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Health system review

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CONTENTS

Preface	v
Acknowledgements	vii
List of abbreviations	ix
List of tables, figures and boxes	xi
Abstract	xiv
Executive summary	xv
1 Introduction	1
1.1 <i>Geography and sociodemography</i>	2
1.2 <i>Economic context</i>	4
1.3 <i>Political context</i>	6
1.4 <i>Health status</i>	7
2 Organization and governance	14
2.1 <i>Historical background</i>	14
2.2 <i>Organization</i>	15
2.3 <i>Decentralization and centralization</i>	22
2.4 <i>Planning</i>	23
2.5 <i>Intersectorality</i>	24
2.6 <i>Health information systems</i>	26
2.7 <i>Regulation</i>	28
2.8 <i>Patient empowerment</i>	35
3 Financing	42
3.1 <i>Health expenditure</i>	43
3.2 <i>Sources of revenue and financial flows</i>	50
3.3 <i>Overview of the statutory financing system</i>	50
3.4 <i>Out-of-pocket payments</i>	63
3.5 <i>Voluntary health insurance</i>	69
3.6 <i>Other financing</i>	70
3.7 <i>Payment mechanisms</i>	71

4	Physical and human resources	75
4.1	<i>Physical resources</i>	76
4.2	<i>Human resources</i>	83
5	Provision of services	91
5.1	<i>Public health</i>	92
5.2	<i>Patient pathways</i>	97
5.3	<i>Primary care</i>	101
5.4	<i>Specialised care</i>	106
5.5	<i>Urgent and emergency care</i>	113
5.6	<i>Pharmaceutical care</i>	115
5.7	<i>Rehabilitation/intermediate care</i>	117
5.8	<i>Long-term care</i>	118
5.9	<i>Services for informal carers</i>	120
5.10	<i>Palliative care</i>	120
5.11	<i>Mental health care</i>	121
5.12	<i>Dental care</i>	122
6	Principal health reforms	124
6.1	<i>Analysis of recent reforms</i>	125
6.2	<i>Future developments</i>	133
7	Assessment of the health system	135
7.1	<i>Monitoring health system performance</i>	136
7.2	<i>Health system impact on population health</i>	138
7.3	<i>Access</i>	142
7.4	<i>Financial protection</i>	144
7.5	<i>Health system efficiency</i>	144
7.6	<i>Health care quality and safety</i>	147
7.7	<i>Transparency and accountability</i>	149
8	Conclusions	151
9	Appendices	154
9.1	<i>References</i>	154
9.2	<i>HiT methodology and production process</i>	162
9.3	<i>The review process</i>	165
9.4	<i>About the authors</i>	165

PREFACE

The Health Systems in Transition (HiT) series consists of country-based reviews that provide a detailed description of a health system and of reform and policy initiatives in progress or under development in a specific country. Each review is produced by country experts in collaboration with the Observatory's staff. In order to facilitate comparisons between countries, reviews are based on a template, which is revised periodically. The template provides detailed guidelines and specific questions, definitions and examples needed to compile a report.

HiTs seek to provide relevant information to support policy-makers and analysts in the development of health systems in Europe. They are building blocks that can be used to:

- learn in detail about different approaches to the organization, financing and delivery of health services, and the role of the main actors in health systems;
- describe the institutional framework, process, content and implementation of health care reform programmes;
- highlight challenges and areas that require more in-depth analysis;
- provide a tool for the dissemination of information on health systems and the exchange of experiences of reform strategies between policy-makers and analysts in different countries; and
- assist other researchers in more in-depth comparative health policy analysis.

Compiling the reviews poses a number of methodological problems. In many countries, there is relatively little information available on the health system and the impact of reforms. Due to the lack of a uniform data source, quantitative data on health services are based on a number of different sources, including the World Health Organization (WHO) Regional Office for Europe's European Health for All database, data from national statistical offices,

Eurostat, the Organisation for Economic Co-operation and Development (OECD) Health Data, data from the International Monetary Fund (IMF), the World Bank's World Development Indicators and any other relevant sources considered useful by the authors. Data collection methods and definitions sometimes vary, but typically are consistent within each separate review.

A standardized review has certain disadvantages because the financing and delivery of health care differ across countries. However, it also offers advantages because it raises similar issues and questions. HiTs can be used to inform policy-makers about experiences in other countries that may be relevant to their own national situations. They can also be used to inform comparative analysis of health systems. This series is an ongoing initiative and material is updated at regular intervals.

Comments and suggestions for the further development and improvement of the HiT series are most welcome and can be sent to contact@obs.who.int.

HiTs and HiT summaries are available on the Observatory's website (<http://www.healthobservatory.eu>).

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The Health Systems in Transition (HiT) profile on Finland was co-produced by the European Observatory on Health Systems and Policies and the Finnish Institute for Health and Welfare, which is a member of the Health Systems and Policy Monitor (HSPM) network.

The HSPM is an international network that works with the Observatory on Country Monitoring. It is made up of national counterparts that are highly regarded at national and international level and have particular strengths in the areas of health systems, health services, public health and health management research. They draw on their own extensive networks in the health field, and their track record of successful collaboration with the Observatory, to develop and update the HiT.

This edition was written by Ilmo Keskimäki, Liina-Kaisa Tynkkynen, Eeva Reissell, Meri Koivusalo, Vesa Syrjä, Lauri Vuorenkoski, Bernd Rechel and Marina Karanikolos. It was edited by Marina Karanikolos and Bernd Rechel, working with the support of Anna Maresso and Ewout van Ginneken of the Observatory's team at the University of Technology, Berlin. The basis for this edition was the previous HiT on Finland, which was published in 2008, written by Lauri Vuorenkoski and edited by Philipa Mladovsky and Elias Mossialos.

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The HiT uses data available in July 2019, unless otherwise indicated. The HiT reflects the organization of the health system and the data availability as it was in June 2019 (unless otherwise indicated).

The Observatory is a partnership that includes the Governments of Austria, Belgium, Finland, Ireland, Norway, Slovenia, Sweden, Switzerland and the United Kingdom; the Veneto Region of Italy; the French National Union of Health Insurance Funds (UNCAM); the World Health Organization; the European Commission; the World Bank; the London School of Economics and Political Science (LSE); and the London School of Hygiene & Tropical Medicine (LSHTM). The partnership is hosted by the WHO Regional Office for Europe. The Observatory is composed of a Steering Committee, core management team, research policy group and staff. Its Secretariat is based in Brussels and has offices in London at LSE, LSHTM and the Technical University of Berlin. The Observatory team working on HiTs is led by Josep Figueras, Director; Elias Mossialos, Martin McKee, Reinhard Busse (Co-directors); Richard Saltman, Ewout van Ginneken and Suszy Lessof. The Country Monitoring Programme of the Observatory and the HiT series are coordinated by Anna Maresso. The production and copy-editing process was coordinated by Jonathan North, with the support of Caroline White and Andrea Kay (copy-editing).

LIST OF ABBREVIATIONS

ATH	Regional Health and Well-being Survey
AVTK	Survey on Health Behaviour and Health among the Finnish Adult Population
BMI	Body Mass Index
CHE	Current Health Expenditure
COHERE	Council for Choices in Health Care
CT	Computed Tomography
DALY	Disability-adjusted life year
DRG	Diagnosis-related group
DTaP-IPV-Hib	Diphtheria, Tetanus, Pertussis, Polio, Haemophilus influenzae Type b
EEA	European Economic Area
EHIS	European Health Interview Survey
EU	European Union
EU28	Member States of the European Union
EUnetHTA	European Network for Health Technology Assessment
FCCA	Finnish Competition and Consumer Authority
FIMEA	Finnish Medicines Agency
FinCCHTA	Finnish Coordinating Centre for Health Technology Assessment
FinOHTA	Finnish Office for Health Technology Assessment
FIQH	Finnish Institute for Occupational Health
FSHS	Finnish Student Health Service
GDP	Gross domestic product
GGE	General Government Expenditure
GHED	Global health expenditure database
GP	General practitioner
HBSC	Health Behaviour in School-aged Children
HiAP	Health in All Policies

HILMO	National Care Register
HIV	Human immunodeficiency virus
HPV	Human papillomavirus
HTA	Health technology assessment
HUCH	Helsinki University Central Hospital
ICT	Information and communication technology
ID	Identifier
IHD	Ischaemic heart disease
Kanta	National digital data system services
Kela	Social Insurance Institution of Finland
LTC	Long-term care
MMR	Measles, mumps and rubella
MRI	Magnetic resonance imaging
MSAH	Ministry of Social Affairs and Health
NGO	Nongovernmental organization
NHI	National Health Insurance
OECD	Organisation for Economic Co-operation and Development
OOP	Out-of-pocket
OTC	Over-the-counter
PERFECT	Performance, Effectiveness and Cost of Treatment Episodes Project
PPB	Pharmaceuticals Pricing Board
PPP	Purchasing power parity
RSAA	Regional State Administration Agencies
SDR	Standardized death rate
SHI	Social health insurance
STEA	Funding Centre for Social Welfare and Health Organisations
STUK	Radiation and Nuclear Safety Authority
TB	Tuberculosis
THL	Finnish Institute for Health and Welfare
Tukes	Finnish Safety and Chemicals Agency
Valvira	National Supervisory Authority for Welfare and Health
VAT	Value added tax
WDI	World Development Indicators
VHI	Voluntary Health Insurance
WHO	World Health Organization

LIST OF TABLES, FIGURES AND BOXES

■ Tables

TABLE 1.1	Trends in population/demographic indicators, selected years	4
TABLE 1.2	Microeconomic indicators, selected years	5
TABLE 1.3	Mortality and selected health indicators	8
TABLE 1.4	Disability-adjusted life years (DALYs), age-standardized rate per 100 000 population, selected years	9
TABLE 1.5	Risk factors affecting health status in adults, EHIS, 2014	11
TABLE 2.1	Overview of provider regulation	31
TABLE 2.2	Patient information	37
TABLE 2.3	Patient choice	38
TABLE 2.4	Patient rights	39
TABLE 3.1	Trends in health expenditure in country, 2000 to latest available year	44
TABLE 3.2	Expenditure for selected health care functions by health care financing schemes, 2017 (% of CHE)	46
TABLE 3.3	User charges for health services in 2019 (maximum levels)	66
TABLE 3.4	Average income of health workers in Finland in 2018, € per month	73
TABLE 4.1	Diagnostic equipment in Finland and the EU, per 100 000 population, 2016	80

■ Figures

FIGURE 1.1	Map of the country	3
FIGURE 2.1	Overview of the health system	16
FIGURE 3.1	Current health expenditure as a share (%) of GDP in the WHO European Region, 2016	45

FIGURE 3.2 Trends in health expenditure as a share (%) of GDP in country and selected countries, 2000 to latest available year	46
FIGURE 3.3 Current health expenditure in US\$ PPP per capita in the WHO European Region, 2016	47
FIGURE 3.4 Public sector health expenditure as a share (%) of current health expenditure in the WHO European Region, 2016	48
FIGURE 3.5 Public expenditure on health as a share (%) of general government expenditure in WHO European Region, 2016	49
FIGURE 3.6 Financial flows	51
FIGURE 4.1 Hospital beds per 1 000 in Finland, 2000–2017	79
FIGURE 4.2 Access time to health facilities in Finland	81
FIGURE 4.3 Practising physicians per 1 000 population in Finland and selected countries, 2000–2017	86
FIGURE 4.4 Practising nurses per 1 000 population in Finland and selected countries, 2000–2017	87
FIGURE 5.1 Number of all GP contacts including phone calls per 1 000 population, 2017	104
FIGURE 5.2 Care periods for patients treated in hospitals with admission through emergency departments as a percentage of all care periods by hospital district, 2017	108
FIGURE 5.3 Day care surgery patients per 1 000 population in Finnish hospital districts, 2017	110
FIGURE 7.1 Amenable and preventable mortality in Finland and the EU28 (age-standardized rate per 100 000 population), 2000 and 2016	140
FIGURE 7.2 Unmet medical need due to cost, waiting time or travel distance, 2018 or latest	143

■ Boxes

BOX 1.1 Assessing inequalities in health	12
BOX 2.1 Is there sufficient capacity for policy development and implementation?	24
BOX 3.1 What are the key gaps in coverage?	56
BOX 3.2 Is health financing fair?	58
BOX 4.1 Assessing the geographical distribution of health care resources	81

BOX 4.2 Evaluating the geographical distribution of health workers	87
BOX 5.1 Are public health interventions making a difference?	96
BOX 5.2 Example of a patient pathway	99
BOX 5.3 What are the key strengths and weaknesses of primary care?	105
BOX 5.4 Are efforts to improve integrated care working?	111
BOX 5.5 What do patients think of the care they receive?	112
BOX 5.6 Patient pathway in emergency care	114
BOX 5.7 Is there waste in pharmaceutical spending?	116
BOX 6.1 Major health reforms and policy measures in Finland, 2007–2019	126
BOX 6.2 An example of the challenges in reforming health and social care in Finland	128
BOX 7.1 Equity of outcomes	142

ABSTRACT

This analysis of the Finnish health system reviews developments in its organization and governance, financing, provision of services, health reforms and health system performance. Finland is a welfare state with a high standard of social and living conditions and a low poverty rate. Its health system has a highly decentralized administration, multiple funding sources, and three provision channels for statutory services in first-contact care: the municipal system, the national health insurance system, and occupational health care. The core health system is organized by the municipalities (i.e. local authorities) which are responsible for financing primary and specialized care. Health financing arrangements are fragmented, with municipalities, the health insurance system, employers and households all contributing substantial shares. The health system performs relatively well, as health services are fairly effective, but accessibility may be an issue due to long waiting times and relatively high levels of cost sharing. For over a decade, there has been broad agreement on the need to reform the Finnish health system, but reaching a feasible policy consensus has been challenging.

EXECUTIVE SUMMARY

■ Finland is a high-income welfare state

Finland is a high-income country located in northern Europe with a population of 5.5 million. It has a GDP of about €40 000 per person, a high standard of social and living conditions typical of a Nordic welfare state, and a low poverty rate. Finland has a long-standing cooperation with the other Nordic countries on a range of areas. It is also a member of the EU and the Euro zone.

The Finnish economy is largely based on industry and services with traditional areas (forestry and metal industry) now co-existing with emerging ones, such as medical technology, software and electronic products and services. Over the past three decades Finland has suffered several economic downturns, including severe recessions in 1991–1993 and 2009. The economy has recovered since, and unemployment rates have reduced substantially.

Finland is a parliamentary democracy. The Government formulates national policies and proposes legislation. There is national, regional and local level governance, with over 300 municipalities currently playing a key role in health and social care services. Administrative reform seeking to centralize health and social care in fewer regions has long been in the making but is yet to materialize.

Population health is fairly good, with many indicators exceeding the EU average. Life expectancy at birth is 81.7 years, compared with an EU average of 80.9 years. Since 1995, life expectancy in Finland has increased by 5 years, as care for many chronic conditions has improved substantially, with several large-scale national prevention and treatment programmes playing an important role. Some issues, however, remain. High levels of alcohol consumption persist but fluctuate in response to policies affecting alcohol availability and affordability. Obesity rates are growing rapidly among both adults and children. Health inequalities, both geographical and socioeconomic, are fairly wide. This

is partly a reflection of the prevalence of lifestyle risk factors, such as smoking and use of alcohol, which is higher in people with lower levels of income or education. In addition, people living in central and northern regions experience higher levels of morbidity than those living in the south and south-east.

- The health system is very decentralized, and health financing and service provision are fragmented

Finland has a health system with a highly decentralized administration, multiple funding sources, and three provision channels for statutory services in first-contact care: the municipal system, the national health insurance system, and occupational health care. The core health system is organized by the municipalities (i.e. local authorities) which are responsible for financing primary and specialized care.

Legislation and general policy guidelines are prepared at the national level, relying on a vast network of non-state experts, while governance measures are mainly soft and each of the subsystems enjoys a large degree of freedom in the organization of its services.

Intersectoral action and Health in All Policies have a long tradition in Finland, particularly in the field of nutrition, but also transport and environment. This is reflected in both explicit legal obligations and long-term institutional practices. Over the past few years, tobacco control has been strengthened, and Finland has adopted a vision to become a smoke-free country by 2030. Recent policies on alcohol control have been mixed, with increases in alcohol tax, but also some relaxation in sales regulation.

