10 different diseases and 15 medications, and you try to see what's going on. The health centre's patients are different from OHC. This is why OHC is so popular among doctors, it is light field work.”

In interviews with health workers and health experts, it was consistently noted that the average appointment time per patient is generally the same in both PHC and OHC – but patient needs can often be more complicated in PHC. For example, older people may have several conditions and need a range of medications; people who use drugs or experience mental health problems may require social

¹⁷⁷ OECD, *Health at a Glance: Europe 2022: State of health in the EU cycle, 2022*, oecd-ilibrary.org/docserver/507433b0-en.pdf?expires=1673621793&id=id&accname=guest&checksum=57B4027E4CAF79EC598F13676BC92D72, p. 186.

¹⁷⁸ Union of Health and Social Care Professionals (Tehy), “Tehyn tuore kysely: Lähes kaikki nuoret hoitajat harkinneeet alan vaihtoa”, 10 September 2021, tehy.fi/fi/mediatiedote/tehy-tuore-kysely-lahes-kaikki-nuoret-hoitajat-harkinneeet-alan-vaihtoa.

¹⁷⁹ Tehy, “Tehyn tuore kysely: Lähes kaikki nuoret hoitajat harkinneeet alan vaihtoa”, 10 September 2021, tehy.fi/fi/mediatiedote/tehy-tuore-kysely-lahes-kaikki-nuoret-hoitajat-harkinneeet-alan-vaihtoa.

¹⁸⁰ Yle Uutiset, “Tehy ja Super valmistelevat joukkorintoutumisia, peruvat hoitajalakon – ”Ministeri mursi lakon pakkotyölailla”, sanoo Millariikka Rytönen”, 19 April 2022, yle.fi/a/3-12409797.

¹⁸¹ It total, 997 removals were done by request in 2022, when the figure for 2021 was 46. In February 2023, there were nearly 300 pending removal requests in processing at the registry. HS, “Liki tuhannelta hoitajalta poistettiin ammattioikeudet viime vuonna, satoja poistopyyntöjä jonossa”, 6 February 2023 hs.fi/kotimaa/art-2000009375512.html?share=63830aca07867b44426a192a1fa8dbe7.

¹⁸² Yle Uutiset, “Hoitoalan työkiistaan sopu – kiistan osapuolet hyväksyivät valtakunnansovittelijan esityksen”, 3 October 2022, yle.fi/a/3-12647307.

¹⁸³ Ilmo Keskimäki, *Development of Primary Health Care in Finland, 2022*, lshtm.ac.uk/media/62361, p. 15.

¹⁸⁴ Ilmo Keskimäki, *Development of Primary Health Care in Finland, 2022*, lshtm.ac.uk/media/62361, p. 4.

¹⁸⁵ Ilmo Keskimäki, *Development of Primary Health Care in Finland, 2022*, lshtm.ac.uk/media/62361, p. 18.

¹⁸⁶ Pasi Eskola et al., *Hoidon jatkuvuusmalli: Omalääkäri 2.0 -selvityksen loppuraportti, 2022*,

julkaisut.valtioneuvosto.fi/bitstream/handle/10024/164291/STM_2022_17_rap.pdf, p. 84.

¹⁸⁷ The mail and online survey were implemented during the fall of 2019. The sample included 8,000 randomly selected physicians and 2,121 physicians belonging to the follow-up sample from previous similar surveys. The question regarding burnouts had 2,753 respondents. The Finnish Medical Association, *Lääkäriin työolot ja terveys tutkimus, 2019*, laakariliitto.fi/site/assets/files/5229/tyoolot_ja_terveys_tutkimuksesta_nettiin.pdf, p. 26.

work expertise; and children or young people with mental health needs also require time and particular expertise. This was echoed in Amnesty International's interviews with people using health care services. Mikael, aged 48 and in receipt of a work disability pension, said: "There are doctors who say there is no time to raise any more issues [at the appointment]. It means that if there is nothing acute, you'll have to wait to the grave for treatment."

In interviews, several healthcare professionals and experts stated that not having sufficient appointment times to tackle complicated patient needs can lead to increased pressure and even moral distress.¹⁸⁸ According to research, experiences of cognitive and moral distress are common among healthcare professionals in Finland.¹⁸⁹ In an interview with Amnesty International, Liisa Suominen, Professor of Oral Public Health, University of Eastern Finland, described the workload of dentists and the difficulty of arranging follow-up appointments: "The staff of the health centre [oral health] report that they have patients that have problems that are so difficult to treat that they just want to throw their hands up. After the [early 2000s] dental reform, when all adults became entitled to come to the health centre for treatment, the number of patients with such problems has increased clearly. It's an impossible pattern, for instance if there is a patient with mental ill health who is treated for an acute oral health problem, the follow-up appointment is in six months. It's not sustainable care. It puts health centre dentists under stress for not being able to treat their patients as well as they should."

5.3 LACK OF MEASURES IN SOCIAL AND HEALTHCARE REFORM TO TACKLE INEQUALITY

The current social and healthcare reform follows decades of incremental reforms and failed government initiatives.¹⁹⁰ The aim of the current social and healthcare reform is to bring all public social, healthcare and rescue services, which were previously a municipal responsibility, under regional administration, with stronger central government stewardship.¹⁹¹ Under this latest reform, new regional WBSCs are responsible for these services.

OHC is not part of the reform, which only covers the public health system. This is concerning since, as the OECD and the European Observatory on Health Systems and Policies stated in *State of Health in the EU – Finland Country Health Profile 2019*, not only does the OHC system reinforce inequality in access to healthcare in Finland, but the excess capacity in OHC raises concerns about efficient allocation of resources in the healthcare system overall.¹⁹²

Funding for the WBSCs comes from the central government and OOP payments. Government funding is based on estimated service need factors, changes in cost levels, and regional pre-reform operational costs and is reviewed annually against actual operational costs.

A central concern regarding the funding of WBSCs is that after 2024 state funding will account for only 80% of the estimated annual rise in service needs.¹⁹³ The reasoning given is that funding only 80% of estimated needs will "encourage WBSCs to organize social and healthcare services more efficiently".¹⁹⁴ Additional funding can be granted to a WBSC if the county does not have the ability to provide adequate social and healthcare services or rescue services.¹⁹⁵ However, frequent fiscal deficits lead to state assessment of the county and can even result in counties being merged.¹⁹⁶ The funding model raises questions about whether funding will be sufficient to not only provide the services mandated by law, but also to develop services in a way that will improve the availability, accessibility and use of services for groups who experience difficulties in service use.

¹⁸⁸ Moral distress refers to the distress a health care worker experiences when they feel powerless to carry out the ethically appropriate action. In healthcare, this is being unable to provide high-quality care to patients due to for example staff shortages or inadequate resources.

¹⁸⁹ Terhi Tevameri, *Toimialaraportit: Katsaus sote-alan työvoimaan – Toimintaympäristön ajankohtaisten muutosten ja pidemmän aikavälin tarkastelua*, 2021, julkaisut.valtioneuvosto.fi/bitstream/handle/10024/162852/TEM_2021_02_t.pdf, pp. 73–74.

¹⁹⁰ Ilmo Keskimäki, *Development of Primary Health Care in Finland*, 2022, lshtm.ac.uk/media/62361, pp. 16, 18.

¹⁹¹ Ilmo Keskimäki, *Development of Primary Health Care in Finland*, 2022, lshtm.ac.uk/media/62361, p. 4.

¹⁹² OECD, *State of Health in the EU: Finland - Country Health Profile 2019*, 2019, oecd-ilibrary.org/docserver/20656739-en.pdf?expires=1671538813&id=id&accname=guest&checksum=F92E5E413958CBF90B4ED35CE1E63B25, p. 22.

¹⁹³ The estimates of the service needs are based on research by THL. In addition, the funding for rescue services is decided on based on cost levels; Laki hyvinvointialueiden rahoituksesta, 2021, finlex.fi/fi/laki/alkup/2021/20210617, Chapter 2, section 7.

¹⁹⁴ Sote-uudistus, "Rahoituksen tason määräytyminen ja vuosittainen tarkistaminen", 2022, soteuudistus.fi/rahoituksen-maaraytyminen-ja-tarkistaminen, accessed 30.5.2023.

¹⁹⁵ Hallituksen esitys eduskunnalle hyvinvointialueiden perustamista ja sosiaali- ja terveydenhuollon sekä pelastustoimen järjestämisen uudistusta koskevaksi lainsäädännöksi sekä Euroopan paikallisen itsehallinnon peruskirjan 12 ja 13 artiklan mukaisen ilmoituksen antamiseksi (HE 241/2020 vp), eduskunta.fi/Fi/vaski/HallituksenEsitys/Documents/HE_241+2020.pdf, p. 209.

¹⁹⁶ Hallituksen esitys eduskunnalle hyvinvointialueiden perustamista ja sosiaali- ja terveydenhuollon sekä pelastustoimen järjestämisen uudistusta koskevaksi lainsäädännöksi sekä Euroopan paikallisen itsehallinnon peruskirjan 12 ja 13 artiklan mukaisen ilmoituksen antamiseksi (HE 241/2020 vp), eduskunta.fi/Fi/vaski/HallituksenEsitys/Documents/HE_241+2020.pdf, pp. 1133–1134.

“The success of the social and healthcare reform depends purely and simply on resources. We need money and leadership.”

Doctor

The social and healthcare reform began implementation in January 2023 in particularly challenging circumstances. Among the challenges faced were: the care “debt” caused by the Covid-19 pandemic; chronic personnel shortages in social and healthcare; labour disputes among health workers which began in 2022; an energy crisis due to Russia’s war of aggression in Ukraine; high inflation and rising operational costs; and accumulated long waiting lists for non-urgent treatment. Inadequate funding for the WBSCs was a regular headline in the media in 2022 and early 2023. All respondents to Amnesty International’s survey of WBSCs stated that their funding is either inadequate or likely to be inadequate to cover provision of services in 2023.

In January 2023, the THL published assessments of all the new WBSCs.¹⁹⁷ According to the assessment, due to personnel shortages, nearly all counties struggled to provide timely access to PHC and SHC.¹⁹⁸ Limited access to these services leads to patients waiting in crowded emergency rooms for transfers to other facilities.¹⁹⁹

5.3.1 FRAGMENTED EFFORTS TO IMPROVE SERVICE PROVISION

The government started a programme titled “Social and health centre of the future” for 2020-2023 with the aim of developing PHC in the context of the social and healthcare reform. In parallel with the administrative and structural reforms discussed in the previous section, the “Social and health centre of the future” is intended to reform service provision.²⁰⁰ The goals of the programme are to:

1. Improve the equitable availability, timely accessibility, and continuity of services;
2. Shift the operational emphasis towards preventive work;
3. Improve the quality and impact of services;
4. Ensure the integration of services; and
5. Control rising costs.²⁰¹

The mid-term evaluation of the programme was published in June 2022. This noted that “ - - rather than being a consistent programmatic entity, the programme is more of a collection of development projects under the administration of the Ministry of Social Affairs and Health”.²⁰² The programme is based on project-led development and does not, for instance, include recruitment of permanent staff. As regards the WBSCs, the evaluation found the programme to be fragmented and overlapping and that, in many areas, sparse personnel resources proved to be a challenge for implementation.²⁰³

In expert interviews with Amnesty International, several interviewees also noted that typically healthcare development in Finland has been based on short-term projects that are not necessarily integrated in the system. Such initiatives have not produced the hoped results of improving the accessibility and quality of services.

¹⁹⁷ THL, “Ikääntyvä väestö, henkilöstöpula ja koronan aiheuttama hoito- ja palveluvelka vaikeuttavat sote-palvelujen järjestämistä hyvinvointialueilla”, 31 January 2023, thl.fi/fi/-/ikaantyyva-vaesto-henkilostopula-ja-koronan-aiheuttama-hoito-ja-palveluvelka-vaikeuttavat-sote-palvelujen-jarjestamista-hyvinvointialueilla?redirect=%2Ffi%2F.

¹⁹⁸ THL, “Ikääntyvä väestö, henkilöstöpula ja koronan aiheuttama hoito- ja palveluvelka vaikeuttavat sote-palvelujen järjestämistä hyvinvointialueilla”, 31 January 2023, thl.fi/fi/-/ikaantyyva-vaesto-henkilostopula-ja-koronan-aiheuttama-hoito-ja-palveluvelka-vaikeuttavat-sote-palvelujen-jarjestamista-hyvinvointialueilla?redirect=%2Ffi%2F.

¹⁹⁹ THL, “Ikääntyvä väestö, henkilöstöpula ja koronan aiheuttama hoito- ja palveluvelka vaikeuttavat sote-palvelujen järjestämistä hyvinvointialueilla”, 31 January 2023, thl.fi/fi/-/ikaantyyva-vaesto-henkilostopula-ja-koronan-aiheuttama-hoito-ja-palveluvelka-vaikeuttavat-sote-palvelujen-jarjestamista-hyvinvointialueilla?redirect=%2Ffi%2F.

²⁰⁰ Ministry of Social Affairs and Health, *Tulevaisuuden sosiaali- ja terveyskeskus -ohjelman arvioinnin väliraportti, 2022*, soteuudistus.fi/documents/16650278/21777209/Tulevaisuuden_sote-keskus_v%C3%A4liraportti_final_140622.pdf/d681e3d5-48be-5e44-e695-1354ec5220cd/Tulevaisuuden_sote-keskus_v%C3%A4liraportti_final_140622.pdf?t=1660040343950, p. 9.

²⁰¹ Ministry of Social Affairs and Health, *Tulevaisuuden sosiaali- ja terveyskeskus -ohjelman arvioinnin väliraportti, 2022*, soteuudistus.fi/documents/16650278/21777209/Tulevaisuuden_sote-keskus_v%C3%A4liraportti_final_140622.pdf/d681e3d5-48be-5e44-e695-1354ec5220cd/Tulevaisuuden_sote-keskus_v%C3%A4liraportti_final_140622.pdf?t=1660040343950, p. 3.

²⁰² Ministry of Social Affairs and Health, *Tulevaisuuden sosiaali- ja terveyskeskus -ohjelman arvioinnin väliraportti, 2022*, soteuudistus.fi/documents/16650278/21777209/Tulevaisuuden_sote-keskus_v%C3%A4liraportti_final_140622.pdf/d681e3d5-48be-5e44-e695-1354ec5220cd/Tulevaisuuden_sote-keskus_v%C3%A4liraportti_final_140622.pdf?t=1660040343950, p. 9.

²⁰³ Ministry of Social Affairs and Health, *Tulevaisuuden sosiaali- ja terveyskeskus -ohjelman arvioinnin väliraportti, 2022*, soteuudistus.fi/documents/16650278/21777209/Tulevaisuuden_sote-keskus_v%C3%A4liraportti_final_140622.pdf/d681e3d5-48be-5e44-e695-1354ec5220cd/Tulevaisuuden_sote-keskus_v%C3%A4liraportti_final_140622.pdf?t=1660040343950, p. 32.

5.4 IMPACT OF THE COVID-19 PANDEMIC AND COST-OF-LIVING CRISIS

COVID-19 PANDEMIC

“It didn’t use to be this hard to get an appointment at healthcare services. That was before Covid.”

Kirsi, a 72-year-old pensioner

Healthcare providers were able to adapt service provision relatively well during the pandemic by reducing non-urgent services at both the PHC and SHC levels to allocate resources to pandemic-related measures.²⁰⁴

According to the THL, the Covid-19 pandemic put enormous strain on the healthcare system and created a service and care “debt”, especially as regards PHC for marginalized patients, non-urgent SHC, as well as oral healthcare.²⁰⁵ The effect of the pandemic on public healthcare has been estimated to be greater in areas where the pandemic was more severe, mainly larger cities, compared to small municipalities.²⁰⁶

The pandemic has put pressure on the waiting times for healthcare services. The government relaxed the rules for maximum waiting times in March 2020 because additional resources were needed for the pandemic response.²⁰⁷ Following this, the number of patients on waiting lists for more than six months increased from 1,500 to almost 18,000 (12.9% of all patients) in August 2020. Waiting times started to shorten in 2021.²⁰⁸

The pandemic also put great strain on those working in the healthcare system. According to a 2021 survey by the Finnish Medical Association, one in four physicians experienced an increase in their workload, with workloads increasing the most for those working in health centres and the least for those working in private facilities.²⁰⁹ A 2022 survey by the Finnish Institute of Occupational Health found that 63% of nurses had experienced an increase in their workload due to the pandemic.²¹⁰ According to a 2021 survey commissioned by the Union of Health and Social Care Professionals in Finland, 77% of their members felt that the pandemic had reduced their wellbeing at work.²¹¹

COST-OF-LIVING CRISIS

The cost-of-living crisis has had a profound impact on those on lower incomes since 2021. The inflation rate in Finland started to rise in already 2021, with the rate rising to 4.4% by January 2022.²¹² In December 2022, the inflation rate was as high as 9.1%.²¹³

The cost-of-living crisis caused by inflation impacted the ability of those on lower incomes to afford health spending, for example purchasing medicines. According to a survey commissioned by the Consumers’ Union of Finland from November 2022, 14% of respondents had been forced to save on medicine purchases due to the cost-of-living crisis.²¹⁴ Those on lower incomes (gross income

²⁰⁴ Tiina Hetemaa et al., *Tiedosta arviointiin – tavoitteena paremmat palvelut: Sosiaali- ja terveystieteiden tutkimus Suomessa 2020, 2022*, julkari.fi/bitstream/handle/10024/144240/PT2022_003%20verkko%20k.pdf?sequence=4&isAllowed=y, p. 4.

²⁰⁵ Tiina Hetemaa et al., *Tiedosta arviointiin – tavoitteena paremmat palvelut: Sosiaali- ja terveystieteiden tutkimus Suomessa 2020, 2022*, julkari.fi/bitstream/handle/10024/144240/PT2022_003%20verkko%20k.pdf?sequence=4&isAllowed=y, p. 4.

