

Hannu Valtonen, Jari Kempers and Anna Karttunen
Supplementary health insurance in Finland
Consumer preferences and behaviour



Authors

Hannu Valtonen, PhD
Professor
Department of Health and Social Management
University of Eastern Finland
firstname.lastname@uef.fi

Jari Kempers, Master of Health Economics, Policy & Law
Health Economist
Qalys Health Economics
firstname.lastname@qalys.eu

Anna Karttunen, Bachelor of Health Sciences
Research Assistant
Department of Health and Social Management
University Of Eastern Finland
annaka@student.uef.fi

© Authors and Kela Research Department

www.kela.fi/research

ISSN 2323-9239

Helsinki 2014

Preface

The idea for the study was developed by several persons. For some time, it has become increasingly obvious that the Finnish public-health-centre-based primary care system was not functioning satisfactorily. There also seemed to be fragmented information about supplementary private health insurance and its consequences for healthcare. The study was implemented as an Internet and postal survey. Our impression was that the respondents found it relatively easy to answer questions about children's insurance, but not as easy to answer questions on adult insurance, which features a more complicated market of various insurance plans. We thank all the respondents for answering our long questionnaire.

The study was financed by the Social Insurance Institution of Finland (Kela, Kansaneläkelaitos), the Federation of Finnish Financial Services (FK, Finanssialan keskusliitto) and the University of Eastern Finland. We would also like to thank Assistant Professor Richard van Kleef of the University of Rotterdam for consultation in the planning phase of the study. We received many useful comments on the structure of our study and questionnaire at our meetings with Hennamari Mikkola (Chief of Health Research, Kela), Päivi Luna (Research and Development Manager, FK) and Timo Silvola (Head of Public-Private Partnership & Life Insurance, FK).

This study was conducted in the autumn of 2013 and the spring of 2014, at a time of intense public discussion concerning the re-organisation of the Finnish healthcare system. We hope that the results of our study contribute to this discussion.

Contents

List of tables.....	5
Summary.....	6
Tiivistelmä.....	7
Acronyms	8
1 Introduction.....	9
1.1 Objectives.....	9
1.2 The Finnish healthcare system.....	9
1.3 Supplementary health insurance.....	12
2 Methods and data.....	15
2.1 Data.....	15
2.2 Modelling strategy.....	17
3 Results.....	18
3.1 Current utilisation and trends.....	18
3.2 Socio-demographic characteristics.....	20
3.3 Consumer preferences and motivations.....	23
3.4 Modelling the SHI purchase choice.....	23
3.5 Consequences of SHI in healthcare utilisation.....	26
4 Discussion.....	30
4.1 Current situation	30
4.2 Socio-demographic characteristics.....	30
4.3 Utilisation of SHI	31
4.4 Consumer motivations.....	31
4.5 The impact on healthcare utilisation.....	31
4.6 Limitations	31
References.....	32
Appendices	34
Appendix 1. Respondent background information. Unweighted and weighted portions of responses and the original sample.	34
Appendix 2. Health insurance system of the Netherlands.....	36
Appendix 3. The questionnaire and the frequencies of the variables (in Finnish).....	37

List of tables

Table 1. The numbers of insured persons in 2009 and 2013 (Sairauskuluvaluuutuksen lukumäärätilasto)	11
Table 2. Survey postings, quantities, sequencing of online and paper questionnaires, responses and response rates	16
Table 3. Insurance companies' market share of adults' self- and employer-purchased SHI and child SHI	19
Table 4. Healthcare services reimbursed by SHI providers during the past year	20
Table 5. Socio-demographic characteristics that had a significant influence on choosing adult and children's SHI. Percentages and number of respondents that had SHI. Parents' (respondents') socio-demographic characteristics were used for children's SHI	22
Table 6. The main motivations for choosing SHI. The three most important reasons. Unweighted percentages	23
Table 7. Insurance purchase: a probit regression with robust standard errors	24
Table 8. Is there a regional effect? Insurance and hospital districts	25
Table 9. Adults' insurance purchase mode	26
Table 10. Percentage of utilisation of health services by supplementary health insurance status.....	27
Table 11. Percentage of utilisation of both public and private health services by insurance status	27
Table 12. Sector choice if insurance is endogenous, conditional mixed procedure (probit regression)	28
Table 13. The frequency of service utilisation, conditional mixed procedure (ordinal probit regression, utilisation equation)	28
Table 14. The impact of insurance purchase method on the frequency of visits, working population, conditional mixed procedure (ordinal probit regression, utilisation equation)	29

Summary

This nationally representative questionnaire survey provides insight into the demographics, motivations and behaviour of consumers opting for supplementary health insurance (SHI), and the impact of SHI on consumer utilisation of healthcare services. The data was collected from a combination of online and paper-based surveys (N = 1,620, response rate 41%) in October 2013 – January 2014. The questionnaire covers both adult and children's SHI. The data comprises information on respondents' socio-economics, health insurance, motivations for purchasing (or not purchasing) SHI and utilisation of healthcare services.

We analyse 1) the current utilisation of and trends in SHI, 2) the preferences and motivations of Finnish consumers in opting for SHI in relation to their background characteristics, and 3) the consequences of SHI on primary healthcare service utilisation.

A total of 22.7% of Finnish adults and 52.0% of children had SHI. The reasons for purchasing SHI were faster access, wider choice, better quality and willingness to use private healthcare (PRH) services. For adults, labour market position, level of education, better health and household income were significantly associated with SHI. For children, the most important factor associated with purchasing insurance seems to be the educational level of the (responding) parent. There was a significant interdependence between parents' and children's SHI. For adults, the insurance decreases the probability they will choose a public provider and increases the utilisation of private services. For children, the insurance increases the probability of choosing a private provider. The SHI decreases the utilisation of public services for adults and increases the utilisation of private services. For children, there seems to be no effect on the utilisation of public services, but a significant increase in the utilisation of private services.

Also the mode of purchase, i.e. self-purchased or employer-purchased, seems to influence healthcare utilisation in the working population. Self-purchased SHI increases the utilisation of private services, but employer-purchased SHI has no impact on healthcare utilisation.

Key words: health insurance, consumer behaviour, survey, moral hazard, adverse selection, Finland, health service utilisation

Tiivistelmä

Tällä väestöä edustavaan otokseen perustuvalla tutkimuksella selvitetään vakuutusten hankkimisen sosio-demografiaa, kansalaisten motivaatioita, käyttäytymistä ja vakuutusten vaikutusta terveystalouden käyttöön. Aineisto on koottu yhdistetyllä verkko- ja paperilomakekyselyllä (N = 1 620, vastausprosentti oli 41 %) lokakuun 2013 ja tammikuun 2014 välisenä aikana. Tutkimus kattaa sekä aikuisten että heidän lastensa terveyteen liittyvät vakuutukset. Aineisto sisältää tietoja vastaajien sosio-ekonomisesta asemasta, terveystalouksista, vakuutuksen valinnan (tai valitsematta jättämisen) motiiveista, vakuutuksen käytöstä ja vaikutuksesta terveystalouden käyttöön.

Selvitämme tässä tutkimuksessa; 1) terveystalouksien määrää ja niiden käytön trendejä, 2) kansalaisten preferenssejä ja motiiveja vakuutusten hankinnassa ja 3) vakuutusten seurauksia terveystalouden käytössä.

Suomalaisista aikuisista 22,7 %:lla ja lapsiperheistä 52,0 %:lla on yksityinen terveystalouksien vakuutus. Syyt vakuutuksen hankintaan ovat nopea hoitoon pääsy, laajempi palveluvalikoima ja koettu yksityisten palvelujen parempi laatu. Aikuisten vakuutuksen valintaa selittävät työmarkkina-asema, koulutustaso ja kotitalouden tulot. Aikuisilla vakuutuksen omaajilla on parempi terveydentila kuin ilman vakuutusta olevilla. Aikuisten ja lasten vakuutukset keskittyvät samoihin kotitalouksiin. Lasten vakuutusten valintaa selittää ensisijaisesti vanhemman koulutus. Aikuisten ja lasten vakuuttamista selittävät täten hieman erilaiset seikat. Vakuutus selittää terveystalouksien tuottajan valintaa ja palvelujen käytettyä määrää. Vakuutus näyttää johtavan yksityisten palvelujen käyttöön ja lisääntyneeseen palvelukäyttöön erityisesti lapsilla. Aikuisilla vakuutus vähentää julkisen ja lisää yksityisen palveluntuottajan valinnan todennäköisyyttä. Lapsilla taas vakuutus lisää yksityisen tuottajan valinnan todennäköisyyttä. Vakuutus vähentää aikuisilla julkisten ja lisää yksityisen palvelujen käytettyä määrää. Lapsilla julkisten palvelujen käyttö ei vähene, mutta yksityisten palvelujen käyttö lisääntyy. Myös vakuutuksen hankinnan tavalla on yhteys palvelujen käyttöön. Työssäkäyvien aikuisten itse hankkima vakuutus tuottaa lisäyksen yksityisten palvelujen käytetyssä määrässä, mutta työnantajan hankkima vakuutus ei ole yhteydessä julkisten, yksityisten tai työterveyshuollon palvelujen käytettyyn määrään.

Acronyms

CMP	Conditional mixed process
FK	Federation of Finnish Financial Services
GP	General practitioner
KELA	Social Insurance Institution of Finland
NHI	National health insurance
PHC	Primary healthcare
PRH	Private healthcare
PUH	Public healthcare
SHI	Supplementary health insurance
THL	National Institute for Health and Welfare

1 Introduction

1.1 Objectives

The detailed objectives of the study were to support policymaking by producing new information on:

- 1) **The current utilisation of and trends in supplementary health insurance (SHI) in Finland:**
 - a. What percentage of Finnish consumers (adults and children) have SHI?
 - b. With which insurance company they are insured?
 - c. What healthcare services were they reimbursed for under their SHI during the past year?
 - d. What percentage of Finnish consumers seriously considered purchasing or terminating SHI during the past year?

- 2) **Finnish consumer preferences and motivations in opting for SHI in relation to their background characteristics:**
 - a. What are the demographics, income level, level of education, labour market position, place of residence and health status of persons who have SHI?
 - b. What are the main reasons why they opted for SHI?

- 3) **The consequences of SHI for healthcare utilisation.**
 To ascertain the consequences, we tested the following hypotheses:
 - a. SHI increases the probability that consumers will choose a private healthcare (PRH) provider.
 - b. SHI increases the utilisation of primary healthcare (PHC) services (moral hazard).
 - c. Consumers with a poorer health status take out SHI more often (adverse selection).
 - d. Parents' and children's SHI plans are interdependent.

1.2 The Finnish healthcare system

In Finland, there are in practice three different healthcare provision systems: publicly funded municipal healthcare, PRH and occupational healthcare. Employed persons can usually choose between these three options. "In addition to the public municipal system, Finns can receive partial reimbursement¹ for private healthcare services through the obligatory National Health Insurance (NHI) system. A separate, third funding mechanism renders occupational healthcare a distinct form of care, even though occupational services are often delivered by private and municipal providers.

¹ For example, a common fee for a 20-minute appointment with a private GP is €47-54 . The NHI reimburses 60% of a "standard fee" of €27, i.e. €16.20, about one-third of the GP's fee.

While there is some overlap, significant differences exist in the scope of services, user-fees and waiting times across the three systems” (Teperi et al. 2009, 37). There are significant differences between the systems, for example in the scope of services, user fees and waiting times.

The main sector is public municipal healthcare, which provides the largest share of PHC, including more than 70% of outpatient physician consultations and nearly 60% of dentist visits (Vuorenkoski et al. 2008). Municipal health centres provide a wide range of services, from general outpatient care to laboratory services and dental care. Many health centres also have inpatient facilities (typically 30 to 60 beds), mainly providing long-term care for the chronically ill elderly. Health centres provide a wide access to care, as they charge only modest user fees – an average of 8.9% of total costs (2009) – and annual ceilings on out-of-pocket payments prevent patients from catastrophic costs. They constitute the only available care option for the poor and unemployed, who have no access to occupational care and cannot afford the user fees of the PRH sector. Hence, ensuring the ability of health centres to provide timely quality healthcare is essential from an equity standpoint. The main levels of political and administrative organisation are the national government and the local municipalities. The regional-level authorities (i.e. the municipalities) are financially much weaker than in most other OECD countries (Häkkinen and Lehto 2005; see also OECD 2012).

The second sector, occupational healthcare, provides a substantial amount of PHC to employees, who account for about a third of the population. Companies are required by law to provide preventive care for their employees, but many large and medium-sized employers also provide extra services – in particular, access to GPs – free of charge. In the mid-2000s, additional services were provided to some 90% of employees with access to compulsory occupational healthcare services, and 45% of employees’ physician consultations – 13% of the total number of consultations – were in occupational care (Vuorenkoski et al. 2008; Teperi et al. 2009).

Occupational healthcare is either supplied by healthcare units owned by employers or purchased from private or municipal providers. More than half of the cost is funded by employers, and the remainder is borne by the earned income insurance sector of the NHI, which collects social contributions from employers (66% of revenues) and employees (26%) and receives a state subsidy (5.5%).

The third sector, PRH, offers a complement to public provision, enhancing user choice for patients who can afford to pay the high co-payments and offering a “safety valve” whenever the PUH sector struggles to respond to demand. The PRH sector mainly supplies primary care, accounting for 16% of the overall number of consultations and 25 to 30% of specialist visits. The private share is especially high in dental visits (about 40%), as the municipal sector suffers from a shortage of

dentists. NHI reimburses up to 60% of the basic tariffs set by the government, but since many health professionals charge fees well above the tariffs, the effective reimbursement rate is roughly 30% (OECD 2012, 88–90).