There has been a rapid development of various sources of information on health and the health sector for patients and the public, as a result of political initiatives to increase transparency and freedom of choice. There are designated platforms with information, such as on legislation, entitlements, fees, service availability and treatment options, and e-services. Patient rights and service guarantees are stipulated in various pieces of legislation.

- Health expenditure remains stable, but the share of out-of-pocket spending has increased

Overall, Finland spends less on health than its Nordic neighbours and many other EU countries. Spending as a percentage of GDP has decreased in

2016 and 2017 in comparison with 2015, while per capita expenditure kept increasing. Over the past five years, the share of public funding for health care has slightly decreased, and out-of-pocket payments now comprise over 20% of current health expenditure. While a large part of public financing for health (coming from income tax) is progressive, an increasing share of out-of-pocket payments undermines progressivity.

Health financing arrangements are very fragmented, with municipalities, the national health insurance system, employers and households all contributing substantial shares. Together, they finance municipal, private and occupational health services. As a result, coverage in Finland is also fragmented. While all residents are covered by municipal health care, availability of services, particularly in terms of primary care, vary across municipalities. In addition, employees are covered by occupational health care, the scope of which also varies.

The four largest areas of health spending are outpatient care (33%), inpatient care (25%), long-term care (19%) and pharmaceuticals (12%). Outpatient care, pharmaceuticals and long-term care account for about three quarters of all out-of-pocket payments. User fees exist across all service areas, with occupational health being the only exception. Mechanisms for financial protection are limited: high caps on user fees, exemptions for children and treatment of specific diseases, and an option to apply for income assistance.

■ Regional differences persist in the availability of human and physical resources

Most health care facilities in Finland are owned by the public sector, although the number of privately or jointly owned hospitals is increasing. The public hospital network, including 15 central hospitals and five university hospitals, is owned by the country's 20 hospital districts (federations of municipalities). The municipalities and hospital districts also run and finance a network of primary and secondary care facilities, as well as separate psychiatric care institutions. A wave of hospital closures and mergers has substantially reduced the number of facilities and beds since 2000.

Electronic patient records are used widely in both the public and the private sector. However, due to the decentralized health system, their interoperability is often deficient. Currently two major information system projects are ongoing, with one aiming to link health and social welfare services in

the capital region and the other unifying information systems across the remaining 19 hospital districts.

Responsibility for specialist training for physicians was shifted to the Ministry of Social Affairs and Health (MSAH) in 2015, with a steering and planning function based on the current and future needs for specialists. The shortage of physicians that previously afflicted the health system has been overcome by an increased intake of students in Finland and an increase in students studying abroad. However, availability of physicians still varies more than twofold across regions. At the same time, the ratio of nurses to population in Finland is one of the highest in the EU, and their role keeps gradually expanding to meet the needs of the population.

■ Care is delivered through three parallel provision channels

Health promotion and disease prevention are cornerstones of the Finnish health system. Health promotion is carried out at the national and municipal level, and involves several agencies and institutions subordinated to the Ministry, as well as NGOs and other actors.

There are three parallel systems for health service provision. The principal system is publicly financed and organized by the municipalities, for all levels of care. The other two systems are private and occupational health care, mostly providing ambulatory primary and some specialist services.

Municipal primary care is provided by health centres, delivering a wide range of services, although waiting times can be long. Public specialist and inpatient care is provided through 20 hospital districts; these provider networks have been undergoing centralization, as well as a shift from inpatient care to other settings. The numbers of district and specialist hospitals have decreased and their role in service provision has reduced markedly in the 2000s, largely through mergers with larger hospitals. A Government Decree on the further centralization of specialties has recently entered into force and is expected to reduce the number of surgical treatment centres.

On-call services have undergone a shift towards emergency departments that provide primary and specialist care and are located mostly in hospitals. The array of services in larger hospitals includes around the clock social welfare advice.

Long-term care is largely within the remit of social services and increasingly provided at home or in sheltered housing. Mental health care is provided

closer to somatic specialist care and substance abuse problems have been recognized as an important part of mental illness.

- **Despite broad agreement on the need for structural changes, passing major reforms has been challenging**

There has been broad agreement on the need to reform the Finnish health system for over a decade, but reaching a feasible policy consensus on how the reform should be implemented appeared to be challenging. The major proposed reform of the 2015–2019 Government was to integrate primary care, specialist care and social services under the same administrative structure and budget, with newly-created regional authorities anticipated to play a key role. In addition, the reform envisaged an increase in patient choice and provider competition. The reform was not implemented due to a conflict of the proposed legislation with the country's Constitutional Law, leading to the resignation of the Government in March 2019. With the election of the new Government in April 2019, it is expected that attempts to make structural changes to the health sector will continue, due to a broadly recognized need for the administrative centralization and improved integration of service provision. Preparations over the past few years mean that some aspects of these changes have already been implemented on a small scale (for example, the establishment of more centralized joint authorities for health and social care, aiming to achieve a greater integration of services).

Reforms that have taken place in the past decade have largely been incremental and mainly focused on modifying existing features without fundamentally changing the structure of the health system. A series of measures were taken to reduce the share of public spending on health. Some of these translated into reduced levels of reimbursement for medicines, and increased user fees.

- **Health services are fairly effective, but accessibility may be an issue due to long waiting times and high levels of cost sharing**

Finnish health policy seeks to incorporate Health in All policies into all aspects of public decision-making. The main goals are to promote population health and welfare, reduce health inequalities, ensure universal access to services, improve quality, and increase responsiveness of the system.

In terms of health outcomes Finland performs relatively well in international comparisons. Mortality from preventable causes (related to public health and intersectoral policies) is also relatively low, although with little progress in recent years, reflecting a weakening of alcohol control.

In terms of access to care, waiting times and high levels of cost sharing result in relatively high levels of (self-reported) unmet need for medical services. In addition, although the average incidence of households experiencing catastrophic payments due to spending on health care is low, it affects vulnerable groups to a greater degree. Mechanisms for financial protection of people with lower income or higher need are weak, and largely reliant on annual ceilings for out-of-pocket payments for services, pharmaceuticals and ambulance transfers, which are set to the combined total of over €1 500.

Overall, Finland compares favourably to many EU countries in terms of efficiency and quality of services, despite high levels of fragmentation in financing and service delivery. A lot of progress has been made in the past two decades in terms of strengthening primary care (particularly around optimizing the skill-mix of the health professionals involved in providing this type of care), improving the effectiveness of specialist and hospital care, and containing pharmaceutical spending.

■ Challenges going forward

The Finnish health system performs relatively well, but a number of challenges remain. Socioeconomic inequalities in health have declined but remain substantial; they can be largely attributed to variations in the prevalence of risk factors among different population groups, and geographical inequities, to the detriment of people living in the northern, eastern and central regions. Moreover, fragmented organization and soft governance at the national level leave municipalities with varying ability to deliver health services.

There is no overall budget for health services in Finland, due to the complex financing arrangements in place. The dual public financing system via municipalities and the national health insurance system creates challenges for the overall efficiency of service provision. Nonetheless, current health expenditure in Finland is below comparable countries, including other Nordic countries, the United Kingdom and the Netherlands. Roughly one fifth of total health spending comes from out-of-pocket payments. Private

expenditure on outpatient prescription medications is particularly high, amounting to about one third of total pharmaceutical spending. User fees are very widely used, and payment caps are set at high levels, particularly affecting people with lower incomes.

Infrastructure and facilities for health care provision have undergone marked changes in the 2000s. Information and communication technology (ICT) systems to assist data collection, harmonization and coordination of care have been developed. Hospital districts have invested heavily in new buildings and worked towards rationalizing resources, resulting in closures and mergers of smaller hospitals.

Nevertheless, capacity to deliver services that match population needs has weakened in the past decade. This is reflected in long waiting times in primary care (up to several weeks for a non-urgent GP appointment in some health centres), but also in elective specialist care. The relatively high rates of (self-reported) unmet needs have been associated with long waiting times for the first appointment. This is particularly the case for those outside employment who do not have access to occupational health care.

Achieving greater administrative centralization remains the main goal of proposed health reforms. There is broad consensus that the Finnish health system has inherent flaws, such as weak national stewardship and a large degree of fragmentation. The separate organization of primary and specialized care and social services, particularly in the context of an ageing population, is seen as an obstacle to improving health system performance. Over the past two decades, several governments have attempted reforms, with three core aims irrespective of political profiles: i) centralization of organizational structures; ii) improving access to primary care; and iii) integration of services (both horizontal and vertical). The implementation of these reforms, however, has yet to succeed. Nevertheless, some aspects of reform attempts have been achieved, such as a larger degree of centralization of emergency care and specialist services, as well as the creation of a functioning example of joint health authorities. The Government in power since April 2019 announced that it will continue to pursue the reform based on the creation of regional authorities (counties), which are anticipated to have responsibility for organizing and providing all health and social services.

Introduction

■ Summary

- Finland is a high-income country located in northern Europe with a population of 5.5 million. It has a GDP of about €40 000 per person, a high standard of social and living conditions, and a fairly low poverty rate.
- The Finnish economy is largely based on industry and services. Traditional areas (forestry and metal industries) coexist with newly emerging ones such as health technology, software and electronic products and services. Over the past three decades Finland has suffered several economic downturns, including recessions in 1991–1993 and 2009, with further negative growth in 2012–2014. The economy has recovered since then, and unemployment rates have reduced substantially.
- Finland has a long-standing cooperation with the other Nordic countries on a range of areas. It is also a member of the EU and the Euro zone.
- Finland is a parliamentary democracy, with a President as head of state. Administratively, it consists of national, regional and local levels, with over 300 municipalities playing key roles in health and social services. Administrative reform seeking to centralize health and social care in fewer regions has long been in the making but is yet to materialize.

- Population health is fairly good, with many indicators above the EU average. Care for many chronic conditions has improved substantially over the past decades, with several national large-scale prevention and treatment programmes playing an important role. Some issues, however, remain. High levels of alcohol consumption persist but fluctuate in response to policies affecting alcohol availability and affordability. Obesity rates are growing rapidly among both adults and children.
- Health inequalities, both geographical and socioeconomic, are fairly wide. This is partly a reflection of the prevalence of lifestyle risk factors, such as smoking or alcohol use, which is higher in people with lower income or education level. In addition, people living in central and northern regions experience higher levels of morbidity than those living in the south and south-east.

■ 1.1 Geography and sociodemography

Finland is located to the north-east of the Baltic Sea. It is bordered by Norway to the north, the Gulf of Finland to the south, Sweden and the Gulf of Bothnia to the west, and the Russian Federation to the east (Fig. 1.1). Estonia is situated only about 50 km away, across the Gulf of Finland.

The land area is 338 145 km². Some 68% of it is covered by forests, 10% by water, and 6% is used for agriculture. Much of the country is sparsely populated, with an average population density of 18 people per km² (Table 1.1). The bulk of the population is concentrated in the urban areas of the southern and western parts of the country, while 15% of the population lives in rural areas.

In 2017 the population of Finland was 5.5 million (Table 1.1). Over 70% of the population in 2017 identified their religion as Evangelic Lutheran. The majority of the population (88%) speaks Finnish as their first language. Swedish is the second official language and 5.2% of the population speaks Swedish as their first language. In addition, about 2 000 inhabitants speak the indigenous Sami languages as their first language. With an increase in immigration into Finland since 2000, the proportion of inhabitants speaking foreign languages as their first language more than tripled between 2000 and 2017, from 1.9% to 6.4% (Statistics Finland, 2019a). Migration has been the

main component of population growth, while the fertility rate has declined since 2010. Population ageing is a concern, as the number of people aged 65 years or over is expected to increase by one fifth in the next 30 years.

FIGURE 1.1 Map of the country



Source: National Land Survey of Finland (2019)

TABLE 1.1 Trends in population/demographic indicators, selected years

	1995	2000	2005	2010	2015	2017
Total population (thousands)	5 108	5 176	5 246	5 363	5 480	5 511
Population ages 0–14 (% of total)	19.0	18.1	17.3	16.5	16.4	16.4
Population ages 65 and above (% of total)	14.3	15.0	16.0	17.2	20.3	21.2
Population growth (% annual growth rate)	0.4	0.2	0.3	0.5	0.3	0.3
Fertility rate, total (births per woman)	1.8	1.7	1.8	1.9	1.7	1.5
Population density (people per sq km)	16.8	17.0	17.2	17.6	18.0	18.1
Distribution of population (% rural)	19.0	17.8	17.1	16.2	14.8	14.7

Sources: World Bank (2019); Statistics Finland (2019a)

1.2 Economic context

The Finnish economy is primarily based on industry and services. Finland's industry has traditionally been built on harnessing forest resources, which has dominated export and trade policies. Today the Finnish economy and exports remain dominated by the forest industry, particularly the pulp and paper industry, and the metal and ship-building industries. However, in the past few years, new areas have emerged, such as medical technology, the software and games industry, and broader electronic products and services.

Between 1990 and 1993, Finland suffered a major economic recession, as the economy shrank by almost 15%, with unemployment rising to 19%. As a result, public spending was cut and there was a shift towards increasing financial responsibilities for regional and local governments. Administrative powers in Finnish politics have also shifted to strengthen the roles of the Ministry of Finance and the Ministry of Trade and Industry (currently Economic Affairs and Employment) in all policy-making. Economic recovery began in 1994, and by 2003 real GDP adjusted for purchasing power parity (PPP) was close to the EU-15 average.

Since the mid-2000s the growth of the Finnish economy has slowed and eventually stalled (Table 1.2), marked by the decline of the Nokia company, the global economic crisis and EU economic sanctions against Russia. Worsening economic indicators have also resulted in the increased role of the European Commission and external oversight over national public spending in Finland.

TABLE 1.2 Microeconomic indicators, selected years

	1995	2000	2005	2010	2015	2017
GDP per capita (current €)	19 295	26 324	31 335	34 885	38 316	40 647
GDP per capita, PPP\$	19 557	26 753	31 993	38 737	42 221	46 344
GDP growth (annual %)	4.2	5.6	2.8	3.0	0.5	2.7
General government final consumption expenditure (% of GDP)	21.9	19.8	21.5	23.9	24.4	23.0
Cash surplus/deficit (% of GDP)	-5.9	6.9	2.6	-2.6	-2.8	-0.8
Public debt (% of GDP)	55.1	42.5	40.0	47.1	63.4	61.3
Unemployment, total (% of labour force)	15.4	9.8	8.4	8.4	9.4	8.6
At-risk-of-poverty rate ^a	8.0	11.0	11.7	13.1	12.4	11.5
Income inequality (Gini coefficient)	22.0	24.0	26.0	25.4	25.2	25.3

Notes: ^a 60% of median equivalized income. 1996 earliest year for poverty rate and GINI.

Sources: World Bank (2019); European Commission (2019)

The economy showed signs of recovery in 2016 when growth returned as a result of household consumption and expansion of housing markets. Finland's export recovered as well, reflecting the strengthened global economic outlook (Bank of Finland, 2016). Unemployment in Finland was 8.6% in 2017 (compared with an EU average of 7.6%) but, since then, has declined and was 6.8% in January 2019.

Despite the recovery and due to the shift in public spending to the local level, municipalities still experience indebtedness and challenges with long-term provision and financing of public services. This is particularly severe in areas that have lost working-age and younger people to regional centres, in search of better economic opportunities. This internal economic migration to larger cities leaves some regions with a diminishing workforce, changing the nature of social networks and affecting the provision of services.

Nevertheless, Finland remains a relatively equal country with good social and living conditions for the majority of the population. However, socioeconomic inequality increased in the aftermath of the fairly recent double-dip recession. Regional socioeconomic disparities have also widened, both as result of a lower level of public resources and out-migration.

Extensive public services support fairly high standards of social and living conditions, a highly regarded educational system, and access to childcare and social care. However, the minimum support is means-tested. Under the remit of the Council of Europe, Finland has been subject to scrutiny

by the European Committee of Social Rights (ECSR, 2017), and still is subject to follow-up and periodic reporting on the adequacy of its social security provisions.