²⁰⁶ Laura Kestilä et al. (editors), *Covid-19-epidemiaan vaikutukset hyvinvointiin, palvelujärjestelmään ja kansantalouteen: Asiantuntija-arvio kevät 2021, 2021*, julkari.fi/bitstream/handle/10024/142536/THL_Rap3_2021-Covid-seuranta%20kev%C3%A4t%202021_f_web.pdf?sequence=4&isAllowed=y, p. 98.

²⁰⁷ OECD, *State of Health in the EU: Finland - Country Health Profile 2021, 2021*, oecd-ilibrary.org/docserver/2e74e317-en.pdf?expires=1667898441&id=id&accname=guest&checksum=BB94A78D61BC40195F7DFF19E2FAC143, p. 15.

²⁰⁸ OECD, *State of Health in the EU: Finland - Country Health Profile 2021, 2021*, oecd-ilibrary.org/docserver/2e74e317-en.pdf?expires=1667898441&id=id&accname=guest&checksum=BB94A78D61BC40195F7DFF19E2FAC143, p. 15.

²⁰⁹ The email survey was sent to 5 000 members of the association in May 2021 and had 834 respondents. Finnish Medical Association, “Koronaepidemiaan vaikutukset lääkärin työhön”, 2021, laakariliitto.fi/site/assets/files/5227/laakariliitto_koronan_vaiikutukset_kevat_2021_raportti.pdf, p. 6.

²¹⁰ Finnish Institute of Occupational Health, “Sote- ja kunta-alan tutkimustuloksia”, 2023 titi.fi/sites/default/files/2023-01/Mediainfo%202501%20Sote-%20ja%20kunta-alan%20tutkimustuloksia.pdf, p. 24.

²¹¹ The survey was sent in June – Aug 2021 to union members working in hospitals and had a response rate of 35% (3 490 respondents). Aula Research, “Kysely tehyläisille 2021”, 2021, tehy.fi/system/files/mfiles/dokumentti/aula_researchin_kysely_hoitajien_tyossajaksamisesta_ja_tyohyvinnosta_2021_id_17362.pdf, p. 6.

²¹² Statistics Finland. 2022. Finland inflation rate (in Finnish): stat.fi/pxgrafi/api/v1/sq-filed/58bd76bf-7908-439b-ac1a-528cef4cb0b8?lang=fi&format=xlsx.

²¹³ Statistics Finland. 2022. Finland inflation rate (in Finnish): stat.fi/julkaisu/ci8bkshgb6g8z0bw0h415hbnu.

²¹⁴ The online survey had 1 090 adult respondents from different parts of Finland. Consumers’ Union of Finland. 2022. ‘Consumers’ Union of Finland citizen survey 2022’: docplayer.fi/231116756-Kuluttajaliiton-kansalaiskysely-luottamuksellinen-1.html, p. 3.

less than EUR 20,000 annually) were hit the hardest, with more than one in five respondents being forced to reduce medicine purchases due to the rise of costs-of-living.²¹⁵ (For more on the affordability of health care, see section 6.1.)

Chapter 5 has described the inadequate funding for healthcare in Finland as well as the inability of the health and social services reform to fully tackle the issues related to this and other shortcomings in the health care system. In summary, the reform doesn't work for its purpose i.e., to narrow health inequalities, or fulfil the enjoyment of the right to health if it sustains the resource deficit that affects the WBSCs potential to offer services. Problems with financing and understaffing have an impact particularly on vulnerable groups who are reliant on public health care services. These pre-existing problems have been exacerbated by the pandemic and cost-of-living crisis. The state is obliged to ensure the right to health for everyone but so far, the measures taken by the government haven't been adequate for this to happen.

²¹⁵ Consumers' Union of Finland. 2022. 'Consumers' Union of Finland citizen survey 2022': docplayer.fi/231116756-Kuluttajaliiton-kansalaiskysely-luottamuksellinen-1.html, p. 6.

6. MULTIPLE BARRIERS TO REALIZING THE RIGHT TO HEALTH

Finland has the obligation to ensure access to timely and affordable health care services for all.²¹⁶ A rights-based approach to health requires that health policy prioritizes the needs of those furthest behind first towards greater equality.²¹⁷ This is not realized, as people who do not have access to OHC or private healthcare services face a number of obstacles in accessing the healthcare they need. These include financial barriers, long waiting times, inability to make contact with services, poor availability of specific services, geographical inequality and digital barriers. A lack of trust that they will be able to access services and receive good quality care in public services can also negatively influence people who rely on them.

6.1 FINANCIAL BARRIERS

Finland has an obligation to ensure that healthcare is affordable for all. According to the CESCR, a person's social or economic situation should not lead to unequal access to healthcare.²¹⁸ However, evidence gathered by Amnesty International shows that this is not the case in Finland, and financial barriers cause a significant number of people to experience distress and can cause people not being able to use the healthcare services or prescribed medicines they need.

Table 1. Unmet healthcare needs for financial reasons in different healthcare services in Finland and the EU in 2019.²¹⁹

	Total	Medical care	Dental care	Mental healthcare	Prescribed medicine
Finland	25.7 %	10.5 %	22.2 %	29.8 %	8.1 %
EU	13.0 %	5.5 %	10.8 %	3.7 %	4.2 %

As Figure 6. shows, in 2019 about 25% of people in Finland reported having had unmet needs for healthcare-related services owing to financial reasons, compared to an EU average of 13%. Differences were notable in all categories: medical, oral, and mental healthcare

²¹⁶ CESCR General Comment 14, Para 17.

²¹⁷ CESCR General Comment 14, Paras 52, 43.

²¹⁸ CESCR General Comment 20, Para 35.

²¹⁹ Eurostat, "Self-reported unmet needs for specific health care-related services due to financial reasons by sex, age and income quintile", [https://ec.europa.eu/eurostat/databrowser/product/page/HLTH_EHIS_UN21\\$DEFAULTVIEW](https://ec.europa.eu/eurostat/databrowser/product/page/HLTH_EHIS_UN21$DEFAULTVIEW).

and prescription medicines. According to a 2020 population survey by the THL, in the preceding 12 months 18.3% of respondents had had to compromise on food, medicines or doctors' appointments due to lack of money.²²⁰

Statistics also show that those on lower incomes have more unmet healthcare needs than those on higher incomes. In a 2019 survey, 37.1% of respondents in the first income quintile in Finland reported unmet needs for healthcare owing to financial reasons; the corresponding figure for the fifth income quintile was 11.9%. In contrast the EU average was 21.9% for the first quintile and 6.5% for the fifth quintile.²²¹

High costs of healthcare can cause financial distress with people having to rely on income support²²² to pay for their healthcare costs. According to a report by European Anti-Poverty Network Finland, the inability to pay user fees and medicines can lead to indebtedness, debt recovery proceedings, the use of "quickie loans"²²⁴ and loss of credit rating.²²⁵ The loss of credit rating can have long-term adverse consequences, for example preventing people from renting a home or getting insurance.²²⁶ Furthermore, indebtedness can cause feelings of shame and anxiety.²²⁷

"I am not the only one who has financial concerns regarding health expenditure. I know many people my age who have also fallen into a poverty trap because of it. Then they don't go to the doctor any more. Usually, I just put off going to the doctor."

Tuulia, a 64-year-old pensioner on a low income

The inability to pay the cost of treatment or the fear of getting into financial difficulties because of high fees can lead people to postpone or skip necessary care.²²⁸ People may put off getting a doctor's appointment for as long as possible or might not take medicine prescribed for them.²²⁹ In interviews with Amnesty International, several people shared experiences of neglecting their health due to high health costs. Annika Häggqvist, director of the NGO Klubitalo Sarastus, told Amnesty International: "Firstly, people might put off visiting the doctor for the fear of the costs. They may not even know what it costs. As time goes by, their symptoms get worse and their need for treatment increases... Once there was a situation that a person needed an ambulance and asked me what it costs and whether they could afford it. These are rough situations."

USER FEES CAUSE FINANCIAL DISTRESS

"Prices have gone up in health care services. It's expensive if you must visit frequently. And the bills are due fast."

Hilkka, a 69-year-old pensioner

²²⁰ Statistics and Indicator Bank Sotkanet, Rahanpuutteen vuoksi ruoasta, lääkkeistä tai lääkärikäynneistä tinkimään joutuneiden osuus (%), 2020, sotkanet.fi/sotkanet/fi/taulukko/?indicator=szY0cgEA®ion=s07MBAA=&year=sy5zsk7W0zUEAA==&gender=t&abs=f&color=f&buildVersion=3.0-SNAPSHOT&buildTimestamp=202109301228.

²²¹ Eurostat, Self-reported unmet needs for health care by sex, age, specific reasons and income quintile, ec.europa.eu/eurostat/databrowser/view/HLTH_EHIS_UN11_custom_5659697/default/table?lang=en.

²²² Income support is a last-resort form of financial assistance for individuals and families which is granted to cover some of the basic necessities.

²²³ Katri Aaltonen et al., "Toimeentulotuen käyttö terveys- ja lääkemenoihin Helsingissä 2008–2010", in Elina Ahola and Heikki Hiilamo (editors), *Köyhyttä Helsingissä: Toimeentulotuen saajat ja käyttö 2008–2010*, 2013, helda.helsinki.fi/bitstream/handle/10138/38938/Tutkimuksia127.pdf, p. 102.

²²⁴ A quickie loan is a short-term, unsecured, and high-interest consumer credit.

²²⁵ Tiina Saarela (editor), *Asiakasmaksut aiheuttavat ahdinkoa: Raportti kyselystä julkisen sosiaali- ja terveydenhuollon maksuista johtuvasta taloudellisesta ahdingosta paljon palveluja käyttävien arjessa*, 2020, eapn.fi/wp-content/uploads/2020/05/Asiakasmaksut-aiheuttavat-ahdinkoa.pdf, p. 24.

²²⁶ Tiina Saarela (editor), *Asiakasmaksut aiheuttavat ahdinkoa: Raportti kyselystä julkisen sosiaali- ja terveydenhuollon maksuista johtuvasta taloudellisesta ahdingosta paljon palveluja käyttävien arjessa*, 2020, eapn.fi/wp-content/uploads/2020/05/Asiakasmaksut-aiheuttavat-ahdinkoa.pdf, p. 24.

²²⁷ Tiina Saarela (editor), *Asiakasmaksut aiheuttavat ahdinkoa: Raportti kyselystä julkisen sosiaali- ja terveydenhuollon maksuista johtuvasta taloudellisesta ahdingosta paljon palveluja käyttävien arjessa*, 2020, eapn.fi/wp-content/uploads/2020/05/Asiakasmaksut-aiheuttavat-ahdinkoa.pdf, p. 25.

²²⁸ Tiina Saarela (editor), *Asiakasmaksut aiheuttavat ahdinkoa: Raportti kyselystä julkisen sosiaali- ja terveydenhuollon maksuista johtuvasta taloudellisesta ahdingosta paljon palveluja käyttävien arjessa*, 2020, eapn.fi/wp-content/uploads/2020/05/Asiakasmaksut-aiheuttavat-ahdinkoa.pdf, p. 24.

²²⁹ Tiina Saarela (editor), *Asiakasmaksut aiheuttavat ahdinkoa: Raportti kyselystä julkisen sosiaali- ja terveydenhuollon maksuista johtuvasta taloudellisesta ahdingosta paljon palveluja käyttävien arjessa*, 2020, eapn.fi/wp-content/uploads/2020/05/Asiakasmaksut-aiheuttavat-ahdinkoa.pdf, pp. 44–45.

Although Finland has an obligation to ensure that healthcare is affordable for all, there are still many people struggling with payments related to healthcare. According to CESCR the affordability of healthcare services and health goods must be guaranteed to everyone, including vulnerable groups and people without financial means, for the right to health to be realized.²³⁰

In Finland, OOP payments cover a larger share of health expenditure than the EU average.²³¹ In 2019, OOP payments accounted for 17.4% of current health expenditure, while the EU average was 15.4%.²³² According to the OECD (2019), Finland is among the nine OECD countries with the highest income-related inequalities for unmet health needs to the detriment of people on lower incomes.²³³ Moreover, OOP payments can potentially increase poverty, since it has been found in micro-simulation modelling by the THL that deducting OOP payments from household income increases poverty rates.²³⁴

In Finland, user fees are charged for most public health services, such as PHC, outpatient and inpatient SHC, emergency care, as well as medicines.²³⁵ Some healthcare services are free at the point of use, such as health advice and check-ups, nurses' appointments, screenings and visits to the maternity and child health clinics.²³⁶ Depending on the service, the fee is either a fixed amount or based on the patient's income.²³⁷ Fixed fees are charged for healthcare services, such as health centre services, which include appointments for healthcare professionals and oral healthcare. For instance, the maximum user fee in 2023 is EUR 20.90 for a doctor's appointment and EUR 13.30 for a dentist's appointment.²³⁸ Fees that are based on the patient's income are usually charged for continuous and regular in-home services, care homes and institutional care.²³⁹ User fees for these services are lower for people on lower incomes.

The law sets the maximum limit for user fees which is revised every two years a.²⁴⁰ WBSCs can charge lower user fees, provide services free of charge and apply waivers and reductions to fixed fees or for certain groups. For example, since 2013, the city of Helsinki has provided doctors' appointments at health centres free of charge. However, in 2023, 20 out of the 21 WBSCs charge the maximum user fee allowed for doctors' appointments.²⁴¹ In seven WBSCs patients can apply for waivers and reductions for fixed user fees such as health centre, clinic, and oral healthcare payments.²⁴² Amnesty views that extending these payment practices also to the above-mentioned fixed fees would be a good way to improve the affordability and accessibility of health care services.

In line with research, Amnesty International views fixed fees as a regressive way to fund healthcare services as people on lower incomes pay more than people on higher incomes as a proportion of their income.²⁴³ According to research, fees that depend on the patient's income are more progressive on the level of the individual.²⁴⁴ However, studies indicate that people on lower incomes use more services where user fees are charged based on the patient's income than people on higher incomes. Therefore, they also tend to pay more user fees in general.²⁴⁵ In 2015, fixed user fees accounted for 2.2% of the disposable income of people in the lowest income decile, when in services where fees are income-related accounted for 20.1% of this group's disposable income.²⁴⁶ The corresponding figures of those in the highest income decile were much lower at 0.2% and 10.2% respectively.²⁴⁷

²³⁰ CESCR, General Comment 14, Para 12b.

²³¹ OECD, *State of Health in the EU: Finland - Country Health Profile 2021*, 2021, oecd-ilibrary.org/docserver/2e74e317-en.pdf?expires=1665999496&id=id&accname=guest&checksum=D13E7211CB4537399088CADA5F3A981E, p. 14.

²³² OECD, *State of Health in the EU: Finland - Country Health Profile 2021*, 2021, oecd-ilibrary.org/docserver/2e74e317-en.pdf?expires=1665999496&id=id&accname=guest&checksum=D13E7211CB4537399088CADA5F3A981E, p. 14.

²³³ OECD, *Health for Everyone?: Social inequalities in health and health systems*, 2019, oecd-ilibrary.org/docserver/3c8385d0-en.pdf?expires=1674135849&id=id&accname=guest&checksum=051308FB0740BD84BE85F970C73FE1D7, p. 27.

²³⁴ Jussi Tervola et al., *The distributional effects of out-of-pocket health payments in Finland 2010–2018*, 2018, julkari.fi/bitstream/handle/10024/137236/URN_ISBN_978-952-343-220-8.pdf?sequence=1&isAllowed=y, p. 17.

²³⁵ OECD, *State of Health in the EU: Finland - Country Health Profile 2021*, 2021, oecd-ilibrary.org/docserver/2e74e317-en.pdf?expires=1665999496&id=id&accname=guest&checksum=D13E7211CB4537399088CADA5F3A981E, p. 10.

²³⁶ Ministry of Social Affairs and Health, "Terveydenhuollon maksut", 2023, stm.fi/terveydenhuollon-maksut.

²³⁷ Ministry of Social Affairs and Health, "Sosiaali- ja terveydenhuollon asiakasmaksut", 2023, stm.fi/sotehuollon-asiakasmaksut.

²³⁸ For doctor's appointments the fee of EUR 20.90 can be charged up to three times per calendar year at one health centre. Alternatively, an annual fee of maximum EUR 41.80 per calendar year may be charged. Ministry of Social Affairs and Health, "Terveydenhuollon maksut", 2023, stm.fi/terveydenhuollon-maksut; Ministry of Social Affairs and Health, "Hammashuollon maksut", 2023, stm.fi/hammashuollon-maksut.

²³⁹ Ministry of Social Affairs and Health, "Terveydenhuollon maksut", 2023, stm.fi/terveydenhuollon-maksut; Ministry of Social Affairs and Health, "Kotona annettavan palvelun ja asumispalvelujen maksut", stm.fi/maksut-kotipalvelu-kotisairaanhoido.

²⁴⁰ Laki sosiaali- ja terveydenhuollon asiakasmaksuista, 1992, finlex.fi/fi/laki/ajantasa/1992/19920734.

²⁴¹ Suomen sosiaali ja terveys ry (SOSTE), "SOSTE selvitti: Lähes kaikki hyvinvointialueet perimässä lääkärikäynnistä suurimman mahdollisen maksun", 29 December 2022, soste.fi/uutiset/soste-selvitti-lahes-kaikki-hyvinvointialueet-perimassa-laakarikaaynnista-suurimman-mahdollisen-maksun/.

²⁴² Maaseudun tulevaisuus, "Näillä alueilla pienituloinen voi hakea alennusta lääkärikäynteihin tai suun terveydenhuollon maksuihin", 13 January 2023, maaseuduntulevaisuus.fi/uutiset/3a9cece8-a98a-4c5f-a397-cbfad04537d6.

²⁴³ Maria Vaalavuo (editor), *Sosiaali- ja terveydenhuollon asiakasmaksujen kohdentuminen, vaikutukset ja oikeudenmukaisuus*, 2018, julkaisut.valtioneuvosto.fi/bitstream/handle/10024/160727/30-2018-Asiakasmaksut.pdf, p. 19.