Occupational health expenditure was EUR 767 million in 2012 (Health 2014, 4), and primary outpatient care expenditure in the municipal services totalled EUR 1795.8 million (Health 2014, 1). Thus the size of the occupational healthcare sector, as measured by expenditure, is about 42% of the outpatient care cost of public health centres. There are no statistics available for the compensation paid by private SHI. The insurance premiums collected by insurance companies in 2013 totalled EUR 278 million (K. Koivisto, Federation of Finnish Financial Services, e-mail of 15 May 2014): i.e. the monetary size of these money flows is 15% of the primary outpatient care expenditure in public health centres.

Table 1. The numbers of insured persons in 2009 and 2013 (Sairauskuluvakuutuksen lukumäärätalasto).

Insured	2009	2013	Increase 2009–2013
Children	392,931	438,421	12%
Adults, self-purchased	327,763	363,382	11%
Adults, employer-purchased	98,359	171,007	74%
Total	819,053	972,810	19%

“The Finnish healthcare system offers good quality healthcare at a moderate cost, provides universal coverage, and enjoys high public satisfaction” (OECD 2012, 80). However, the Finnish healthcare system is facing severe functional and equality problems. A recent OECD report stated that

“[t]he Finnish health system provides universal coverage for a wide range of services and enjoys high public satisfaction. Nevertheless, performance has been mixed: infant mortality is low, life expectancy is high for women but below OECD average for men, health inequalities are large across socio-economic groups and regions, and efficiency has been declining in recent years. As the fragmentation of healthcare provision is a major source of inefficiencies, planned reform to restructure municipalities and services should improve efficiency and quality of care, provided enough mergers are achieved to bring municipalities to a sufficient size” (OECD 2012, 79).

“In the 1990s and early 2000s, Finland’s healthcare was affected by a lack of responsiveness to demand, a common problem in public integrated systems combining mostly tax financing with mainly public healthcare provision. Waiting

times in PHC (measured by the proportion of patients having to wait more than two days for a consultation with a general practitioner) in the mid-90s were the third highest in a sample of 16 European OECD countries, only surpassed in Sweden and Norway. Waiting times for the most common elective surgical procedures were the longest in a sample of seven OECD countries in 2000, with an average of over 200 days (OECD 2005). Furthermore there were large variations in waiting times across municipalities” (Vuorenkoski et al. 2008; Teperi et al. 2009; OECD 2012, 85–86).

In a large number of Finnish municipalities, there are queues for access to the health centres, i.e. to public municipal healthcare. In October 2011, 18% of the population lived in areas where patients have to wait more than five weeks and 21% of the population in areas where an appointment to a PHC doctor could be organised within two weeks (THL 2013). Thus there is a time cost attached to public PHC services, whereas in the private services providers charge a monetary fee. The waiting lists have been found to increase utilisation of private health insurance (Besley et al. 1999; Jofre-Bonet 2000).

1.3 Supplementary health insurance

Private SHI may have important effects on consumer behaviour. First, the choice to purchase SHI may depend on the preferences and socio-economic background of the individual. This choice may have several different rationalisations: for example, a consumer might have learned from his/her own experience that an insurance plan brings value for money, or he/she has ideological reasons (“willingness to use private services”) for choosing a private insurance plan. The choice may also depend on the health status of the individual (the need for health services).

Two traditional notions in insurance studies are *moral hazard* – the impact of insurance on healthcare utilisation – and *adverse selection*, i.e. if low-risk people do not insure themselves and there are only high-risk individuals in the insured pool (see e.g. Doiron et al. 2008; Buchmueller et al. 2013). SHI as such may have an effect on the choice between the PUH and PRH sectors, for reasons of shorter waiting times in the PRH sector or a perceived higher quality of PRH services. Further, SHI may result in an increase in the volume of services used (i.e. moral hazard) and increase the total volume of health services used (PRH plus PUH services) if the service volume in the public sector is regulated by longer waiting times.

The empirical results concerning the effect of private insurance on healthcare utilisation vary from country to country and study to study, from negative (Hulleger and Klein 2010 in Germany) to

“strong and significant” (Buchmueller et al. 2004 in France). According to a Finnish patient choice and healthcare utilisation study in five large cities and with a population of 20–80-year-old persons, 15.8% had private health insurance, and private insurance increased the probability of subjects choosing a private provider (Jäntti 2008).

We assume that the individual’s own decision to purchase SHI, the choice of provider, and the number of visits to a provider are all endogenous variables. This means that the population is not randomly divided in two homogenous groups, the only difference between them being insurance status: i.e. one group having insurance and the other group not having it. However, employer-purchased SHI is an exogenous variable. Thus the statistical models to be used in explaining the consequences of private insurance are instrumental variable models. An additional technical feature in our data is that the frequency of services use is measured on a scale that is more like an ordinal scale than a count variable. The utilisation variables for private, public and occupational health services during the past year were measured on the same scale.

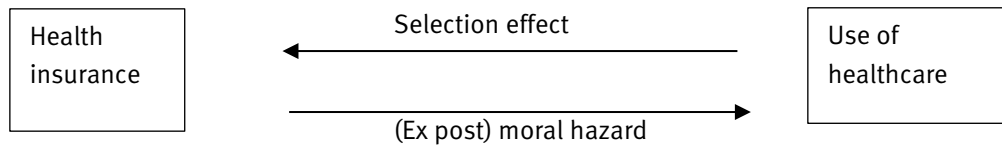
Dong (2013) has built a model (Figure 1) of the potential associational links between an individual’s characteristics, SHI and healthcare utilisation. Dong argues that, in the traditional setting, the use of healthcare and insurance are seen to depend simultaneously on each other. When an individual is expecting to make doctor visits in the future, he/she might purchase private insurance, and the higher the expected probability of utilisation is, the higher is also the probability that he/she will purchase insurance (“the selection effect”). Once a person has private insurance, the probability of a doctor visit increases (“ex post moral hazard”). In the broader view of the causalities, health insurance might depend on health-related behaviour (e.g. risky behaviour might have an effect on the insurance decisions) in addition to the selection effect. By lowering the costs involved, insurance may increase the probability of a doctor visit (price effect), and it may have an effect on the individual’s health behaviour, which, in turn, might have an effect on the probability of healthcare utilisation. Estimating Dong’s entire framework is not an easy task.

We estimate in this paper:

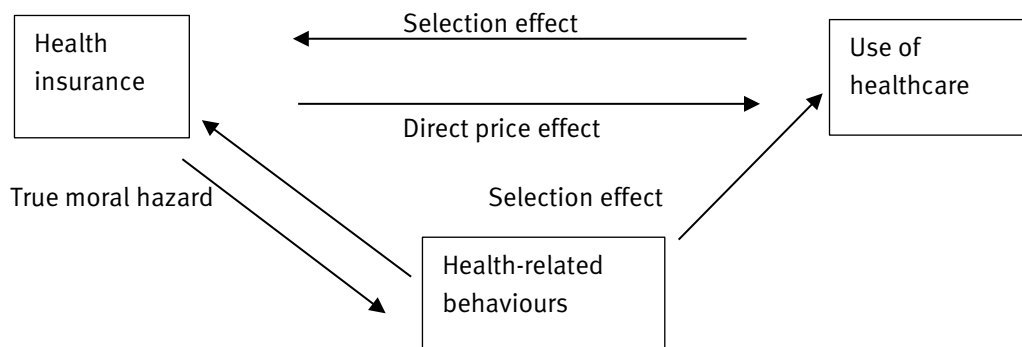
- a) One form of the insurance selection effect, i.e. how health status and various socio-demographic and regional variables explain the choice of insurance.
- b) The healthcare utilisation effect, i.e. how the supplementary health insurance explains healthcare utilisation (sector choice and frequency of utilisation). Our modelling structure is thus recursive.

Figure 1. The potential associations of health insurance utilisation of healthcare and health-related behaviour (Dong 2013).

(1) Causalities traditionally studied



(2) A broader view of the causalities



The selection effect can take two different forms: the traditional adverse selection, where there is a tendency for healthier and less-healthcare-utilising individuals not to insure themselves – “insurance is not needed” – which leaves only the highest-risk individuals in the insured pool. The second alternative is a social selection process whereby health status does not explain insurance status, which is instead explained by other factors such as income or education.

There are two kinds of selection processes in the purchase of SHI for adults: first, selection of those from the entire population who purchased SHI themselves and, second, selection between individuals belonging to the labour force who have an employer-purchased SHI. In the case of children, all SHI is purchased by their parents.

In the service utilisation choice, working people have a choice from three alternatives for a PHC physician – public, private and occupational health – whereas non-working individuals only have the choice between public and private services.

2 Methods and data

2.1 Data

The data were collected with a specially developed and tested questionnaire (Appendix 3). The respondents were asked about their and their children's socio-demographic background, utilisation of healthcare services, SHI and utilisation of SHI. The questions about respondents' socio-demographic background included gender, age, place of residence, household size, level of education, labour market status, household income, health status and chronic illness. Respondents were asked about their utilisation of public, private and occupational healthcare services during the past year. Questions about SHI included whether they had SHI; the type, price and deductibles of their SHI; their insurance company; whether a medical check was required; whether there were limitations on their insurance coverage; their motivations for choosing (or not choosing or changing) their SHI or insurance company; and their intention to take out (or terminate) their SHI. Finally, the utilisation of SHI was investigated through questions on selection of healthcare providers, utilisation and reimbursements by their SHI providers.

A random sample of 4,000 persons aged 18–60 was drawn from the population register of Finland. Parents were asked about SHI of their children under 18. Persons older than 60 were excluded, as they no longer qualify for (most) SHI at that age. The data were collected with a combination of online and paper-based questionnaires. The survey included four posting rounds: one invitation and three reminder letters. The online questionnaire was offered as a primary alternative. A paper questionnaire was sent with the first and third reminder letters. The online questionnaire was implemented using SurveyMonkey® software. The paper responses were filled in manually. Table 2 provides an overview of the data collection and responses.

The data was analysed using Stata® software. Incomplete questionnaires were included in the analysis to the degree it was possible to do so. After cleaning up the data, 1,620 (40.5%) suitable responses remained. There were enough responses for statically representative results (population 18–60 years old, CL 95%, CI $\pm 2,5\%$, Statistics Finland 2012a).

The group that responded to the survey was biased from the original sample. Firstly, the respondents' average age was older than in the sample, 43.3 and 38.2 years respectively ($P=0.000$). Secondly, females answered more frequently than the percentage of females in the sample, 55.7% and 48.3% respectively ($P=0.000$). Moreover, it can be assumed that the group that did not respond to the survey included more persons who did not use healthcare services and/or did not have SHI.

Table 2. Survey postings, quantities, sequencing of online and paper questionnaires, responses and response rates.

Posting round	Date	Sent	Questionnaire Online/paper	Responses			
				Online/paper	N	%	Cumulative, %
1	31 Oct 13	4,000	Yes/no	541/0	541	14	14
2	13 Nov 13	3,652	Yes/yes	177/365	542	15	27
3	2 Dec 13	3,246	Yes/no	237/0	237	7	33
4	22 Jan 14	2,756	Yes/yes	118/281	399	14	43
Total				1,073/646	1,719		

The response bias was corrected in the following way: the sample of 4,000 persons was explained by using a logistic regression on age, gender and place of residence. The answering probability for each person was estimated from the regression. Inverse values of the answering probabilities were used as analytic weights. In this way, the importance weight of a respondent's answers increases when his/her answering probability decreases. Hence, the respondents with a lower answering probability also represent other persons with similar characteristics.

To investigate possible regional differences in insuring behaviour, respondents' home municipalities were categorised in three municipality types according to the definition of Statistics Finland (Statistics Finland 2012b): 1) *cities or city-like* municipalities, with >90% of residents living in population centres, or the largest population centre has >15,000 residents; 2) *densely populated* municipalities, with >60% residents living in population centres and the largest population centre has 4,000–15,000 residents; and 3) *rural* municipalities, with <60% residents living in population centres and the largest population centre has <15,000 residents, and municipalities with >60% residents living in population centres, but the largest population centre has <4,000 residents. In addition, regional differences between SHI plans were analysed by grouping respondents' home municipalities with hospital districts and investigating possible relationships between average waiting times for a GP appointment in the PUH sector (THL 2013) and SHI behaviour.

Statistical relationships between respondents' socio-demographic characteristics and their insuring behaviour were analysed by using the Chi-squared test (the significance levels: X^2 , $p < 0.001$ = highly significant, $p = 0.001 - 0.010$ = significant, $p = 0.010 - 0.050$ = almost significant, and $p > 0.050$ = non-significant).

2.2 Modelling strategy

The choice to purchase SHI is, in our modelling, an endogenous variable, i.e. some individual characteristics (such as gender, income, education, and labour market status) explain this choice. Further, the SHI influences the choice between private and public healthcare sectors, and it may have an effect on the frequency of visits. The choice variables are binary (no, yes) and ordinal choices. In our data, the frequency of visits was measured with a pre-classified variable (has used the healthcare service 0, 1–3, 4–6, 7–9 or ≥ 10 times during the last year), which can be understood to be an ordinal scale.