■ 1.3 Political context

Finland is a parliamentary democracy with 200 representatives elected on the basis of proportional representation every 4 years. Parliament has three main functions: 1) it passes laws; 2) it debates and approves the national budget; and 3) it supervises the way the country is governed. Proposed legislation requires a parliamentary majority to become law, and must be signed by the President.

Finland has a Constitution which was last reviewed in 2000. Executive power is vested in both the Government and the President, although presidential powers are limited. The President is the head of state, and is elected for a period of 6 years by direct popular vote. In practice, the President's power beyond foreign policy largely rests in accepting (or rejecting) legislation and appointing senior civil servants.

The Government is the executive body that governs the country, formulates policy and proposes legislation. The Parliament elects the Prime Minister (who is then formally appointed by the President). The Prime Minister's Office is responsible for coordinating Finland's EU policy, overseeing the state ownership policy and steering state-owned companies. The Prime Minister proposes the Cabinet of Ministers who are appointed by the President. The Government (and different ministries) can in certain cases enact lower level decrees. Judicial power is vested in independent courts. At the highest level these are the Supreme Court and the Supreme Administrative Court.

Since the voting system is proportional, no single party can generally form a majority to govern, which leads to coalitions, and a relative stability of the political system. After the parliamentary elections in April 2019, the seats were divided among the political parties as follows: Social Democratic Party, The Finns Party, and the National Coalition Party received 40, 39 and 38 seats respectively, followed by the Centre Party (31), the Green League (20), the Left Alliance (16), Swedish People's Party and Åland coalition (9+1), Christian Democrats (5), and Movement Now (1). In June 2019, the centre-left coalition Government between the Social Democrats, the Centre Party and

Greens, the Left Alliance and Swedish People's Party was formed. The previous Government (2015–2019) was originally a coalition of centre-right parties.

The administration comprises regional and local level governance with six administrative regions, including the autonomous Åland Islands. In June 2019, there were 311 self-governing municipalities in line with uniform national legislation (including the 16 municipalities in the Åland Islands). Many responsibilities, including primary education and social and health services, are devolved to the level of municipalities. Municipal councils are elected for four-year terms and are the main decision-making bodies at the local level. Municipalities levy some taxes and, with Government subsidies, provide basic services, such as social and health care, primary education, cultural services and infrastructure.

Trade and employer federations play an important role in national decision-making. In particular, issues closely related to employment (such as national health insurance or occupational health) are usually agreed in negotiations between the Government and the federations.

Cooperation with the other Nordic countries (Denmark, Iceland, Norway and Sweden) is long-standing and covers a large number of issues, ranging from social and cultural to technical matters. Finland became a member of the EU in 1995. The impact of EU membership on the Finnish economy is strongly mediated through membership in the Euro zone and how fiscal oversight is managed in the context of the European Union Semester.

Finnish policies traditionally emphasized support for the welfare state, with a high degree of corporatism in decisions related to the wider economy. The recent economic downturn gave rise to nationalist and anti-immigrant policies, but also increased the role of entrepreneurialism and the commercial sector in defining national policy priorities.

■ 1.4 Health status

In 2017, life expectancy at birth in Finland reached 81.7 years – almost a year above the EU average of 80.9 years. It still lags behind Sweden (82.5 years) but is above that of Denmark (81.1 years). Since 2000, life expectancy at birth has increased in Finland by almost 4 years (Table 1.3). There is a 5.6 years gap in longevity between females and males, although this has reduced by 1.4 years since 2000, as increase in life expectancy in men grew at a faster

pace than in women. There is also a similar longevity gap between people of different socioeconomic status: in 2016, people at the age of 30 with a university education are expected to live 5.1 years more than those who have not graduated from school (European Commission, 2019).

In terms of mortality, circulatory diseases (largely ischaemic heart disease and stroke) and cancers remain the leading causes of deaths (Table 1.3). While death rates for these persistent challenges have reduced over the past two decades, dementia and Alzheimer's has emerged as a second largest cause of death (172 per 100 000) after ischaemic heart disease (186 per 100 000) by 2016. Among other major causes, which have increased since 2000, are pancreatic cancer and chronic liver disease (amounting to age-standardized rates of 21 and 19 deaths per 100 000 respectively in 2016) (European Commission, 2019). Infant and maternal mortality have improved substantially, nearly halving since 2000; however, there was an increase in infant mortality from 1.7 in 2015 to 2.0 in 2017.

TABLE 1.3 Mortality and selected health indicators

	1995	2000	2005	2010	2015	2017	EU28
Life expectancy at birth, total	76.7	77.8	79.1	80.2	81.6	81.7	80.9
Life expectancy at birth, male	72.8	74.2	75.6	76.9	78.7	78.9	78.3
Life expectancy at birth, female	80.4	81.2	82.5	83.5	84.4	84.5	83.5
Mortality, SDR per 100 000							
All causes	1 381.4	1 268.7	1 106.7	1 034.1	968.8	975.9	1 002.3
Circulatory diseases	685.2	569.9	475.8	425.2	364.1	360.2	358.3
Malignant neoplasms	267.3	250.7	234.7	230.1	218.7	219.7	259.5
Communicable diseases	10.5	10.0	8.6	8.9	4.7	4.6	15.7
External causes	97.5	88.8	87.9	77.0	60.4	61.9	46.2
Infant mortality rate (per 1 000 live births)	3.9	3.8	3.0	2.3	1.7	2.0	3.6
Maternal mortality rate per 100 000 live births (World Bank, 2019)	5	5	4	3	3		8

Note: Latest mortality by cause data is for 2016

Source: Eurostat, July 2019 (European Commission, 2019) unless noted otherwise

Disability-adjusted life years (DALYs) (i.e. number of years lived with disability) amount to 29 000 per 100 000 population in Finland in 2017,

which is the same as the EU average (Table 1.4). Cardiovascular diseases contribute to about 20% of ill-health measured in DALYs, followed by cancers (16%), musculoskeletal and neurological disorders (10% each), as well as mental health issues (7%) and injuries (6%) (IHME, 2018).

European Health Interview Survey (EHIS) data from 2014 (European Commission, 2019) show high self-reported prevalence of musculoskeletal disorders, with back and neck problems affecting about one in three people (34% vs 23% for back and 17% for neck problems in the EU on average). About 9% of people report having asthma (vs 6% EU average) and 32% report having allergies (vs 17% EU average). Finland also has higher rates of self-reported chronic depression (11% vs 7% EU average), high blood pressure (25% vs 21% EU average) and diabetes (8% vs 7% EU average).

TABLE 1.4 Disability-adjusted life years (DALYs), age-standardized rate per 100 000 population, selected years

	1995	2000	2005	2010	2015	2017	EU28
All causes	31 269	30 845	30 370	29 819	28 555	29 091	29 135
Communicable, maternal, neonatal, and nutritional diseases	1 788	1 723	1 394	1 210	1 101	1 106	1 312
Noncommunicable diseases	25 438	25 204	25 186	25 182	24 541	25 083	25 224
Injuries	4 043	3 919	3 789	3 427	2 912	2 902	2 599

Source: IHME (2018)

In the 1970s a major North Karelia project was launched in response to the very high burden of ischaemic heart disease in the region. The project, in the form of a comprehensive community-based prevention programme, mainly aimed to reduce high cholesterol and blood pressure levels, as well as smoking prevalence and improve treatment for hypertension. By the late 1970s the prevention programme was rolled out nationally, followed by substantial declines in cholesterol, blood pressure and smoking levels (Vartiainen, 2018). It was estimated that two thirds of the decline in mortality from cardiovascular diseases between 1972 and 2014 was explained by changes in risk factors, while improved treatments contributed to a third of improvement.

More recently, other national programmes, such as those on suicide prevention in 1986–1996, asthma in 1994–2004, prevention and care of diabetes

in 2000–2010, and allergy in 2008–2018, have been carried out. Despite the complexities in assessing the results of such large national initiatives, there is evidence that these have had a positive effect on both prevention and treatment. For instance, the asthma programme resulted in the development of better treatment practices and strengthened the role of primary care, which was accompanied by a substantial decrease of the burden of asthma. Although the prevalence of asthma increased, the number of hospital days due to the condition decreased by 54% in 1993–2003 (Haahtela et al., 2006). The diabetes programme (DEHKO) focused on the development of approaches to early diagnosis of type 2 diabetes as well as on improving the treatment of diabetes and its comorbidities, including cardiovascular diseases. In addition, a large-scale programme covering 1.5 million people and focusing on primary and secondary prevention was rolled out. It involved reduction in prevalence of diabetes and cardiovascular risk factors; identifying persons unaware of their diabetes; and the generation of regional and local models for diabetes prevention (Saaristo et al., 2007)

Despite the efforts described above, metabolic risk factors, such as high blood pressure, blood sugar and cholesterol levels, as well as high body mass index, are still estimated to contribute to 40% of all deaths in Finland in 2017 (IHME, 2018). Behavioural risk factors are also a large contributor (estimated at 36%). Of these behavioural factors, poor diet contributes the most (20% of all deaths), followed by smoking (10%), alcohol use (4%) and low physical activity (3%).

In Finland, about 15% of adults were daily smokers in 2016 (OECD, 2019), compared with 23% in 2000. Reduction in smoking was more noticeable in males than in females: while in 2000, prevalence of daily smoking in men was 27%, compared with 20% in females, by 2016 this difference between the sexes had almost evened out and stood at 16% in men and 15% in women. European Health Interview Survey (EHIS) data show even lower estimates for daily smoking – approximately 12% in 2014 (which is similar to Norway and Denmark, and among the EU's lowest rates), compared with approximately 18% in the EU on average (Table 1.5). In 2016 Finland introduced legislation to tackle smoking, aiming to make the country smoke-free by 2030 (MSAH, 2016b). The new law prohibits sales of flavoured and some other tobacco products, treats electronic cigarettes (e-cigarettes) in the same way as tobacco products, bans all advertising, standardizes packaging and is expanding smoke-free areas.

TABLE 1.5 Risk factors affecting health status in adults, EHIS, 2014

	FINLAND (%)	EU AVERAGE (%)
Smoking (daily smokers of cigarettes)	11.6	18.4
Alcohol (consumption every week)	36.6	29.6
Obesity (BMI >30)	17.8	15.4
Physical activity (health-enhancing aerobic exercise at least once a week)	54.6	30.8
Consumption of fruit and vegetables (5 or more a day)	12.9	14.3

Source: Eurostat (European Commission, 2019)

In terms of alcohol consumption, in 2014, 37% of EHIS survey respondents reported to consume alcohol every week, compared with 30% in the EU on average. In 2016, the alcohol consumption rate was 8.4 litres per capita, higher than in Sweden (7.2 litres) but lower than in Estonia (9.9 litres) (OECD, 2019). There has been a rise in alcohol consumption in Finland throughout most of the 2000s, peaking at 10.5 litres per adult in 2007, with a rapid fall since 2012. This corresponded to a rapid rise in deaths from chronic liver disease, which increased from 14 per 100 000 in 2000 to a peak of 23 per 100 000 in 2007, and then somewhat reduced to 19 per 100 000 in 2015 (European Commission, 2019). The sharp increase in alcohol consumption and alcohol-related deaths in the 2000s (also see Box 1.1) coincided with a marked decrease in alcohol excise duties (by 44% for spirits, 32% for beer and 10% for wine) in Finland in March 2004 (Österberg et al., 2014). In 2007–2008 a series of measures were adopted to restrict alcohol sales hours and advertising; however, increased affordability of alcohol in Finland keeps having an adverse effect on population health, as mortality rates from chronic liver disease in recent years were substantially higher than the levels seen in the 1990s. In 2018 a liberalization of alcohol sales restrictions increasing the strength of alcohol sold in regular retail stores from 4.7% to 5.5% seems to have turned the decade-long declining trend in alcohol consumption to a small rise which is expected to increase alcohol-related harm.

About one in five people in Finland reported to be obese in 2016 – almost double than in 2000. This is both among the highest rates and the fastest growth in the EU. Nevertheless, people in Finland (along with Denmark, Sweden, Norway and Austria) report the highest levels of health-enhancing physical activity, measured in aerobic exercise, taken up by more than half of

adults, compared with 31% in the EU on average (European Commission, 2019). Uptake of fruit and vegetables (5 portions or more a day) is lower in Finland than in many other EU countries (13% compared with $\geq 25\%$ in Denmark and Netherlands), and below the EU average (14%).

BOX 1.1 Assessing inequalities in health

EHS survey data show that the prevalence of many of the risk factors, such as smoking, obesity, lack of physical activity, are linked to socioeconomic status, with people with lower incomes being affected more; for example, smoking rates are 14% in the poorest income quintile compared with 7% in the richest (European Commission, 2019). Moreover, the rise in mortality driven by increased alcohol consumption in the mid-2000s was driven by marked increase in deaths in lower socioeconomic groups (Lumme et al., 2018). In terms of geographical inequalities, there are also large variations in health outcomes. People living in central and northern regions experience higher levels of morbidity than those living in the south and south-east (THL, 2017).

Prevalence of communicable diseases, such as TB and HIV, in Finland is comparatively low. There is a national vaccination programme, which currently regulates the immunization calendar for 12 conditions. In the past two decades, Finland consistently exceeded 95% immunization coverage threshold for most childhood vaccinations (WHO, 2018c). Since 2009, Finland has had a nationwide vaccination register, which allows vaccination coverage for all vaccines and age groups to be monitored in real time (Baum et al., 2017).

Given the persisting burden of chronic disease, tackling noncommunicable diseases remains one of the main current challenges as well as one of the main priorities for health care in Finland. To a large extent, noncommunicable diseases are affected by lifestyles, as consumption of alcohol is still high, despite a slow recent reduction, while the prevalence of obesity is growing rapidly. In addition, health inequalities, both socioeconomic as well as regional, continue to persist.

The HBSC survey, whose aim was to assess the health of children (Currie et al., 2004; Inchley et al., 2016), shows that 15% of boys and 11% of girls in Finland smoked at the age of 15 in 2013–2014. The average prevalence for the EU for both boys and girls is 14%. Smoking rates among children in Finland reduced substantially since 2001–2002 from 32% for girls and 28% for boys. Repeated drunkenness in 15-year olds has also reduced – from 53% for boys

and 56% for girls in 2001–2002 to 32% and 27%, respectively, in 2013–2014 (compared with the EU average of 27% for boys and 24% for girls). Prevalence of overweight (including obesity) is high – at 20% (compared with 17% on average in the EU) – and growing fast – from 13% in 2001–2002; while only one in eight boys and one in five girls reported performing at least moderate physical activity in the past week in 2013–2014.

Apart from the international sources of data on population health cited above, Finland has a large amount of national data collection initiatives, mostly run by THL. These include the National Health, Well-being and Service Survey, FinSote; the Migrant Health and Well-being Survey, FinTerveys; and the Health Examination Survey, as well as a number of registers (see section 2.6).

2

Organization and governance

■ Summary

- Finland has a health system with a highly decentralized administrative structure, multiple funding sources, and three provision channels for statutory services in first-contact care: the municipal system, the national health insurance system, and occupational health care.
- Municipalities (i.e. local authorities) are responsible for organizing and financing primary and specialized care in the public system. There is a large degree of integration with social care.
- Legislation and general policy guidelines are prepared at the national level, relying on a vast network of non-state experts, while governance measures are mainly soft and municipalities and hospital districts enjoy a large degree of freedom in the organization of services.

■ 2.1 Historical background

The 1972 Primary Health Care Act established the role of municipalities as being the basis for the national health system. The broader financing and planning framework was changed in the 1980s as part of the Valtava reform, resulting in changes in the spending of state subsidies. These reforms changed

the focus of financing and other incentives from expansion to maintenance. Further reforms in the late 1980s and early 1990s increased municipal self-governance and autonomy, giving greater powers to local governments in the allocation of resources. They resulted in more devolution and delegation, and greater variation in service provision. The deep economic crisis in the 1990s resulted in an increasing role of municipalities in the financing of health services, as the share of central Government funding declined and the share of financing by municipalities increased. This was complemented by the reintroduction of user fees in primary care in 1992, allowing local governments a means to seek further funds through service users and representing in practice a partial privatization of health financing.