²⁴⁴ Maria Vaalavuo (editor), *Sosiaali- ja terveydenhuollon asiakasmaksujen kohdentuminen, vaikutukset ja oikeudenmukaisuus*, 2018, julkaisut.valtioneuvosto.fi/bitstream/handle/10024/160727/30-2018-Asiakasmaksut.pdf, p. 19.

²⁴⁵ Maria Vaalavuo (editor), *Sosiaali- ja terveydenhuollon asiakasmaksujen kohdentuminen, vaikutukset ja oikeudenmukaisuus*, 2018, julkaisut.valtioneuvosto.fi/bitstream/handle/10024/160727/30-2018-Asiakasmaksut.pdf, p. 119.

²⁴⁶ Maria Vaalavuo (editor), *Sosiaali- ja terveydenhuollon asiakasmaksujen kohdentuminen, vaikutukset ja oikeudenmukaisuus*, 2018, julkaisut.valtioneuvosto.fi/bitstream/handle/10024/160727/30-2018-Asiakasmaksut.pdf, p. 99.

²⁴⁷ Maria Vaalavuo (editor), *Sosiaali- ja terveydenhuollon asiakasmaksujen kohdentuminen, vaikutukset ja oikeudenmukaisuus*, 2018, julkaisut.valtioneuvosto.fi/bitstream/handle/10024/160727/30-2018-Asiakasmaksut.pdf, p. 99.

According to a survey conducted by THL, nearly one in five respondents had faced difficulties in accessing healthcare due to high user fees.²⁴⁸ The situation can be particularly burdensome for people on lower incomes as user fees take up a larger share of their disposable income.²⁴⁹ Reports suggest that as OOP payment costs increase, individuals are more likely to report unmet care needs.²⁵⁰

THE CLIENT CHARGES IN HEALTHCARE AND SOCIAL WELFARE ACT

The Client Charges in Healthcare and Social Welfare Act was reformed in 2021 with the aim of increasing the number of free healthcare services and making payments more equitable. Some services, such as nurses' visits, psychiatric treatment in PHC and outpatient care for children under 18 years of age were made cost-free. The payment ceiling for public services was extended to cover fees charged for oral healthcare, therapy, temporary home nursing and certain remote services.

Section 11 of the Act obliges WBSOs to reduce or waive user fees which are based on the patient's ability to pay if charging the payment would "endanger the livelihood" of the patient. The Act emphasizes that reductions or waivers take priority over income support. WBSOs are also required to inform patients about their right to reductions and waivers.²⁵¹ According to CESCR, realization of the right to health requires that healthcare services be accessible in relation to information. This includes the right to receive information concerning health issues.²⁵²

The Act has been criticized by civil society actors as inadequate to remove financial barriers to care. According to law, waivers and reductions for user fees only apply to fees based on the patient's ability to pay, not to fixed fees.

Amnesty International's interviews with service users revealed that many people are not always aware of their right to apply for waivers and reductions. As Suvi, a 62-year-old woman experiencing unemployment, explained when interviewed by Amnesty International: "I haven't applied for waivers. I wasn't aware of my right to waivers or reductions for user fees. Nobody informed me, I didn't know anything about this. I've just tried to avoid those situations, so I don't have to go there [to health care]." Jonna, a 34-year-old woman experiencing unemployment, shared similar experiences: "I have received income support in order to pay my healthcare payments... No one has informed me about my right to waivers or reductions for user fees. I have wondered how people manage with their healthcare bills when they don't have money."

Studies show that people are often unaware of waivers and reductions.²⁵³ This can lead to further financial difficulties and force people to rely on income support to pay user fees. However, income transfers are not sufficient to overcome obstacles to the accessibility of services, especially when they are based on retrospective reimbursement.²⁵⁴

WBSOs can choose to offer more favourable payment practices than what the law requires. For instance, the possibility for patients to apply for waivers and reductions for fixed user fees differs between regions.²⁵⁵ This however creates and strengthens geographical inequalities in the affordability of healthcare.

In Finland, social and healthcare user fees are directly eligible for recovery proceedings,²⁵⁶ a legal tool for the recovery of an unpaid debt or invoice. The number of recovery proceedings for social and healthcare user fees has gone up significantly in recent years.²⁵⁷ There were fewer than 200,000 recovery proceedings in 2012 and over 480,000 in 2022.²⁵⁸

²⁴⁸ The national population survey is conducted annually by THL using online and postal surveys. The annual sample is 10,000 (over 20 years old). FinSote, Korkeat asiakasmaksut haitanneet hoidon saantia, (%) terveyspalveluja käyttäneistä, 2020, terveytemme.fi/finsote/2020/html/fs_hc_access_payment_cr.html.

²⁴⁹ Maria Vaalavuo (editor), *Sosiaali- ja terveydenhuollon asiakasmaksujen kohdentuminen, vaikutukset ja oikeudenmukaisuus*, 2018, tietokayttoon.fi/documents/10616/6354562/30-2018-Asiakasmaksut.pdf/82c084e6-829e-4a46-b552-f9a9ad4d2b96/30-2018-Asiakasmaksut.pdf?version=1.0&t=1522993100000, pp. 100–101.

²⁵⁰ Sabine Chappain-Guillot and Olivier Guillot, "Health system characteristics and unmet care needs in Europe: an analysis based on EU-SILC data", *The European Journal of Health Economics*, Volume 16, [sci-hub.se/https://doi.org/10.1007/s10198-014-0629-x](https://doi.org/10.1007/s10198-014-0629-x), p. 11.

²⁵¹ Laki sosiaali- ja terveydenhuollon asiakasmaksuista, 1992, finlex.fi/fi/laki/ajantasa/1992/19920734, Section 11.

²⁵² CESCR, General Comment 14, Para 12b.

²⁵³ Tiina Saarela (editor), *Asiakasmaksut aiheuttavat ahdinkoa: Raportti kyselystä julkisen sosiaali- ja terveydenhuollon maksuista johtuvasta taloudellisesta ahdingosta paljon palveluja käyttävien arjessa*, 2020, eapn.fi/wp-content/uploads/2020/05/Asiakasmaksut-aiheuttavat-ahdinkoa.pdf, p. 8.

²⁵⁴ Maria Vaalavuo (editor), *Sosiaali- ja terveydenhuollon asiakasmaksujen kohdentuminen, vaikutukset ja oikeudenmukaisuus*, 2018, julkaisut.valtioneuvosto.fi/bitstream/handle/10024/160727/30-2018-Asiakasmaksut.pdf?sequence=1&isAllowed=y, p. 42.

²⁵⁵ Maaseudun Tulevaisuus, "Näillä alueilla pienituloisen voi hakea alennusta lääkärikäynteihin tai suun terveydenhuollon maksuihin", 13 February 2023, maaseuduntulevaisuus.fi/uutiset/3a9cece8-a98a-4c5f-a397-cbfad04537d6.

²⁵⁶ Laki sosiaali- ja terveydenhuollon asiakasmaksuista, 1992, finlex.fi/fi/laki/ajantasa/1992/19920734, Section 17.

²⁵⁷ Anne Perälähti, "Asiakasmaksulaki nyt eduskunnassa – esitys ei suojaa paljon sairastavia kohtuuttomilta maksuilta", 10 September 2020, soste.fi/blogikirjoitus/asiakasmaksulaki-nyt-eduskunnassa-esitys-ei-suojaa-paljon-sairastavia-kohtuuttomilta-maksuilta/.

²⁵⁸ National Enforcement Authority Finland, Office of Director General, information request, January 2023.

Table 2. Recovery proceedings for social and healthcare user fees²⁵⁹ between 2012 and 2022²⁶⁰:

2012	180,527
2013	213,205
2014	305,857
2015	326,877
2016	387,437
2017	355,468
2018	420,961
2019	456,568
2020	663,997
2021	559,453
2022	487,121

As Figure 7. shows, the number of user fee recovery proceedings has declined a little since the 2021 law reform of user fees. Nevertheless, many people still struggle with their healthcare payments. Surveys reveal that recovery proceedings have a wider impact that goes beyond financial distress. People have reported long-term distress and shame over losing their credit rating, feeling marginalized and not being able to participate in activities as a full member of society.²⁶¹

In interviews with Amnesty International, people agreed that doctors' appointments should be affordable for everyone. In addition, geographical inequality was raised because user fees are different in different regions. This can create inequalities in the affordability of care between people living in different parts of Finland.

“After all, it’s unequal that in some places you must pay for a doctor’s appointment and in other places you don’t.”

Kirsi, a 72-year-old pensioner

There are separate annual healthcare-related payment ceilings or maximum payment limits for: public services, medicines, and health-related travel expenses. In 2023, the limit beyond which patients do not have to pay fees is EUR 692 for public healthcare services;²⁶² EUR 592.16 for medicines;²⁶³ and EUR 300 for health-related travel expenses.²⁶⁴ Patients are responsible for monitoring when they have reached the annual payment ceiling. Survey studies have shown that people often find this difficult and may not be able to keep track of when the payment ceiling has been reached.²⁶⁵

²⁵⁹ Including: payment matters for social and health services; hospital and other inpatient fees; health centre fees; oral health care fees; child day care fees; home service fees; other fees for social and health services.

²⁶⁰ National Enforcement Authority Finland, Office of Director General, information request, January 2023.

²⁶¹ Tiina Saarela (editor), *Asiakasmaksut aiheuttavat ahdinkoa: Raportti kyselystä julkisen sosiaali- ja terveydenhuollon maksuista johtuvasta taloudellisesta ahdingosta paljon palveluja käyttävien arjessa*, 2020, eapn.fi/wp-content/uploads/2020/05/Asiakasmaksut-aiheuttavat-ahdinkoa.pdf, pp. 24–25.

²⁶² Ministry of Social Affairs and Health, “Terveydenhuollon maksukatto”, 2023, stm.fi/terveydenhuollon-maksukatto.

²⁶³ Kela, “Vuosiomavastuu eli lääkekatto”, 2023, kela.fi/laakkeet-laakekatto.

²⁶⁴ Kela, “Matkakorvauksen määrä ja omavastuu”, 2023, kela.fi/matkakorvaus-omavastuu.

²⁶⁵ Tiina Saarela (editor), *Asiakasmaksut aiheuttavat ahdinkoa: Raportti kyselystä julkisen sosiaali- ja terveydenhuollon maksuista johtuvasta taloudellisesta ahdingosta paljon palveluja käyttävien arjessa*, 2020, eapn.fi/wp-content/uploads/2020/05/Asiakasmaksut-aiheuttavat-ahdinkoa.pdf, p. 16.

HIGH MEDICINE COSTS

Medicines can be a significant expense for households in Finland. Kela, the Social Insurance Institution, reimburses part of the costs of prescribed medicines, but part is paid as a user fee or deductible.²⁶⁶ Medicines account for about a quarter of all expenditure²⁶⁷ on social and healthcare user fees – significantly more than the proportion of fixed fees.²⁶⁸ Reimbursement levels for medicines are relatively low as patients pay on average 34% of prescription medicine costs.²⁶⁹

“I have not taken some of my medications because they cost too much. For example, I have one diabetes medicine that costs about 90 Euros. At some point I didn’t use it for six months. I thought I didn’t need it. But on the other hand, my blood sugar was constantly high... Absolutely, I’ve had to neglect medical treatment because of the costs many times.”

Mikael, aged 48, in receipt of a work disability pension

The annual deductible for pharmaceuticals – that is, the limit for annual OOP payments after which Kela reimburses all additional costs – is high in Finland in comparison with other countries.²⁷⁰ In Finland the cap for medicines was EUR 580 in 2021²⁷¹ and EUR 592.16 in 2023.²⁷² In Sweden, payments for prescription medicines were capped at EUR 235 in 2021²⁷³ and Norway had a cap of EUR 235 that included prescription medicines and various health services, including, for instance, doctors’ appointments.²⁷⁴

Since the annual ceiling is relatively high and not based on the patient’s income, some people face difficulties affording their payments.²⁷⁵ This is especially true for families where several people need expensive medicines since the annual ceiling applies to each individual.²⁷⁶ Fanni, a 76-year-old pensioner, told Amnesty International: “The annual payment ceiling for medicines is never met. My payments reach about 500 Euros and then the year changes. I’ve never had any benefit from it [payment ceiling for medicines].”

²⁶⁶ People can get reimbursed for their medicine expenses after having met the initial deductible (EUR 50 per calendar year). Any products belonging to the reimbursement system and purchased on prescription count towards the initial deductible. The initial deductible is applied to adults. Once a person meets the initial deductible, they are reimbursed for medicine purchases at the pharmacy. The co-payment rates depend on the reimbursement category of the medicine and reimbursement entitlements. Kela, "Cost sharing for prescription medicines", 2023, kela.fi/reimbursements-for-medicine-expenses-cost-sharing.

²⁶⁷ Fixed fees, fees that depend on the patient's income, oral health care co-payments and deductibles paid for private health care services, medicines, and health care-related travel costs.

²⁶⁸ Maria Vaalavuuo (editor), *Sosiaali- ja terveydenhuollon asiakasmaksujen kohdentuminen, vaikutukset ja oikeudenmukaisuus*, 2018, tietokayttoon.fi/documents/10616/6354562/30-2018-Asiakasmaksut.pdf/82c084e6-829e-4a46-b552-f9a9ad4d2b96/30-2018-Asiakasmaksut.pdf?version=1.0&t=1522993100000, pp. 101–102.

²⁶⁹ Figure from 2017. Liina-Kaisa Tynkkynen et al. *Finland: Health system summary*, 2023, apps.who.int/iris/rest/bitstreams/1495991/retrieve, p. 7.

²⁷⁰ Leena K. Saastamoinen et al., "Keitä lääkekustannusten vuotuisen omavastuusuuden ylittäneet ovat?", in Ilpo Airio (editor), *Toimeentuloturvan verkkoa kokemassa: Kansalaisten käsitykset ja odotukset*, 2013, helda.helsinki.fi/bitstream/handle/10138/38496/Toimeentuloturva.pdf, p. 227.

²⁷¹ OECD, *State of Health in the EU: Finland - Country Health Profile 2021*, 2021, health.ec.europa.eu/system/files/2021-12/2021_chp_fi_english.pdf, p. 10.

²⁷² Kela, "Vuosiomavastuu eli lääkekatto", 2023, kela.fi/laakkeet_laakekatto.

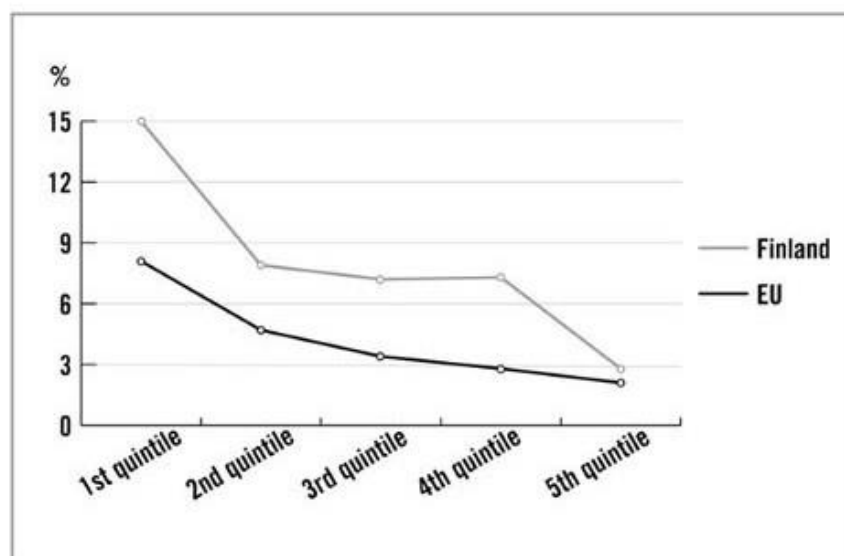
²⁷³ OECD, *State of Health in the EU: Sweden - Country Health Profile 2021*, 2021, health.ec.europa.eu/system/files/2021-12/2021_chp_sv_english.pdf, p. 10.

²⁷⁴ OECD, *State of Health in the EU: Norway - Country Health Profile 2021*, 2021, health.ec.europa.eu/system/files/2021-12/2021_chp_no_english.pdf, p. 10.

²⁷⁵ WHO, *Medicines reimbursement policies in Europe*, 2018, euro.who.int/_data/assets/pdf_file/0011/376625/pharmaceutical-reimbursement-eng.pdf, p. 59.

²⁷⁶ WHO, *Medicines reimbursement policies in Europe*, 2018, euro.who.int/_data/assets/pdf_file/0011/376625/pharmaceutical-reimbursement-eng.pdf, p. 59.

Figure 6. Self-reported unmet needs for prescription medicines due to financial reasons by income quintile in EU countries and Finland in 2019.²⁷⁷



Foregoing medicines due to high costs is most common among people on lower incomes and people in a worse state of health.²⁷⁸ In other words, people who need medicines the most can face the most obstacles in getting them.²⁷⁹ Several of the people Amnesty International interviewed had experiences of not being able to take all their prescribed medicines because of high costs. As Elisa, a 64-year-old pensioner, explained: “For now, I have a medical expenses insurance and it helps me with my medicine costs. When it expires at the end of this year, I’ll have trouble with my medicines. I’m probably going to have to stop taking one medicine altogether... The payment ceiling for medicines is very high. My most expensive medicine doesn’t even accumulate the ceiling, as far as I know.”

“I had a client who couldn’t afford to buy medicines for their blood pressure. My co-worker measured their blood pressure, and it was so high that we had to get them medication from the inpatient ward so they could make it to the next payment date... It’s common that people can’t afford medication. They ration them. They take them every other day or every now and then.”

Veera Luoto, social worker, Finnish National Organization of the Unemployed

One concrete example of the impact of medicine costs on people’s lives is the change in the reimbursement of diabetes medicine made in 2017. Reimbursements for medicines used to treat type 2 diabetes were cut by increasing the deductibles paid by patients. In one

²⁷⁷ Eurostat, “Self-reported unmet needs for specific health care-related services due to financial reasons by sex, age and income quintile”, ec.europa.eu/eurostat/databrowser/product/page/HLTH_EHIS_UN2I_custom_5585684.