Respondents' household incomes were divided into eight classes: 0–1000, 1001–2000, 2001–3000, 3001–4000, 4001–6000, 6000–7000 and > 7001 euros/month, and “Don't know”. Educational background was divided into four classes: higher, mid-level or lower-level education and “Other/don't know”). The number of adults in a household was grouped into two classes: one adult or two or more adults. Labour market participation was divided into six classes (working, entrepreneur, unemployed, student, not working and don't know), which we also transferred to a binary variable (0 = not working; 1 = working). The health status was the standard five-class variable (excellent, good, average, fair and poor). Chronic illness was measured using a binary (0 = no, 1 = yes).

Our modelling strategy was to model for both adults and children the choice of SHI in order to investigate which factors (health status, socio-economic background or region) explain the purchase of supplementary insurance. In the second phase, we modelled the healthcare choices (sector choice, i.e. public vs. private, and the frequency of the visits) with SHI as an endogenous variable. The decision to use health services depends on the SHI, quite naturally, because – especially in the Finnish context – the SHI lowers both the monetary and the time costs of using PRH services. In the respective tables on healthcare utilisation, only the second-stage equations are shown.

Finally, we tested whether the purchasing method of private insurance (by oneself or employer) is associated with healthcare utilisation and whether the effect of self-purchased insurance differs from that of employer-purchased insurance.

The dependent variables in the models were either binary (having SHI, sector choice) or ordinal (the frequency of visits to public or private sector: “How many times have you made use of public/private/occupational healthcare services during the past year?” The sector choice is a binary variable, and probit models were used. The visit-frequency variables were ordinal, and

consequently, ordinal probit models were used. The models were also estimated separately for children and adults.

The sample for these models were the respondents who had used the services of either public and/or private/occupational health services during the past year. Due to missing observations, the number of cases varies somewhat between the models. All individuals in the sample are thus assumed to have a reason, some kind of perceived health problem, for their utilisation of the services in question. Occupational health services were included in the analysis, although there is no specific reason to assume that SHI had any effect on the utilisation of these services.

For the estimation of two-stage models, we used the conditional mixed process (CMP) procedure for Stata (Roodman 2009 and 2011). The CMP procedure is “appropriate for two broad types of estimation situations: 1) those in which a truly recursive data-generating process is posited and fully modelled; and 2) those in which there is simultaneity but instruments allow the construction of a recursive set of equations, as in two-stage least squares (2SLS). CMP is fundamentally an SUR estimation program. But it turns out that the ML SUR can consistently estimate parameters in an important subclass of mixed-process simultaneous systems: ones that are recursive, with clearly defined stages; and that are fully observed, meaning that endogenous variables appear on the right hand side only as observed” (Roodman 2009). The procedure allows testing for the endogeneity of the instrumented variables. Heteroskedasticity in the models may, however, lead to inconsistent results (see Williams 2009). We tested for the presence of heteroskedasticity when applicable. The standard errors in the models are robust standard errors.

3 Results

The results are presented in weighted values, unless otherwise stated. In the various regression models, unweighted values were used. A summary of respondents’ background characteristics can be found in Appendix 1.

3.1 Current utilisation and trends

In our study, 22.7% of adults and 52.0% of children had SHI: 74.8% of the insured adults had a self-purchased SHI, 16.2% an employer-purchased SHI and 9.0% had both. The insured consumers estimated that on average they spent €272 on adult SHI and €336 on children SHI per person per

year. Table 3 shows the insurance companies with which the respondents were insured. The three largest companies – LähiTapiola, Pohjola and If – covered more than 70% of the adult (self-purchased) and children’s SHI market. In the employer-purchased group, a large percentage of the respondents did not know what their insurance company was (31.8%). Yet, the top three insurance companies were the same as for the two other groups.

Table 3. Insurance companies’ market share of adults’ self- and employer-purchased SHI and child SHI.

Insurance company	Self-purchased adult SHI, %	Employer-purchased adult SHI, %	Children’s SHI, %
LähiTapiola	24.6	16.7	33.1
Pohjola	28.9	19.6	19.6
If	17.3	17.5	20.3
Other	8.0	4.9	3.1
Fennia	5.8	6.3	9.1
Pohjantähti	4.4	1.1	5.0
Mandatum	3.8	-	0.5
I don’t know	3.7	31.8	1.4
Turva	1.2	-	5.3
Aktia	1.5	2.0	1.3
Folksam	0.7	0.0	1.0
POP Vakuutus	-	-	0.3

Table 4 summarises healthcare services that were reimbursed under SHI policies over the past year. Respondents were not requested to state quantities or monetary values of the healthcare services provided. For adults, the most-reimbursed healthcare services were medical tests at 29.2%, consultations at self-selected PRH centres at 22.9% or at PRH centres recommended by the insurance company at 16.7%, and medicines at 10.4%. For children the most reimbursed services were; consultations in self-chosen PRH centres 35.4%, medicines 27.2% and medical test 20.9%. The difference between the 16.7% adult and the 1.0% children’s consultations in PRH centres recommended by the insurance company is related to occupational healthcare services.

Intention to purchase. 9.5% of adults and 10.0% parents’ of children who did not have SHI seriously considered taking out SHI during the past year. The main reason why they did not purchase the insurance was its high price.

Intention to end. 6.9% of adults and 7.6% parents of children who have SHI seriously considered terminating their SHI in the past year. The main reasons were the high price of SHI and that SHI was not needed. Note: these persons seriously considered it, but did not terminate their SHI.

Change of insurance company. 3.3% of adults and 3.6% of children changed their SHI company during the past year.

Previous SHI. 11.2% of adults and 14.7% of children who did not have SHI, had previously had SHI (time frame not specified). Their main reasons for ending the insurance were the high price and limited coverage of SHI and that a child's SHI ended when he/she turned 18.

Table 4. Healthcare services reimbursed by SHI providers during the past year.

Healthcare service	Insured adults, %	Insured children, %
Medical tests prescribed by a doctor	29.2	20.9
Consultations in a private healthcare centre (self-selected)	22.9	35.4
Consultations in a private healthcare centre (recommended by the insurance company)	16.7	1.0
Medicines	10.4	27.2
I don't know	8.3	1.9
Other	8.3	0.2
Consultations at a private hospital (self-selected)	2.1	3.2
Service charge of a public hospital	2.1	5.8
Service charge of a public healthcare centre	0.0	3.9
Consultations at a private hospital (recommended by the insurance company)	0.0	0.5

Box 1. Comparison of consumer mobility in the SHI markets of Finland and the Netherlands. 27.2% of Finnish adults and 84.7% of Dutch adults had SHI (Vektis 2013). In Finland, 3.3% of adults had changed their insurance company during the last year. In the Netherlands, the percentage of changers was 7.2%, a figure that has increased in recent years as a result of policies aimed at stimulating competition in the health insurance market (Centraal Bureau voor de Statistiek 2014). A brief description of the health insurance system of the Netherlands can be found in Appendix 2. The main reasons for changing companies or terminating SHI were similar in both countries: its high price and limited coverage. Opinions about the necessity of SHI among consumers who seriously considered SHI but did not purchase it were different. For Finnish consumers, the main reason for not purchasing SHI was its high price. Interestingly, only 6.4% of the Finnish respondents thought that SHI was unnecessary, in comparison with the Netherlands, where 64.6% of consumers who seriously considered but did not take out SHI thought it was unnecessary. This large difference is most likely caused by the selection bias of Finnish respondents (who considered taking out SHI) and the different motivations for consumers wanting to insure their healthcare expenses (Box 2 below).

3.2 Socio-demographic characteristics

Table 5 summarises the socio-demographic characteristics that had a significant influence on consumers' preferring SHI. The respondents' age group had a highly significant influence on adult

SHI ($P=0.000$) and an almost significant effect on children's SHI ($P=0.014$). The age group 31–40 had the highest (28.3%) and the oldest age group, 51–60, the lowest (15.8%) percentage of SHI.

The respondents' position on the labour market had a highly significant relationship with adults' SHI ($P=0.000$), but non-significant with children's SHI ($P=0.066$). Entrepreneurs and their children had the highest percentage of SHI (adults 42.3%, children 61.4%). Interestingly, students were the second-highest group (adults 23.7%). A total of 22.1% of employed adults and 53.0% of their children had SHI. Unemployed and other not-working (e.g. housewives) groups had the lowest percentage of adult SHI at 12.9% and 11.4% respectively.

Consumers' tendency to purchase SHI increased with rising household income (for adults $P=0.000$, and for children $P=0.046$). In a lower income group, €501–1000, 11% had adult and 27.3% children's SHI, in comparison with the most earning group, > €7000, in which 36.4% had adult SHI and 55.3% children SHI. An exception to the relationship was the lowest-income group, < €500, which had more adult SHI (26.5%). These persons are likely to be students, whose parents pay for their SHI. Educational level also had a significant influence on SHI (for adults $P=0.043$, for children $P=0.001$). People with higher or mid-level education and their children had SHI more often than people with lower-level education.

The reported health status of the respondents had a significant influence on their tendency to purchase SHI ($P=0.001$). Persons with an excellent or good health status had SHI more often than persons in fair or poor health. Similarly, persons who reported they did not have a chronic illness had SHI more than the group with a chronic illness ($P=0.006$). Together, the health and chronic illness status results seem to indicate that there is no adverse selection, i.e. sicker persons purchasing more health insurance coverage than healthier persons.

The following socio-demographic characteristics that did **not** have a significant influence on respondent behaviour in opting for SHI. Gender was not significant in choosing to take out SHI (adults $P=0.560$, children $P=0.431$). The number of adults in respondents' household was statistically non-significant (adults $P=0.254$, children $P=0.113$). Surprisingly, the municipality type (cities, densely populated and rural municipalities) was not significantly associated with SHI (adults $P=0.712$, children $P=0.315$).

Table 5. Socio-demographic characteristics that had a significant influence on choosing adult and children's SHI. Percentages and number of respondents that had SHI. Parents' (respondents') socio-demographic characteristics were used for children's SHI.

	SHI adult		SHI children	
	%	N	%	N
Age group				
18–30 years	24.0	309	51.0	49
31–40 years	28.3	290	60.7	183
41–50 years	24.2	410	45.6	239
51–60 years	15.8	576	45.3	75
χ^2 p	0.000		0.014	
Labour market status				
Entrepreneur	42.3	55	61.4	27
Student	23.7	33	31.3	5
Working	22.1	219	53.0	204
Unemployed	12.9	17	34.4	11
Other, not working	11.4	22	47.7	31
χ^2 p	0.000		0.066	
Household income per month				
< €500	26.5	34	0.0	3
€501–1000	11.0	100	27.3	11
€1000–2000	17.7	175	36.8	38
€2001–3000	17.5	211	42.9	56
€3001–4000	20.2	233	49.4	85
€4001–6000	23.1	420	55.9	177
€6000–7000	23.3	150	60.3	73
> €7000	36.4	173	55.3	85
Don't know	18.7	75	40.0	15
χ^2 p	0.000		0.046	
Education level, respondent				
Higher education: University or polytechnic	24.7	181	56.8	171
Mid-level education: College	23.1	36	58.7	27
Lower-level education: Vocational school or training, or no vocational training	19.1	95	46.4	71
Other, don't know	17.4	34	21.4	9
χ^2 p	0.043		0.001	
Health status reported by respondent				
Excellent	25.4	610	n/a	n/a
Good	22.4	594	n/a	n/a
Average	17.7	289	n/a	n/a
Fair	7.1	70	n/a	n/a
Poor	10.5	19	n/a	n/a
χ^2 p	0.001		n/a	
Chronic illness, respondent				
No	24.1	995	n/a	n/a
Yes	18.2	584	n/a	n/a
χ^2 p	0.006		n/a	

3.3 Consumer preferences and motivations

Table 6 summarises the main motivations in opting for SHI. The most important factor was faster access to healthcare, for both adults (19.0%) and especially for children (34.1%). Secondly, the insured respondents deemed PRH services to have better quality than the in the PUH sector (adults 15.6%, children 17.8%). Thirdly, SHI was purchased to gain more choice (adults 15.5%, children 16.0%). Fourthly, consumers explicitly wanted to access PRH (adults 15.3%, children 16.6%). All the four main reasons indicate consumers' preference for PRH services (*pull*) and their dissatisfaction with PUH services (*push*). Other push factors, such as low reimbursement and limited coverage of the KELA, played only a minor role in opting for SHI. The "other" category included acquiring additional security and continuation of a child's SHI after he/she turned 18.

Table 6. The main motivations for choosing SHI. The three most important reasons. Unweighted percentages.

Reason	Insured adults, %	Parents of insured children, %
I want faster access	19.0	34.1
Better quality of PRH services	15.6	17.8
I want more choice	15.5	16.0
I want to use PRH services	15.3	16.6
Other; what?	9.9	4.2
Recommendation of a representative of an insurance company	8.3	1.4
I don't know	7.3	1.5
Low NHI reimbursements	4.3	2.4
Recommended by acquaintances	2.7	4.2
NHI does not cover treatment, tests or medicines that I need	1.6	1.7
Insurance company advertisement	0.5	0.2

Box 2. Comparison of SHI consumer motivations between Finland and the Netherlands. In Finland, the main reasons for adults purchasing SHI were faster access, better quality of PRH and more choice. In the Netherlands, the main motivations for adults choosing additional SHI on the top of their mandatory basic insurance package were adding healthcare services to their insurance coverage, especially dental care, and the opportunity to take out a lower-priced SHI via their employer (Laske-Aldershof and Schut 2005). In general, Finnish consumers opt for SHI to access PRH services and the Dutch to add more services to their insurance coverage. The differences are most likely related to differences in organisation and financing of the PHC in the two countries.