■ 2.2 Organization

Finland has a health system with a highly decentralized administration, multiple funding sources, and three separate channels for delivering services in first-contact care (Fig. 2.1). Municipalities, the private sector, the national health insurance (NHI) system and employers are the main actors in the health system. The role of the state is to oversee and steer the system's functioning through legislation, decrees and the provision of information.

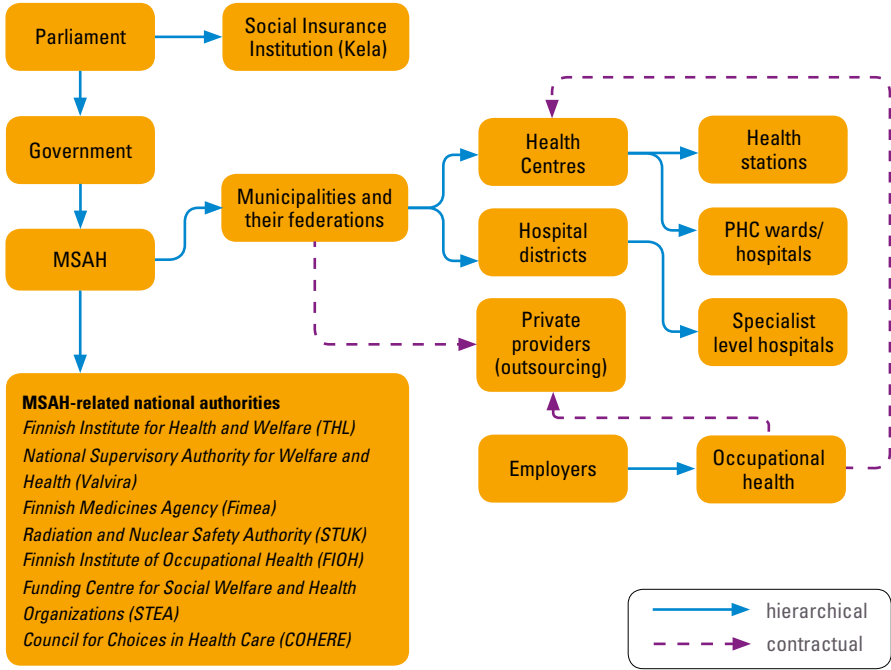
The core health system is organized by the municipalities (i.e. local authorities). Municipalities can arrange health care for their populations themselves or transfer this responsibility to another municipality or a joint municipal authority (see section 5). The organizing function includes being responsible for:

- defining and monitoring service volume and quality;
- assessing the need of the population;
- ensuring equal distribution of services;
- deciding on the method of provision (e.g. service delivered by municipality, purchased or financed by a client voucher);
- acting as public authority in decision-making, especially in social care.

Municipalities act as purchasers and are responsible for the financing of their functions, even if the service arrangement has been transferred to another municipality or a joint municipal authority. Primary care is organized

by one or several municipalities, and specialist care is organized by 20 regional federations of municipalities, called hospital districts.

FIGURE 2.1 Overview of the health system



Source: Authors' compilation

In parallel, residents can use private health services, mainly financed through out-of-pocket payments (with patients eligible for NHI reimbursement) and voluntary health insurance (see Chapter 3). In addition, employers also play a part in the organization of health services, as they are obliged to organize preventive occupational health services for their employees, while many large- or medium-sized employers also provide employees with access to outpatient medical care.

Three main acts, the Primary Health Care Act (1972), the Act on Specialized Medical Care (1991) and the Health Care Act (2010), set most of the framework for regulation and governance of health services in Finland. The 2010 Health Care Act mainly covers the service delivery aspect, while the Acts on primary and specialized care define administrative structures. Care for older people and most of the long-term care in Finland fall under

social care (see section 5.8) and are regulated by the Social Welfare Act (1982) and other legislation).

The Ministry of Social Affairs and Health (MSAH)

The Government decides on key national strategies and priorities and proposes bills for discussion by the Parliament. Health policy is primarily led by the Ministry of Social Affairs and Health (MSAH), which currently holds two ministerial posts: the Minister of Social Affairs and Health (with responsibilities for NHI, medicines, occupational health and safety) and the Minister of Family Affairs and Social Services (with responsibilities for health services, public health, health promotion, environmental health care and occupational health care). However, both ministers deal with health and social care matters. The MSAH provides the direction of social and health policy, prepares legislation and key reforms, and steers their implementation.

The MSAH was reorganized in 2018, partly in preparation for an envisaged reform of health and social care and regional government (see Chapter 6). Currently, the Ministry is divided into four departments: 1) Steering of Healthcare and Social Welfare, 2) Insurance and Social Security, 3) Well-being and Services, and 4) Work and Gender Equality. In addition, for general tasks, there are separate units for management support, administration, international affairs, and communications. The Department for Steering of Healthcare and Social Welfare is responsible for the overall steering, planning and development of health and social welfare services. It also provides guidance to the Finnish Institute for Health and Welfare (THL). The Department for Insurance and Social Security directs and steers insurance policy and is responsible for drafting social and other insurance legislation. It is also responsible for the national health insurance (NHI) scheme and hosts the Pharmaceutical Pricing Board (PPB), which approves prices and the reimbursement status of pharmaceuticals (see also sections 2.7.4 and 5.6). The Department for Well-being and Services promotes well-being, social inclusion, health and functional capacity and is responsible for the development and legislation of the health and social services system, as well as the steering of Fimea and Valvira (see below). The Department for Work and Gender Equality steers the supervision and administration of occupational safety and health, and drafts legislation and policies on occupational safety and health.

Given the scope and volume of policies, programmes, legislation and budgeting handled by the MSAH, its staff size is relatively small, amounting

to 390 employees. This is explained by the fact that the Ministry relies on the extensive use of a well-functioning system of agencies and institutions that are responsible for various issues related to social welfare and health care in Finland.

Finnish Institute for Health and Welfare (THL)

The Finnish Institute for Health and Welfare (THL) is a statutory statistical authority specializing in health and welfare. It plays an important role in the governance of the system through the provision of information. THL produces statistical and comparative information and information on best practices in the health and welfare sectors and disseminates it to decision-makers and other actors in the field. It also manages two psychiatric hospitals (mainly for forensic psychiatry), health services for prisoners, and national forensic medical services.

National Supervisory Authority for Welfare and Health (Valvira)

The National Supervisory Authority for Welfare and Health (Valvira) supervises and provides guidance to health and social service providers, alcohol administration authorities and environmental health bodies, and manages related licensing activities. It aims to protect the right of all residents to live in an environment that promotes their health and welfare and to assure access to social and health services that are both safe and adequate.

Finnish Medicines Agency (Fimea)

Fimea is the national authority under the MSAH that is responsible for regulating pharmaceuticals. It maintains and promotes the safe use of medicines, medical devices and blood products. It grants permissions for sales of pharmaceutical products and assesses the quality and other documentation related to market authorization of medical products. It also supervises the manufacture, import and distribution of medicines and disseminates information on pharmaceuticals.

Radiation and Nuclear Safety Authority (STUK)

This authority sets out the regulations for radiation and nuclear safety and ensures their implementation. It also carries out research on radiation and its effects, determines risks caused by radiation and monitors levels of radiation in the environment.

Finnish Institute of Occupational Health (FIOH)

The Finnish Institute of Occupational Health (FIOH) carries out research, offers training for occupational health and safety professionals, provides advisory services and disseminates information on occupational health.

Other ministries

Other ministries with a role in the health system include the Ministry of Economic Affairs and Employment (mainly from a commercial and business promotion perspective, aiming to increase economic efficiency in both the private and public sector) and the Ministry of Education and Culture (which is responsible for planning and subsidizing education and training of health personnel, as well as research).

Association of Finnish Local and Regional Authorities (Kuntaliitto)

This Association represents all Finnish municipalities at the national level. The Association aims to promote the opportunities for local authorities to operate for the benefit of their residents. It looks after the interests of municipalities and provides them with research, development and other expert services.

Council for Choices in Health Care (COHERE)

The establishment of the Council for Choices in Health Care (COHERE) in 2011 was driven by the EU's Patients' Rights Directive that entered into force in April 2011. This directive forced the MSAH to consider what health services are covered by the statutory health system and thus belong to the Finnish health service basket. The council is a permanent body appointed by the Government that works in conjunction with the MSAH. Its tasks include recommending which health services should be included in or excluded from the state-funded benefits basket (see section 2.7.3). It is also responsible for monitoring and assessing the range of publicly funded health services and for issuing clarifications.

Regional governments

The regional level of administration is part of the state administration. Six regional administrations promote national and regional objectives. Each region has its own Regional State Administration Agency (RSAA) with several departments, including a department for services, legal protection and licensing which is responsible among other things for guiding and supervising

both public and private health care providers and for assessing basic services in municipalities. The responsibilities of RSAA also include the handling of complaints related to health service provision, as well as supporting training and development activities in their respective regions. RSAs also include Occupational Health and Safety Inspectorates, which are responsible for ensuring healthy and safe working conditions.

Municipalities

At the local level, municipalities have the main responsibility for organizing basic services, such as primary and secondary education, as well as social and health services for their residents. Municipalities can either provide these services themselves or jointly with neighbouring municipalities. Decisions on the planning and organization of health services are taken by the health committee, the municipal council and the municipal executive board. The heads of municipal health centres are often also included in the planning and organization of health services. Recently, the traditionally separate health boards and social welfare and services boards have gradually been merged into single boards and these functions are currently integrated for nearly all municipalities in order to improve the coordination between social and health services.

Hospital districts

Hospital districts are federations of municipalities. They are managed and funded by municipalities and are responsible for organizing and providing specialist medical services for the residents of member municipalities. Each municipality must be a member of one hospital district. There are currently 20 hospital districts, with the number of member municipalities varying from 6 to 35. The role of hospital districts has been slowly changing in recent years. Increasingly, several districts have started to organize a part of primary care services or specialized social services on behalf of member municipalities. In some regions, the municipalities have transformed hospital districts into joint regional health and social care authorities (Keskimäki et al., 2018). The hospital district council, appointed for the period between municipal elections, is responsible for decision-making. It adopts the annual budget, approves financial statements and makes decisions on major investments. Each municipality has a specified number of seats, depending on the size of its population. The executive board is elected by the council and is responsible

for developing strategic goals, coordination of activities, employer duties and administrative steering. Usually members of both the council and the executive board are local politicians and the composition of representatives of political parties reflects the support received by the political parties in municipal elections. Hospital districts are further grouped into five tertiary care catchment areas around the five hospital districts which hold a university hospital. These are located in Helsinki, Tampere, Turku, Kuopio and Oulu.

Social Insurance Institution (Kela)

Kela runs the statutory NHI scheme, which financed 13.4% of the total costs of health services in 2017 (Table 3.2). Kela falls under the authority of the Parliament. NHI covers all residents in Finland and includes outpatient drug reimbursement, reimbursement of medical costs in the private sector, compensation of travel costs to health care units, sickness allowance, maternity leave allowance and compensation for some rehabilitation services. In addition, NHI reimburses part of the costs of occupational health services. NHI is funded by employers (21% in 2017), the insured (36%), the state (42%) and reimbursement from other EU/EEA countries (1%) (see section 3.3).

Employers

Employers can supplement compulsory occupational health services by voluntarily organizing additional health services, and they are free to decide the scope of these. Employers can either provide occupational health services themselves, or purchase them from other employers, municipal health centres or private providers.

Finnish Student Health Service (FSHS)

The Finnish Student Health Service (FSHS) is a foundation that provides ambulatory health care to university students. In 2021, the services will cover also students in the universities of applied sciences (polytechnics). The organization is funded by the NHI scheme (63%), the university cities (14%) and fees paid by students (23%).

Funding Centre for Social Welfare and Health Organisations (STEA)

STEA is a stand-alone state-aid authority founded in 2017. It is independent but operates in connection with the MSAH and is responsible for the distribution, monitoring, and impact evaluation of funds granted to social and

health organizations from the income of the state-owned gaming company, Veikkaus Ltd. STEA funding can be granted to non-profit organizations and foundations for activities that promote health and social welfare.

Private providers

The Private Health Care Act (152/1990) regulates the provision of private health services. Provision of private health services requires a licence granted by the RSAAs which jointly supervises these providers with Valvira. Since 2010, the private health care sector has changed considerably, partly due to a rapidly consolidating market. Altogether there are around 16 000 private firms in the health system, but three large corporations and their affiliated companies currently account for close to half of total revenue. Private providers have a large impact in many services, such as the care for older people, occupational health services, dental care and outpatient specialist services. The private sector accounts for around 5% of hospital care activity.

Private insurers

About 17% of the population is covered by voluntary health insurance (VHI) (see section 3.5). Given the rise in VHI coverage in recent years, insurers increasingly aim to provide both financing and service delivery. For instance, a cooperative OP Pohjola (a large finance organization providing banking and insurance services) established a number of hospitals, aiming to treat high-cost patients. Other insurance companies have also announced their plans to further expand the scope and scale of the health services they provide.

Other actors

Other organizations playing varying roles in the health sector include patient organizations, professional associations and trade unions, trustees of private enterprises engaged in health, and private consultancy companies.

■ 2.3 Decentralization and centralization

The Finnish health system is highly decentralized in the provision of health services, with some centralized elements (i.e. the NHI system) in health financing. Municipalities are responsible for organizing the health services for their residents and have a comparatively large autonomy in decision-making

which was strengthened in the early 1990s when the earlier centralized health and social care planning system was dismantled.

Since the early 2000s, governments have attempted to reform the health and social care system to increase the size of units that organize services and to strengthen central steering (see section 6). Due to mergers, the number of municipalities has been decreased by about a quarter to the current 311.

In addition to organizing hospital care through municipal federations (hospital districts), the municipalities are increasingly organizing health services in collaboration with each other and lately also through regional joint health and social care authorities (see section 2.2). In hospital care, the centralization of emergency services and certain medical tasks, such as deliveries and demanding surgical treatments, have obliged hospital districts to collaborate and has strengthened the mandate of the university hospital districts to plan the coordination of hospital services in the areas for which they are responsible (Haapiainen, Kaila & Salomaa 2019; Government Decrees 582/2017 and 583/2017). However, these changes have not substantially influenced the formal power of the central Government to steer the system.

■ 2.4 Planning

The MSAH has the main responsibility for national level planning of the health system. Over the years the management of the MSAH's operations has changed. In 2015 the MSAH drew up an action plan for the 4-year term of the then Government. The action plan was based on the Government programme and the MSAH strategy and has then been updated by documenting specific measures to be implemented annually. The overall governance of the system also takes place through various national level projects through which funding is allocated to strategically important development tasks. Through these projects, the MSAH has also allocated funding for implementation at the local and regional level.

At the municipal level, planning is performed by the chief physician and other senior professionals responsible for planning, human resources and financing, the municipal council, the municipal social and health committee and the executive board. In hospital districts, planning is performed by chief physicians and other senior staff, the council of the hospital district and the executive board. Citizens can participate in planning through electing

the municipal council and through municipal health committees. Local planning activities are supported by the Association of Finnish Local and Regional Authorities.

BOX 2.1 Is there sufficient capacity for policy development and implementation?

In health care, the highly decentralized and fragmented administrative structure makes the governance of the system difficult. The central Government's means for steering are based only on high-level regulation and soft guiding by recommendations and project funding aiming to develop different aspects of the services.

The municipalities are in principle responsible for organizing health and social services for their residents. However, quite often their capacity to plan and evaluate performance of services and to make decisions on alternative models to organize services is limited. In specialized care, the smaller municipalities in particular do not have sufficient power and expertise to impact the process of decision-making in their hospital district. In primary care, the fragmented, parallel provision of services through three uncoordinated channels (municipal health services, occupational care and the private sector) creates a substantial challenge for adequate planning.

A tangible example of challenges in health care governance and planning is well reflected in the stagnated resources in municipal health centres compared with increases in hospitals and occupational health care since 2000, which is in contrast to overall Government policy, which emphasizes the development of primary care services.