²⁷⁸ Katri Aaltonen et al., “Kenellä ei ole varaa lääkkeisiin?”, in Ilpo Airio (editor), *Toimeentuloturvan verkkoa kokemassa: Kansalaisten käsitykset ja odotukset*, 2013, helda.helsinki.fi/bitstream/handle/10138/38496/Toimeentuloturva.pdf, pp. 235–236.

²⁷⁹ Katri Aaltonen et al., “Kenellä ei ole varaa lääkkeisiin?”, in Ilpo Airio (editor), *Toimeentuloturvan verkkoa kokemassa: Kansalaisten käsitykset ja odotukset*, 2013, helda.helsinki.fi/bitstream/handle/10138/38496/Toimeentuloturva.pdf, p. 243.

study, nearly half of respondents reported that the change had had an impact on their lives.²⁸⁰ The most common reported impact was a financial one such as increased expenditure, difficulties in buying medicines and saving or borrowing money to buy medicines.²⁸¹

People on lower incomes who have difficulties in paying for their medicines may have to economize, for example on food expenditure or other essential expenses.²⁸² However, it has also been noted that people may not prioritize medicines when having to decide on whether to afford food or medicines.²⁸³ Postponing care can potentially cause more serious health problems in the future, which is not only harmful for the individual but also places an avoidable additional burden on the healthcare system since SHC is often more expensive than PHC.²⁸⁴

6.2 LONG WAITING TIMES IN PUBLIC HEALTHCARE

“The truth is that that people can’t access doctors’ nor even really nurses’ appointments.”

Doctor

Finland has the obligation to provide equal and timely access to healthcare services for all. Persistently long waiting times in public healthcare services, while waiting times in OHC are generally miniscule, create inequality – with those who rely on public services too often waiting for unreasonable times to access the services they need. Furthermore, people may struggle to even make contact with public service providers in order to book first or follow-up appointments.

A 2021 survey conducted by the Finnish Medical Association revealed that 30% of respondents who visited a health centre had had problems in accessing doctors’ appointments due to long waiting times.²⁸⁵ In previous surveys the figures were lower: 28% in 2017 and 26% in 2014. In the same survey, 66% of health centre medical directors agreed that residents in their municipality faced some or significant difficulties in accessing doctors’ appointments in health centres due to long waiting times.²⁸⁶

Access to services and waiting times are not the same across the country. However, some patients had had to wait for care for more than three months across all regions.²⁸⁷ According to a 2022 patient survey by the THL on health centre service satisfaction, experiences of regional differences in access to services persist, with poorer results especially in the Uusimaa region.²⁸⁸ There were also notable differences in access to services within regions.²⁸⁹

People interviewed by Amnesty International agreed that long waiting times made it harder to access healthcare services when they needed them. Several interviewees said that waiting causes them to worry about their health and feel stressed. Some also mentioned that it forces them to put up with their symptoms or pain. Some felt that waiting had made their health problems worse. When interviewed by Amnesty International, Oskari, a 76-year-old pensioner, said: “My hope is to get to [health services] as quickly as possible. Because now I see that the biggest problem is access. That’s what causes the problem. And, in fact, it causes bitterness when they tell you that your appointment is in one month. Then you just suffer with the pain.”

²⁸⁰ Hanna Rättö et al., “Diabeteslääkkeiden korvauksia leikattiin – miten kävi potilaiden?”, 2022, invest.utu.fi/wp-content/uploads/2022/01/Diabeteslaakkeiden-korvauksia-leikattiin-miten-kavi-potilaiden.pdf, p. 3.

²⁸¹ Hanna Rättö et al., “Diabeteslääkkeiden korvauksia leikattiin – miten kävi potilaiden?”, 2022, invest.utu.fi/wp-content/uploads/2022/01/Diabeteslaakkeiden-korvauksia-leikattiin-miten-kavi-potilaiden.pdf, p. 3.

²⁸² Leena K. Saastamoinen et al., “Keitä lääkekustannusten vuotuisen omavastuusuuden ylittäneet ovat?”, in Ilpo Airio (editor), *Toimeentuloturvan verkkoa kokemassa: Kansalaisten käsitykset ja odotukset*, 2013, helda.helsinki.fi/bitstream/handle/10138/38496/Toimeentuloturva.pdf, p. 224.

²⁸³ Kirsi Kvarnström, *Why patients do not take medication as prescribed: The complexity of medication adherence as a phenomenon*, 2022, helda.helsinki.fi/bitstream/handle/10138/349782/Kvarnstr%c3%b6m_Kirsi_dissertation_2022.pdf?sequence=1&isAllowed=y, p. 93.

²⁸⁴ Hallituksen esitys eduskunnalle laiksi terveydenhuoltolain muuttamisesta ja siihen liittyviksi laeiksi (HE 74/2022 vp), 2022, eduskunta.fi/FI/vaski/HallituksenEsitys/Sivut/HE_74+2022.aspx.

²⁸⁵ The information was collected by Kantar TNS through phone interviews 25.10.–9.11.2021. There were 1,003 respondents. Respondents were people from the Finnish population that were of age 15–79. Finnish Medical Association, “Väestökysely hoitoon pääsystä 2021”, 2021, laakariliitto.fi/site/assets/files/5227/vaestokysely_hoitoon_paaasyta_2021.pdf, p. 14.

²⁸⁶ Finnish Medical Association, “Väestökysely hoitoon pääsystä 2021”, 2021, laakariliitto.fi/site/assets/files/5227/vaestokysely_hoitoon_paaasyta_2021.pdf, p. 17.

²⁸⁷ THL, “Mitä mieltä asiakkaat ovat terveyskeskusten vastaanottopalveluista 2022”, 2022, thl.fi/documents/9716163/9879162/Terveysasemat_asiakaspalaute_2022.pdf/f18aff45-547b-d166-7eb7-dbddef89d4ce?t=1672839459154.

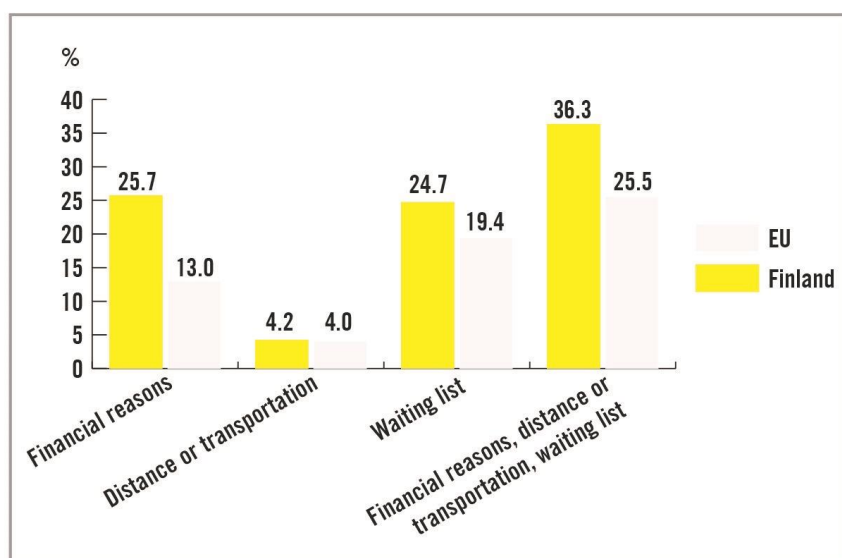
²⁸⁸ The survey included about 13,900 respondents from almost 200 municipalities who had used health centre services either in person or online. THL, “Mitä mieltä asiakkaat ovat terveyskeskusten vastaanottopalveluista 2022”, 2022, thl.fi/documents/9716163/9879162/Terveysasemat_asiakaspalaute_2022.pdf/f18aff45-547b-d166-7eb7-dbddef89d4ce?t=1672839459154.

²⁸⁹ THL, “Mitä mieltä asiakkaat ovat terveyskeskusten vastaanottopalveluista 2022”, 2022, thl.fi/documents/9716163/9879162/Terveysasemat_asiakaspalaute_2022.pdf/f18aff45-547b-d166-7eb7-dbddef89d4ce?t=1672839459154.

In August 2022, 44% of patients couldn't access a non-urgent doctor's appointment within a week and 33% within two weeks following a treatment needs assessment.²⁹⁰ A smaller number of patients, 1%, had had to wait for a doctor's appointment in PHC for more than three months.²⁹¹ It is important to note that these statistics on waiting times only include those patients who have been able to contact their health centre (see next section for obstacles people experience in contacting their health centre).

Long waiting times are closely associated with lower incomes. As stated above, before the pandemic in 2019, one in four people in Finland reported having unmet needs for healthcare due to long waiting times.²⁹² The EU average was less than one in five.²⁹³ The share of self-reported unmet needs for healthcare due to long waiting times decreases as income levels rise.²⁹⁴ This indicates that long waiting times impact people on lower incomes more than people on higher incomes, who can use other than public services. Similarly, in an OECD country mapping, in 16 out of 30 countries, people on lower incomes had a significantly higher probability than those on higher incomes of postponing care due to waiting times.²⁹⁵ Finland had one of the widest gaps (15 percentage points) of the compared countries.²⁹⁶

Figure 7. Self-reported unmet needs for healthcare owing to financial reasons, distance or transport, and waiting lists in EU countries and Finland in 2019.²⁹⁷



²⁹⁰ In a treatment needs assessment, a health care professional assesses the patient's need for medical help based on the patient's symptoms and the urgency of the matter. Usually, this includes making an appointment to the patient and/or providing home care instructions. Kaisa Mölläri and Tiina Marttila, "Hoitoonpääsy perusterveydenhuollossa syksyllä 2022: Terveyskeskusten kiireettömistä lääkärikäynneistä vajaa 60 prosenttia toteutui viikossa syksyllä 2022", 2022, julkari.fi/bitstream/handle/10024/145778/Tilastoraportti%2046%202022.pdf?sequence=1&isAllowed=y, p. 1.

²⁹¹ Kaisa Mölläri and Tiina Marttila, "Hoitoonpääsy perusterveydenhuollossa syksyllä 2022: Terveyskeskusten kiireettömistä lääkärikäynneistä vajaa 60 prosenttia toteutui viikossa syksyllä 2022", 2022, julkari.fi/bitstream/handle/10024/145778/Tilastoraportti%2046%202022.pdf?sequence=1&isAllowed=y, p. 2.

²⁹² Eurostat, Self-reported unmet needs for health care by sex, age, specific reasons and income quintile, ec.europa.eu/eurostat/databrowser/view/HLTH_EHIS_UN1/default/table?lang=en&category=hlth.hlth_care.hlth_unm.

²⁹³ Eurostat, Self-reported unmet needs for health care by sex, age, specific reasons and income quintile, ec.europa.eu/eurostat/databrowser/view/HLTH_EHIS_UN1/default/table?lang=en&category=hlth.hlth_care.hlth_unm.

²⁹⁴ Eurostat, Self-reported unmet needs for health care by sex, age, specific reasons and income quintile, ec.europa.eu/eurostat/databrowser/view/HLTH_EHIS_UN1_custom_3789746/default/table?lang=en.

²⁹⁵ OECD, *Health for Everyone?: Social inequalities in health and health systems*, 2019, oecd-ilibrary.org/docserver/3c8385d0-en.pdf?expires=1675082037&id=id&accname=guest&checksum=B7F1768493416F0BD45119FD8BBD79D2, p. 140.

²⁹⁶ OECD, *Health for Everyone?: Social inequalities in health and health systems*, 2019, oecd-ilibrary.org/docserver/3c8385d0-en.pdf?expires=1675082037&id=id&accname=guest&checksum=B7F1768493416F0BD45119FD8BBD79D2, p. 155.

²⁹⁷ Eurostat, "Self-reported unmet needs for health care by sex, age, specific reasons and income quintile", [ec.europa.eu/eurostat/databrowser/product/page/HLTH_EHIS_UN1%\\$DEFAULTVIEW](https://ec.europa.eu/eurostat/databrowser/product/page/HLTH_EHIS_UN1%$DEFAULTVIEW).

TREATMENT TIME GUARANTEES FAIL TO ENSURE ACCESS TO SERVICES

“There used to be talk of a treatment time guarantee, but nothing is being said about it any more. They are just beautiful words, not reality.”

Nurse

Long waiting times in public healthcare had already been recognized as a problem by the 1990s.²⁹⁸ To curb chronically long waiting times and improve the availability of public healthcare services, a treatment time guarantee was introduced in a 2004 law which came into force in 2005.²⁹⁹ According to the Health Care Act,³⁰⁰ patients in Finland must be able to contact PHC immediately on weekdays during office hours. An assessment of the need for treatment must be made no later than on the third working day after initial contact. If the patient is referred to SHC, the needs assessment must be started within three weeks of referral. Non-urgent care should start within three months of assessment for PHC and six months for SHC and oral healthcare.

According to a 2008 audit report by the National Audit Office, due to a shortage of doctors, there had been problems in implementing the treatment time guarantee and ensure quick access to doctors' appointments.³⁰¹ During the first years of implementation of the guarantee, the public healthcare system began to experience a shortage of nurses in addition to a shortage of doctors.³⁰² Implementation of the treatment time guarantee continues to be difficult, even more so in the wake of the Covid-19 pandemic.

Despite notable challenges in implementing the current treatment time guarantee, the government decided to tighten guarantees during 2023-2024, so that from 2024 onwards, treatment in PHC must start within seven days of needs assessment and within three months for oral healthcare.³⁰³ However, as noted in the government proposal on the treatment time guarantee, the implementation of the guarantee in outpatient PHC requires an increase in permanent healthcare personnel, for which there are no quick and easy solutions.³⁰⁴

DIFFICULTIES IN CONTACTING SERVICES AND GETTING APPOINTMENTS

“When calling [for an appointment] after ‘1, 2, 3’ comes ‘leave a call-back request’. And when you leave a call-back request, no one calls.”

Nina, user of public services, aged 57

In Finland, access to a health centre is generally only possible after contacting them and receiving an appointment. Usually this happens by calling the health centre. On weekdays during opening hours, patients should be able to contact the health centre

²⁹⁸ Valtiontalouden tarkastusvirasto, *Hoitotakuu: Valtiontalouden tarkastusviraston toiminnantarkastuskertomus 167/2008*, vtv.fi/app/uploads/2018/07/03110102/hoitotakuu-167-2008.pdf, p. 17.

²⁹⁹ Hallituksen esitys Eduskunnalle laeiksi kansanterveyslain ja erikoissairaanhoidolain sekä eräiden muiden lakien muuttamisesta, 2004, eduskunta.fi/FI/vaski/HallituksenEsitys/Documents/he_77+2004.pdf, pp. 1, 25.

³⁰⁰ Terveydenhuoltolaki – Health Care Act, 2010, finlex.fi/fi/laki/ajantasa/2010/20101326#L6P51, Chapter 6, section 51, 52.

³⁰¹ Valtiontalouden tarkastusvirasto, *Hoitotakuu: Valtiontalouden tarkastusviraston toiminnantarkastuskertomus 167/2008*, vtv.fi/app/uploads/2018/07/03110102/hoitotakuu-167-2008.pdf, p. 93.

³⁰² Seppo Tuomola et al., *Arviointiselvitys vuosina 2002–2007 toteutetusta kansallisesta terveyshankkeesta: Terveydenhuollon tulevaisuuden turvaamista koskevan valtioneuvoston periaatepäätöksen toteutuminen*, 2008, julkaisut.valtioneuvosto.fi/bitstream/handle/10024/74145/Arviointiselvitys_vuosina_2002_2007_toteutetusta_Kansallisesta_terveyshankkeesta_fi.pdf?sequence=1, p. 19.

³⁰³ Eduskunta, "Eduskunta hyväksyi seitsemän päivän hoitotakuuta koskevan lain", 16 November 2022, eduskunta.fi/FI/tiedotteet/Sivut/Eduskunta-hyvaksyi-seitseman-p%C3%A4ivan-hoitotakuuta-koskevan-lain-.aspx.

³⁰⁴ Hallituksen esitys eduskunnalle laiksi terveydenhuoltolain muuttamisesta ja siihen liittyviksi laeiksi (HE 74/2022 vp), 2022, eduskunta.fi/FI/vaski/HallituksenEsitys/Documents/HE_74+2022.pdf, p. 84.

immediately via phone or by going to the health centre without calling first.³⁰⁵ If the treatment needs assessment cannot be done during the first contact, it should be carried out no later than on the third weekday after the initial contact.³⁰⁶ However, people may not always be familiar with the different ways in which they can contact healthcare services as Kimmo, a 44-year-old on a work disability pension, told by Amnesty International: “In addition to waiting times, it hasn’t always been clear to me how to get contact with the health centre.”

In 2022, there were numerous media reports about problems with phone services at health centres around the country.³⁰⁷ According to media reporting, there were significant delays in call-backs to patients. The Regional State Administrative Agency for Southern Finland issued a notice to the Joint Municipal Authority for Social and Healthcare in Central Uusimaa in June 2022 and again in December 2022.³⁰⁸ According to these notices, access to health centres has not complied with the law.³⁰⁹ People have been unable to contact health centres; some have waited for call-backs for days or even weeks while some of the links and telephone numbers given on health centres’ websites have not worked and access to doctors’ appointments have been delayed.³¹⁰

In January 2023, there were reports of serious backlogs in non-urgent call-back times in Western Uusimaa WBSC.³¹¹ People in the cities of Espoo and Kirkkonummi had to wait for three to 10 days to get a call. There were 4,000 people on call-back lists. In Central Uusimaa WBSC there was a backlog of almost 2,900 call-backs at the end of January 2023.³¹² Some people had to wait for call-backs for several weeks. After the call, if the matter was not resolved over the phone, a doctor assessed remotely when the patient needed an appointment, with some people waiting well over three weeks before they see a doctor in person. One of the causes of such delays was said to be staff shortages.