3.4 Modelling the SHI purchase choice

The choice made to purchase insurance was modelled with probit regression. In Table 7, we have two models for both adults and children. The first two columns are probit regressions, where the choice of insurance is explained by health status, socio-economic characteristics and family structure. The last

two columns are models to which we added a regional effect (hospital district) and the mean waiting time for the public health centres in the hospital district as an explanatory variable: the purpose was to test the existence of a potential regional effect in the insurance markets (see also Table 8).

Table 7. Insurance purchase: a probit regression with robust standard errors.

	Probit regression				Panel data, probit regression			
	Adults		Children		Adults		Children	
N	1540		535		1540		535	
No. of groups (hospital districts)					20		20	
Pseudo R2	0.064		0.077					
	Coef.	p	Coef.	p	Coef.	p	Coef.	p
Gender	-0.094	0.392	-0.277	0.143	-0.088	0.418	-0.266	0.168
Age ^a	-0.008	0.001	-0.021	0.000	-0.008	0.001	-0.023	0.000
Woman, age < 46	0.215		0.403		0.210		0.406	
Vocational school or training	0.210	0.324	0.209	0.001	0.200	0.400	0.169	0.001
No vocational training	-0.030		-0.255		-0.025		-0.240	
Cannot say	-0.049		-0.873		-0.043		-0.946	
Entrepreneur	0.673	0.000	0.404	0.122	0.682	0.000	0.427	0.112
Unemployed	-0.204		-0.254		-0.195		-0.194	
Student	0.022		-0.587		0.025		-0.679	
Homemaker	-0.568		-0.151		-0.565		-0.157	
Cannot say	-0.095		-0.245		-0.094		-0.266	
€1001–2000	0.135	0.011	0.318	0.485	0.147	0.012	0.439	0.489
€2001–3000	0.111		0.515		0.123		0.586	
€3001–4000	0.259		0.564		0.269		0.650	
€4001–6000	0.325		0.742		0.336		0.846	
€6001–7000	0.255		0.821		0.271		0.940	
> €7001	0.690		0.657		0.701		0.785	
Cannot say	0.092		0.352		0.108		0.448	
Two or more adults in the household	-0.121	0.234	-0.074	0.700	-0.115	0.269	-0.075	0.696
No. of children	0.044	0.220	-0.038	0.509	0.045	0.211	-0.033	0.601
Chronic illness, adult	-0.084	0.333	0.224	0.088	-0.086	0.322	0.227	0.094
Perceived health, adult	0.072	0.128	0.043	0.586	0.075	0.123	0.024	0.768
Mean waiting time in public health centre, by SHP					-0.005	0.476	-0.035	0.016
Constant	-0.952	0.006	0.267	0.708	-0.919	0.012	0.704	0.361
Rho					0.010		0.071	
Likelihood test rho = 0, p					0.126		0.003	

^a The significance figures are joint values for age + female, age <46, education levels (university + polytechnic as the comparison group), labour market status (comparison: in work), and income (< 1001 € / month).

For adults, statistically significant factors are age (increasing age lowers and being a woman in fertile age increases the probability of having private insurance), labour market status (working especially in private sector increases the probability of insurance) and incomes (high incomes increase the probability of supplementary insurance). Health status or the structure of the household did not explain the insurance purchase.

Table 8 illustrates regional effects between hospital districts and SHI. For adults, there is no significant regional effect ($P=0.034$) after all the other variables are taken into account. For children, the age of adult respondents (correlating, obviously, with the age of the children) and their educational background explain the insurance purchase. For children, there is also a significant regional effect ($P=0.001$), but it cannot be explained by the mean waiting time at public health centres. For adults, the mean waiting time variable is not significant, and for children, the coefficient is significant, but sign of the variable is 'wrong': the longer the waiting time, the smaller the probability of private health insurance.

The standard adverse selection notion is not supported by our results. The consumers with private insurance are healthier than consumers who do not have the insurance, nor does their health status (chronic illness and perceived health) explain the insurance purchase.

Table 8. Is there a regional effect? Insurance and hospital districts.

	Persons covered by insurance			
	Adults		Children	
Hospital district	%	N	%	N
Etelä-Karjala	9.7	31	45.5	11
Etelä-Pohjanmaa	30.6	49	54.6	22
Etelä-Savo	15.2	33	28.6	7
HUS	24.0	425	54.3	151
Itä-Savo	37.5	16	50.0	4
Kainuu	17.9	28	45.5	11
Kanta-Häme	22.2	54	76.9	13
Keski-Pohjanmaa	6.7	15	20.0	5
Keski-Suomi	21.3	94	48.4	31
Kymenlaakso	17.3	52	27.3	22
Lappi	29.0	38	33.3	15
Länsi-Pohja	23.5	17	0.0	1
Pirkanmaa	16.5	152	55.6	63
Pohjois-Karjala	11.3	62	38.1	21
Pohjois-Pohjanmaa	17.3	133	37.1	35
Pohjois-Savo	21.3	94	32.1	28
Päijät-Häme	27.8	72	56.0	25

	Persons covered by insurance			
	Adults		Children	
Hospital district	%	N	%	N
Satakunta	26.9	67	87.5	24
Vaasa	9.7	31	30.0	10
Varsinais-Suomi	30.3	122	69.8	43
Total	21.8	1585	51.3	542
X ² , p	0.032		0.001	

One of the reasons why the factors explaining the purchase of insurance are different may be that, for children, the insurance decision is always made by parents, but, for adults, the decision may be made by the employer (Table 9).

Table 9. Adults' insurance purchase mode.

	All, %	Working at the moment, %
Self-purchased	75.0	73.2
Employer-purchased	16.6	17.3
Both	8.4	9.6
N	344	272

3.5 Consequences of SHI in healthcare utilisation

In order to assess the consequences of SHI in healthcare utilisation, we studied two questions: 1) what is the impact of SHI on the probability of choosing a PRH provider, i.e. sector choice, and 2) what is the impact of SHI on the frequency of utilisation of primary healthcare (PHC) services, i.e. moral hazard?

Table 10 shows utilisation of health services by SHI status. The adults with SHI tend to use public services less ($P=0.069$), and they use private services significantly more ($P=0.001$). For children, the differences in use of public and private services are statistically significant ($P=0.026$), and there is a dramatic difference in private health service utilisation ($P=0.000$). Almost 75% of the uninsured children did not use private services, and only 29% of uninsured children. The tendency in service utilisation is that both insured and uninsured individuals use public services, but there is a difference in utilisation of private services.

Table 10. Percentage of utilisation of health services by supplementary health insurance status.

	Adults						Children			
	Insurance									
	Public		Private		Occupational health if working		Public		Private	
Utilisation	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes
No use	33.6	38.7	58.3	45.4	29.8	30.7	24.7	29.8	74.5	28.8
1–3 times	45.3	46.8	33.7	44.8	51.6	48.9	49.8	45.5	24.0	42.5
4–6 times	11.0	8.7	5.2	7.3	13.6	15.0	18.6	17.5	1.5	20.5
7–9 times	3.9	2.9	1.0	1.7	2.9	4.4	5.7	2.6	0.0	3.6
10+ times	5.7	2.9	1.1	0.6	2.0	1.1	1.1	4.7	0.0	4.7
Cannot say	0.6	0.0	0.7	0.3	0.1	0.0	0.0	0.0	0.0	0.0
N	1,578		1,568		1,117		538		263	
Insurance vs. no insurance, X^2 , p	0.069		0.001		0.635		0.026		0.000	

The tendency to use both public and private services can also be seen in Table 11: 51.4% of children with insurance have used both private and public services and only 20.8% of uninsured children. The difference among adults is smaller.

Table 11. Percentage of utilisation of both public and private health services by insurance status.

Healthcare sector	Adults		Children	
	No insurance	Insurance	No insurance	Insurance
No public, no private	20.3	17.6	19.7	9.7
Public	38.4	27.6	54.6	19.1
Private	13.4	20.8	4.9	19.8
Both	27.9	34.0	20.8	51.4
N	1208	341	264	278

In the first stage, the purchase of SHI was separately modelled (Table 7). The variables that seem to explain this choice are different for adults and children (Table 7). In the next step, the SHI purchase was treated as an endogenous variable (Table 12). The health service utilisation was explained as a binary variable (has not used = 0, has used = 1) and then as a frequency variable measured on an ordinal scale. For adults, SHI seems to decrease the probability of using public services and increase the probability of using private services, i.e. to some extent, SHI moves utilisation from public to private services. For children, however, the insurance has no effect or a “symptomatic” effect on the probability of using public services ($P= 0.090$), but it increases the probability of choosing private services.

Table 12. Sector choice if insurance is endogenous, conditional mixed procedure (probit regression, choice equation).

	Adults				Children			
	Public		Private		Public		Private	
	Coef.	p	Coef.	p	Coef.	p	Coef.	p
Age	-0.015	0.000	0.011	0.000	-0.002	0.792	0.020	0.005
Gender	0.293	0.000	0.315	0.000	0.095	0.426	0.186	0.083
Health status	-0.254	0.000	-0.081	0.019	-0.133	0.097	0.042	0.509
Chronic illness	0.268	0.000	0.141	0.029	0.186	0.164	-0.098	0.351
Insurance	-1.115	0.000	1.564	0.000	-0.790	0.090	2.229	0.000
Two or more adults in the household	0.012	0.876	0.050	0.495	0.018	0.919	-0.052	0.749
No. of children	-0.004	0.906	0.003	0.931	0.313	0.000	0.090	0.076
Constant	2.057	0.000	-0.875	0.000	0.963	0.124	-2.359	0.000
N	1557		1556		537		540	

The frequency of healthcare visits (Table 13) shows that, for adults, the ‘natural’ factors (age, female gender, perceived health and chronic illness) explain the utilisation of both public and private services. The negative coefficient for age should be interpreted as the impact of age when health status, gender, and all other variables in the model have been accounted for. SHI lowers the frequency of public healthcare visits and increases the frequency of private healthcare visits. For children, the SHI has no effect on the frequency of public healthcare visits, but it increases the number of private visits.

Table 13. The frequency of service utilisation, conditional mixed procedure (ordinal probit regression, utilisation equation).

	Adults				Children			
	Public		Private		Public		Private	
	Coef.	p	Coef.	p	Coef.	p	Coef.	p
Age (adult)	-0.017	0.000	0.008	0.001	-0.002	0.775	0.011	0.111
Female	0.322	0.000	0.311	0.000	0.085	0.387	0.224	0.030
Perceived health, adult	-0.363	0.000	-0.103	0.002	-0.248	0.000	-0.009	0.871
Chronic illness, adult	0.302	0.000	0.162	0.009	0.095	0.386	-0.088	0.370
Insurance	-1.16	0.000	1.446	0.000	0.135	0.717	2.206	0.000
More than one adult in the household	-0.018	0.784	-0.013	0.852	0.054	0.711	-0.092	0.540
No. Children	0.037	0.165	0.005	0.846	0.316	0	0.085	0.084
N	1557		1556		537		537	

The working population may have employer-purchased SHI, and, in our analysis, this can be considered as an exogenous variable: a decision made by the employer. There is a difference between self-purchased and employer-purchased SHI in healthcare utilisation. In Table 14, we have the presently working individuals. In the model, self-purchased SHI is considered endogenous. Self-purchased SHI increases the utilisation of private services, but employer-purchased SHI has no effect on utilisation. There is also an almost ($p = 0.061$) significantly decreasing effect from employer-purchased insurance on private services. The insurance status does not explain the utilisation of occupational health services, as one could assume.

Table 14. The impact of insurance purchase method on the frequency of visits, working population, conditional mixed procedure (ordinal probit regression, utilisation equation).

	Public		Private		Occupational health	
	Coef.	p	Coef.	p		
Age	-0.016	0.000	0.007	0.055	0.005	0.268
Female	0.312	0.000	0.263	0.000	0.143	0.036
Health status	-0.399	0.000	-0.143	0.001	-0.196	0.000
Chronic illness	0.299	0.000	0.162	0.029	0.245	0.001
Self-purchased, endog.	-0.232	0.835	1.322	0.000	0.243	0.753
Employer-purchased, exog.	-0.343	0.061	0.186	0.253	0.205	0.215
Adults in household	0.025	0.776	-0.070	0.416	-0.256	0.002
Children in household	-0.051	0.145	-0.017	0.621	0.023	0.486
N	1092		1092		1091	

In the working population, women use all three service classes more than men; good perceived health reduces the number of doctor visits, but a chronic illness increases them. SHI seems only to have a significant effect on the number of private doctor visits. Importantly, employer-purchased SHI has no effect on the number of doctor visits.

This result is similar to results from a Danish study: in the sample of occupationally active population, the employment-based private health insurance “does not significantly affect the probability of having had any hospitalisations, physiotherapist, chiropractor, psychologist, specialist, or ambulatory contacts within a 12 month period” (Kiil 2012). Pita Barros (et al. 2008) used the same idea of treating employer-purchased insurance as exogenous. According to their results, the supplementary results show a positive (but non-significant) effect on the number of doctor visits and significant effects of insurance coverage on tests among the young (18–30 years old).

4 Discussion

4.1 Current situation

According to our survey, 22.7% of Finnish adults and 52.0% children had SHI. Of the insured adults, 74.8% had self-purchased SHI, 16.2% employer-purchased SHI and 9.0% both. Three insurance companies – LähiTapiola, Pohjola and If – covered more than 70% of the adult (self-purchased) and children's SHI market. The insured consumers estimated that, on average, they spent €272 on adult and €336 on children's SHI per person per year.