■ 2.5 Intersectorality

Intersectoral action (engagement with other sectors) and Health in All Policies have a long tradition in Finland. This is reflected in both explicit legal obligations and long-term institutional practices. The 1999 Primary Health Care Act enables the MSAH to establish an Intersectoral Committee for Public Health for 3 years at a time, although this is not a legal requirement (Amendment to the Primary Health Care Act in 1999). The last committee was functional until 2015, but intersectoral work continues as part of institutional cooperation on specific programmes and joint ministerial initiatives. The 1999 Primary Health

Care Act obliges the local government to take health into account as part of other policies and to be responsible for disease prevention and promotion. In addition, Finland played a major role in health promotion and support of Health in All Policies (HiAP) during its Presidency of the EU Council in 2006 and in WHO's Global Conference on Health Promotion in 2013 (Ståhl et al., 2006; Ollila et al., 2013; Melkas, 2013). However, the role of HiAP as part of Finland's national policies has changed, with the current focus being on the local level and an emphasis on both health and well-being.

Intersectoral action in Finland has been particularly strong in the field of nutrition. The National Nutrition Council was established in 1954 with an initial focus on ensuring nutritious school meals. Later, the scope of the council, based in the Ministry of Agriculture and Forestry, widened and to date it remains responsible for official guidance on nutrition. Food safety and regulation is the responsibility of the Ministry of Agriculture and Forestry, with examples of effective actions in cooperation with MSAH, including in addressing antibiotic resistance and the prohibition of the use of antimicrobials in animal production. The North Karelia project is Finland's best-known example of intersectoral action (Puska et al., 2009). It combined mass dietary interventions (in schools and workplaces) with initiatives on tobacco and alcohol control.

The Ministry of Transport and Communications has been a traditional partner in intersectoral policies, playing a key role in expanding walkways and cycling routes. The Ministry of the Environment has played a key role in air quality control with regard to wood-burning and transport pollution, joined intersectoral cooperation on housing, as well as, more recently, in promoting national parks as areas to relieve stress and improve well-being. However, the role of the MSAH has been limited in intersectoral cooperation on environmental health and sustainability issues.

There is also a tradition of formal consultation across Government on policies of relevance to other sectors. Intersectoral action and relevant parliamentary decision-making also engages with different NGOs, trade unions, local government and relevant commercial and corporate representatives, with the exception of the tobacco industry. However, involvement is dominated by a few actors, including the Finnish Business and Policy Forum, EVA, the Association of Finnish Local and Regional Authorities and the Finnish Central Union of Agricultural Producers and Forest Owners, with relatively strong influence of commercial and corporate representatives in legislative

work. Research and development institutions and NGOs have served as institutional structures in support of policy-making at the national and local level. In addition to the THL, the Finnish Institute of Occupational Health (FIOH) has been an important actor with regard to occupational health.

In terms of alcohol and tobacco control, the state has the monopoly on alcohol distribution for wine, strong beer and spirits. The alcohol tax was lowered by 33% in 2004 and since then raised five times. Current taxation in relation to ethyl alcohol is more lenient for wine than beer and more stringent towards cider and strong alcohol. In 2018 the current Government relaxed, to some extent, alcohol control policies by increasing the maximum strength of alcoholic beverages allowed to be sold in ordinary retail shops from 4.7% to 5.5% by volume, as well as by liberalizing opening hours for restaurants and bars. As a countermeasure, the Government increased excise taxes on alcohol by 10%.

In 2016, the tobacco tax was raised and new legislation was enacted, with prohibition of added flavours, the inclusion of e-cigarettes and snus under the tobacco law, the introduction of a 25-hour import restriction from countries outside the European Economic Area (EEA), and making it easier for municipalities to prohibit smoking on balconies as well as inside apartments and flats (Tobacco Act 549/2016). Earmarking part of the income from tobacco taxation to support health promotion activities by NGOs has provided a useful, although limited, addition to available resources for health promotion.

Health impact assessment has not played a major role in the implementation of intersectoral action in Finland, although it has been legally required as part of environmental impact assessments. Integrated impact assessments with a focus on regulatory measures are often required, but have been applied to health only to a limited extent (Kauppinen, 2011). In 2015, the MSAH has produced guidance for improved human impact assessments as part of integrated impact assessment work with a broader focus on assessing impact on humans, including gender, child, social, environmental health and equality.

■ 2.6 Health information systems

An eHealth and eSocial Strategy 2020 was adopted in 2015 with the goal of improving information management and expanding the volume of online

services in health and social welfare. All patient information in Finland is now in electronic format. MSAH is responsible for the legislation and strategic steering of health information systems, while THL issues regulations and guidelines on the standardization of information management.

THL also maintains and supports information systems for health care in Finland. THL's health monitoring system is based on national surveys and national administrative registers. The data are used for monitoring reports, evaluation and policy-making. Administrative national and local health registers cover a wide range of data, including information on mortality, cause of death, morbidity, service utilization, as well as on health-related benefits and reimbursements, which can be linked using an ID. All public and private providers are obligated to deliver the required data to THL or to other authorities. Overall, health information is widely used in Finland to evaluate how national health policy targets have been met in different parts of the country and in different population groups (Kilpeläinen et al., 2016).

Most comprehensive data collection systems exist in the hospital sector, i.e. HILMO, that has been in use for several decades. Since 2019, encrypted data for this register are extracted daily by THL directly from care providers' electronic information systems. Similar data collection methods have been in place for primary care and dental care services since 2011, and a separate one for social welfare services. In particular, the specialist care data are comprehensive and used for hospital efficiency and productivity analyses. Also, electronic reports with benchmarking data are available for hospital districts to use for their annual planning. THL also runs another monitoring system for hospital care performance, based on the Performance, Effectiveness and Cost of Treatment Episodes (PERFECT) project launched in 2004 (Häkkinen & Malmivaara, 2011).

Automated data collection from primary care (including dental and home care) on the use of services by region and provider also contains information on diagnoses and procedures, as well as waiting times. The data can be assessed at various frequencies; for example, daily for influenza surveillance, monthly for waiting times, or annually. THL runs provider surveys on waiting times in specialized care three times a year.

The national information system (Kanta) (see also section 4.1.4), maintained by Kela, was established in 2010 and now includes electronic prescription, the Patient Data Repository and an online platform for service users

(My Kanta; see section 2.8). Kanta allows access to clients' data at any point of service. For social welfare services, a similar archive (Kansa) was launched for public and private services in 2018, but the system is not expected to be fully operative before 2023.

In addition, a uniform performance measurement framework (KUVA) was launched in 2019. It includes multiple indicators for assessing the health and welfare needs of the population, and monitors quality, impact, costs and efficiency of services. These are the key indicators for national and regional monitoring, evaluation and guidance.

■ 2.7 Regulation

Several bodies established at the national level have some direct regulatory functions. Valvira supervises health care providers, health professionals, municipalities and hospital districts, while Fimea supervises the pharmaceutical sector (see Table 2.1). THL plays an important role in supporting planning and governance at the national and local level by collating and disseminating information, producing guidelines, as well as through carrying out research and development projects (see section 2.2).

Apart from legislation, the formal role of the central state in terms of the governance and planning of services is fairly limited and is mainly based on soft governance measures, such as providing information and recommendations.

■ 2.7.1 Regulation and governance of third-party payers

The public financing of health services comes from three main sources (see section 3.3): municipal taxation, state subsidies and the national health insurance (NHI). The state subsidizes municipalities but does not act as a purchaser. The NHI is run by Kela and is regulated by the Parliament through the Sickness Insurance Act and through the board of Kela Parliamentary Trustees. The legislation defines which services are reimbursed by the NHI. The NHI is also controlled to some extent by the Insurance Department of the MSAH. For example, the department contains the Pharmaceuticals Pricing Board (PPB) which decides on the inclusion of drugs in the drug reimbursement system (see section 5.6).

Private insurance companies, handling both statutory and voluntary insurance in Finland, are subject to licensing. The Insurance Department of MSAH regulates insurance policies and is responsible for drafting insurance legislation.

■ 2.7.2 Regulation and governance of provision

The general oversight of municipal health services is mainly carried out in response to complaints or other highly visible issues. The state-level administration (either the MSAH, Valvira or RSAAs) can intervene if it detects a violation or neglect of existing health service legislation, usually in the form of highlighting a problem, or issuing a reminder or a formal warning. An option of imposing a conditional fine or stopping the operation of the provider exists for special situations, but is rarely used in practice.

Legislation provides for municipalities to have overall responsibility for organizing care. In 2018, around one quarter of the municipalities organized primary care services themselves. However, these municipalities were on average larger and corresponded to 50% of the Finnish population. For the rest, primary care services were organized by health and social care collaboration areas, which are administratively either federations of municipalities or based on a collaboration agreement according to which one municipality organizes services on behalf of other municipalities. About one fifth of municipalities (mainly smaller ones) are participating in these collaborations (Kuntaliitto, 2018b). The scope of health services provided by municipalities is not defined in detail in the legislation (see section 2.7.3). Only a few have adopted a purchaser–provider split in their governance model (Tynkkynen et al., 2013), which changes the relationship between the municipality’s central administration and the health centre to a contractual one.

Municipal regulation of specialized care is more complex. Hospital districts are governed by member municipalities which can influence them through their representatives in the executive board and the council (see section 2.2). The main mechanism is through negotiations on volumes and costs (see section 3.4.1). Beyond this, municipal regulation of hospital districts is rather weak. This is particularly the case with small municipalities, where there is a major information and economic asymmetry between the municipality and the hospital district (Häkkinen & Lehto, 2005).

Regulation of private health care provision is stipulated in the Private Health Care Act, and is quite weak. Private health care providers must be licensed by RSAA, which monitors services to ensure they meet standards and quality criteria. Independent private practitioners and private health care providers are also monitored by Valvira through patient complaints (see section 2.4.4). Private physicians who are members of the Finnish Medical Association normally conform to its code of conduct. Municipalities and hospital districts which purchase services from the private sector regulate and control purchased services through contracts. Kela does not regulate private providers which are reimbursed by the NHI.

The quality of care is seen as a basic principle of health care provision. The Health Care Act (2010) states that health care has to be evidence-based, safe, appropriate and of good quality. The law on patient rights states that patients have the right to health care of good quality. THL has set out that the key elements in terms of quality are patient-centredness, access and accessibility, equality, freedom of choice, patient safety, high professional competence and effectiveness of care. There are no national level quality registers that would enable systematic monitoring of quality of care. However, in 2019 five quality register pilots were launched by THL. Valvira and RSAAs monitor access to care. Valvira also monitors safety of care through handling patient complaints (ex-post) and professional competence through licensing health care professionals.

The main mechanism at the national level to ensure quality of care are MSAH and THL guidelines, such as the Current Care Guidelines, produced by the Finnish Medical Society Duodecim, guidelines on health promotion (2006) and services for older people (2013). At the local and regional level all health care facilities have to draw up a plan to ensure quality and safety. The content of the plan is regulated by the 2011 MSAH Decree on quality management and patient safety in health care. The plan should include procedures for patient feedback and complaints, managerial responsibilities and leadership practices for quality and safety, staff development and safety training, procedures to identify risks, etc. In addition, there is a web-based service for voluntary reporting of patient safety incidents, HaiPro, developed with funding from the MSAH, Fimea and the Technical Research Centre; it is currently used by approximately 200 health and social care providers of various sizes.

TABLE 2.1 Overview of provider regulation

LEGISLATION		PLANNING	LICENSING/ ACCREDITATION	PRICING/ TARIFF SETTING	QUALITY ASSURANCE	PURCHASING/ FINANCING
Public health services	Health Care Act, Public Health Act, Act on Infectious Diseases	Municipalities MSAH	Valvira RSAA	Municipalities	Municipalities RSAA	Municipalities
Ambulatory care (primary and secondary care)	Public Health Act, Act on Specialized Medical Care, Health Care Act	Municipalities Hospital districts MSAH	Valvira RSAA	Municipalities Hospital districts Private providers Kela	Municipalities Hospital districts Valvira	Municipalities
Inpatient care	Public Health Act, Act on Specialized Medical Care, Health Care Act	Municipalities Hospital districts MSAH	Valvira RSAA	Municipalities Hospital districts	Municipalities Hospital districts Valvira	Municipalities
Dental care	Public Health Act, Act on Specialized Medical Care, Health Care Act	Municipalities MSAH	Valvira RSAA	Municipalities Hospital districts Private providers Kela	Municipalities Valvira	Municipalities
Pharmaceuticals (ambulatory)	Medicines Act, Health Insurance Act	Fimea	Fimea	Fimea	Fimea	Kela
Long-term care	Health Care Act, Social Welfare Act, Act on Supporting the Functional Capacity of the Older Population and on Social and Health Services for Older Persons, Act on Disability Care	Municipalities MSAH	Valvira RSAA	Municipalities Private providers	Municipalities Valvira RSAA	Municipalities
University education of personnel	Law on Healthcare Personnel	MOEC, MSAH Universities	Valvira	Valvira	Valvira	State

■ 2.7.3 Regulation of services and goods

Basic benefit package

The Constitution requires the state to guarantee adequate health services for everyone. This provision ultimately sets the limits within which the service range can be defined. Under the 2010 Health Care Act, health services comprise disease prevention, diagnostic procedures, treatment and rehabilitation. There is no comprehensive list of publicly funded health services. Existing services are needs-based, with a health professional assessing a patient's need.

COHERE (see section 2.2) can further decide whether a service should be publicly funded, based on significance of the health problem and medically justified need of treatment, effectiveness and safety of the intervention, and ethical considerations. In addition, the introduction of new technologies is assessed from the perspective of the overall financial capacity of the health system and in view of the health benefits to be gained at population level.

Health technology assessment (HTA)

The Finnish Office for Health Technology Assessment (FinOHTA) was established in 1995 and was responsible for Health Technology Assessment (HTA) activities until 2016 when it was dismantled due to the budget cuts of its host organization, THL. In 2018, in line with an MSAH Decree, the Northern Ostrobothnia Hospital District, which runs Oulu University Hospital, launched the Finnish Coordinating Centre for Health Technology Assessment (FinCCHTA). The unit coordinates HTA in Finland and cooperates with international HTA bodies, such as the European Network for Health Technology Assessment (EUnetHTA). Other key objectives are to develop HTA methodological training and strengthen related research. FinCCHTA also coordinates the national HTA network which involves HTA medical officers operating in university hospitals and other hospital districts.

■ 2.7.4 Regulation and governance of pharmaceuticals

Fimea (see section 2.2) is responsible for the regulation of pharmaceuticals. It grants market authorizations, classifies drugs and decides whether they can be sold over-the-counter (OTC), monitors the quality of medicines, supervises

wholesalers and pharmacies, and oversees the advertising of pharmaceuticals. Fimea maintains a register of adverse reactions to medicines.

Regulation of pharmacies is fairly stringent. Fimea decides on the number of pharmacies in municipalities and issues a license to pharmacists to run them. When a new pharmacy owner is needed, Fimea issues a public notice. Community pharmacies are privately owned by pharmacists, but they cannot be owned by companies (with the exception of the University of Helsinki and the University of Eastern Finland, which have special rights to own pharmacies). One pharmacist can own only one pharmacy (and possibly some subsidiary pharmacies). Pharmacists are required to hold a Master of Science degree in pharmacy and to be a citizen of the EU.

Pharmacies must pay a pharmacy fee collected for the state by the Tax Administration. The fee is progressive. In 2017, it amounted on average to about 6.6% of the annual turnover of pharmaceutical sales ranging from 0% to over 10%. The purpose of the pharmacy fee is to decrease existing differences in income across pharmacies. Pharmaceutical pricing is uniform, with wholesale prices of a drug being the same for all pharmacies. Companies can change the wholesale price every 2 weeks. The Government decides on the formula by which the retail price is calculated from the wholesale price. In addition, there is a 10% value added tax (VAT) for pharmaceuticals. On average, of the price of a medicine, 60% comes from the wholesale price, 24% from the pharmacy margin, and 16% from VAT and the pharmacy fee. Because of regulation, there is no price competition between pharmacies.