These problems are not new. In 2021, the Deputy Chancellor of Justice reprimanded the City of Espoo for illegally and systematically deleting thousands of unanswered calls by patients waiting for a call-back and considered this to have threatened the health of some callers.³¹³ The same year, the City of Turku had sent text messages to callers, with a delay of two or three days, informing them that their call had been deleted and that if they still needed to contact the health centre, they needed to call again.³¹⁴

Most of the people Amnesty International interviewed had at some point had difficulties in contacting healthcare services. Many said that it takes too long to receive a call after leaving a call-back request. Some mentioned that promises to contact the patient regarding their appointments are not always kept and people are left to wait even for a first contact with healthcare professionals without knowing when that first contact will happen.

“It has happened often to me that they promise to call me and then they never do. For example, I was transferred [as a patient] to an internal medicine clinic, but that clinic no longer exists. Then I was transferred to the health centre, but I didn’t have an appointment. I had to try to get another appointment to a place where none was available.”

Mimmi, aged 30, who has experienced unemployment

Some of the people Amnesty International interviewed shared their experiences regarding the phone services of health centres. They spoke of the stress and frustration of waiting for a call-back without knowing if or when it would happen and possibly missing the call when it finally comes. For some, phone calls are not that accessible as Tuulia, a 64-year-old pensioner on a low income, explained to

³⁰⁵ Ministry of Social Affairs and Health, “Hoitoon pääsy (hoitotakuu)”, 2023, <https://stm.fi/hoitotakuu>.

³⁰⁶ Terveydenhuoltolaki – Health Care Act, 2010, finlex.fi/fi/laki/ajantasa/2010/20101326#L1P10-2, Chapter 6, section 51.

³⁰⁷ See, for example, Aamulehti, “Mies joutui odottamaan terveys-aseman takaisin-soittoa yli viikon ajan – Tampereen terveysasemien puhelinruuhkia puretaan nyt uuden käytännön avulla”, 5 August 2022, aamulehti.fi/tampere/art-2000008971960.html; Epari, “Korona sotkee terveyskeskuksen soitto-ruumaa – Siru Manninen odotti takaisinsoittoa 17 päivää”, 11 March 2022, epari.fi/uutiset/korona-sotkee-terveyskeskuksen-soitto-ruumaa-siru-manninen-odotti-takaisinsoittoa-17-p%C3%A4iv%C3%A4%C3%A4; MTV Uutiset, “Porvoolaisäiti järkyttyi terveyskeskuksen puhelinjonon pituudesta: ‘Olet jonotuspaikalla 308’”, 19 November 2022, mtvuutiset.fi/artikkeli/porvoolaisaiti-jarjytyi-terveyskeskuksen-puhelinjonon-pituudesta-olet-jonotuspaikalla-308/8567468#gs.n26j55.

³⁰⁸ Information request: Regional State Administrative Agency for Southern Finland, February 2023.

³⁰⁹ Information request: Regional State Administrative Agency for Southern Finland, February 2023.

³¹⁰ Information request: Regional State Administrative Agency for Southern Finland, February 2023.

³¹¹ Yle Uutiset, “4 000 ihmistä jumissa terveydenhuollon takaisinsoittojonossa Espoossa ja Kirkkonummella – odotusaika jopa 10 päivää”, 4 January 2023, yle.fi/a/74-20011516.

³¹² Yle Uutiset, “Tuhannet suomalaiset odottavat soittoa terveysasemaltaan: Maiju Tirkkonen tarkkaili puhelintaan jopa koulun loppukokeessa”, 27 January 2023, yle.fi/a/74-20014428.

³¹³ Chancellor of Justice, Kaupungin terveydenhuollon toiminta takaisinsoittopyyntöjen käsittelyssä (OKV/1597/10/2020), 2021, oikeuskansleri.fi/-/kaupungin-terveydenhuollon-toiminta-takaisinsoittopyyntöjen-kasittelyssa.

³¹⁴ Yle Uutiset, “Terveyskeskusten takaisinsoittopalvelut ovat ruuhkautuneet korona-aikana – puheluiden poistaminen ei ole sallittua, mutta silti niin tapahtuu”, 2 August 2021, yle.fi/a/3-12041117.

Amnesty International: “You can’t go to the health centre for something acute. There’s no one there. You must call them. And then if the phone doesn’t work for some reason or it’s breaking up, it’s hard that there is no one there... Also, for people with hearing loss, I have a little hearing problem too, it’s terribly difficult to talk on the phone. It’d be easier if there was a person there. You wouldn’t have to watch your phone all the time. When are they going to call or are they going to call at all.”

Accessibility of phone services was also raised when Amnesty International interviewed a senior social worker: “Homeless clients who don’t have phones or other people who don’t have phones or access to internet. We have a lot of customers who don’t have either. We here in social services have been given a so-called hotline to healthcare. If a customer is in a meeting with us and we make a call [to the health centre] together, it is very rare to get an appointment for the customer. They must be able to reach the customer for them to give an appointment. A call-back doesn’t help if we call from the social worker’s phone and the call comes after five hours.”

In addition to making initial contact, people experience difficulties in accessing follow-up appointments, for instance, getting hold of the results of tests or appointments regarding follow-ups on their medication. Miia, who has experienced unemployment, told Amnesty International: “I’ve been to the [special care unit] at TYKS when I was examined there. That ended at the beginning of this year, and I was told that my hepatic [liver] values should be monitored because of the medication. I tried to get to the health centre’s laboratory, but I couldn’t. I’ve been trying to call there since the beginning of the year until summer... Well, then I gave up on the laboratory.” Similarly, Suvi, a 62-year-old woman experiencing unemployment, explained: “When I’ve had [laboratory] tests, I’ve never received the results. They said they’d call, but they’ve never called. When I’ve called them, I don’t know who I should’ve called, and that has been the end of the matter. I’m really surprised it’s so careless. It’s really confusing. If I had money, I’d go to a private clinic.”

Some people told Amnesty International that they were not given any sort of treatment plan or were passed from one service to another. Delayed treatment results not only in prolonged suffering for the patient and loss of trust in the system but can also worsen the prognosis.

“I wondered why I was prescribed medicines that I can’t talk about with the personnel... When I used the medication, I would’ve liked to have been able to tell the doctor that they made my heart hurt. To ask if that’s normal. If the doctor had only called. I haven’t really taken the medications because I’ve been scared. I’ve been trying to call the health centre. It’s always been the case that they promise to call back, but they don’t necessarily.”

Olivia, a 23-year-old student

6.3 LIMITED AVAILABILITY AND AFFORDABILITY OF CERTAIN HEALTH SERVICES

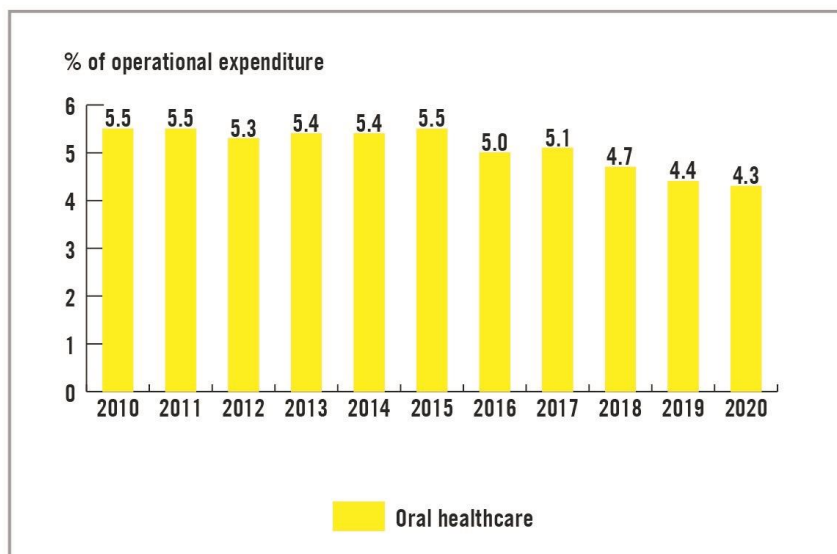
This section details difficulties in accessing specific services, including oral healthcare services, mental health services and gynaecological services. This is not an exhaustive survey as access difficulties were also reported regarding other services, such as healthcare services for eye diseases and several interviewees who use drugs talked about difficulties in accessing treatment for drug dependency as well as the stigmatization they experience when using healthcare services. The services detailed below were brought up most frequently in interviews with health experts and with people talking about their difficulties in accessing the services they needed.

6.3.1 DEEP SOCIOECONOMIC INEQUALITY IN ORAL HEALTHCARE

Finland has the obligation to ensure access to timely and affordable oral health care services. Minimising inequality requires allocation of resources for the benefit of those who are marginalised or at risk of discrimination. However, public oral health services in Finland are poorly available, with long waiting times. Both public and private services can be expensive for patients. As a result, unmet needs

for oral health care in Finland are high, with especially those marginalised or at risk of discrimination having difficulties accessing and using services.

Figure 8. Oral healthcare expenditure in Finland 2010-2020, percentage of total healthcare operational expenditure.³¹⁵



“I didn’t get a dentist’s appointment although I tried many times. I gave up.”

Irja, a 68-year-old pensioner

Oral healthcare services are available through a multitude of providers: WBSCs, private providers, student healthcare services and, to a lesser extent, through OHC. Private service providers are significant actors in Finnish oral healthcare services, with half of adult oral healthcare services delivered privately.³¹⁶

Socio-economic inequality in oral health in Finland is a long-term phenomenon: since the 1980s, oral health has improved most among those on higher incomes and with a higher level of education.³¹⁷ In the early 2000s, publicly supported oral health services were made available to adults – previously they were available only to children and certain other groups, such as those with specific chronic conditions.³¹⁸

In a Ministry of Social Affairs and Health overview of trends in socioeconomic health inequality during 1980-2005, it was noted that relative to need, those with a high income use oral healthcare services more often than people on a low income.³¹⁹ The Finnish Dental Association and the Finnish Dental Society Apollonia have stated that socio-economic inequality in oral health persists due to inadequate oral health services for adults.³²⁰ They also noted that especially vulnerable groups, such as those experiencing long-term unemployment, people living with mental health conditions, people who use drugs and older people living alone, experience considerable problems accessing oral healthcare and services for them are lacking.³²¹

³¹⁵ THL, "Terveystieteiden tutkimuskeskus 2020", Liitetaulukko 3. Terveystieteiden tutkimuskeskusten rakenteen toiminnollinen 2000–2020, % käypähintaisista käyttämönoista, julkari.fi/bitstream/handle/10024/146539/TR18_23.pdf?sequence=1&isAllowed=y.

³¹⁶ Finnish Dental Association, "Hammaslääkäriiliiton lausunto Hallituksen esityksestä eduskunnalle sairausvakuutuslain 2 ja 3 luvun muuttamisesta, HE 237/2022 vp", eduskunta.fi/FI/vaski/JulkaisuMetatieto/Documents/EDK-2022-AK-60338.pdf, p. 1.

³¹⁷ Lisa Bøge Christensen et al., "Suunterveyteen liittyvä eriarvoisuus Pohjoismaissa", *Hammaslääkäri*, 6/2021, lehtiluukku.fi/lehti/hammaslaakarilehti/read/06-2021/278197.html, p. 51.

³¹⁸ Ilmo Keskimäki et al., *Finland: Health system review*, 2019, apps.who.int/iris/bitstream/handle/10665/327538/HiT-21-2-2019-eng.pdf?sequence=7&isAllowed=y, p. 122.

³¹⁹ Hannele Palosuo, "Summary and conclusions", in Hannele Palosuo et al. (editors), *Health inequalities in Finland: trends in socioeconomic health differences 1980–2005*, 2009, julkaisut.valtioneuvosto.fi/bitstream/handle/10024/72254/URN%3aNBN%3afe201504224334.pdf?sequence=1&isAllowed=y, p. 225.

³²⁰ Finnish Dental Association, "Tiedote: Suunterveyden eriarvoisuus pitää ratkaista", 11 June 2021, hammaslaakariliitto.fi/fi/ajankohtaista/ajassa/tiedote-suunterveyden-eriarvoisuus-pitaa-ratkaista#.Y9zFkK1ByUm.

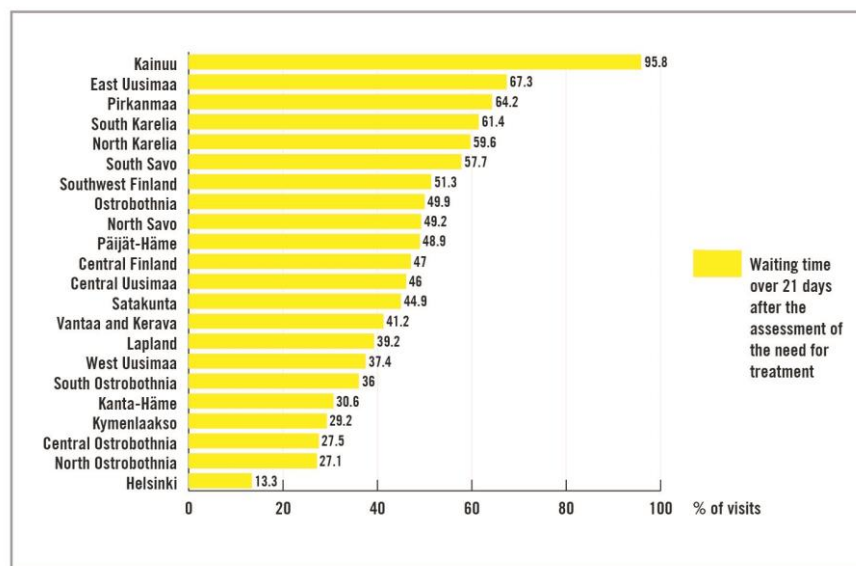
³²¹ Finnish Dental Association, "Tiedote: Suunterveyden eriarvoisuus pitää ratkaista", 11 June 2021, hammaslaakariliitto.fi/fi/ajankohtaista/ajassa/tiedote-suunterveyden-eriarvoisuus-pitaa-ratkaista#.Y9zFkK1ByUm.

As noted in section 5.2, there is a notable shortage of dentists in health centres. There are also regional differences in the number of dentists³²² and large differences in the number of specialist dentists in relation to population.³²³ In 2022, the share of unfilled health centre dentist vacancies was largest in the hospital districts of East Savonia (47%), Åland (44%) and Länsi-Pohja (33%) and smallest in the hospital districts of North Savonia (1%), and Helsinki and Uusimaa (4%).³²⁴

Health centre capacity was never designed to respond to the needs of the whole population – about half of adults are treated in public healthcare and half in private healthcare.³²⁵ Employers are not required to provide oral health services as a part of OHC, but some do.³²⁶ Kela reimburses part of patient costs for using private oral healthcare services, but reimbursements, which cover only about 15% of costs,³²⁷ are received especially by those on higher incomes.³²⁸ This could indicate that people on higher incomes use private services more than those on lower incomes, since with the low reimbursement level, services are still expensive for those on lower incomes.

According to a 2020 survey by the THL, nearly one in four (23.8%) of respondents had unmet needs for dental services.³²⁹ The proportion of people who experience difficulties accessing oral healthcare services varied widely between different regions.³³⁰ In Helsinki and the Kainuu region, approximately one in three people had had difficulties in receiving care whereas in South Ostrobothnia the proportion of people was approximately one in seven.³³¹ A 2021 patient satisfaction survey by the THL found that accessing oral healthcare services was more difficult in larger cities.³³²

Figure 9. Waiting times for a non-acute dental appointments over 21 days after the assessment of the need for treatment in March 2021.³³³



³²² Finnish Dental Association, "Hammaslääkärit sairaanhoitopiireittäin", 2018, hammaslaakariliitto.fi/liiton-toiminta/tutkimukset-ja-tilastot/tilastot/hammaslaakarit-sairanhoitopiireittain#.Y-JAinZBy5c.

³²³ Johanna Rellman et al., *Erikoislääkäri- ja erikoishammaslääkäritilanne ja koulutustarve vuoteen 2035, 2022, julkaisut.valtioneuvosto.fi/bitstream/handle/10024/164401/STM_2022_21_rap.pdf?sequence=7&isAllowed=y*, p. 26.

³²⁴ Statistics and Indicator Bank Sotkanet, "Täyttämättömien terveyskeskushammaslääkärin virkojen/toimien (hammaslääkäriavaj) osuus kaikista terveyskeskushammaslääkärin viroista/toimista, %, 2022, sotkanet.fi/sotkanet/fi/taulukko?indicator=s45MBQA=®ion=s7YssM7SM4y3BAA=&year=sy5zBgA=&gender=t.

³²⁵ Finnish Dental Association, "Tiedote: Suun terveydenhuollon resurssipula näkyy monella hyvinvointialueella", 27 January 2023, hammaslaakariliitto.fi/fi/ajankohtaista/ajassa/tiedote-suun-terveydenhuollon-resurssipula-nakyy-monella-hyvinvointialueella#.Y9u4A61ByUJ; Hallituksen esitys eduskunnalle sairausvakuutuslain 2 ja 3 luvun muuttamisesta (HE 237/2022 vp), 2022, eduskunta.fi/Fl/vaski/HallituksenEsitys/Documents/HE_237+2022.pdf, p. 13.

³²⁶ Ilmo Keskimäki et al., *Finland: Health system review, 2019*, apps.who.int/iris/bitstream/handle/10665/327538/HIT-21-2-2019-eng.pdf?sequence=7&isAllowed=y, p. 122.

³²⁷ Figure from 2017. Liina-Kaisa Tynkynen et al. *Finland: Health system summary, 2023*, apps.who.int/iris/rest/bitstreams/1495991/retrieve, p. 12.

³²⁸ HE 237/2022 vp, eduskunta.fi/Fl/vaski/HallituksenEsitys/Documents/HE_237+2022.pdf, p. 8.

³²⁹ FinSote, "Hammaslääkärin palveluita riittämättömästi saaneiden osuus, (%) tarvinneista, 2020, terveytemme.fi/finsote/2020/html/fs_htc_need_dentist_cr.html.

³³⁰ FinSote, "Hammaslääkärin palveluita riittämättömästi saaneiden osuus, (%) tarvinneista, 2020, terveytemme.fi/finsote/2020/raportti/atlas.html?select=1001&data=fs_htc_need_dentist_cr.