4.2 Socio-demographic characteristics

Our results indicate that persons who have SHI are likely; 1) 31–40 years old, 2) working or entrepreneurs, 3) have a background of higher or mid-level education, 4) are in good or excellent health, and 5) live in a high-earning household. On the other hand, the results show that persons who do not have SHI are likely to be 1) 51–60 years old, 2) unemployed or not working, 3) of a lower-educational background, 4) in fair or poor health and 5) live in a less-earning household. Obviously, these stereotypes are only for illustration and should be interpreted carefully. Nevertheless, this distribution raises questions about the equity of PHC in Finland. Interestingly, respondent home municipality type (cities or city like, densely populated and rural) was not significantly associated with SHI.

The consumer characteristics explaining the purchase of SHI in the regression models are different for adults and children. For adults, the most important factor explaining the purchase of SHI is labour market status, together with age and income. Persons who are working, have a high income and are younger are more likely to purchase SHI. For children, however, the most important factor is the educational level, in addition to the age (correlating with the age of the children) of the responding parent. More highly educated individuals tend to insure their children. The difference in purchasing logic may reflect the supply conditions: working individuals have a wider choice of services than children. It may also reflect a difference in thinking, preferences and needs: insuring a child is different from insuring an adult. For children, there is also a small but significant regional (hospital district) effect. In our analysis, this effect could not be explained by the length of the health centre queues. We found no signs of adverse selection.

4.3 Utilisation of SHI

The most frequently reimbursed healthcare services for adults and children were medical tests, consultations in private primary healthcare centres, and medicines. Respondents were not asked to indicate quantities or monetary values of the healthcare services in the survey.

4.4 Consumer motivations

The main motivations for choosing SHI were 1) faster access to healthcare, 2) better quality of PRH services, 3) more choice, and 4) explicitly to access PRH. All these four main reasons indicate a consumer preference for using PRH services and their dissatisfaction with PUH services.

4.5 The impact on healthcare utilisation

SHI has an impact on healthcare utilisation. For adults, insurance – when other characteristics are taken into account – decreases the probability of choosing a public provider and increases the utilisation of private services. For children, the decreasing effect on the choice of a public provider is near significance, and SHI increases the probability of choosing a private provider. As regards the frequency of the utilisation, SHI decreases the utilisation of public services for adults and increases the utilisation of private services. For children, there seems to be no effect on the utilisation of public services, but a significant increase in the utilisation of private services.

Also the mode of purchase, whether the insurance is self- or employer-selected, seems to affect healthcare utilisation in the working population. In the sense of ex post moral hazard, when a person purchases SHI him- or herself, it increases (as an endogenous variable) the utilisation of private services, but has no impact on public or occupational service utilisation. However, employer-purchased (exogenous) SHI does not have any impact on healthcare utilisation.

4.6 Limitations

The response rate in our study was lower than is traditional in Finland. This leads to a response bias towards insured persons and persons who had used healthcare services. In calculating the percentages, we adjusted for this response bias. Another limitation in the study is the small number

of insured persons. In the comparison between Finland and the Netherlands, one must remember that these countries have two different systems of healthcare organisation and financing.

References

Barros PP, Machado MP, Sanz-de-Galdeano A. Moral hazard and the demand for health services. A matching estimator approach. *J Health Econ* 2008; 27 (4): 1006–1025.

Besley T, Hall J, Preston I. The demand for private health insurance. Do waiting lists matter? *J Public Econ* 1999; 72 (2): 155–181.

Buchmueller TC, Couffinhal A, Grignon M, Perronnin M. Access to physician services. Does supplemental insurance matter? Evidence from France. *Health Econ* 2004; 13 (7): 669–687.

Buchmueller TC, Fiebig DG, Jones G, Savage E. Preference heterogeneity and selection in private health insurance. The case of Australia. *J Health Econ* 2013; 32 (5): 757–767.

Centraal Bureau voor de Statistiek. Health Accounts; expenditure and funding 2013, 2013. Available at: <http://statline.cbs.nl/StatWeb/publication/?DM=SLNL&PA=71914ned&D1=37-43&D2=a&HDR=G1&STB=T&VW=T>. Cited 10.6.2014.

Centraal Bureau voor de Statistiek 2014. Het Centraal Bureau voor de Statistiek. Health Accounts; expenditure and funding 2013. Available at: <http://statline.cbs.nl/StatWeb/publication/?DM=SLNL&PA=71914ned&D1=37-43&D2=a&HDR=G1&STB=T&VW=T>. Cited 10.6.2014.

Doiron D, Jones G, Savage E. Healthy, wealthy and insured? The role of self-assessed health in the demand for private health insurance. *Health Econ* 2008; 17 (3): 317–334.

Dong Y. How health insurance affects health care demand? A structural analysis of behavioral moral hazard and adverse selection. *Econ Inq* 2013; 51 (2): 1324–1344.

Häkkinen U, Lehto J. Reform, change, and continuity in Finnish health care. *J Health Polit Polic* 2005; 30 (1–2): 79–96.

Hullegie P, Klein TJ. The effect of private health insurance on medical care utilization and self-assessed health in Germany. *Health Econ* 2010; 19 (9): 1048–1062.

Jofre-Bonet M. Public health care and private insurance demand. The waiting time as a link. *Health Care Manag Sci* 2000; 3 (1): 51–71.

Appendices

Appendix 1. Respondent background information. Unweighted and weighted portions of responses and the original sample.

	N	Unweighted	Weighted
		%	%
Gender			
Male	705	43.52	49.9
Female	915	56.48	50.1
Total	1620	100	
Age			
< 31	308	19.04	29.5
31–40	297	18.36	21.1
41–50	419	25.9	23.1
51–	594	36.71	26.4
Total	1618	100	
One adult's household			
Yes	393	24.9	25.1
No	1185	75.1	74.9
Total	1578	100	
Children			
No	973	63.39	62
Yes	562	36.61	38
Total	1535	100	100
Municipality types			
Cities or city-like	1162	69.08	72.1
Densely populated	268	15.93	15.9
Rural	252	14.98	12
Total	1620	100	100
Education level			
Lower education: Vocational school or training, or no vocational training	769	48.21	46.4
Higher education: University or polytechnic	738	46.27	48.1
Other, don't know	88	5.52	5.5
Total	1595	100	100
Labour market status			
Working	1122	70.39	66.5
Unemployed	135	8.47	8.9
Student	139	8.72	13.4
Not working	198	12.42	11.2
Total	1594	100	100

	N	Unweighted	Weighted
		%	%
Household income per month			
< €4000	763	48.38	48.9
> €4000	741	46.99	46
Don't know	73	4.63	5.2
Total	1577	100	100
Reported health status			
Excellent	634	38.38	42.7
Good	613	37.11	36.1
Average	305	18.46	16
Fair	77	4.66	4.1
Poor	23	1.39	1.2
Total	1587	100	100
Chronic illness			
Yes	592	37.37	32.5
No	951	60.04	65
Don't know	41	2.59	2.5
Total	1584	100	100

Appendix 2. Health insurance system of the Netherlands.

This brief description of the health insurance system of the Netherlands focuses on SHI. Healthcare in the Netherlands is financed by a dual system: 1) mandatory private health insurance that covers short-term healthcare and 2) a tax-funded social insurance that covers long-term healthcare. The former financed 42% of total healthcare costs in the Netherlands in 2013 (Centraal Bureau voor de Statistiek 2013).

All residents of the Netherlands (older than 18) are required to purchase a private basic health insurance. Children under 18 are covered by their parents insurance, for which insurance companies receive compensation from the regulator's fund. Basic health insurance coverage is defined and annually revised by the Ministry of Health, Welfare and Sport. The basic package covers a broad range of healthcare services, including primary care (GPs and specialists), short-term hospitalisation, medicines, rehabilitation and prevention. Basic health insurance coverage must be the same regardless of insurance company. Insurance providers may charge whatever they want for basic coverage, but the price must to be the same for all consumers regardless of age, health status or other characteristics. Moreover, insurance companies must accept all applicants. On average, basic insurance cost €1,280 per person per year in 2013 (Vektis 2013), and the minimum deductible was €350 per year. The same fixed coverage and free pricing make comparison of the basic insurance policies easy. Consumers can change their basic health insurance provider once a year.

Moreover, consumers can purchase additional SHI policies on top of their basic insurance. Typical SHI policies cover dental care, physiotherapy, medical equipment, maternity and/or eyeglasses. Insurance companies can price and package SHI products freely. Consequently, it is difficult for consumers to compare SHI products. Consumers must purchase their SHI from the same insurance company that provides their basic insurance, and they may change their SHI and insurance company once a year. Insurance companies are permitted to reject or limit SHI coverage. At the time of the study, 85.7% of Dutch adults had SHI, and they spent an average of €304 per year for additional insurance coverage.

Appendix 3. The questionnaire and the frequencies of the variables (in Finnish).

		Painottamaton^a	Painotettu
Taustatiedot			
1 Mikä on sukupuolenne?	N	%	%
Mies	713	43.6	50.1
Nainen	921	56.4	49.9
Yhteensä	1634	100.0	100.0
2 Mikä on syntymävuotenne?	Keskiarvo	Keskihajonta	Keskiarvo
Ikä	43.6	12.3	39.7
Yhteensä	1634		
3 Mikä on kotipaikkakuntanne?	233 eri paikkakuntaa Vastaajia 1–161 paikkakuntaa kohden		
4 Mikä on kotitaloudessanne asuvien aikuisten lukumäärä? (yli 18v. Teidät itsenne mukaan luettuna)	N	%	%
1	396	24.9	25.0
2	976	61.4	60.2
3	170	10.7	10.9
4	39	2.5	3.2
5	8	0.5	0.6
6	1	0.1	0.0
10	1	0.1	0.1
Yhteensä	1591	100.0	100.0
5 Mikä on kotitaloudessanne asuvien lasten (alle 18 v.) lukumäärä?	N	%	%
0	979	63.4	62.0
1	237	15.4	16.3
2	222	14.4	14.3
3	79	5.1	5.3
4	14	0.9	1.0
5	5	0.3	0.4
6	1	0.1	0.0
7	1	0.1	0.1
8	2	0.1	0.3
9	2	0.1	0.2
17	2	0.1	0.1
Yhteensä	1544	100.0	100.0
6 Mikä on Teidän koulutuksenne? Valitkaa ylin koulutuksenne tai koulutus jota olette opiskelemissa	N	%	%
Ei ammatillista koulutusta	113	7.0	7.7
Ammattikurssi tai muu vastaava lyhyt ammatillinen koulutus	111	6.9	5.7

^a 'Painottamaton' prosenttiosuus tarkoittaa suoraan aineistosta saatavaa vastausten jakaumaa. 'Painotettu' prosenttiosuus tarkoittaa vastausten jakaumaa, jossa vastaajien vastauksia on painotettu vastaamistodennäköisyyden käänteisluvulla vastanneiden joukon valikoitumisen korjaamiseksi.

		Painottamaton	Painotettu
	N	%	%
Ammattikoulu	398	24.8	27.6
Alempi opistotason tutkinto	156	9.7	8.2
Opistotaso- tai ammattikorkeakoulututkinto	426	26.5	28.4
Yliopistotutkinto	316	19.7	22.1
En osaa sanoa	4	0.3	0.3
Muu mikä?	84	5.2	5.3
Yhteensä	1608	100.0	100.0
7 Mikä on Teidän tämänhetkinen pääasiallinen työnne tai tilanteenne?	N	%	%
Työtön	135	8.4	8.8
Opiskelija	141	8.77	13.5
Töissä julkisella sektorilla	431	26.82	23.7
Töissä yksityisellä sektorilla	526	32.73	32.7
Töissä kolmannella sektorilla (esim. yhdistys)	43	2.68	2.7
Yrittäjä	132	8.21	7.4
Kotiäiti/koti-isä	44	2.74	2.9
Eläkeläinen	75	4.67	3.7
En osaa sanoa	5	0.31	0.4
Muu mikä?	75	4.67	4.2
Yhteensä	1607	100.0	100.0
Työ			
8 Mikä on tämän hetkinen työnantajanne/yrittäjämuoto?	N	%	%
Valtio	83	6.92	7.4
Kunta	264	22.02	19.2
Suuri yritys (vähintään 250 työntekijää)	308	25.69	27.2
Keskisuuri yritys (50–249 työntekijää)	122	10.18	10.6
Pieni yritys (alle 50 työntekijää)	181	15.1	16.6
Yrittäjä (alaisuudessa työntekijöitä)	51	4.25	4.0
Yksinyrittäjä (ei alaisuudessa työntekijöitä)	77	6.42	6.4
Säätiö yhdistys tai seurakunta	49	4.09	4.0
En osaa sanoa	5	0.42	0.6
Muu mikä?	59	4.92	4.2
Yhteensä	1198	100.0	100.0
9 Mikä on työssäkäyntikuntanne?	192 eri paikkakuntaa Vastaajia 1–168 per paikkakunta		
10 Missä työpaikkanne työterveyshuolto on järjestetty?	N	%	%
Yksityisellä terveysasemalla tai lääkäriasemalla (esim. Terveystalo)	596	50.08	52.5
Terveyskeskuksessa	195	16.39	15.5
Työnantajanne omalla tai yritysten yhteisellä työterveysasemalla	271	22.77	21.3
Ei ole työterveyshuoltoa	104	8.74	8.2
En osaa sanoa	24	2.02	2.5
Yhteensä	1190	100.0	100.0