Municipalities and hospital districts have their own hospital pharmacies and medicine dispensaries, with 24 pharmacies and 37 medicine dispensaries in 2019. They can issue medicines only to their own wards and departments. Medicines are tendered according to the public procurement legislation. Hospital pharmacies and medicine dispensaries dispense medicines with their own margins to customers (wards, departments, clinics). They are not allowed to sell medicines to patients or members of the public. Only on special occasions may a patient who has been discharged be issued with medicines from the hospital to ensure the continuation of the medication. Inpatient pharmaceuticals are covered by hospital budgets and are provided to patients free of charge.

Outpatient drugs are reimbursed by NHI. The vast majority of drugs are reimbursed, but some of them are not, mainly due to their high prices or lack of efficacy.

The Pharmaceutical Pricing Board (PPB), made up of seven representatives from different state agencies, decides whether a medicine is reimbursed (positive list) and sets a maximum wholesale price for each pharmaceutical substance. The price is based on the cost of the medicine and how this compares to its benefits, as well as how it compares to the costs and benefits of its therapeutic alternatives. In addition, the proposed price is compared with prices in other EU countries. There are no restrictions on pricing of other drugs with a marketing licence.

Decision-making in PPB is based on applications from pharmaceutical companies. They have to apply to PPB for a reimbursement at a specific level (basic or special, limited basic or limited special categories, see section 3.3 and 3.4) and a maximum wholesale price, and propose a reasonable wholesale price for the drug. Applications for a new pharmaceutical substance require a pharmacoeconomic evaluation. Before applying for special reimbursement, the drug must already be in a basic reimbursement category. Medicines reimbursed at 65% level must be essential and used for treatment of severe and long-term conditions. Drugs in the 100% reimbursement category must have a corrective or supplementary effect, in addition to being essential. In order to obtain a limited basic or limited special reimbursement, patients have to comply with certain criteria which are decided by Kela. This means that one medicine can have different reimbursement levels for different patients. Reimbursement is granted for a maximum of 5 years before needing a renewal, and is paid directly to pharmacies.

A clawback system was introduced in Finland in 2017 as a pilot, but its effect is not yet clear. Within this system, the state can for example receive compensation if sales of pharmaceuticals exceed a defined level or new data on effectiveness emerge. A pharmaceutical company has to apply for this when applying for reimbursement from PPB and a special agreement will be made between the company and PPB if negotiations are successful.

There is no obligation to prescribe generic substances in Finland, but this is encouraged by generic substitution. After introduction of voluntary generic substitution in the early 1990s without much success, compulsory generic substitution was introduced in Finland in 2003. According to the Medicines Act, pharmacies are obliged to substitute a prescribed medicine that costs more than a maximum price limit with a product containing the same substance but costing less than that limit. PPB reviews the price limits for generic substitution every 3 months and calculates the maximum

price by adding €0.50 to the price of the cheapest alternative in Finland at that moment. Fimea defines the list of substitutable medicinal substances, which contains most reimbursable drugs, but excludes some, e.g. insulin and antiepileptic medicines. In addition, physicians are obliged to take account of cost-efficiency when prescribing drugs and to prescribe a long-lasting medication from a small package size.

Prescribing physicians may decline generic substitution for medical or therapeutic reasons. In this case “no substitution” is marked on the prescription. Patients can decline substitution but are then reimbursed by NHI according to the price limit (€0.50 plus cheapest alternative) if the drug is more expensive than the price limit. If the drug costs less than this price limit, reimbursement is calculated from the actual costs of the prescription. Physicians rarely decline substitution (1.2% of possible substitutions) and patients refuse only 4.4% of the potentially substitutable prescriptions (Fimea, 2015).

Outpatient pharmaceuticals can be sold to patients only through pharmacies (including OTC drugs), with nicotine replacement products being the only exception that can be sold in retail. Direct-to-consumer advertising of prescription drugs is not allowed. However, disease-oriented advertisements without specifying drugs are permitted. On the Internet, only text containing patient information can be presented. Direct-to-consumer advertising of OTC drugs is permitted, but regulated. Fimea and the Pharmaceutical Industry Finland (a national industry association) enforce regulations concerning drug promotion to the public and health professionals.

■ 2.8 Patient empowerment

■ 2.8.1 Patient information

Increased need for transparency and access to reliable up-to-date patient information, as well as changes in health care legislation related to freedom of choice, among other aspects (e.g. Healthcare Voucher Act, 569/2009 and Health Care Act, 1326/2010), led to a number of initiatives to improve the provision of information to the public and patients. The state-level administration hosts an online portal called Suomi.fi (transl. Finland.fi) that contains

e-services and forms, legislation, information packages and links, as well as news from the public administration.

The Contact Point for Cross-border Health Care hosted by Kela runs an online service that provides information on cross-border health care and freedom of choice in the Finnish health system. Information covers patients' rights and options when seeking health care in Finland and other countries, as well as costs of treatment and available reimbursements. The service also provides country-specific information about health services in some other countries.

Finnish municipalities and hospital districts maintain websites where patients can find general information about their health services, voucher schemes and treatment options, as well as user fees. The mechanisms guiding patients around the health system are mainly local and depend on the efforts of municipalities to establish such services. Typically, municipalities have at least a case management service for patients with multiple needs (e.g. older people). Private providers have their own websites containing information on their services.

All in all, the information systems for patients are underdeveloped in terms of their ability to monitor quality and performance, and they are scattered across different operators.

There are many online sources that provide general health information in Finnish. In 2006, the Finnish Medical Society, Duodecim, built an Internet portal Terveyskirjasto (transl. Health library), containing thousands of articles concerning diseases and treatments. Additionally, many patient organizations provide information through their websites and printed materials.

All official documents are provided in both Finnish and Swedish. In larger cities information on services is often also available in English and other languages. For instance, the website of Helsinki municipality provides information in English, Estonian, French, Russian, Somali, Turkish, Spanish and Arabic.

Kanta is the national online platform for health care providers and citizens (see section 2.6). Patients can access their clinical and prescription record through My Kanta pages and determine the extent to which it is available to health professionals. The My Kanta personal health record system also allows patients to state their organ donation wishes, and issue certificates to authorities.

TABLE 2.2 Patient information

TYPE OF INFORMATION	IS IT EASILY AVAILABLE?
Information about statutory benefits	Yes
Information on hospital clinical outcomes	No
Information on hospital waiting times	Yes
Comparative information about the quality of other providers (e.g. GPs)	No
Patient access to own medical record	Yes
Interactive web or 24/7 telephone information	No
Information on patient satisfaction collected (systematically or occasionally)	Yes
Information on medical errors	No

■ 2.8.2 Patient choice

In theory, health care users in Finland have the option of choosing between three health systems: municipal health care, private health care and occupational health care (see section 2.2). However, user fees can be a barrier to accessing private care, while occupational health care is available to employed people only. Furthermore, the extent of occupational care is determined by the employer. Therefore, in practice, the municipal health system may be the only option, particularly for people on low incomes or without employment.

Until 2011, patients had very limited choice of providers or physicians in the municipal health care system. The 2010 Health Care Act, however, introduced the right to choose a health centre within the municipality once a year. Since 2014, the freedom of choice in both primary and hospital care was extended to the whole country. Choice only covers the provider but it is recommended, if feasible, to allow patients to also choose their doctor. Under the NHI, patients can choose any private provider without referral, but patients are only subsidized a small fraction of the costs. In occupational health care, the provider is chosen by the employer and care is free of charge at the point of use. In terms of private health insurance, patients can often choose the provider of outpatient care, but for costly treatments and hospitalizations, the provider is usually chosen by the insurer. Key aspects of patient choice are summarized in Table 2.3.

A primary care patient survey on patient choice carried out in large cities in 2014 found that in municipal health care services, about 8% of health

centre patients had switched health centres at some point, but there were large variations across municipalities (Sinervo et al., 2016). It also found that service users considered patient choice, particularly their ability to select health professionals, to be important. In addition, the location of services was the most important factor for choosing providers, followed closely by quality, access to services, good transport connections and the reputation of the health centre. Older people were less aware of the possibility of changing a health centre and of the quality of services. Overall, information on the quality of care and availability of services was perceived to be insufficient.

TABLE 2.3 Patient choice

TYPE OF CHOICE	IS IT AVAILABLE?	COMMENTS
Choices around coverage		
Choice of being covered or not	No	Everyone is covered with NHI and via residence in a municipality
Choice of public or private coverage	No (M, O) Yes (P)	Everyone is publicly covered but can choose to top-up or use only private services funded by VHI
Choice of purchasing organization	No (M, O) Yes (P)	The purchaser is determined by the place of residence or employment. A person can choose a private insurer
Choice of provider		
Choice of primary care provider	Yes (M, P) No (O)	In occupational health care the choice is limited to the contracted provider
Direct access to specialists	No (M, O) Yes (P)	In occupational health care access to specialists is by referral from staff physician
Choice of hospital	Yes (M, P)	
Choice to have treatment abroad	Yes	
Choice of treatment		
Participation in treatment decisions	Yes	
Right to informed consent	Yes	
Right to request a second opinion	Yes	
Right to information about alternative treatment options	Yes	

Notes: M: municipal care; O: occupational care; P: private care

■ 2.8.3 Patient rights

The Act on the Status and Rights of Patients (785/1992) came into effect in 1993 and was the first such law in Europe. It applies to every part of the

health system and also covered health services provided in social welfare institutions. The Act mainly concerns the patients' right to information, informed consent to treatment, the right to see any relevant medical documents, the right to complain and the right to autonomy. It also introduced a patients' ombudsman system in health care institutions. Other legislation, including the Health Insurance Act (1963), the Primary Health Care Act (1972), the Consumer Protection Act (1978), the Occupational Health Care Act (1978), the Patient Injuries Act (1986), the Act on Specialized Medical Care (1989), the Waiting-time Guarantee (2004), the Act on Health and Social Service Vouchers (2004), and the Health Care Act (2010), is also relevant. Key aspects of patient rights are summarized in Table 2.4.

TABLE 2.4 Patient rights

	YES/NO
Protection of patient rights	
Does a formal definition of patient rights exist at national level?	Yes
Are patient rights included in specific legislation or in more than one law?	Yes
Does the legislation conform with WHO's patient rights framework?	Yes
Patient complaints avenues	
Are hospitals required to have a designated desk responsible for collecting and resolving patient complaints?	Yes
Is a health-specific ombudsman responsible for investigating and resolving patient complaints about health services?	Yes
Other complaint avenues?	Yes
Liability/compensation	
Is liability insurance required for physicians and/or other medical professionals?	Yes
Can legal redress be sought through the courts in the case of medical error?	Yes
Is there a basis for no-fault compensation?	Yes
If a tort system exists, can patients obtain damage awards for economic and non-economic losses?	Yes
Can class action suits be taken against health care providers, pharmaceutical companies etc.?	No

There are several mechanisms in place for patients to complain about health services. Patients or their next of kin who are dissatisfied with the care provided are entitled to submit an objection to the Health Care Director of the unit in question or the RSAA. Most serious cases (e.g. severe injury or death) are handled by Valvira (around 300–400 annually) and may result in administrative supervision, precautionary measures, or disciplinary actions.

Patients can also appeal to administrative courts if they are not satisfied with public sector health care services.

Every health care unit must name a patients' ombudsman whose duty it is to inform patients of their rights, advise them on standards of care and act in the patients' interests. Ombudsmen assist in resolving issues with the health care unit, give advice and assist patients in submitting an objection, appeal, or notification of patient injury to the Patient Insurance Centre. In addition, there is also a parliamentary ombudsman who handles complaints about public authorities, including health services.

According to the 1987 Patient's Injury Act (585/1986), patients have the right to compensation for unforeseeable injuries resulting from treatment or diagnosis; the Act requires all health care providers to have liability insurance. Applications for compensation are handled by the Finnish Patient Insurance Centre. In 2017, the Centre received 8 655 applications. In the same year, 27% of decided cases led to compensations and the Centre paid compensations totalling €40.9 million. The most common treatments leading to compensations were hip and knee endoprosthesis, and spinal orthopaedic operations.

■ 2.8.4 Patients and cross-border health care

Collaboration in cross-border health care has a long tradition between Nordic countries, based on multilateral agreements on reciprocal rights to use health services. In the north of Finland and for the Åland Islands, patients can be referred to health services in neighbouring Sweden and Norway. Finland has also social security agreements providing rights to use health services in Australia and Quebec, Canada.

The Finnish Government has also transposed the EU Patients' Right Directive (2011), although it has opted for a dual reimbursement model. When someone who is covered by health insurance in Finland is staying temporarily in another EU/EEA country or in Switzerland and falls suddenly ill or needs treatment due to pregnancy or childbirth, they are entitled to a reimbursement for the cost of care which corresponds to the cost sharing of health services provided by their municipality in Finland. However, if the person travels deliberately to another EU/EEA country in order to use health services, they are entitled to a much lower reimbursement, corresponding to NHI rates for the costs of private services in Finland (around 15% in 2017)

(Act on Cross-border Health Care 1201/2013). The EU Commission has considered Finland's reimbursement model to violate the Patients' Right Directive and started infringement procedures (Heinonen et al., 2019).

For health care costs in countries other than EU/EEA countries and Switzerland, Finland is also using a dual reimbursement model in cases in which there is no bilateral social security agreement. According to the Health Insurance Act (1224/2004), the persons falling ill suddenly or in need of treatment for pregnancy or childbirth are entitled to NHI reimbursement, but not those who travel to a country for the purpose of obtaining treatment.

However, in quantitative terms, cross-border health care is relatively insignificant in Finland. In 2017 Kela made decisions on 20082 reimbursement applications for the cost of medical treatment received abroad by persons insured in Finland. Of these, 82% led to actual reimbursement. Most applications (41%) concerned treatment received in Estonia, with a high proportion of dental services (32%). With regard to persons insured in other countries, in 2017 Kela decided on 17 323 state reimbursements to public health care providers (Kela, 2018d).

3

Financing

■ Summary

- Finland spends less on health than many other Nordic and EU countries, and spending as a percentage of GDP has decreased in recent years. The share of public expenditure has also decreased, and out-of-pocket payments comprise one fifth of current expenditure on health. While a large part of health financing (that coming from income tax) is progressive, an increasing share of out-of-pocket payments results in an increase in regressivity.
- The four largest areas of spending are outpatient care (33%), inpatient care (25%), long-term care (19%) and pharmaceuticals (12%). Outpatient care, pharmaceuticals and long-term care also account for about three quarters of all out-of-pocket payments.
- Financing arrangements of the Finnish health system are very fragmented, with municipalities, NHI, employers and households all contributing substantial shares. Together, they finance municipal, private and occupational health services. As a result, coverage in Finland is also fragmented. While all residents are covered by municipal health care, availability of services, particularly in terms of primary care, varies across municipalities. In addition, employees are covered by occupational health care, the scope of which also varies.
- Extensive user fees exist across all service areas, with occupational health care being the only exception. Mechanisms for financial

protection are limited: high caps on user fees, certain exemptions for children and treatment of specific diseases, and an option to apply for income assistance.

■ 3.1 Health expenditure

Between 2000 and 2017 health expenditure per person in Finland (when measured in PPP) more than doubled, from US\$ 1 806 to US\$ 4 128 (Table 3.1). As a percentage of GDP, current health expenditure (CHE) in Finland was the ninth highest among EU countries in 2016 (Fig. 3.1). Finland's health expenditure has grown from 6.8% in 2000 to 9.2% in 2017, and is below that of comparable countries, including the Nordic region, the United Kingdom and the Netherlands (Figs. 3.2 and 3.3).

Public expenditure on health as a share of GDP has increased from 4.9% in 2000 to 6.9% in 2017. About three quarters of health expenditure comes from public sources (Fig. 3.4). About four-fifth of private expenditure comes from out-of-pocket payments, while private health insurance constitutes less than a fifth of private spending (Table 3.1). Public expenditure on health as a share of general government expenditure remained relatively stable around 13%, which is substantially below other Nordic countries (Fig. 3.5).

Table 3.2 shows the latest available breakdown of health expenditure by function from 2017. In Finland, the dominant functions for public expenditure are outpatient care (24%), inpatient care (23%) and long-term care (16%). In addition, about a third of outpatient care (9%) is financed from private sources. Just under half of pharmaceutical expenditure is privately financed (5.6%), consisting almost entirely of out-of-pocket payments. Between 2005 and 2017, the share of health expenditure spent on outpatient pharmaceuticals and other medical non-durables dropped from 16.1% to 12.3%.