³³¹ FinSote, "Hammaslääkärin palveluita riittämättömästi saaneiden osuus, (%) tarvinneista, 2020, terveytemme.fi/finsote/2020/raportti/atlas.html?select=1001&data=fs_htc_need_dentist_cr.

³³² The survey was conducted in November-December 2021. There were 13 200 respondents who had used public oral health care services. THL "Tätä mieltä asiakkaat suun terveydenhuollon palveluista 2021", thl.fi/documents/9716163/9879398/Suun_th_tulokset_2021.pdf/1af8691e-9f75-d203-29f8-fe0188b397c9?t=1672839902580, pp. 5–6.

³³³ Tilasto- ja indikaattoriportti Sotkanet, "Perusterveydenhuollon suun terveydenhuollon hammaslääkärin kiireettömän käynnin odotusaika yli 21 pv hoidon tarpeen arvioinnista, % toteutuneista käynneistä (maaliskuun tilanne)", 2021, sotkanet.fi/sotkanet/fi/taulukko?indicator=s3YLBgA=®ion=s0GntM7VM7TWNTWwNky01k0qjDcyNDGyNtlzjDcytk7WMwQA&year=sy5zAgA=&gender=t&abs=f&color=f&buildVersion=3.1.1&buildTimestamp=202211091024.

“When they said that there are 14,000 people on the waiting list for oral healthcare, and I think of a line with that number of people, it makes me wonder how anyone can get anywhere.”

Kaarina, a 78-year-old pensioner

According to a recent doctoral dissertation by Jari Linden from the University of Helsinki, the trend in public oral healthcare services in Finland is that of worsening quality, lengthening gaps between examinations and increased tooth extractions compared to preventive and high-quality comprehensive care.³³⁴ This is echoed in the experiences of dentists. In a 2022 survey by the Finnish Dental Association, 54% of dentists working in health centres said they did not think that their health centre was able to provide good treatment for patients and 72.4% said that treatment intervals for patients are too long.³³⁵ Furthermore, 53.7% said that instead of giving patients the complete treatment that they need, they were often forced to resort to partial treatment solutions.³³⁶ Only one in 10 dentists working in health centres thought that better care would be provided to patients in the future.³³⁷

“When a problem is at a point that it takes a dentist to do something surgical, the game is somewhat over. It would be most cost-effective if the problem would be tackled earlier, and oral diseases could be prevented. That is also the best kind of healthcare.”

Liisa Suominen, Professor of Oral Public Health, University of Eastern Finland

Long waiting times are common in public oral healthcare services. In August 2022, 16% of patients had to wait for a non-urgent dentist's appointment for more than three months and 4% of patients had to wait for more than six months.³³⁸ In January 2023, nearly 8,000 people were waiting for non-urgent oral healthcare services in the City of Helsinki alone;³³⁹ some had been waiting for as long as nine months.³⁴⁰

“You must always wait in line [when you call] and if you leave a call-back request, it may never come. Especially with oral healthcare – they don't call back.”

Elisa, a 64-year-old pensioner

Payment commitments – that is when the WBSC opts to pay a pre-agreed sum for the health care services provided by an approved private service provider – and appointments with dental hygienists are utilized to shorten waiting times in public oral healthcare.³⁴¹ However, even when using a payment commitment, the amount that patients are expected to pay can come as a surprise to them, as

³³⁴ Jari Linden, *Register study on dental treatment in Finland*, 2022,

helda.helsinki.fi/bitstream/handle/10138/352673/Linden_Jari_dissertation_2023.pdf?sequence=1&isAllowed=y, p. 47.

³³⁵ Finnish Dental Association, “Työmarkkinatutkimus 2022”, 2022, hammaslaakariliitto.fi/sites/default/files/mediafiles/tmt2022_nettiin.pdf, p. 46.

³³⁶ Finnish Dental Association, “Työmarkkinatutkimus 2022”, 2022, hammaslaakariliitto.fi/sites/default/files/mediafiles/tmt2022_nettiin.pdf, p. 46.

³³⁷ Finnish Dental Association, “Työmarkkinatutkimus 2022”, 2022, hammaslaakariliitto.fi/sites/default/files/mediafiles/tmt2022_nettiin.pdf, p. 46.

³³⁸ Kaisa Mölläri and Tiina Marttila, “Hoitopääsy perusterveydenhuollossa syksyllä 2022: Terveyskeskusten kiireettömistä lääkärikäynneistä vajaa 60 prosenttia toteutui viikossa syksyllä 2022”, 2022, julkari.fi/bitstream/handle/10024/145778/Tilastoraportti%2046%202022.pdf?sequence=1&isAllowed=y, p. 4.

³³⁹ Yle Uutiset, “Pääkaupunkiseudulla kiireetöntä hammashoitoa voi joutua odottamaan jopa yhdeksän kuukautta”, 11 January 2023, yle.fi/a/74-20010761.

³⁴⁰ Yle Uutiset, “Pääkaupunkiseudulla kiireetöntä hammashoitoa voi joutua odottamaan jopa yhdeksän kuukautta”, 11 January 2023, yle.fi/a/74-20010761.

³⁴¹ Ilmo Keskimäki et al., *Finland: Health system review*, 2019, apps.who.int/iris/bitstream/handle/10665/327538/HIT-21-2-2019-eng.pdf?sequence=7&isAllowed=y, p. 123.

all the costs incurred are not covered. Also, user fees for oral health services using payments commitments are not included in the annual payment ceiling. In the public sector, user fees were raised significantly in the 2010s.³⁴²

User fees for oral healthcare appointments range from EUR 10.30 for a dental hygienist appointment to EUR 19.50 for a specialized dentist's appointment.³⁴³ In addition to the appointment user fee, separate fees are levied for each procedure, ranging from EUR 8.50 to over EUR 200.³⁴⁴ Additionally different charges can be issued for materials and anticipating the costs can be difficult for patients.³⁴⁵ In a 2021 patient satisfaction survey by the THL, the lowest score in the survey was given to the statement: "I was given clear and understandable information on the price of care and payment arrangements", with some patients surprised by the high price of public oral healthcare.³⁴⁶

According to a 2014 European Health Interview Survey, 15% of people who needed oral health services in Finland were not able to access them due to costs, with the highest levels for dental care.³⁴⁷ One person interviewed by Amnesty International, who works for an NGO supporting people experiencing unemployment, noted that costs for visiting a dentist are often too high for people and that a person experiencing unemployment had recently told them of having to pull out their own tooth because they could not afford to visit a dentist.

Several experts interviewed by Amnesty International noted that oral healthcare has long been overlooked in healthcare development, despite the stark inequalities in service access and use. As Professor of Social Policy Anne Kouvonen from the University of Helsinki said when interviewed by Amnesty International: "According to research, oral healthcare is the largest single source of inequality in healthcare because oral health problems affect health so much. If we could fix it, it would have a positive secondary effect on other things."

6.3.2 INADEQUATE MENTAL HEALTHCARE SERVICES

"You can't get a doctor's appointment. They'll say 'No no, maybe in three weeks or something' and at other times they don't say anything about the time... I was on antidepressants when I became seriously depressed, and terrible things happened to me. [I heard the nurse say] 'they are on antidepressants, they can wait'. The nurse had left the phone line open, and I heard everything they said."

Suvi, a 62-year-old woman experiencing unemployment

Finland has the obligation to provide equal and timely access to appropriate mental health treatment and care.³⁴⁸ As with many other health services, public mental health services in Finland struggle to uphold the right to health due to long waiting times as well as socioeconomic and geographical inequality.

³⁴² Maria Vaalavuo (editor), *Sosiaali- ja terveydenhuollon asiakasmaksujen kohdentuminen, vaikutukset ja oikeudenmukaisuus*, 2018, tietokayttoon.fi/documents/10616/6354562/30-2018-Asiakasmaksut.pdf/82c084e6-829e-4a46-b552-f9a9ad4d2b96?version=1.0, p. 35.

³⁴³ Figures for 2023. Ministry of Social Affairs and Health, "Hammashuollon maksut", stm.fi/hammashuollon-maksut.

³⁴⁴ Ministry of Social Affairs and Health, "Hammashuollon maksut", stm.fi/hammashuollon-maksut.

³⁴⁵ Maria Vaalavuo (editor), *Sosiaali- ja terveydenhuollon asiakasmaksujen kohdentuminen, vaikutukset ja oikeudenmukaisuus*, 2018, tietokayttoon.fi/documents/10616/6354562/30-2018-Asiakasmaksut.pdf/82c084e6-829e-4a46-b552-f9a9ad4d2b96?version=1.0, pp. 34–35.

³⁴⁶ THL, "Tätä mieltä asiakkaat suun terveydenhuollon palveluista 2021", thl.fi/documents/9716163/9879398/Suun_th_tulokset_2021.pdf/1af8691e-9f75-d203-29f8-fe0188b397c9?t=1672839902580, p. 7.

³⁴⁷ Survey results quotes in Ilmo Keskimäki et al., *Finland: Health system review*, 2019, apps.who.int/iris/bitstream/handle/10665/327538/HIT-21-2-2019-eng.pdf?sequence=7&isAllowed=y, p. 144.

³⁴⁸ CESCR General Comment 14, Para 17.

As with other forms of PHC, primary level mental health services are available through multiple channels: public PHC, OHC, student healthcare and private healthcare.³⁴⁹ Public PHC is responsible for providing care for most usual mental ill-health related symptoms and conditions, with the support of SHC.³⁵⁰ Not-for-profit service providers also play a significant role.

Statistics on primary level mental health services are incomplete because this information is not comprehensively and systematically gathered. However, it is clear that waiting times, especially for specialized mental health services, have lengthened since the Covid-19 pandemic.³⁵¹ Geographical inequality in service availability is persistent, with the availability of services varying significantly across the country. Mimmi, a 30-year-old woman who has experienced unemployment, told Amnesty International: “It takes eight months to get mental health services here... While [in another locality] you can have a phone call with a psychiatrist even in three days. It’s a terrible difference.”

According to a THL report, PHC is currently not able to provide adequate and coordinated mental health services for school-age children.³⁵² The dire situation was recognized by the Deputy Chancellor of Justice in a decision issued in January 2023 regarding mental health services for children and young people which stated that: “the long-term inadequacy of these services is a significant constitutional rights problem that causes widespread human suffering.”³⁵³

Mental health services for adults are inadequate. In a 2019 study by the Finnish Central Association for Mental Health, 91% of mental health professionals said that people in need of mental health services do not receive adequate services.³⁵⁴ Furthermore, 59% of respondents agreed with the statement “patients come for follow-up appointments once in three months, but often they don’t receive actual care”.³⁵⁵

Before the pandemic, in 2018, Finland had the highest estimated prevalence of mental health disorders of any EU country at 18.8%.³⁵⁶ A Finnish study indicated that those in lower socioeconomic groups at the age of 30 have a much higher risk of later being diagnosed with a mental disorder than those from higher socioeconomic groups.³⁵⁷ According to research, people who experience unemployment also experience poorer mental health than those who are employed.³⁵⁸ Indeed, mental ill-health is the most common reason for decreased capacity to work among people experiencing unemployment.³⁵⁹ In addition, mental health disorders among those experiencing long-term unemployment remains largely undiagnosed and consequently untreated.³⁶⁰ This creates a vicious cycle as mental health problems drastically decrease the likelihood of finding employment.³⁶¹

In a 2019 study by the Finnish Central Association for Mental Health, 88% of mental health professionals considered the staffing of outpatient mental health services to be inadequate.³⁶² The amount allocated to mental health services overall has decreased as a percentage of total health spending since the economic recession of the 1990s.³⁶³ Primary care level mental health services formed just 1% of total healthcare costs in 2020.³⁶⁴

³⁴⁹ Outi Linnanranta et al., (editors), *Mielenterveysstrategia 2020–2030 – toimeenpanon ensimmäiset vuodet ja yhteisen tekemisen tahto*, 2022, julkari.fi/bitstream/handle/10024/145933/URN_ISBN_978-952-343-990-0.pdf?sequence=1&isAllowed=y, p. 69.

³⁵⁰ Outi Linnanranta et al., (editors), *Mielenterveysstrategia 2020–2030 – toimeenpanon ensimmäiset vuodet ja yhteisen tekemisen tahto*, 2022, julkari.fi/bitstream/handle/10024/145933/URN_ISBN_978-952-343-990-0.pdf?sequence=1&isAllowed=y, p. 69.

³⁵¹ Outi Linnanranta et al., (editors), *Mielenterveysstrategia 2020–2030 – toimeenpanon ensimmäiset vuodet ja yhteisen tekemisen tahto*, 2022, julkari.fi/bitstream/handle/10024/145933/URN_ISBN_978-952-343-990-0.pdf?sequence=1&isAllowed=y, p. 46–47.

³⁵² Terhi Aalto-Setälä and Eeva Huikko “Lasten, nuorten ja perheiden mielenterveyspalvelut”, in Outi Linnanranta et al., (editors), *Mielenterveysstrategia 2020–2030 – toimeenpanon ensimmäiset vuodet ja yhteisen tekemisen tahto*, 2022, julkari.fi/bitstream/handle/10024/145933/URN_ISBN_978-952-343-990-0.pdf?sequence=1&isAllowed=y, p. 70.

³⁵³ Apulaisoikeuskansleri, “Lasten ja nuorten mielenterveys- ja psykiatristen palvelujen toteutuminen covid-19-epidemian aikana”, 2023, oikeuskansleri.fi/documents/1428954/145162814/julkaistu_ratkaisu_lasten_ja_nuorten_mielenterveys_ja_psykiatristet_palvelut_OKV_294_70_2020.pdf/8a71ab3a-2e79-bdcb-566d-2f889c65ff5f/julkaistu_ratkaisu_lasten_ja_nuorten_mielenterveys_ja_psykiatristet_palvelut_OKV_294_70_2020.pdf?t=1673855590030, p. 31.

³⁵⁴ The views of mental health professionals were surveyed with an online survey in May-June 2019. In total, 624 psychiatrists and psychologists took part; Mielenterveyden keskusliitto, “Mielenterveysbarometri 2019”, 2019, mtkl.fi/uploads/2019/11/76679c12-mielenterveysbarometri_2019.pdf, p. 6.

³⁵⁵ Mielenterveyden keskusliitto, “Mielenterveysbarometri 2019”, 2019, mtkl.fi/uploads/2019/11/76679c12-mielenterveysbarometri_2019.pdf, p. 51.

³⁵⁶ The EU average was 17.3%; OECD, *Health at a Glance: Europe 2018 – State of health in the EU cycle*, 2019, oecd-ilibrary.org/docserver/health_glance_eur-2018-en.pdf?expires=1673623815&id=id&accname=guest&checksum=E9A8552E8F7F3F022C297D8DDFB9A271, pp. 21–22.

³⁵⁷ The register-based study’s results are based on a nationwide cohort of over 1.2 million Finnish people that were followed from 1996 to 2017. Christian Hakulinen et al., “Socioeconomic position at the age of 30 and the later risk of a mental disorder: a nationwide population-based register study”, 2023, *J Epidemiol Community Health*, jech.bmj.com/content/jech/early/2023/01/04/jech-2022-219674.full.pdf, p. 6.

³⁵⁸ Kaarina Reinini et al., “Mielenterveyden ja työttömyyden välinen yhteys: Mitä kertovat kansainväliset ja kotimaiset tutkimukset?”, 2018, *Yhteiskuntapolitiikka*, Volume 83, julkari.fi/bitstream/handle/10024/137548/YP1804_Reiniym.pdf?sequence=1&isAllowed=y, p. 435.

³⁵⁹ Tuija Oivo and Raija Kerätär, *Osatyökykyisten reitit työllisyyteen - etuudet, palvelut, tukitoimet: Selvityshenkilöiden raportti*, 2018, julkaisut.valtioneuvosto.fi/bitstream/handle/10024/161151/STM%20rap%2043%202018%20Osatyökykyisten%20reitit%20työllisyyteen.pdf?sequence=4&isAllowed=y, p. 27; Raija Kerätär, *Kun katsoo kauempaa, näkee enemmän: Monialainen työkyvyn ja kuntoutustarpeen arviointi pitkäaikaistyöttömillä*, 2016, jultika.oulu.fi/files/isbn9789526210865.pdf, p. 93.

³⁶⁰ Raija Kerätär, *Kun katsoo kauempaa, näkee enemmän: Monialainen työkyvyn ja kuntoutustarpeen arviointi pitkäaikaistyöttömillä*, 2016, jultika.oulu.fi/files/isbn9789526210865.pdf, p. 93.

³⁶¹ Liina Junna, *Unemployment, health and mortality: Evidence from longitudinal register data*, 2022, helda.helsinki.fi/bitstream/handle/10138/347466/Junna_Liina_dissertation_2022.pdf?sequence=1&isAllowed=y, p. 66.

³⁶² Mielenterveyden keskusliitto, “Mielenterveysbarometri 2019”, 2019, mtkl.fi/uploads/2019/11/76679c12-mielenterveysbarometri_2019.pdf, p. 41.

³⁶³ Outi Linnanranta et al., (editors), *Mielenterveysstrategia 2020–2030 – toimeenpanon ensimmäiset vuodet ja yhteisen tekemisen tahto*, 2022, julkari.fi/bitstream/handle/10024/145933/URN_ISBN_978-952-343-990-0.pdf?sequence=1&isAllowed=y, p. 91.

³⁶⁴ THL, *Terveydenhuoltomenojen rakenne toiminnoittain 2000–2020. % käypähintaisista käyttömenoista*, thl.fi/documents/10531/0/Terveystuulokkainen+menot+ja+rahoitus+2020%2C+ennakkotiedot%2C+THL_v09_2022.xlsx/e21a307b-f4ce-deb3-ab52-78ca13d29d5a?t=1664360130176, Table 3.

6.3.3 LACK OF SEXUAL AND REPRODUCTIVE HEALTH SERVICE PROVISION

“It’s not possible to access a gynaecologist’s appointment in public health care.”

Aulikki, a 67-year-old pensioner

Finland is committed to promoting gender equality and eradicating gender-based discrimination.³⁶⁵ The realization of women’s right to health requires Finland to remove all barriers interfering with access to health services, including in the area of sexual and reproductive health.³⁶⁶ Barriers discussed in this section include poor availability of public services while private services are too expensive for many, limited services provided by the public sector, and geographical inequalities in service provision.