		Painottamaton	Painotettu
11 Kuinka paljon ovat kotitaloutenne yhteenlasketut tulot kuukaudessa (palkka ansio- ja eläketulot sekä tuet ja muut mahdolliset tulot) veroja vähentämättä (bruttotulot)?	N	%	%
Alle 500 euroa/kk	34	2.1	3.1
501–1000 euroa/kk	103	6.5	7.5
1001–2000 euroa/kk	180	11.3	11.3
2001–3000 euroa/kk	215	13.5	13.2
3001–4000 euroa/kk	237	14.9	13.7
4001–6000 euroa/kk	420	26.4	25.6
6001–7000 euroa/kk	151	9.5	9.3
7001 euroa tai enemmän/kk	174	11.0	11.0
En osaa sanoa	75	4.7	5.3
Yhteensä	1589	100.0	100.0
Terveys			
12 Millainen terveydentilanne on ollut viimeisen vuoden aikana keskimäärin?	N	%	%
Huono	20	1.3	1.1
Melko hyvä	71	4.4	3.9
Keskikertainen	296	18.5	15.9
Melko huono	598	37.4	36.2
Huono	614	38.4	42.9
Yhteensä	1599	100.0	100.0
13 Onko Teillä lääkärin toteamia pitkäaikaissairauksia?	N	%	%
Kyllä	592	37.1	32.2
Ei	963	60.3	65.3
En osaa sanoa	41	2.6	2.5
Yhteensä	1596	100.0	100.0
Terveydenhoitopalveluiden käyttö			
14 Kuinka monta kertaa olette käyttänyt <u>julkisen</u> terveydenhuollon palveluita viimeisen vuoden aikana?	N	%	%
En ole käyttänyt	549	34.5	35.5
1–3 kertaa	724	45.5	45.5
4–6 kertaa	173	10.9	10.2
7–9 kertaa	58	3.7	3.5
10 kertaa tai enemmän	80	5.0	4.9
En osaa sanoa	7	0.4	0.4
Yhteensä	1591	100.0	100.0
15 Kuinka monta kertaa olette käyttänyt <u>yksityisen</u> terveydenhuollon palveluita viimeisen vuoden aikana? <i>Ei koske työterveyshuollon käyntejä.</i>	N	%	%
En ole käyttänyt	879	55.6	58.0
1–3 kertaa	569	36.0	33.7
4–6 kertaa	89	5.6	5.6
7–9 kertaa	18	1.1	1.1
10 kertaa tai useammin	16	1.0	1.0

		Painottamaton	Painotettu
	N	%	%
En osaa sanoa	10	0.6	0.6
Yhteensä	1581	100.0	100.0
16 Kuinka monta kertaa olette käyttänyt työterveyshuollon palveluita viimeisen vuoden aikana? (työssäkäyvät henkilöt)	N	%	%
En ole käyttänyt	336	29.9	31.8
1–3 kertaa	572	50.9	50.2
4–6 kertaa	158	14.1	13.0
7–9 kertaa	36	3.2	3.3
10 kertaa tai enemmän	20	1.8	1.6
En osaa sanoa	1	0.1	0.1
Yhteensä	1123	100.0	100.0
Etäisyys terveydenhoitopalveluihin			
17 Kuinka kaukana kodistanne on lähin käytettävissänne oleva terveyskeskuslääkärin vastaanotto?	N	%	%
Alle 5 km	1067	66.9	67.9
5–9 km	255	16.0	16.2
10–14 km	102	6.4	5.7
15–19 km	56	3.5	3.2
20–25 km	46	2.9	2.8
Yli 25 km	45	2.8	2.3
En osaa sanoa tai en tiedä	24	1.5	1.9
Yhteensä	1595	100.0	100.0
18 Kuinka kaukana kodistanne on lähin käytettävissänne oleva yksityislääkärin vastaanotto?	N	%	%
Alle 5 km	740	46.3	47.7
5–9 km	300	18.8	19.2
10–14 km	131	8.2	7.7
15–19 km	64	4.0	3.5
20–25 km	93	5.8	5.2
Yli 25 km	181	11.3	9.3
En osaa sanoa tai en tiedä	88	5.5	7.4
Yhteensä	1597	100.0	100.0

	Painottamaton	Painotettu	
Sairauskuluvakuutukset			
<u>Ohjeistus</u>			
Kysymys koskee:			
<ul style="list-style-type: none"> • itsenne tai työnantajanne Teille hankkimia vapaaehtoisia sairauskuluvakuutuksia • Itse hankittu sairauskuluvakuutus on Teidän itsenne hankkima ja maksama vapaaehtoinen vakuutus joka korvaa sairauskuluja • Työnantajan hankkima vakuutus tarkoittaa työnantajan Teille hankkimaa ja maksamaa vapaaehtoista vakuutusta joka korvaa sairauskuluja 			
Kysymys ei koske:			
<ul style="list-style-type: none"> • tapaturmavakuutuksia • matkavakuutuksia • henkivakuutuksia • urheiluvakuutuksia • lastenne tai muiden perheenjäsenten vakuutuksia 			
19 Onko Teillä itsellänne vapaaehtoinen sairauskuluvakuutus?	N	%	%
Kyllä	347	21.9	22.7
Ei	1239	78.1	77.3
Yhteensä	1586	100.0	100.0
20 Mitä kautta olette hankkinut vapaaehtoisen sairaskuluvakuutuksenne? <i>Valitkaa yksi vaihtoehto.</i>	N	%	%
Itse hankkimani	258	75.0	74.8
Työnantajani hankkima	57	16.6	16.2
Molemmat	29	8.4	9.0
Yhteensä	344	100.0	100.0
Itse hankittu sairauskuluvakuutus			
<u>Ohjeistus</u>			
Seuraavat kysymykset koskevat:			
<ul style="list-style-type: none"> • Teidän itsellenne hankkimaa vapaaehtoista sairauskuluvakuutusta joka korvaa sairauden hoitamisesta aiheutuneita kuluja. 			
Kysymykset eivät koske:			
<ul style="list-style-type: none"> • työnantajan hankkimia vakuutuksia • tapaturmavakuutuksia • matkavakuutuksia • henkivakuutuksia • urheiluvakuutuksia • lastenne tai muiden perheenjäsenten vakuutuksia 			
21 Mistä vakuutusyhtiöstä sairauskuluvakuutuksenne on otettu?	N	%	%
Aktia	4	1.3	1.5
Fennia	19	6.1	5.8
Folksam	2	0.6	0.7
If	59	18.9	17.3
LähiTapiola	84	26.9	24.6
Mandatum	10	3.2	3.8
Pohjantähti	13	4.2	4.4
Pohjola	81	26.0	28.9
Turva	4	1.3	1.2
En osaa sanoa	10	3.2	3.7
Muu mikä?	26	8.3	8.0
Yhteensä	312	100.0	100.0

		Painottamaton	Painotettu
22 Kuinka paljon vakuutusmaksunne on vuodessa?	N	%	%
Alle 100 euroa	60	19.7	18.3
100–200 euroa	76	24.9	27.3
201–300 euroa	40	13.1	12.2
301–400 euroa	23	7.5	6.8
401–500 euroa	21	6.9	5.3
501–600 euroa	9	3.0	2.5
601–700 euroa	7	2.3	2.0
701–800 euroa	5	1.6	1.5
Yli 800 euroa	18	5.9	6.2
En osaa sanoa	46	15.1	17.8
Yhteensä	305	100.0	100.0
23 Onko vakuutuksessanne omavastuu?	N	%	%
On sairauskohtainen	70	23.0	22.3
On kausikohtainen (esim. vuosi)	47	15.4	14.0
On käyntikohtainen	17	5.6	4.9
On mutta en osaa tarkemmin sanoa millainen	69	22.6	22.9
Ei, vakuutus on ilman omavastuuta	41	13.4	13.8
En osaa sanoa	61	20.0	22.1
Yhteensä	305	100.0	100.0
24 Pyydettiinkö Teiltä terveystarkastus ennen vakuutuksen myöntämistä?	N	%	%
Kyllä	158	52.2	51.1
Ei	105	34.7	33.5
En osaa sanoa	40	13.2	15.5
Yhteensä	303	100.0	100.0
25 Tehtiinkö vakuutuksen myöntämishetkellä rajoituksia vakuutuksen korvaavuuteen aiemman sairaushistorianne tai terveydentilanne perusteella?	N	%	%
Kyllä mitä?	47	27.2	25.0
Ei	22	12.7	13.0
En osaa sanoa	104	60.1	62.0
Yhteensä	173	100.0	100.0
Vakuutuksen valinta			
26 Mitkä olivat tärkeimmät syyt vapaaehtoisen sairauskuluvakuutuksen ottoon? <i>Mainitkaa enintään 3 tärkeintä.</i>	Mainintoja	%	
Haluan käyttää yksityisiä terveystalouksia	86	15.2	
Haluan enemmän valinnanvapautta	88	15.5	
Haluan päästä nopeammin hoitoon	107	18.9	
Yksityisten terveydenhuolto- ja hoitopalveluiden parempi laatu	88	15.5	
Pienet Kela-korvaukset	24	4.2	
Kela ei korvaa tarvitsemaani hoitoa tutkimuksia tai lääkkeitä	9	1.6	
Tuttavat suosittelivat vakuutusta	15	2.7	
Vakuutusyhtiön edustaja suositteli vakuutuksen hankkimista	48	8.5	

		Painottamaton	Painotettu
	Mainintoja	%	
Vakuutusyhtiön mainos	3	0.5	
En osaa sanoa	41	7.2	
Muu mikä?	57	10.1	
Yhteensä	566	100.0	
27 Mitkä olivat tärkeimmät valintakriteerit nykyisen vakuutusyhtiön valintaan? <i>Mainitkaa enintään 3 tärkeintä.</i>	Mainintoja	%	
Olen jo vakuutusyhtiön asiakas	190	36.5	
Vakuutuksen alhainen hinta	54	10.4	
Vakuutuksen laaja korvaavuus	62	11.9	
Vakuutusyhtiö on suuri ja hyvin tunnettu	45	8.7	
Vakuutusyhtiö on tunnettu hyvästä palvelustaan	51	9.8	
Perheen ystävien tai tuttavien suositus	56	10.8	
En osaa sanoa	33	6.3	
Muu mikä?	29	5.6	
Yhteensä	520	100.0	
Vakuutuksen käyttö			
28 Kuinka valitsette terveydenhoitopaikan kun käytätte vakuutusta?	N	%	%
Valitsen itse yksityisen sektorin terveydenhoitopaikan	111	38.1	39.2
Valitsen itse julkisen sektorin terveydenhuollon	20	6.9	5.3
Käyn sekä yksityisessä että julkisessa terveydenhuollossa	114	39.2	39.0
Menen vakuutusyhtiön suosittelemaan terveydenhoitopaikkaan	5	1.7	1.2
En osaa sanoa	41	14.1	15.3
Yhteensä	291	100.0	100.0
29 Onko sairauskuluvakuutukseenne korvannut terveydenhoitokulujanne viimeisen vuoden aikana?	N	%	%
Kyllä	78	26.8	25.2
Ei	213	73.2	74.8
Yhteensä	291	100.0	100.0
30 Mitä sairauskuluvakuutukseenne on korvannut viimeisen vuoden aikana?	Mainintoja	%	
Hoidon itse valitsemallani yksityisellä lääkäriasemalla	50	28.9	
Hoidon vakuutusyhtiön suosittelemalla lääkäriasemalla	2	1.2	
Asiakasmaksun julkisella terveysasemalla	7	4.0	
Hoidon itse valitsemassani yksityisessä sairaalassa	9	5.2	
Hoidon vakuutusyhtiön suosittelemassa sairaalassa	0	0.0	
Asiakasmaksun julkisessa sairaalassa	12	6.9	
Lääkärin määräämät tutkimukset	28	16.2	
Lääkkeitä	57	32.9	
En osaa sanoa	2	1.2	

		Painottamaton	Painotettu
	Mainintoja	%	
Muu mitä?	6	3.5	
Yhteensä	173	100.0	
31 Miten haette korvausta vakuuksestanne?	N	%	%
Maksan itse ja haen korvaukset (esim. internetissä)	137	64.0	62.0
Vakuutusyhtiö ja hoitopaikka hoitavat korvausten haun suoraan keskenään	21	9.8	8.2
En tiedä	49	22.9	26.7
Muulla tavalla miten?	7	3.3	3.0
Yhteensä	214	100.0	100.0
Vakuutusyhtiön vaihto			
32 Oletteko vaihtanut sairauskuluvakuutuksenne vakuutusyhtiötä viimeisen vuoden aikana?	N	%	%
Kyllä	9	3.1	3.3
En	282	96.9	96.7
Yhteensä	291	100.0	100.0
Aikomus vaihtaa sairauskuluvakuutusta			
33 Oletteko vakavasti harkinnut sairauskuluvakuutuksenne vakuutusyhtiön vaihtamista viimeisen vuoden aikana?	N	%	%
Kyllä	20	7.1	6.9
En	260	92.9	93.1
Yhteensä	280	100.0	100.0
Aikomus lopettaa sairauskuluvakuutus			
34 Oletteko vakavasti harkinnut sairauskuluvakuutuksenne lopettamista viimeisen vuoden aikana?	N	%	%
Kyllä	20	7.1	6.9
En	260	92.9	93.1
Yhteensä	280	100.0	100.0
35 Miksi harkitsitte sairauskuluvakuutuksenne lopettamista? <i>Mainitkaa enintään 3 tärkeintä.</i>	Mainintoja	%	
En tarvitse vakuutusta	6	18.8	
Asuinalueellani ei ole yksityisiä terveyspalveluja joissa voisin käyttää vakuutusta	1	3.1	
Vakuutuksen kallis hinta	12	37.5	
Vakuutusten liian suppea korvaavuus	3	9.4	
Vakuutuskorvausten hakeminen oli hankalaa	4	12.5	
Huono asiakaspalvelu	0	0.0	
Mahdollisuus saada sairauskuluvakuutus työnantajalta	2	6.3	
En osaa sanoa	1	3.1	
Muu syy mikä?	3	9.4	
Yhteensä	32	100.0	