Over a half of public expenditure on health comes from municipalities. Since the mid-2000s the share of the municipalities in Government and overall health expenditure has remained relatively stable and has varied between 34% and 37% of CHE. As in most municipalities social and health care is administratively integrated, it is not possible to get detailed expenditure figures for health at the municipal level. Overall for health and social services in 2017, the municipalities spent on average €3 227 per inhabitant,

of which €1 221 (38%) was used for specialized care, €590 (18%) for primary care, and €621 (19%) for older people and home care (SVT, 2017). However, there are substantial variations between municipalities in health expenditure due to the population and service structure. In 2017, municipal spending on health, older people and home care varied from €1806 to €4744. The total NHI expenditure on health care was €2.8 billion in 2017, amounting to 13% of current health expenditure (Table 3.2). Half of this expenditure (€1.4 billion) was reimbursements for purchasing medicines, with the remaining share being reimbursements for the use of private health care (mostly, by three quarters, rehabilitation), and refunds for employers for organizing occupational health services.

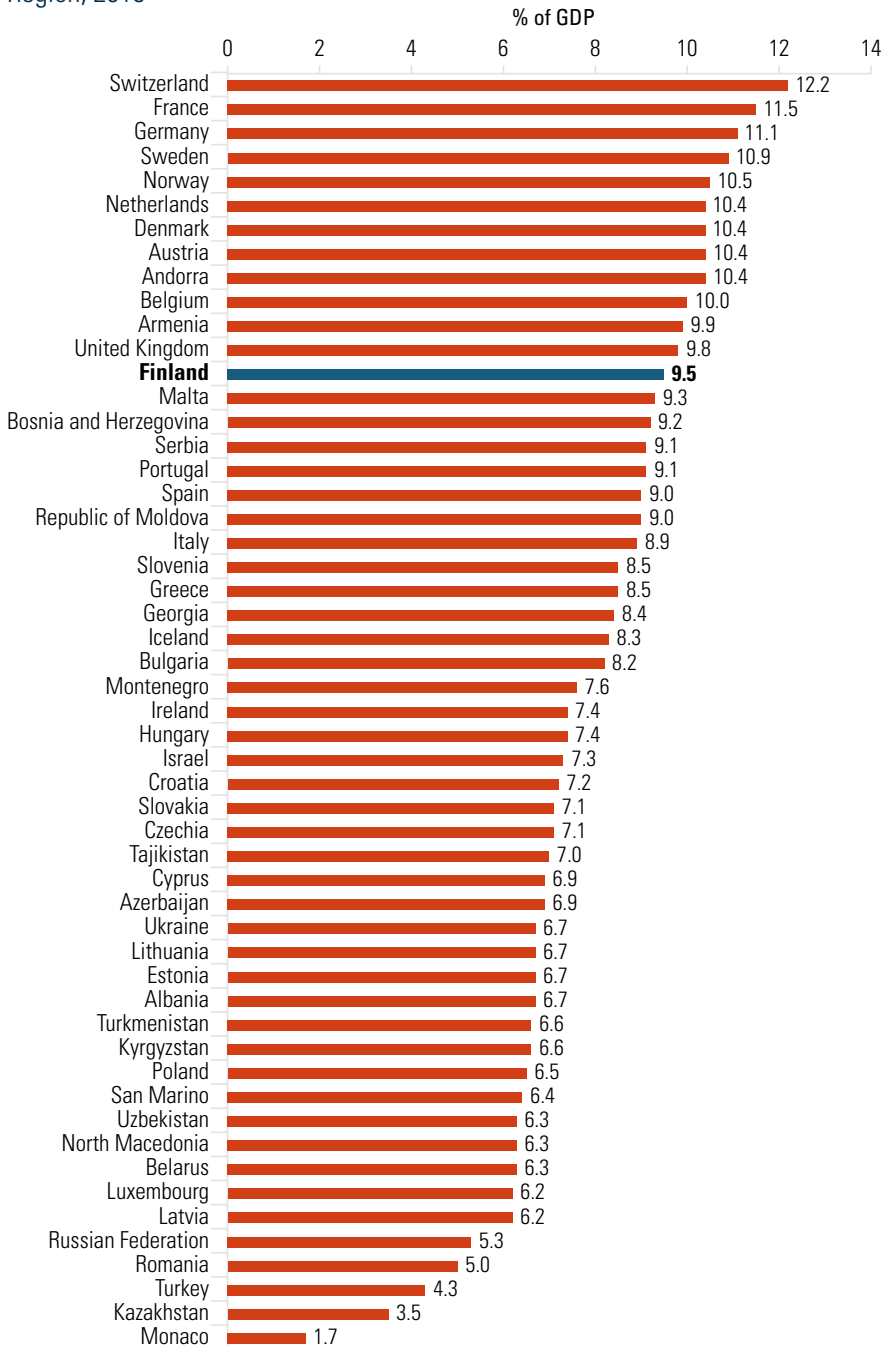
TABLE 3.1 Trends in health expenditure in country, 2000 to latest available year

	2000	2005	2010	2011	2012	2013	2014	2015	2016	2017
Current Health Expenditure (per capita in PPP US\$)	1 806	2 479	3 305	3 471	3 647	3 789	3 808	3 991	4 025	4 128
Current Health Expenditure (as % of GDP)	6.8	8.0	8.9	8.9	9.3	9.5	9.5	9.7	9.4	9.2
Public expenditure on health (as % of CHE)	71.5	75.8	74.5	75.0	75.5	75.4	75.1	76.1	75.0	75.2
Private expenditure on health (as % of CHE)	28.5	24.2	25.5	25.0	24.5	24.6	24.9	23.9	25.0	24.8
General government expenditure on health (GGE-H; as % of GGE)	10.5	12.7	12.5	12.8	13.0	12.9	12.7	13.3	13.1	–
Public expenditure on health (as % of GDP)	4.9	6.1	6.6	6.7	7.0	7.2	7.1	7.4	7.1	6.9
Out-of-pocket payments (as % of CHE)	23.2	19.0	20.0	19.4	18.7	19.0	19.0	19.8	20.5	20.2
Out-of-pocket payments (as % of private spending)	81.4	78.5	78.4	77.6	76.3	77.2	76.3	82.8	82.0	81.5
Private insurance (as % of private spending)	18.6	21.5	21.6	22.4	23.7	22.8	23.7	17.2	18.0	18.5

Note: Break in series from 2015

Source: OECD health statistics, July 2019

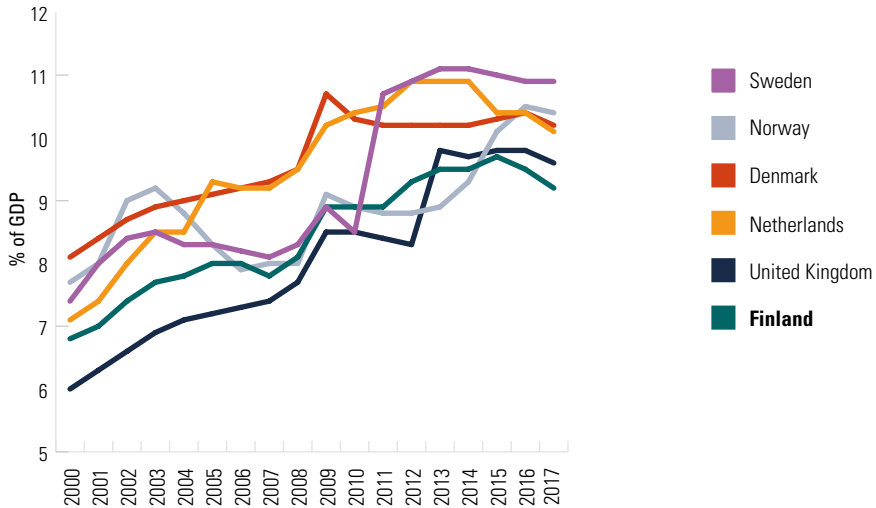
FIGURE 3.1 Current health expenditure as a share (%) of GDP in the WHO European Region, 2016



Note: WHO GHED latest available data are from 2016 and series may slightly differ from OECD statistics shown in Tables 3.1 and 3.2

Source: WHO (2018a)

FIGURE 3.2 Trends in health expenditure as a share (%) of GDP in country and selected countries, 2000 to latest available year



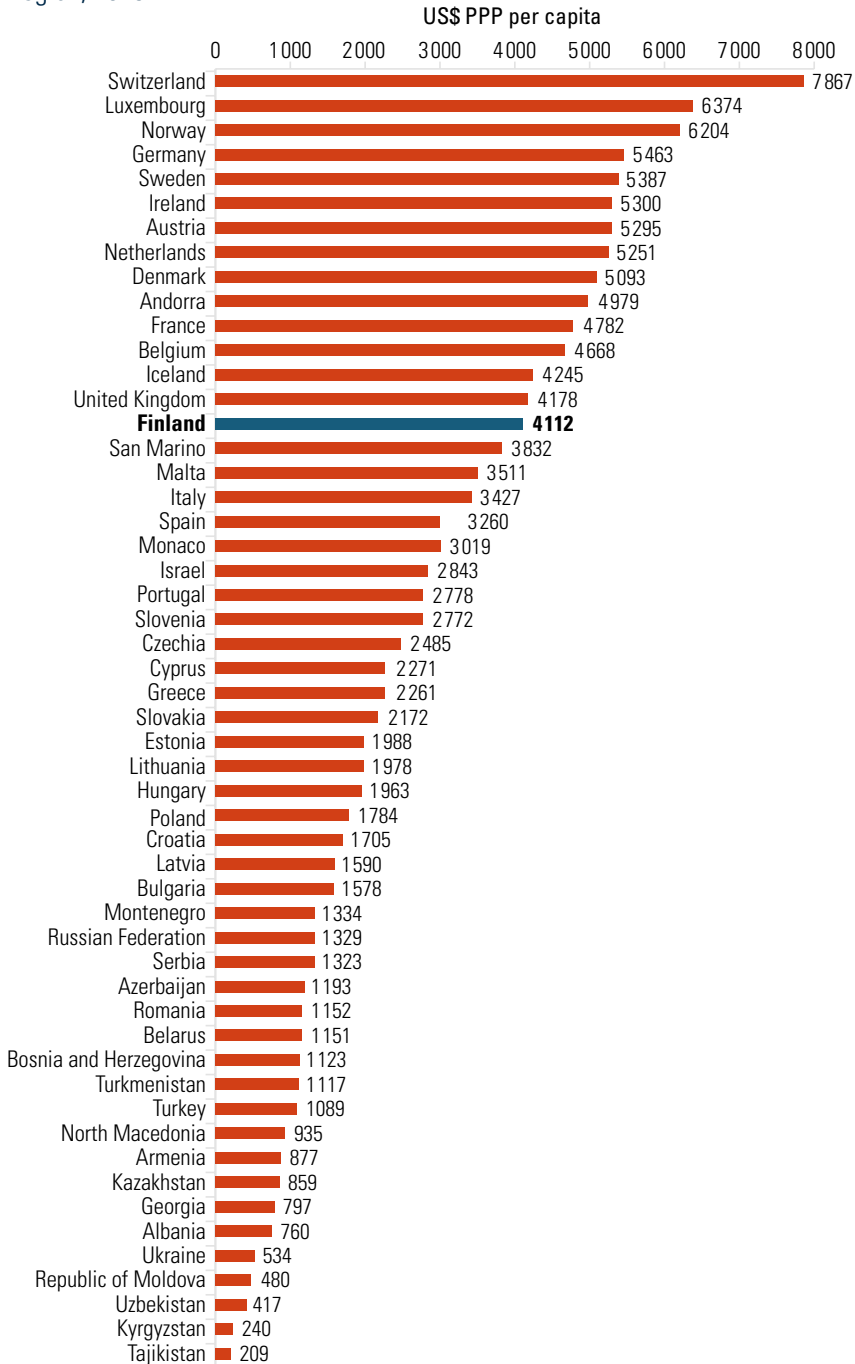
Note: Break in series for Finland from 2015
Source: OECD health statistics, July 2019

TABLE 3.2 Expenditure for selected health care functions by health care financing schemes, 2017 (% of CHE)

	INPATIENT CARE (INCL. DAY CARE)	OUTPATIENT CARE	LONG-TERM CARE	PHARMA-CEUTICALS AND MEDICAL GOODS	PREVENTIVE CARE	HEALTH SYSTEM ADMIN	OTHER SERVICES	CURRENT HEALTH CARE EXPENDITURE (CHE)
Public expenditure	22.6	24.3	15.8	6.7	2.5	0.7	2.6	75.2
General government	20.9	22.1	15.8	0	1.7	0.1	1.1	61.7
Social health insurance	1.6	2.2	0	6.7	0.8	0.6	1.5	13.4
Private expenditure	2.2	8.7	3.2	5.6	1.4	0.2	3.6	24.9
Private out-of-pocket	1.3	6.6	3.2	5.5	0	0	3.6	20.2
Private insurance	0.9	2.1	0	0.1	1.4	0.2	0	4.7
All financing schemes	24.7	33.0	19.0	12.3	3.9	0.9	6.2	100.0

Source: OECD health statistics, July 2019

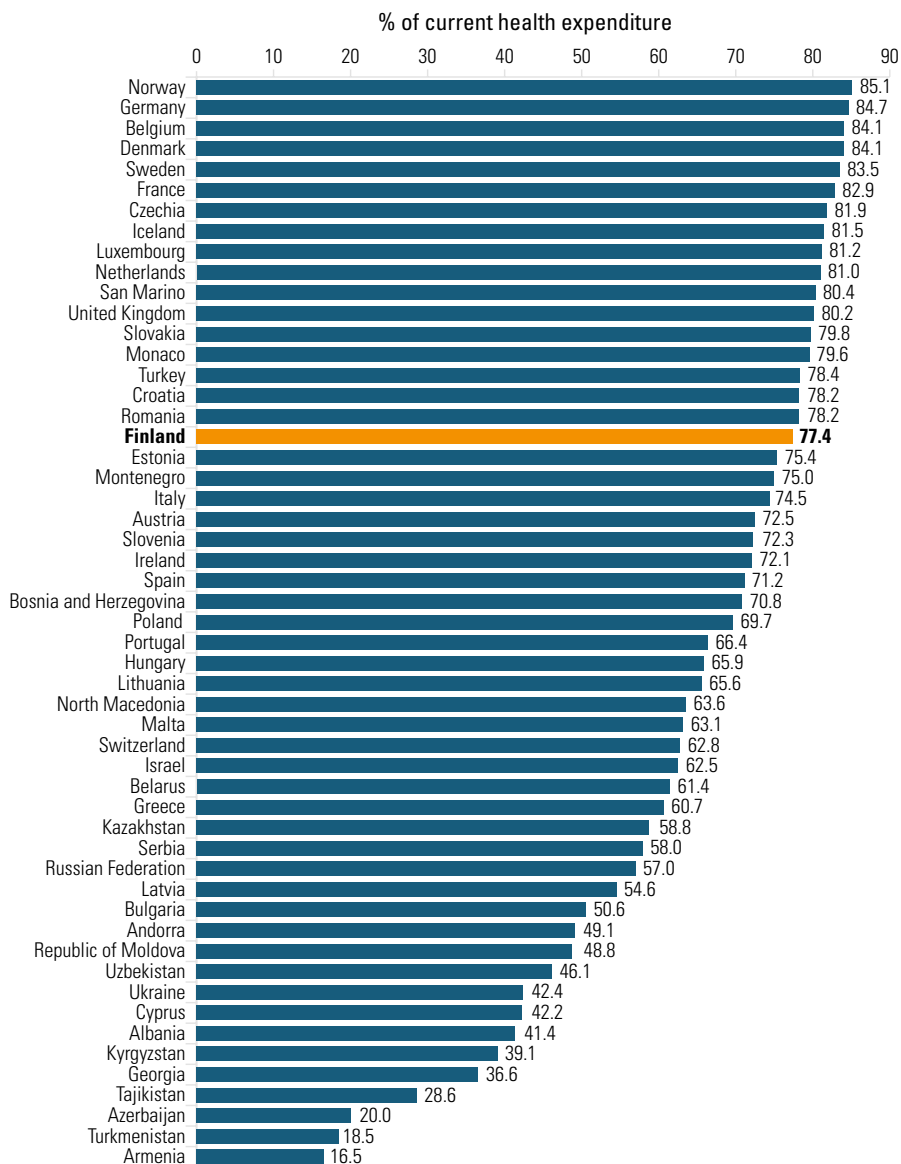
FIGURE 3.3 Current health expenditure in US\$ PPP per capita in the WHO European Region, 2016