According to the Finnish Medical Association, the availability of public gynaecological healthcare services is very poor.³⁶⁷ According to the Finnish Society of Obstetrics and Gynaecology, the availability of gynaecological healthcare services relies heavily on private service providers due to lack of capacity in the public sector and lack of expertise in public healthcare services.³⁶⁸ Silla Kakkola, Secretary General of the Coalition of Finnish Women’s Associations Nytkis told Amnesty International: “Those with extensive OHC can more easily access gynaecological services. However, a huge number of people are excluded from the services, such as workers with limited OHC or those who depend on public healthcare, such as unemployed and older people. Gynaecological services are strongly concentrated in the private sector.”

The prices of private gynaecologists’ appointments vary across the country. According to media reports, a 20-minute appointment with a gynaecologist with service fees can cost as much as EUR 255 in Helsinki and EUR 150 in Kuopio and therefore this is not an option for people on lower incomes.³⁶⁹

“Visits to healthcare cost a lot of money. Especially if you are a woman and need to visit a gynaecologist. It’s impossible... You cannot access a gynaecologist’s appointment in public healthcare.”

Jonna, a 34-year-old woman experiencing unemployment

One gynaecologist interviewed by Amnesty International described how services can be expensive for patients on lower incomes: “I have a private reception in a smaller municipality, where there are a lot of people on lower incomes, and I charge lower rates there than elsewhere. I had a young female patient who had health problems. Then, when she was about to leave, with her hand on the doorknob, she said: ‘My mother gifted me this appointment as a Christmas gift’. That made me think that there is seriously something wrong with this. This is not how things should be. Not everyone needs to visit a specialist, but when it’s needed, it should be possible to get there regardless of one’s wealth.”

Health centres do not always have the necessary equipment or expertise to diagnose and treat gynaecological conditions. As a gynaecologist told Amnesty International: “General practitioners at health centres can diagnose gynaecological diseases based on symptoms, but there is no ultrasound, for example, or the expertise to use an ultrasonic device.”

Several health experts interviewed by Amnesty International noted that the social and healthcare reform provides an opportunity to improve sexual and reproductive healthcare services since now PHC and SHC are under the same administration. This should make it possible to better integrate gynaecological healthcare in outpatient PHC. For instance, the East Savonia hospital district has reported

³⁶⁵ Ministry of Social Affairs and Health Finland, “Gender Equality in Finland”, undated, stm.fi/documents/1271139/5825735/sukupuolten_tasa_arvo_suomessa_UK_verkko_V1.pdf/7464741f-29b4-4acc-b01e-718449d55b01/sukupuolten_tasa_arvo_suomessa_UK_verkko_V1.pdf, accessed 3 May 2023.

³⁶⁶ CESCR General Comment 14, Para 21.

³⁶⁷ Finnish Medical Association, “Hallituksen esitys eduskunnalle sairausvakuutuslain 2 ja 3 luvun muuttamisesta HE 237/2022 vp, Lausunto asiantuntijakuulemiseen perjantaina 11.11.2022”, 2022, eduskunta.fi/FI/vaski/JulkaisuMetatieto/Documents/EDK-2022-AK-61104.pdf, p. 2.

³⁶⁸ Suomen Gynäkologiyhdistys ry, “Asia: Asiantuntijalausunto hallituksen esityksestä eduskunnalle sairausvakuutuslain 2 ja 3 luvun muuttamisesta”, 2022, eduskunta.fi/FI/vaski/JulkaisuMetatieto/Documents/EDK-2022-AK-60869.pdf, p. 1.

³⁶⁹ Iltalehti, “IL-selvitys: Tämä on halvin yksityinen terveysasema – ja tämä kallein”, 17 July 2022, iltalehti.fi/kotimaa/a/d4bb115e-8892-418c-9760-a77d4fd5f126.

good experiences of integrating sexual and reproductive healthcare services by enabling general practitioners to have access to gynaecologists' consultations in the same facility.³⁷⁰

Since 2007, the Ministry for Social Affairs and Health recommended that municipalities, which were responsible for PHC prior to the reform, offer contraception free of charge to young people.³⁷¹ However, in 2019, less than 20% of municipalities were offering such comprehensive services.³⁷² In interviews conducted by Amnesty International, health workers stated that contraceptive services are generally quite readily available in larger cities, but the necessary expertise is lacking in smaller municipalities. In order to reduce geographical inequality, health experts have called for a national policy on the provision of contraceptive services free of charge for those under the age of 25.³⁷³ As a part of the "Social and health centre of the future" programme, a pilot project was launched for WBCs to introduce and develop contraceptive health services that are free of charge for those under the age of 25.³⁷⁴ However, contrary to what was stated in Prime Minister Marin's government programme, no national policy or legislation based on the pilot was introduced during the Marin government.³⁷⁵

6.4 THE DIGITAL DIVIDE – A BARRIER TO ACCESS

“My doctor’s appointment was cancelled three times... Now they gave me a Skype appointment. This, on the other hand, requires that I have a computer or a phone. And that I have Skype and I know how to use it. They just assumed that I have some kind of device.”

Mimmi, a 30-year-old woman experiencing unemployment

While digital technologies can support efforts to improve access to healthcare services for many, there are also legitimate human rights concerns, for example related to equality and marginalised people.³⁷⁶ The state has the obligation to ensure that digitalized health services do not form an obstacle to the accessibility and affordability of healthcare.

Digital healthcare services have been added to the service structure in Finland, especially during the Covid-19 pandemic.³⁷⁷ The pandemic showed that although digital services improved the accessibility of services for some, many people also faced significant difficulties in using digital services.³⁷⁸

Remote services can create barriers and exclude people who may be unable to use digital services.³⁷⁹ Reasons for this can include language barriers, problems with web accessibility, lack of suitable equipment or electronic identification services access (for example, e-banking codes) or insufficient digital skills, among other reasons.³⁸⁰

³⁷⁰ Mediuutiset, "Sosterin ainutlaatuinen lääkäriyhteistyö parantaa gynekologisen hoidon saatavuutta", 8 March 2022, mediuutiset.fi/uutiset/sosterin-ainutlaatuinen-laakariyhteistyo-parantaa-gynekologisen-hoidon-saatavuutta/06e10f6c-18fe-48f6-ac48-33987693c922.

³⁷¹ Ministry of Social Affairs and Health, *Seksuaali- ja lisääntymisterveyden edistäminen. Toimintaohjelma 2007–2011*, 2007, julkaisut.valtioneuvosto.fi/bitstream/handle/10024/73912/julk_2007_17_sexterveys_paino.pdf?sequence=1&isAllowed=y, p. 105.

³⁷² Frida Gyllenberg and Oskari Heikinheimo, "Maksuton raskauden ehkäisy - kenelle tarjoamme?", 2019, Duodecim, Volume 135, duodecimlehti.fi/duo15044.

³⁷³ Frida Gyllenberg and Oskari Heikinheimo, "Maksuton raskauden ehkäisy - kenelle tarjoamme?", 2019, Duodecim, Volume 135, duodecimlehti.fi/duo15044.

³⁷⁴ THL, "Maksuttoman ehkäisyn kokeilu", 2022, thl.fi/fi/tutkimus-ja-kehittaminen/tutkimukset-ja-hankkeet/maksuttoman-ehkaisyn-kokeilu.

³⁷⁵ THL, "Maksuttoman ehkäisyn kokeilu", 2022, thl.fi/fi/tutkimus-ja-kehittaminen/tutkimukset-ja-hankkeet/maksuttoman-ehkaisyn-kokeilu.

³⁷⁶ Human Rights Council, "Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, Tlaleng Mofokeng", A/HRC/47/28, Paras 78, 79, 82.

³⁷⁷ Pekka Rissanen et al., *COVID-19-epidemian vaikutukset väestön palvelutarpeisiin, palvelujärjestelmään ja kansantalouteen – nopea vaikutusarvio*, 2020, julkari.fi/bitstream/handle/10024/139694/URN_ISBN_978-952-343-496-7.pdf?sequence=1&isAllowed=y.

³⁷⁸ Anu Kaihlanen et al., "Haavoittuvat ryhmät etäpalvelujen käyttäjinä – kokemuksia COVID-19-epidemian ajalta", 2021, julkari.fi/bitstream/handle/10024/142805/URN_ISBN_978-952-343-687-9.pdf.

³⁷⁹ Satu Jokela et al. (editors), *Terveystien eriarvoisuus Suomessa: Ehdotus seurantarjestelmän kehittämiseen*, 2021, julkari.fi/bitstream/handle/10024/142576/RAP2021_005_Terveystien_eri-arvoisuus_Suomessa_s_korj2.pdf?sequence=10&isAllowed=y, p. 44.

³⁸⁰ Maiju Kyytsönen et al., *Sosiaali- ja terveydenhuollon sähköinen asiointi 2020–2021: Väestön kokemukset*, 2021, julkari.fi/bitstream/handle/10024/142675/URN_ISBN_978-952-343-680-0.pdf?sequence=1&isAllowed=y; Tarja Heponiemi et al., "The role of age and digital competence on the use of online health and social care services: A cross-sectional population-based survey", 2022, Digital Health, Volume 8, journals.sagepub.com/doi/pdf/10.1177/20552076221074485.

For example, according to a 2020 population survey by the THL, the share of people using the internet for digital services decreases with increasing age and decreasing educational level.³⁸¹ About 80% of respondents had experienced obstacles and concerns in using digital services.³⁸² Over 90% of those over the age of 75 had experienced similar difficulties.³⁸³

According to a report by THL, nearly one in five people reported that they needed assistance on the use of digital social and healthcare services.³⁸⁴ Many of the people Amnesty International interviewed said that they had had at least some difficulties in using digital health services and some had not used them at all due to lack of suitable devices or skills. When interviewed by Amnesty International, Hiikka, a 69-year-old pensioner, stated that their inability to use digital services had led to treatment being postponed: “You must first have a photo of an external disease. First there’s a remote appointment, then there’s a nurse’s appointment and only then there’s a doctor’s appointment. An older person doesn’t know how to take a photo. When I couldn’t send the photo, they first gave me a nurse’s appointment. The doctor said I should’ve come sooner.”

Some regions have introduced e-service portals that give patients access to public healthcare services. For instance, the Joint Authority of the Helsinki and Uusimaa Hospital District HUS and the capital area cities of Helsinki, Vantaa, Kerava and Kauniainen use an e-portal called Maisa.³⁸⁵ On Maisa, patients can book appointments for social and healthcare services. To book an appointment via Maisa the patient generally needs a scheduling permit/ticket from a social or healthcare provider.³⁸⁶ After receiving the scheduling ticket, the patient can search for available appointments on Maisa. According to some of the interviewees Amnesty International spoke with, patients experience a range of problems in using Maisa: using digital services can be difficult for some, they can have difficulties in finding available times and waiting times can be long. Viljami, a 67-year-old pensioner told Amnesty International: “Before, when you called the health centre and there was a call-back, they booked the appointment immediately on the phone. Now there is this system which my wife and I have been agonizing with. You can’t get an appointment but instead they give you this link. Then you search for appointments on the e-service Maisa. I had better luck because I got the appointment relatively easily, considering it wasn’t an acute situation. But my wife has given up. It has been harder for her. She has had problems with her knees, and she has been taking painkillers... But it’s very hard to get a doctor’s appointment. She has given up. She searched for appointments on Maisa every morning at eight o’clock for many days, even weeks but there weren’t any available.”

“If you try to contact healthcare workers through the e-service Maisa, it can take a week or a week and a half before they finally answer.”

Elisa, a 64-year-old pensioner

Digital healthcare services are not suitable for every situation, as there is a risk that some people, for instance older people and people on lower incomes, can be more negatively impacted. This in turn can reinforce existing inequalities. There is a need to review current practices to ensure that accessible alternatives to digital services are available.

³⁸¹ FinSote, Internetiä sähköiseen asiointiin käyttävien osuus (%), 2020, terveytemme.fi/finsote/2020/raportti/atlas.html?select=1001&data=fs_internet_transact_cr.

³⁸² FinSote, Kokenut esteitä ja huolia sähköisten palvelujen käytössä (%), 2020, terveytemme.fi/finsote/2020/raportti/atlas.html?select=1001&data=fs_digi_barriers_cr.

³⁸³ FinSote, Kokenut esteitä ja huolia sähköisten palvelujen käytössä (%), 2020, terveytemme.fi/finsote/2020/raportti/atlas.html?select=1001&data=fs_digi_barriers_cr.

³⁸⁴ Maiju Kyytsönen et al., *Sosiaali- ja terveydenhuollon sähköinen asiointi 2020–2021: Väestön kokemukset*, 2021, julkari.fi/bitstream/handle/10024/142675/URN_ISBN_978-952-343-680-0.pdf?sequence=1&isAllowed=y, p. 41.

³⁸⁵ Apotti, “Maisa makes life easier”, apotti.fi/en/client-portal-maisa/.

³⁸⁶ Maisa, “Frequently asked questions”, ukk.maisa.fi/en/#what-kinds-of-appointments-can-i-book-via-maisa.

6.5 HEALTH CHECK-UPS: FAILURE TO REACH PEOPLE EXPERIENCING UNEMPLOYMENT AND TO INCORPORATE OCCUPATIONAL ISSUES

“I haven't been to a health check-up as unemployed. Nobody has offered it to me. I haven't heard of a health check-up for unemployed persons.”

Jonna, a 34-year-old woman experiencing unemployment

In recognition of the unequal access to healthcare services in Finland, the right to health check-ups for those without access to OHC or student healthcare was set out in the 2010 Health Care Act.³⁸⁷ According to the explanatory memorandum to the Act, young or working-age people who do not have access to OHC or student healthcare are in a disadvantaged position in accessing healthcare services.³⁸⁸ Furthermore, the explanatory memorandum states that due to social exclusion, some people experiencing unemployment do not seek out healthcare services on their own initiative, and healthcare authorities should collaborate with employment services to reach them.³⁸⁹

By law, WBSCs must organize these necessary health check-ups for those excluded from OHC and student healthcare services, to monitor and promote their health. Health guidance and health check-ups must “support work and functional capacity, prevent illness, and promote mental health and life management”. Health guidance and check-ups should be integrated with other social and healthcare services.³⁹⁰

In 2013, the Ministry of Social Affairs and Health, in collaboration with other authorities, issued a guidance letter on how preventive healthcare for people experiencing unemployment should be organized.³⁹¹ It was emphasized that, especially those experiencing unemployment and at those risk of social exclusion should be identified and directed to the healthcare services they need.³⁹²

The capacity to provide preventive health check-ups varies across the country due to differences in resources and expertise.³⁹³ In 2021, there were notable geographical differences in the participation in such health check-ups. In most WBSCs, participation was reported to be less than 5% of people experiencing unemployment, with several WBSCs having a participation rate of less than 1%.³⁹⁴ The highest participation was in Kainuu WBSC (21%).³⁹⁵ The situation was similar before the Covid-19 pandemic, with participation rate fluctuating between 0.3% and 24.3% in 2019 and between 0.4% and 17% in 2018.³⁹⁶

Reasons for low take-up of health check-ups mentioned in Amnesty International interviews included lack of information, poor accessibility, long waiting times and fear of losing unemployment benefits.

Many people experiencing unemployment have never heard about the possibility of getting a health check-up,³⁹⁷ including most of those interviewed by Amnesty International. In addition, several health experts also mentioned that people are not given adequate information about check-ups. WBSCs inform residents about the possibility of signing up for check-ups in different ways. Some give

³⁸⁷ Terveydenhuoltolaki – Health Care Act, 2010, finlex.fi/fi/laki/ajantasa/2010/20101326#L1P10-2, Chapter 2, section 13.

³⁸⁸ Hallituksen esitys Eduskunnalle terveydenhuoltolaiksi sekä laeiksi kansanterveyslain ja erikoissairaanhoidon lain muuttamiseksi sekä sosiaali- ja terveydenhuollon asiakasmaksuista annetun lain muuttamiseksi (HE 90/2010 vp), 2010, finlex.fi/fi/esitykset/he/2010/20100090.pdf, p. 103.

³⁸⁹ HE 90/2010 vp, finlex.fi/fi/esitykset/he/2010/20100090.pdf, p. 103.

³⁹⁰ Terveydenhuoltolaki – Health Care Act, 2010, finlex.fi/fi/laki/ajantasa/2010/20101326#L2P13, Chapter 2, section 13.

³⁹¹ Ministry of Social Affairs and Health, “Kirje: Työttömien terveydenhuollon järjestäminen”, 19 August 2013, stm.fi/documents/1271139/1365032/Ty%C3%B6tt%C3%B6mien+terveydenhuollon+i%C3%A4riest%C3%A4minen/3b1979ea-c36c-4114-9399-6c45e49b40b1.

³⁹² Ministry of Social Affairs and Health, “Kirje: Työttömien terveydenhuollon järjestäminen”, 19 August 2013, stm.fi/documents/1271139/1365032/Ty%C3%B6tt%C3%B6mien+terveydenhuollon+i%C3%A4riest%C3%A4minen/3b1979ea-c36c-4114-9399-6c45e49b40b1, p. 1.

³⁹³ Finnish Government, *Sosiaaliturvakomitean välimietintö*, 2023, valtioneuvosto.fi/documents/1271139/148073972/Sosiaaliturvakomitean+v%C3%A4limietint%C3%B6.pdf/c5db48f7-d8ae-d06d-f64a-b2ffd9c1ad06/Sosiaaliturvakomitean+v%C3%A4limietint%C3%B6.pdf?t=1675087724368, p. 94.

³⁹⁴ Statistics and Indicator Bank Sotkanet, Työttömien terveystarkastukset, % työttömistä, 2018–2021, sotkanet.fi/sotkanet/fi/taulukko/?indicator=szbMLAQ®ion=szZ3tc7UM7Q2yrc2TLTWTsQMN7JOjbQ21zMEMnQN482tdU2tTcA8lz1DAA===&year=sy5zsjbW0zUEAA===&gender=t&abs=f&color=f&buildVersion=3.1.1&buildTimestamp=202211091024.