	Painottamaton	Painotettu
Vakuustarpeen muutos		
36 Oletteko halukas jatkamaan nykyisen vakuutuksenne voimassaoloa täytettyänne 60 vuotta jos vakuutusmaksu kaksinkertaistuu?	N	%
Kyllä	122	43.3
Ei	160	56.7
Yhteensä	282	100.0
Työnantajan hankkimat sairauskuluvakuutukset		
Ohjeistus		
Seuraavat kysymykset koskevat:		
<ul style="list-style-type: none"> • Työnantajanne Teille hankkimaan vapaaehtoista sairauskuluvakuutusta. • Työnantajanne hankkimia sekä yksilöllisiä että ryhmäsairaskuluvakuutuksia 		
Kysymykset eivät koske:		
<ul style="list-style-type: none"> • matkavakuutuksia • tapaturmavakuutuksia • itse hankittua sairauskuluvakuutuksia • perheen muita vakuutuksia • lakisääteistä työterveyshuoltoa • työterveyshuoltoon kuuluvan vakuutuskassan jäsenyyttä tai korvauksia 		
37 Mistä vakuutusyhtiöstä vakuutuksenne on otettu?	N	%
Aktia	1	1.1
Fennia	6	6.7
Folksam	0	0.0
If	16	18.0
LähiTapiola	14	15.7
Pohjantähti	1	1.1
Pohjola	16	18.0
En osaa sanoa	30	33.7
Muu mikä?	5	5.6
Yhteensä	89	100.0
38 Onko työnantajan Teille ottama vakuutus?	N	%
Yksilöllinen vakuutus	11	12.6
Ryhmävakuutus	30	34.5
En osaa sanoa	46	52.9
Yhteensä	87	100.0
39 Pyydettiinkö Teiltä terveys selvitys ennen vakuutuksen myöntämistä?	N	%
Kyllä	27	31.4
Ei	47	54.7
En osaa sanoa	12	14.0
Yhteensä	86	100.0
40 Tehtiinkö vakuutuksen myöntämishetkellä rajoituksia vakuutuksen korvaavuuteen aiemman sairaushistorianne tai terveydentilanne perusteella?	N	%
Kyllä mitä?	5	14.7
Ei	24	70.6
En osaa sanoa	5	14.7
Yhteensä	34	100.0

		Painottamaton	Painotettu
41 Onko sairauskuluvakuutus Teille?	N	%	%
Tuloverossa huomioitava etuus	7	8.5	8.4
Verovapaa etuus	32	39.0	38.2
En tiedä	43	52.4	53.3
Yhteensä	82	100.0	100.0
42 Onko vakuutuksessanne omavastuu?	N	%	%
On sairauskohtainen	4	4.9	5.6
On kausikohtainen (esim. vuosi)	2	2.5	2.4
On käyntikohtainen	4	4.9	4.2
On omavastuu mutta en osaa sanoa millainen	8	9.9	11.1
Ei, vakuutus on ilman omavastuuta.	32	39.5	39.3
En osaa sanoa	31	38.3	37.3
Yhteensä	81	100.0	100.0
Vakuutuksen käyttö			
43 Kuinka valitsette terveydenhoitopaikan kun käytätte vakuutusta?	N	%	%
Valitsen itse yksityisen terveydenhoitopaikan	15	19.2	19.3
Valitsen itse julkisen terveydenhuollon	1	1.3	0.8
Käytän sekä julkista että yksityistä terveydenhuoltoa	10	12.8	13.4
Menen vakuutusyhtiön suosittelemaan hoitopaikkaan	5	6.4	5.4
Hakeudun hoitoon työterveyshuollon kautta	39	50.0	48.2
En osaa sanoa	8	10.3	12.8
Yhteensä	78	100.0	100.0
44 Onko työnantajan Teille ottama sairaskuluvakuutus korvannut terveydenhoitokulujaanne viimeisen vuoden aikana?	N	%	%
Kyllä	30	37.0	40.7
Ei	51	63.0	59.3
Yhteensä	81	100.0	100.0
45 Mitä sairaskuluvakuutukseenne on korvannut viimeisen vuoden aikana?	Mainintoja	%	
Hoidon itse valitsemallani yksityisellä lääkäriasemalla	11	22.9	
Hoidon vakuutusyhtiön suosittelemalla yksityisellä lääkäriasemalla	8	16.7	
Asiakasmaksun julkisella terveysasemalla	0	0.0	
Hoidon itse valitsemassani yksityisessä sairaalassa	1	2.1	
Hoidon vakuutusyhtiön suosittelemassa yksityisessä sairaalassa	0	0.0	
Asiakasmaksun julkisessa sairaalassa	1	2.1	
Lääkärin määräämät tutkimukset	14	29.2	
Lääkkeitä	5	10.4	
En osaa sanoa	4	8.3	
Muu mikä?	4	8.3	
Yhteensä	48	100.0	

		Painottamaton	Painotettu
46 Miten haette korvausta vakuutuksestanne?	N	%	%
Maksan itse ja haen korvaukset (esim. internetissä)	4	12.9	13.5
Vakuutusyhtiö ja hoitopaikka hoitavat korvaustenhaun suoraan keskenään	20	64.5	63.5
En tiedä	5	16.1	11.4
Muulla tavalla miten?	4	12.9	11.6
Yhteensä	31	100.0	100.0
Aiemmat sairauskuluvakuutukset			
47 Onko Teillä joskus ollut vapaaehtoinen sairaskuluvakuutus?	N	%	%
Kyllä	133	10.6	11.2
Ei	1124	89.4	88.8
Yhteensä	1257	100.0	100.0
48 Mitkä olivat syyt siihen että irtisanoitte vapaaehtoisen sairauskuluvakuutuksen? <i>Mainitkaa enintään 3 tärkeintä.</i>	Mainintoja	%	
En tarvitse vakuutusta	13	7.2	
Asuinalueellani ei ole yksityisiä terveystalouksia joissa voisin käyttää vakuutusta	1	0.6	
Vakuutuksen kallis hinta	50	27.6	
Vakuutusten liian suppea korvaavuus	16	8.8	
Vakuutuskorvausten hakeminen oli hankalaa	5	2.8	
Vakuutusyhtiön huono asiakaspalvelu	5	2.8	
Sain sairauskuluvakuutuksen työnantajani kautta joten lopetin omani	9	5.0	
Työnantajan tarjoama vakuutus päättyi tai vaihdoin työpaikkaa	9	5.0	
Lasten sairauskuluvakuutus päättyi tullessaan täysi-ikäiseksi	40	22.1	
En osaa sanoa	16	8.8	
Muu mikä?	17	9.4	
Yhteensä	181	100.0	
Aikomus ottaa sairauskuluvakuutus			
49 Oletteko viimeisen vuoden aikana vakavasti harkinnut ottavanne sairauskuluvakuutuksen itsellenne?	N	%	%
Kyllä	104	8.4	9.5
En	1134	91.6	90.5
Yhteensä	1238	100.0	100.0
50 Miksi harkitsitte sairauskuluvakuutuksen ottamista? <i>Mainitkaa enintään 3 tärkeintä.</i>	Mainintoja	%	
Haluan käyttää yksityisiä terveystalouksia	47	17.9	
Haluan enemmän valinnanvapautta	42	16.0	
Haluan päästä nopeammin hoitoon	78	29.8	
Yksityisten terveydenhuoltopalveluiden parempi laatu	50	19.1	

		Painottamaton	Painotettu
	Mainintoja	%	
Pienet Kela-korvaukset	12	4.6	
Kela ei korvaa tarvitsemaani hoitoa tutkimuksia tai lääkkeitä	4	1.5	
Tuttavat suosittelivat vakuutusta	11	4.2	
Vakuutusyhtiön edustaja suositteli vakuutuksen hankkimista	3	1.1	
Vakuutusyhtiön mainos	2	0.8	
En osaa sanoa	4	1.5	
Muu mikä?	9	3.4	
Yhteensä	262	100.0	
51 Miksi ette harkinnan jälkeen hakenut vapaaehtoista sairauskuluvakuutusta? <i>Mainitkaa enintään 3 tärkeintä.</i>	Mainintoja	%	
En tarvitse vakuutusta	14	6.4	
Asuinalueellani ei ole yksityisiä terveyspalveluja joissa voisin käyttää vakuutusta	3	1.4	
Vakuutuksen kallis hinta	64	29.2	
Vakuutusten liian suppea kattavuus	18	8.2	
Vakuutuskorvausten hakeminen on hankalaa	14	6.4	
Vakuutusyhtiön huono asiakaspalvelu	6	2.7	
Sain työnantajan maksaman sairauskuluvakuutuksen	6	2.7	
Vakuutukseen olisi tullut rajoituksia terveydentilan tai aikaisempien sairauksien takia	19	8.7	
Pelkäsinkin ettei vakuutusta myönnetä terveydentilani takia	19	8.7	
Pelkäsinkin ettei vakuutusta myönnetä ikäni takia	10	4.6	
En osaa sanoa	27	12.3	
Muu mikä?	19	8.7	
Yhteensä	219	100.0	
Aiemmat sairauskuluvakuutushakemukset			
52 Oletteko aiemmin hakenut itsellenne sairauskuluvakuutusta mutta hakemustanne ei hyväksytty?	N	%	%
Kyllä	32	2.6	2.1
En	1198	97.4	97.9
Yhteensä	1230	100.0	100.0
53 Miksi vakuutushakemustanne ei hyväksytty?	Mainintoja	%	
Kroonisen sairauden vuoksi	14	31.8	
Muun terveydentilan takia (ei krooninen sairaus)	12	27.3	
Nykyisen tai ohimenneen mielenterveysongelman vuoksi	7	15.9	
Ylipainon takia	2	4.5	
Synnynnäisen vamman tai invaliditeetin takia	1	2.3	
län takia	1	2.3	
En tiedä	0	0.0	
Muu syy mikä?	7	15.9	
Yhteensä	44	100.0	

		Painottamaton	Painotettu	
Lapset				
54 Onko Teillä alle 18-vuotiaita lapsia?		N	%	%
Kyllä		550	35.2	35.1
Ei		1014	64.8	64.9
Yhteensä		1564	100.0	100.0
56 Minkä ikäisiä lapsenne ovat?	N	Keskiarvo	Keskihajonta	Keskiarvo
1. lapsi vuotta	549	11.2	5.5	10.4
2. lapsi vuotta	328	9.7	4.9	9.1
3. lapsi vuotta	104	8.3	4.5	8.3
4. lapsi vuotta	22	8.8	4.4	8.9
5. lapsi vuotta	10	9.1	4.7	9.2
6. lapsi vuotta	7	7.9	5.1	7.8
7. lapsi vuotta	5	4.8	2.8	5.1
8. lapsi vuotta	4	4.0	2.4	4.7
9. lapsi vuotta	3	3.3	1.5	3.7
10. lapsi vuotta	1	18.0		18.0
Lasten terveydenhoitopalveluiden käyttö				
57 Kuinka monta kertaa lapsenne (<u>kaikki</u> alle 18 v. lapset yhteensä) ovat käyttäneet <u>julkisen terveydenhuollon</u> palveluita viimeisen vuoden aikana sairauden takia? <i>Ei sisällä neuvolakäyntejä.</i>		N	%	%
Ei ole käyttänyt		153	28.0	29.8
1–3 kertaa		259	47.4	45.5
4–6 kertaa		97	17.7	18.3
7–9 kertaa		22	4.0	4.0
10 kertaa tai useammin		16	2.9	2.4
Yhteensä		547	100.0	100.0
58 Kuinka monta kertaa lapsenne (<u>kaikki</u> alle 18v lapset yhteensä) ovat käyttäneet <u>yksityisen terveydenhuollon</u> palveluita viimeisen vuoden aikana?		N	%	%
Ei ole käyttänyt		284	51.6	52.0
1–3 kertaa		182	33.1	32.2
4–6 kertaa		61	11.1	11.6
7–9 kertaa		10	1.8	1.9
10 kertaa tai useammin		13	2.4	2.4
Yhteensä		550	100.0	100.0
Lasten sairauskuluvakuutukset				
Seuraavat kysymykset koskevat:				
<ul style="list-style-type: none"> • Lasten vapaaehtoisia sairauskuluvakuutuksia jotka korvaavat sairauden hoitamisesta aiheutuneita kuluja. 				
Kysymykset eivät koske:				
<ul style="list-style-type: none"> • erillisiä tapaturmavakuutuksia • matkavakuutuksia • henkivakuutuksia • urheiluvakuutuksia • itsenne tai muiden perheenjäsenten kuin lasten vakuutuksia. 				