³⁹⁵ Statistics and Indicator Bank Sotkanet, Työttömien terveystarkastukset, % työttömistä, 2018–2021, sotkanet.fi/sotkanet/fi/taulukko/?indicator=szbMLAQ®ion=szZ3tc7UM7Q2yrc2TLTWTsQMN7JOjbQ21zMEMnQN482tdU2tTcA8lz1DAA===&year=sy5zsjbW0zUEAA===&gender=t&abs=f&color=f&buildVersion=3.1.1&buildTimestamp=202211091024.

³⁹⁶ Statistics and Indicator Bank Sotkanet, Työttömien terveystarkastukset, % työttömistä, 2018–2021, sotkanet.fi/sotkanet/fi/taulukko/?indicator=szbMLAQ®ion=szZ3tc7UM7Q2yrc2TLTWTsQMN7JOjbQ21zMEMnQN482tdU2tTcA8lz1DAA===&year=sy5zsjbW0zUEAA===&gender=t&abs=f&color=f&buildVersion=3.1.1&buildTimestamp=202211091024.

³⁹⁷ Kirsi Lappalainen and Hanna Hakulinen, “Työttömien terveystarkastusten kehittäminen monitahoarvioinnin viitekehyksessä”, 2020, *Työelämän tutkimus*, Vol. 18, journal.fi/tyoelamantutkimus/article/view/97974/55983, p. 220.

information about the check-ups on the county website, while others included it in bulletins and some, as of November 2022, had not decided how to inform residents.³⁹⁸

Prolonged waiting times for health check-ups can cause a chain of consequences. For example, people experiencing unemployment need referrals to get specialist treatment and rehabilitation and long waiting times for initial check-ups can significantly delay these processes.

“We have been collecting information about the WBSCs and there is very harsh news about health check-ups for the unemployed. At worst, the queues are from two years ago, and they have only now started to go through them. Clients’ processes are being delayed and they are unable to get rehabilitation because of the lack of referrals. Not to even mention the state of mental health services.”

Susanna Soikkeli, work ability coordinator, National Employment Services Agency branch of the Uusimaa region

Veera Luoto, social worker from the Finnish National Organization of the Unemployed explained in an interview with Amnesty International that participating in a health check-up can be perceived as a financial risk for a person experiencing unemployment: “If the person is not considered fit for work or the person’s ability to work needs to be examined, their unemployment benefit might be cut off for at least for the duration of the examination. The threat of losing a benefit can cause people not to sign up [for a health check-up] because they are so afraid of losing their income. Those who are long-term unemployed might not have any financial buffers left.”

The accessibility of check-ups can also be an issue. Even if people have heard about the possibility of getting a check-up, they do not know how and where to sign up for them. As Mimmi, a 30-year-old woman experiencing unemployment, explained: “Health check-ups for the unemployed is a more beautiful promise, but it doesn’t work in real life. They are challenging to access at times. Sometimes it’s a project somewhere that some students manage and it’s available only for a certain time, and then again, it’s relocated somewhere else.”

According to an article based on a research project by the Finnish Institute of Occupational Health, people experiencing unemployment who have had access to health check-ups generally have positive experiences.³⁹⁹ However, public healthcare does not always have adequate expertise in occupational health.⁴⁰⁰ This was also mentioned in interviews with representatives of NGOs and employment services. A check-up does not necessarily include any assessment of a person’s occupational health, that is their capability to work and possible needs to support their return to work. Often doctors can only assess the patient’s health and not their overall situation because they may, for instance, lack information regarding the nature of the patient’s work.⁴⁰¹

³⁹⁸ Answers from Amnesty International’s survey to WBSCs in November-December 2022.

³⁹⁹ Kirsi Lappalainen and Hanna Hakulinen, “Työttömien terveyspalvelujen kehittäminen monitahoarvioinnin viitekehyksessä”, 2020, *Työelämän tutkimus*, Vol. 18, journal.fi/tyoelamantutkimus/article/view/97974/55983, p. 220.

⁴⁰⁰ Kirsi Lappalainen, “Työikäisten terveyspalvelut ovat eritasoisia”, *Talous ja yhteiskunta -lehti* 03/2019, 2019, labore.fi/t&y/tyoikaisten-terveyspalvelut-ovat-eritasoisia/.

⁴⁰¹ Finnish Government, *Sosiaaliturvakomitean välimietintö*, 2023, valtioneuvosto.fi/documents/1271139/148073972/Sosiaaliturvakomitean+v%C3%A4limietint%C3%B6.pdf/c5db48f7-d8ae-d06d-f64a-b2ffd9c1ad06/Sosiaaliturvakomitean+v%C3%A4limietint%C3%B6.pdf?t=1675087724368, p. 99.

6.6 LACK OF TRUST IN PUBLIC HEALTHCARE

“I don’t have any trust in healthcare, and neither does anyone else who is marginalized. People don’t want to go to the health centre even if their back is broken. They’d rather die than wait months to see a doctor. You can’t trust. There are so many disappointments.”

Joppe, a 40-year-old man experiencing unemployment

A lack of trust and confidence in the public health system emerged in numerous interviews conducted by Amnesty International for this report. Reasons stated for the lack of trust and confidence in public healthcare included the barriers presented in previous sections of this report: long waiting times, not being able to contact health providers, unaffordability of care and digital barriers. Low levels of trust were expressed by those who rely on the public health care system the most: people experiencing unemployment, families who primarily use public services and older people without the financial means to use private services. People experiencing mental ill-health and people who use drugs consistently reported a lack of trust in public healthcare.

This is also consistent with findings of academic studies and surveys that show a deterioration in trust in public healthcare in Finland. In a 2022 population survey, 56% of respondents strongly or partly disagreed with the statement “public healthcare can guarantee adequate services in case of illness” (up from 40% in 2014).⁴⁰² According to a 2019 population survey commissioned by the Finnish Medical Association, people have greater trust in OHC than public PHC.⁴⁰³

Trust in the Finnish healthcare system is especially low among those experiencing ill health⁴⁰⁴ and those on lower incomes. A research article by the THL noted declining public trust in health services, which was especially low among those that had to depend on last-resort income support.⁴⁰⁵ Trust in healthcare services is also often low among people who have experienced unemployment for a year or more.⁴⁰⁶

Taking action to improve people’s trust in health services is important because of the concrete impact this has on the right to health. Low levels of trust in public services can prevent people from talking about their situation and problems openly⁴⁰⁷ or from seeking the health services they need.⁴⁰⁸ As Hilikka, a 69-year-old pensioner, explained to Amnesty International: “I haven’t had the courage to contact the health centre. I have no trust.” Olivia, a 23-year-old student, shared similar sentiments: “I feel that I don’t trust, and I don’t want to be disappointed at the doctor’s visit anymore... I’m afraid to call [to book an appointment]. I’m afraid they’ll say, ‘call later’ or something like that.”

A lack of trust and confidence in the public healthcare system among those who need it the most and already experience other barriers in accessing and using services, is a serious concern. A doctor interviewed by Amnesty International said: “Low trust always reduces patient satisfaction with the treatment and trust in the treatment and healing. And if there’s no trust, then the patient won’t get better. It’s a vicious circle. The service should be at least moderately good at first in order to build trust. And that requires action.”

⁴⁰² Finanssiala ry, “Vakuutustutkimus 2022”, 2022, finanssiala.fi/wp-content/uploads/2022/06/Vakuutustutkimus-2022.pptx, p. 77.

⁴⁰³ The online survey was conducted in Apr-May 2019 and had 1,098 respondents from different parts of Finland, aged 15-74; Finnish Medical Association, “Luottamus: Väestökysely 2019”, 2019, laakariliitto.fi/site/assets/files/5227/luottamus_kooste_nettiin_2.pdf, p. 12.

⁴⁰⁴ Finnish Medical Association, “Luottamus: Väestökysely 2019”, 2019, laakariliitto.fi/site/assets/files/5227/luottamus_kooste_nettiin_2.pdf, p. 7.

⁴⁰⁵ Anna-Mari Aalto et al. “Sosiaali- ja terveyspalvelujärjestelmä toimintaympäristön myllerryksessä – miten on käynyt väestön kokemalle luottamukselle?”, in Sakari Karvonen et al. (editors), *Suomalaisten hyvinvointi 2022*, 2022,

julkari.fi/bitstream/handle/10024/145692/Suomalaisten%20hyvinvointi%202022%20verkko.pdf?sequence=4&isAllowed=y, p. 295.

⁴⁰⁶ Tuija Oivo and Raija Kerätär, *Osaatyökykyisten reitit työllisyyteen - etuudet, palvelut, tukitoimet. Selvityshenkilöiden raportti*, 2018, julkaisut.valtioneuvosto.fi/bitstream/handle/10024/161151/STM%20rap%2043%202018%200satyokykyisten%20reitit%20tyollisyyteen.pdf?sequence=4&isAllowed=y, p. 27.

⁴⁰⁷ Tuija Oivo and Raija Kerätär, *Osaatyökykyisten reitit työllisyyteen - etuudet, palvelut, tukitoimet. Selvityshenkilöiden raportti*, 2018, julkaisut.valtioneuvosto.fi/bitstream/handle/10024/161151/STM%20rap%2043%202018%200satyokykyisten%20reitit%20tyollisyyteen.pdf?sequence=4&isAllowed=y, p. 31.

⁴⁰⁸ See, for example, Kristiina Manderbacka et al., “Eriarvoisuus somaattisissa terveyspalveluissa”, 2017, Suomen sosiaalinen tila 2/2017, julkari.fi/bitstream/handle/10024/132346/SST2_2017_15062017.pdf?sequence=3&isAllowed=y, p. 3; Peppi Saikku et al., “Työttömien sosiaali- ja terveyspalveluiden käyttö ja kustannukset”, in Sakari Karvonen et al. (editors), *Suomalaisten hyvinvointi 2022*, 2022, julkari.fi/bitstream/handle/10024/145692/Suomalaisten%20hyvinvointi%202022%20verkko.pdf?sequence=4&isAllowed=y, p. 219.

“I got scared that when I’m in bad shape and I must call again. I know that I won’t get help.”

Helga, a 75-year-old pensioner

7. CONCLUSIONS AND RECOMMENDATIONS

The right to health in Finland is far from being enjoyed by all owing to stark inequalities in the accessibility, affordability, and use of health services. As this report shows, people's access to health care in Finland depends on employment status and income. The state has failed to address inequalities and guarantee the right to health by prioritizing those who are marginalized and at risk of discrimination. For many people in Finland, PHC is not accessible or affordable unless they have access to OHC or can afford to pay for private services and, despite the recommendations by international human rights bodies, the state has failed to ensure that universal health coverage is fulfilled in practice and the right to health is guaranteed.

People belonging to disadvantaged groups experience significant difficulties in accessing and using healthcare services. People without access to OHC, pensioners on lower incomes, families without private medical insurance, as well as young people not in education or employment are too often not able to access and use services because of barriers including high costs, lack of available appointments, long waiting times and not being able to use digital services.

High health costs, including user fees for services and medicine costs, can lead to people postponing care or even not using services or medicines. High health costs also cause financial distress for those already struggling with their bills. Almost half a million people in Finland were forced into recovery proceedings due to unpaid social and healthcare bills in 2022.

Long waiting times for services is a chronic problem in Finland where they routinely exceed legal limits, forcing people to manage their ill-health and pain. Many services, from booking appointments to mental health care appointments, have been digitalized without measures being put in place to mitigate the obstacles this poses for people with limited digital skills or without the financial means to buy suitable devices.

Those in stable employment who can turn to OHC, a sector which has expanded considerably in recent years, do not have to deal with prolonged waiting times or out-of-pocket payments. However, it is the employer who decides what services are made available and employees with minimum-level OHC still face the shortcomings and costs associated with using public or private health services, despite paying into the system the same as those who get wider coverage.

The Finnish health system is thus riddled with several levels of inequality as has been noted, for example, by the CESCR and the OECD. Indeed, the state itself has recognized the inequality in healthcare experienced by those without access to OHC, introducing the right for people not in employment or education to have free health check-ups as a measure to address this. However, awareness of and take-up of check-ups remains very low.

Waves of austerity and under-funding have left the healthcare system under-resourced, negatively impacting the enjoyment of the right to health. Public funding is supplemented with OOP payment costs that form a financial barrier for many people on lower incomes and result in financial hardship and recovery proceedings. The under-resourcing of public healthcare services has also left them unable to compete with OHC and the private sector for healthcare professionals, with the result that healthcare worker shortages in the public sector are chronic and worsening.

Inadequate resources mean that many specific services are often inaccessible in the public healthcare system, because of lengthy waiting times and or high OOP payments. These include services such as oral healthcare services, gynaecological services and mental health services; similar services offered by private providers are too expensive for many on lower incomes.

In 2023, implementation of the social and healthcare reform began, but its provisions fail to address the inequalities between different groups of people or the parallel OHC system. The reform is also underfunded, leaving PHC without adequate resources and as a result people on lower incomes are forced to compensate for the inadequate state budget by paying regressive user fees.

Social inequality manifests as health inequality and therefore measures to tackle social inequality are also needed to eradicate health inequality. These include measures to ensure the rights to social security, housing, and work. Social and healthcare services alone cannot eradicate health inequality, but services play an important role, especially for those who are marginalized or at risk of discrimination.

The state has an obligation to ensure that all people can access timely, affordable, and quality healthcare services, especially those who are marginalized, on a basis of equality and non-discrimination. The availability and accessibility of healthcare must be ensured throughout the country. Amnesty International makes the following recommendations which, if implemented, would help ensure that Finland makes progress towards fulfilling this obligation.

RECOMMENDATIONS

TO THE GOVERNMENT AND PARLIAMENT OF FINLAND:

- Guarantee the right to health for all people and ensure Universal Health Coverage by ensuring available, accessible, and affordable healthcare for all, including for people on lower incomes without access to comprehensive occupational healthcare.
- Ensure that the public health system, and specifically primary healthcare, is strengthened and has adequate resources, by:
 - Considering concrete measures to allocate additional resources to primary healthcare, for example earmarking a progressively increasing share of funding to primary healthcare from the funds budgeted to wellbeing services counties.
 - Removing the automatic 20% cut to needs-based funding to wellbeing services counties.
 - Exploring alternative options for accessing the maximum available resources to fulfil human rights obligations, through, for example, taxation measures.
 - Considering further reductions in multi-channel health funding, including the reduction or removal of reimbursements for curative OHC, to promote universal access to healthcare for all.
 - Avoiding austerity measures targeted at public healthcare services and, if any austerity measures are considered, requiring that a human rights impact assessment be conducted to ensure that measures do not impact those who are marginalized or at risk of discrimination.
- Remove financial barriers to healthcare and reduce geographical inequality by reforming the Act on Client Charges in Healthcare and Social Welfare and changing the Regulation of Client Charges in Healthcare and Social Welfare. Reforms should include:
 - Revising user fees for primary healthcare, so healthcare is affordable to all.
 - Pending revision of user fees, expanding the responsibility of wellbeing services counties to waive and lower all user fees.
 - Combining all payment ceilings and transferring responsibility of assessing when the ceiling is reached from patients to the authorities.
- Carry out human rights impact assessments before any healthcare reform:
 - Human rights impact assessments should be comprehensive, including gender impact assessment, child impact assessment and give special consideration to the impact of decisions on those who are marginalized or at risk of discrimination.
 - State allocation of funds should be sufficient to ensure adequate human resources in state administration and sufficient expertise to conduct high-quality assessments.

TO THE MINISTRY OF SOCIAL AFFAIRS AND HEALTH:

- Monitor the different obstacles people experience in accessing and using healthcare services, especially those who are marginalized or at risk of discrimination. Closely examine causes behind non-use of services and unmet needs for services and implement measures to address them.
- Consider implementing a national programme to improve accessibility and affordability of oral healthcare services in WBSs. Consider targeted measures to ensure necessary service use of those who are marginalized or at risk of discrimination.

TO WELLBEING SERVICES COUNTIES:

- Ensure that all decision-making regarding services is human rights-based and grounded in thorough human rights impact assessments.
- Improve the affordability of healthcare services and the implementation of Section 11 of the Act on Client Charges in Healthcare and Social Welfare. Improve communication, information-sharing, and advice to patients about the possibility of waiving or lowering user fees.
- Improve the accessibility and quality of health check-ups for those young or working-age people who do not have access to OHC or student healthcare. Ensure that check-ups are comprehensive and adequately cover mental and oral health. Ensure that service plans are made with the patient and followed up on.
- Work closely with employment services to improve awareness of check-ups, to ensure patient access to check-ups, and to guide patients to necessary follow-up social and healthcare services.
- Improve access to OHC for people experiencing unemployment. Ensure that health centres have adequate staffing of physicians specialized in occupational health.
- Improve access to health services by addressing the barriers to contact with healthcare services, without delay, including via phone, digital services, and in-person.
- Develop and introduce targeted measures to reduce unmet service needs, non-use of services and negative patient-provider contacts, especially among those who are marginalized or at risk of discrimination.
- Integrate PHC and SHC more closely to improve the availability of sexual and reproductive health services.
- Improve access to timely and affordable mental health services.
- Ensure an adequate workforce in public healthcare services, including by improving the working conditions and remuneration of health workers.



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“I KNOW I WON’T GET HELP”

INEQUALITY OF HEALTHCARE IN FINLAND

This report examines inequality in healthcare in Finland. Based on extensive background research and over a hundred interviews with patients, social and healthcare workers, authorities, and experts – this report reveals how the existence of parallel primary healthcare systems, coupled with periods of austerity measures and underfunding have left the Finnish healthcare system unable to ensure the right to health for all.

Healthcare is easily accessible and free at point-of-use for those covered by occupational healthcare, while those who rely on public services face many barriers when trying to access healthcare services: difficulties in contacting service providers, financial barriers, long waiting times, and digital barriers.

The report provides recommendations for Finland to reduce inequality in healthcare and to promote the right to health for all, without discrimination.

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