		Painottamaton	Painotettu
59 Onko lapsellanne/lapsillanne (alle 18 v.) sairauskuluvakuutus?	N	%	%
Kyllä	279	51.1	52.0
Ei	267	48.9	48.0
Yhteensä	546	100.0	100.0
60 Monellako lapsellanne (alle 18 v.) on vapaaehtoinen sairauskuluvakuutus?	N	%	%
1	48	17.8	16.2
2	114	42.2	43.4
3	80	29.6	30.2
4	25	9.3	8.8
5	3	1.1	1.4
Yhteensä	270	100.0	100.0
Lasten vakuutustyyppi			
61 Mistä yhtiöstä lapsenne/lastenne (alle 18 v.) sairauskuluvakuutus/-vakuutukset on otettu?	N	%	%
Aktia	5	1.8	1.3
Fennia	25	8.9	9.1
Folksam	2	0.7	1.0
If	60	21.4	20.3
LähiTapiola	90	32.1	33.1
Mandatum	2	0.7	0.5
Pohjantähti	16	5.7	5.0
Pohjola	54	19.3	19.6
POP Vakuutus	1	0.4	0.3
Turva	13	4.6	5.3
En osaa sanoa	3	1.1	1.4
Muu mikä?	9	3.2	3.1
Yhteensä	280	100.0	100.0
62 Paljonko kaikkien lastenne sairauskuluvakuutukset maksavat Teille vuodessa yhteensä?	N	%	%
Alle 100 euroa	12	4.3	4.0
100–200 euroa	54	19.2	18.6
201–300 euroa	56	19.9	19.1
301–400 euroa	40	14.2	14.3
401–500 euroa	27	9.6	11.7
501–600 euroa	25	8.9	8.5
601–700 euroa	16	5.7	5.9
701–800 euroa	3	1.1	0.9
Yli 800 euroa	6	2.1	1.9
En osaa sanoa	42	15.0	15.1
Yhteensä	281	100.0	100.0
63 Onko lapsenne/lastenne sairauskuluvakuutuksessa omavastuu?	N	%	%
On sairauskohtainen	84	30.2	28.7
On kausikohtainen (esim. vuosi)	120	43.2	44.0
On käyntikohtainen	6	2.2	2.0

		Painottamaton	Painotettu
	N	%	%
On mutta en osaa sanoa millainen	34	12.2	14.1
Ei, vakuutus on ilman omavastuuta	14	5.0	4.0
En osaa sanoa	20	7.2	7.2
Yhteensä	278	100.0	100.0
64 Milloin hankitte sairauskuluvakuutuksen lapsellenne?	N	%	%
Raskauden aikana	174	62.1	65.7
Lapsen synnyttyä	100	35.7	32.0
En osaa sanoa	6	2.1	2.3
Yhteensä	280	100.0	100.0
65 Pyydettiinkö lapseltanne/lapsiltanne tai syntymättömän lapsen äidiltä terveys selvitys ennen vakuutuksen myöntämistä?	N	%	%
Kyllä	148	52.9	54.9
Ei	86	30.7	27.3
En osaa sanoa	46	16.4	17.8
Yhteensä	280	100.0	100.0
66 Tehtiinkö vakuutuksen myöntämishetkellä rajoituksia vakuutuksen korvaavuuteen lastenne/lapsenne aiemman sairaushistorian tai terveydentilan perusteella?	N	%	%
Kyllä mitä?	20	12.5	11.3
Ei	132	82.5	83.5
En osaa sanoa	8	5.0	5.2
Yhteensä	160	100.0	100.0
Lasten vakuutuksen valinta			
67 Mitkä olivat tärkeimmät syyt lasten vapaaehtoisen sairauskuluvakuutuksen ottoon? <i>Mainitkaa enintään 3 tärkeintä.</i>	Mainintoja	%	
Haluan käyttää yksityisiä terveystalvueluita	111	16.6	
Haluan enemmän valinnanvapautta	108	16.2	
Haluan päästä nopeammin hoitoon	228	34.1	
Yksityisten terveydenhoitopalveluiden parempi laatu	118	17.7	
Pienet Kela-korvaukset	16	2.4	
Kela ei korvaa lapseni/lasteni tarvitsemaa hoitoa tutkimuksia tai lääkkeitä	11	1.6	
Tuttavat suosittelivat vakuutusta	28	4.2	
Vakuutusyhtiön edustaja suositteli vakuutusta	9	1.3	
Vakuutusyhtiön mainos	1	0.1	
En osaa sanoa	10	1.5	
Muu syy mikä?	28	4.2	
Yhteensä	668	100.0	
68 Mitkä olivat tärkeimmät valintakriteerit nykyisen vakuutusyhtiön valintaan lasten vakuutuksissa? <i>Mainitkaa enintään 3 tärkeintä.</i>	Mainintoja	%	
Olen jo vakuutusyhtiön asiakas	226	44.8	
Vakuutuksen alhainen hinta	46	9.1	

		Painottamaton	Painotettu
	Mainintoja	%	
Vakuutuksen laaja korvaavuus	76	15.1	
Vakuutusyhtiö on suuri ja hyvin tunnettu	43	8.5	
Vakuutusyhtiö on tunnettu hyvästä palvelustaan	39	7.7	
Perheen ystävien tai tuttavien suositus	24	4.8	
En osaa sanoa	21	4.2	
Muu mikä?	29	5.8	
Yhteensä	504	100.0	
Lasten vakuutuksen käyttö			
69 Kuinka valitsette terveydenhoitopaikan kun käytätte vakuutusta?	N	%	%
Valitaan itse yksityisen sektorin terveydenhoitopaikan	140	50.2	47.5
Valitaan itse julkisen sektorin terveydenhuollon	14	5.0	4.5
Käydään sekä yksityisessä että julkisessa terveydenhuollossa	109	39.1	40.4
Mennään vakuutusyhtiön suosittelemaan terveydenhoitopaikkaan	1	0.4	0.3
En osaa sanoa	15	5.4	7.4
Yhteensä	279	100.0	100.0
70 Onko sairaskuluvakuutus korvannut lapsenne/lastenne terveydenhoitokuluja viimeisen vuoden aikana?	N	%	%
Kyllä	173	62.2	62.0
Ei	105	37.8	38.0
Yhteensä	278	100.0	100.0
71 Oletteko saanut vakuutuksesta korvausta lastenne hoitoon?	Mainintoja	%	
Hoidon itse valitulla yksityisellä lääkäriasemalla	146	35.4	
Hoidon vakuutusyhtiön suosittelemalla yksityisellä lääkäriasemalla	4	1.0	
Asiakasmaksun julkisella terveysasemalla	16	3.9	
Hoidon itse valitussa yksityisessä sairaalassa	13	3.2	
Hoidon vakuutusyhtiön suosittelemassa yksityisessä sairaalassa	2	0.5	
Lääkärin määräämät tutkimukset	86	20.9	
Asiakasmaksun julkisessa sairaalassa	24	5.8	
Lääkkeitä	112	27.2	
En osaa sanoa	8	1.9	
Muuhun mihin?	1	0.2	
Yhteensä	412	100.0	
72 Miten yleensä haette korvausta lasten sairaskuluvakuutuksesta?	N	%	%
Maksan itse ja haen korvaukset (esim. internetissä)	209	88.6	93.5
Vakuutusyhtiö ja hoitopaikka hoitavat korvauksen suoraan keskenään	6	2.5	2.5
En osaa sanoa	12	5.1	6.7
Muuten miten?	9	3.8	6.1
Yhteensä	236	100.0	

		Painottamaton	Painotettu
Lasten vakuutusyhtiön vaihto			
73 Oletteko vaihtanut lapsenne/lastenne sairauskuluvakuutusten vakuutusyhtiötä viimeisen vuoden aikana?	N	%	%
Kyllä → Siirry kysymykseen 75	10	3.5	3.6
En	273	96.5	96.4
Yhteensä	283	100.0	100.0
Aikomus vaihtaa lasten vakuutusyhtiötä			
74 Oletteko vakavasti harkinnut lapsenne/lastenne vakuutusyhtiön vaihtamista viimeisen vuoden aikana?	N	%	%
Kyllä	15	5.7	5.7
En	248	94.3	94.3
Yhteensä	263	100.0	100.0
Aikomus lopettaa lasten sairauskuluvakuutus			
75 Oletteko vakavasti harkinnut lapsenne / lastenne sairauskuluvakuutuksen lopettamista viimeisen vuoden aikana?	N	%	%
Kyllä	18	6.6	7.6
En	257	93.5	92.4
Yhteensä	275	100.0	100.0
76 Miksi harkitsitte lapsenne / lastenne sairauskuluvakuutuksen lopettamista? <i>Mainitkaa enintään 3 tärkeintä.</i>	Mainintoja	%	
En tarvitse vakuutusta	7	17.1	
Asuinalueellani ei ole yksityisiä terveystalouksia joissa voisin käyttää vakuutusta	0	0.0	
Vakuutuksen kallis hinta	14	34.1	
Vakuutusten liian suppea korvaavuus	3	7.3	
Vakuutuskorvausten hakeminen oli hankalaa	3	7.3	
Vakuutusyhtiön huono asiakaspalvelu	3	7.3	
Lapseni on/ovat kasvaneet	2	4.9	
En osaa sanoa	6	14.6	
Muu mikä?	3	7.3	
Yhteensä	41	100.0	
Lasten aikaisemmat vakuutukset			
77 Onko lapsellanne / lapsillanne (alle 18 v.) joskus ollut vapaaehtoinen sairauskuluvakuutus?	N	%	%
Kyllä	41	15.0	14.7
Ei	233	85.0	85.3
Yhteensä	274	100.0	100.0
78 Mitkä olivat syyt siihen että irtisanoitte lapsenne/lastenne (alle 18 v.) vapaaehtoisen sairauskuluvakuutuksen? <i>Mainitkaa enintään 3 tärkeintä.</i>	Mainintoja	%	
Ei tarvita vakuutusta	22	29.3	
Asuinalueella ei ole yksityisiä terveystalouksia joissa voisi käyttää vakuutusta	1	1.3	
Vakuutuksen kallis hinta	21	28.0	
Vakuutusten liian suppea kattavuus	7	9.3	

		Painottamaton	Painotettu
	Mainintoja	%	
Vakuutuskorvausten hakeminen oli hankalaa	8	10.7	
Vakuutusyhtiön huono asiakaspalvelu	0	0.0	
Lapseni tuli täysi-ikäiseksi tai vanhemmaksi kuin lasten vakuutuksen yläikäraja.	4	5.3	
En osaa sanoa	4	5.3	
Muu mikä?	8	10.7	
Yhteensä	75	100.0	
Aikomus ottaa lasten sairauskuluvakuutus			
79 Oletteko viimeisen vuoden aikana vakavasti harkinnut ottavanne sairauskuluvakuutuksen lapsellenne/lapsillenne?	N	%	%
Kyllä	22	8.2	10.0
En	247	91.8	90.0
Yhteensä	269	100.0	100.0
80 Mitkä olivat tärkeimmät syyt siihen että harkitsitte lasten sairauskuluvakuutuksen ottamista? <i>Mainitkaa enintään 3 tärkeintä.</i>	Mainintoja	%	
Halu käyttää yksityisiä terveystalvuita	5	10.0	
Halu enemmän valinnanvapautta	10	20.0	
Halu päästä nopeammin hoitoon	15	30.0	
Yksityisten terveystalvuitiden parempi laatu	11	22.0	
Pienet Kela-korvaukset	0	0.0	
Kela ei korvaa tarvittuja hoitoja tutkimuksia tai lääkkeitä	2	4.0	
Tuttavat suosittelivat vakuutusta	0	0.0	
Vakuutusyhtiön edustaja suositteli vakuutusta	2	4.0	
Vakuutusyhtiön mainos	0	0.0	
En osaa sanoa	5	10.0	
Muu mikä?	0	0.0	
Yhteensä	50	100.0	
81 Miksi ette harkinnan jälkeen ottanut lapsellenne/lapsillenne sairauskuluvakuutusta? <i>Mainitkaa enintään 3 tärkeintä.</i>	Mainintoja	%	
En koe tarvitsevani vakuutusta	6	10.5	
Asuinalueellamme ei ole yksityisiä terveystalvuita joissa voisin käyttää vakuutusta	3	5.3	
Vakuutuksen kallis hinta	15	26.3	
Vakuutusten liian suppea korvaavuus	5	8.8	
Vakuutuskorvausten hakeminen on hankalaa	3	5.3	
Vakuutusyhtiön huono asiakaspalvelu	4	7.0	
Vakuutukseen olisi tullut rajoituksia lapsen/lasten aikaisempien sairauksien takia	4	7.0	
Pelkasin ettei vakuutusta myönnetä lapsen/lasten terveydentilan takia	2	3.5	
Pelkasin ettei vakuutusta myönnetä lapsen/lasten iän takia	0	0.0	
Ei hyväksytty	1	1.8	
En osaa sanoa	5	8.8	
Muu mikä?	9	15.8	

		Painottamaton	Painotettu
	Mainintoja	%	
Yhteensä	57	100.0	
Lasten aiemmat sairauskuluvakuutushakemukset			
82 Oletteko aiemmin hakenut lapsellenne/lapsillenne vakuutusta mutta hakemusta ei hyväksytty?	N	%	%
Kyllä	13	4.7	3.9
En	262	95.3	96.1
Yhteensä	275	100.0	100.0
83 Miksi lapsenne/lastenne vakuutushakemusta ei hyväksytty?	Mainintoja	%	
Kroonisen sairauden vuoksi	2	11.8	
Muun terveydentilan takia (ei krooninen sairaus)	1	5.9	
Nykyisen tai ohimenneen mielenterveysongelman vuoksi	0	0.0	
Ylipainon takia	0	0.0	
Synnynnäisen vamman tai invaliditeetin takia	3	17.6	
En tiedä	0	0.0	
Muu syy mikä?	7	41.2	
Yhteensä	17	100.0	