Note: WHO GHED latest available data are from 2016 and series may slightly differ from OECD statistics shown in Tables 3.1 and 3.2

Source: WHO (2018a)

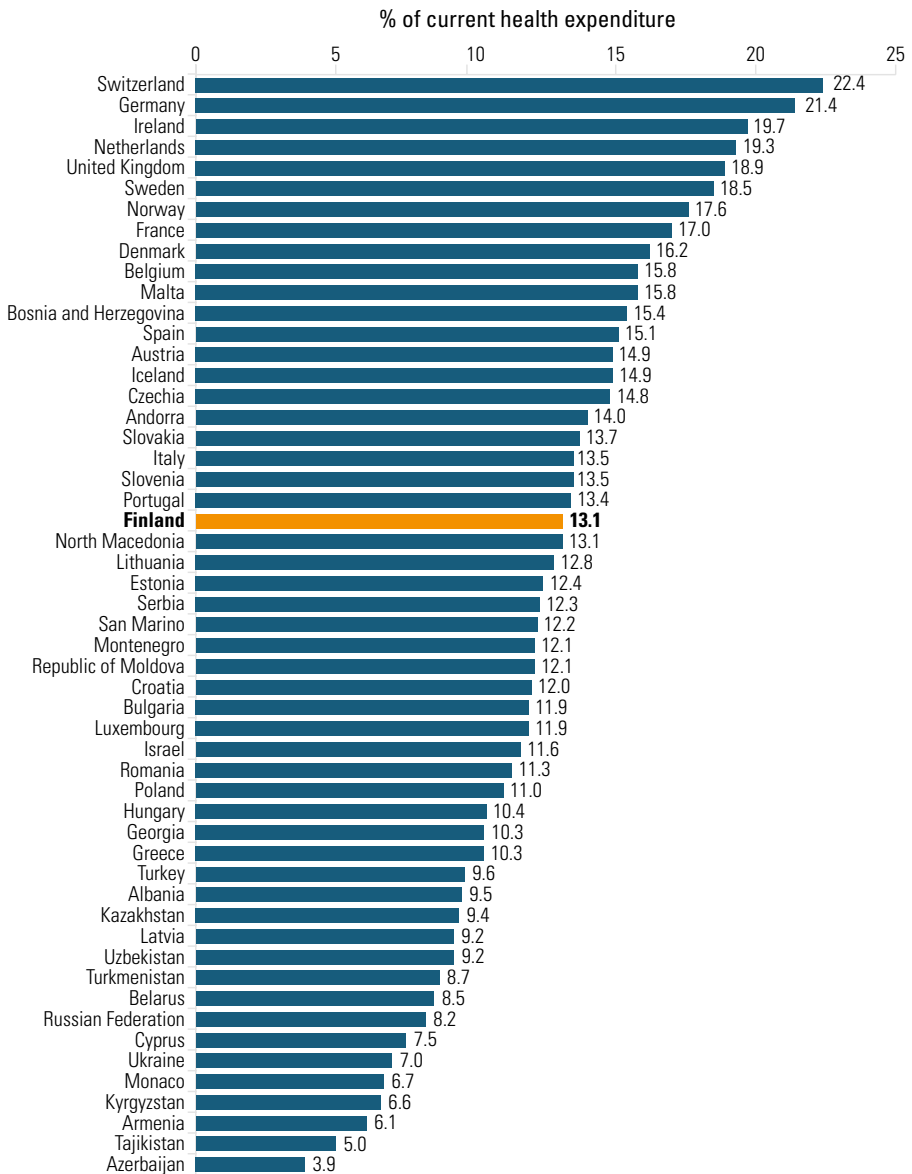
FIGURE 3.4 Public sector health expenditure as a share (%) of current health expenditure in the WHO European Region, 2016



Note: WHO GHED latest available data are from 2016 and series may slightly differ from OECD statistics shown in Tables 3.1 and 3.2

Source: WHO (2018a)

FIGURE 3.5 Public expenditure on health as a share (%) of general government expenditure in WHO European Region, 2016



■ 3.2 Sources of revenue and financial flows

Figure 3.6 shows the financial flows in the Finnish health system. In 2016, municipalities financed 35.6% of total health expenditure, with a further 26.4% being financed by the state, 12.6% by social health insurance (SHI) and 25.4% by private sources of which 20.4% came from the households as out-of-pocket payments, 2% from VHI and 2.2% from employers. The rest of less than 1% came from various sickness relief organizations (THL, 2018b). There is a minor change of balance within public financing from SHI to the state but otherwise these shares have remained fairly stable over the last decade.

Public financing comes mainly from state and municipal taxes. As municipalities play a key role in financing health services, they are subsidized by the state. There is a large variation in state subsidies as well as municipalities' spending on health care. The statutory health insurance scheme reimburses occupational health care, outpatient drugs and part of the cost of private health care and is funded by the state and employees through income-based insurance fees collected alongside income tax. Employers only contribute to the income insurance part of health insurance which is used for financing occupational health services. Out-of-pocket payments amount to a fifth of the current expenditure on health (Table 3.2) while about 5% is financed from private insurance.

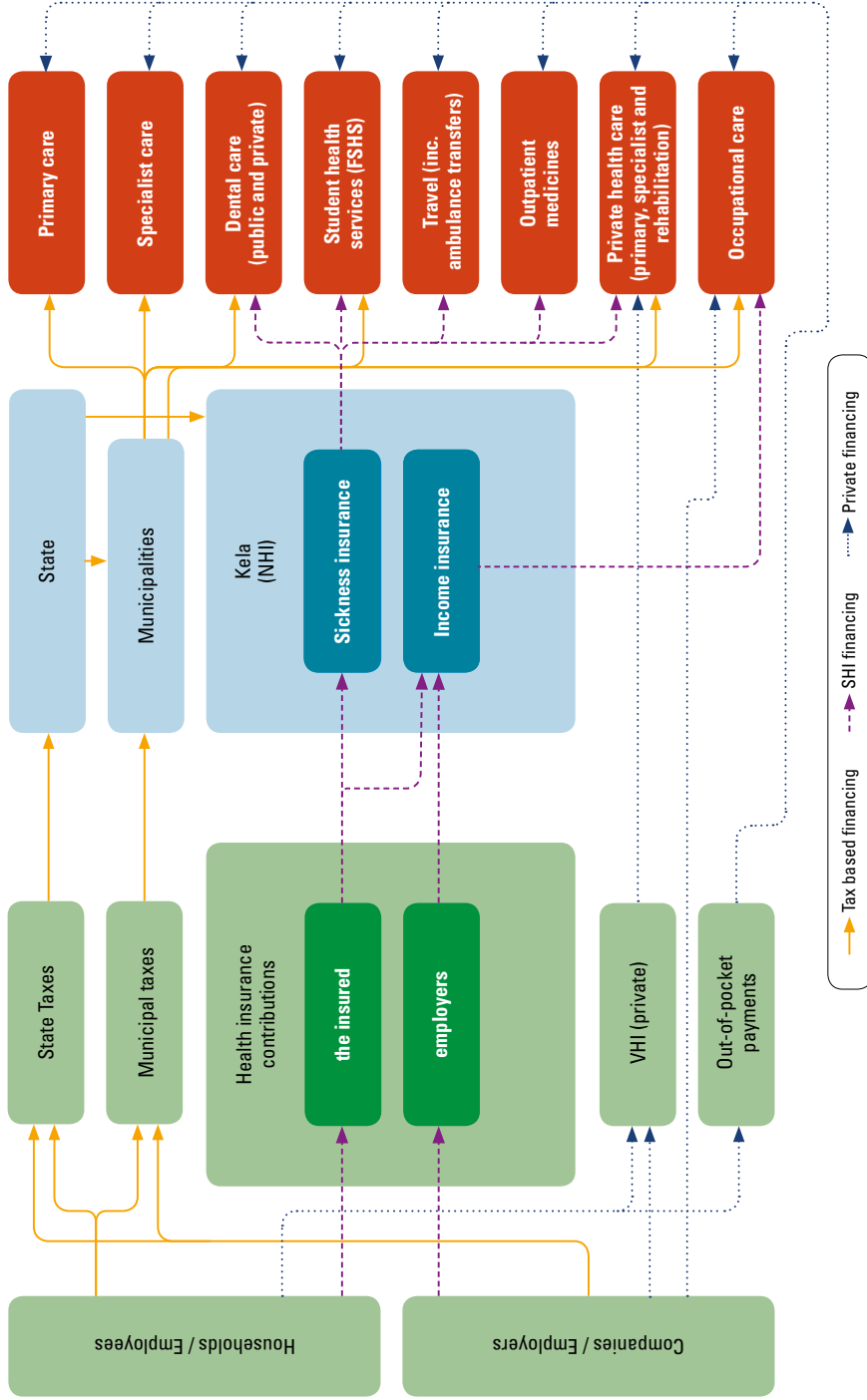
■ 3.3 Overview of the statutory financing system

■ 3.3.1 Coverage

Breadth: who is covered?

In Finland the rights for social security and health services are based on residence. The Constitution states that the public authorities shall guarantee for everyone adequate social, health and medical services and promote the health of the population. Furthermore, everyone has the right to basic subsistence in the event of unemployment, illness and disability and during older age as well as on the birth of a child or the loss of a provider. In practice these rights require registration with a municipality according to the Law

FIGURE 3.6 Financial flows



Note: SHI in Finland comes in the form of the National Health Insurance (NHI) scheme operated by Kela. Source: Adapted from Seppälä & Pekurinen (2014)

of Municipality of Domicile, 201/1994. Residents of a municipality are considered as those who permanently live in Finland. Apart from Finnish citizens, citizens of EU countries, Norway, Iceland, Switzerland and Lichtenstein can reside in Finland. In addition, people with a permit for a permanent or continuous residence, or who have a temporary residence permit but can demonstrate the intention to live in Finland permanently, together with their family members, can be registered with a municipality. Other groups who have rights to access publicly funded health services in Finland are covered in the EU social security regulation or international agreements on social security.

Asylum seekers are not entitled to publicly financed health care or social security benefits but services for them are arranged by reception centres until they have been granted a residence permit. If an asylum and residence permit is not granted, the right to reception services stops after a certain time.

Undocumented migrants and other groups who have no health insurance coverage are entitled to get urgent health care from public providers. According to the Health Care Law, urgent care goes beyond emergency care and includes care for sudden illness, injury, worsening of a long-term condition or a decrease in ability to function that requires immediate assessment and treatment, as well as urgent dental, mental health, substance abuse care and psychological care. However, these individuals are responsible for covering their medical care costs. If these costs cannot be collected, Kela reimburses the provider. In addition to NGOs, municipal health authorities in some larger cities offer a limited range of health services for undocumented migrants at no charge.

Scope: what is covered?

There is no comprehensive list of health services financed from public funds in Finland. The services are considered needs-based and patients' needs for services are assessed by health care professionals. The range of services are defined broadly in legislation, government decrees and recommendations issued by MSAH, such as the uniform criteria for access to non-emergency treatments (MSAH, 2010).

The Health Care Act (2010) specifies the range of publicly financed health services and lists the services which should be organized by municipalities. The latter include a wide range of preventive and curative services provided by health centres and hospital districts, such as screenings, maternity and child health clinics, and school, student and occupational health care services; as well

as diagnostic services, somatic and dental care, mental health services, services for substance abusers, home health care and services for medical rehabilitation. Beyond this, municipalities have substantial autonomy in defining and shaping the services they provide. Therefore, there is variation across municipalities in the basic profile and scope of services provided which can be attributed to, for example, differences in their financial situation, the availability of health workers, and differences in the actual or perceived needs of the population.

Since 2011, the Council for Choices in Health Care (COHERE, see section 2.2) monitors, defines and assesses the range of services and issues recommendations on including and excluding health technologies in the range of publicly financed health services. These recommendations are gradually complementing and updating the range of services covered.

Services covered by NHI are usually reimbursed only partially and include prescribed outpatient medicines, partial reimbursement of all private health care costs (see the section below on the depth of services) and transport costs to health care units (including ambulance service). In terms of private health care reimbursement, Kela has a defined list of procedures and examinations which are included in the reimbursement scheme. It contains such services as dental care, private GP services, pregnancy and childbirth, as well as diagnostic tests, physio- and radiotherapy (Kela, 2018c).

In addition, the NHI covers medical rehabilitation for people with severe disabilities, which includes extensive or elaborate outpatient and inpatient services which go beyond curative treatment and are necessary for improving people's functional and work capacity. Those eligible must be non-institutionalized and in receipt of disability allowance or pensioners' care allowance (for people under 65 years of age). NHI also reimburses vocational rehabilitation for people with impaired work capacity due to illness or injury and includes basic and essential vocational training, assistance with running a business or self-employment, as well as expensive and technically advanced aids for people with severe disabilities.

Kela may, at its own discretion, reimburse vocational and medical rehabilitation services other than those described above, including services such as preventive rehabilitation measures geared towards the requirements of a particular occupation, institutional rehabilitation services, training (to adapt to a sickness or disability) and psychotherapy. NHI also covers, through Kela, rehabilitation costs in certain cases specified by the Act on Rehabilitation Benefits of the Social Insurance Institution.

The NHI scheme also compensates for loss of income during illness, pregnancy and childbirth, and for loss of income for parents caring for a sick child. Sickness allowance provides compensation for loss of earnings caused by incapacity due to illness or injury, lasting less than 12 months for people aged between 16 and 67 years. There is a 9 working day waiting period, starting at the onset of the condition, during which the allowance is not paid. However, many collective labour agreements include a provision that the employer pays up to full salary for its employees during illness for a longer period (in some case up to 3 months). In these cases NHI reimburses the sickness allowance directly to the employer. Sickness allowance can be awarded even if the requirement concerning prior employment is not met and also covers students, the unemployed, and other population groups. The amount of the allowance depends on the taxable income of the recipient. In case of no income, the minimum allowance of €27.86 per day is paid.

Occupational health services organized by employers must cover health assessments when work involves health risks, provide information on those risks and advice on how to avoid them. They also include physical examinations and first aid at the workplace. In general, occupational health care is seen as preventive rather than curative. However, in addition to compulsory occupational health care, employers can voluntarily arrange additional health care services for their employees. Therefore, many employers also offer curative primary care level services. As a result, there are substantial differences in the scope of curative services offered by employers.

Depth: how much of benefit cost is covered?

The Act on User Fees in Social and Health Care (1992, last amended in 2016) and related legislation define services provided free of charge and set limits for the maximum fees which municipalities can charge for services which involve cost sharing. While municipalities can charge less, usually they charge maximum fees (see section 3.4).

Services that are free of charge include maternity and child health clinics, immunizations included in the national vaccination programme, testing and treatment for certain communicable diseases (e.g. sexually transmitted diseases (STDs), tuberculosis, hepatitis and some others), medical aids, such as wheelchairs and other moving aids, prostheses, transportation from a health care unit to another treatment centre, and inpatient medication. In

addition, appointments with a nurse and diagnostic tests are free of charge in the municipal health centres.

Health centres may charge a single or annual payment for an appointment with physicians (children under 18 are exempt), and a daily charge for up to 7 days of treatment on an inpatient ward of a health centre. Hospitals usually charge for outpatient services, a daily hospital fee for inpatient care, and fees for series of treatments and rehabilitation. Fees for care provided at home depend on whether the service is occasional (paid per visit) or long-term (paid monthly). A monthly fee is incurred for continuous treatment, whereas fees for occasional treatments by physicians or dentists are charged per visit.

In the private sector, patients pay full fees, but may claim partial reimbursement from the NHI. Private health care providers who have an agreement with Kela can charge the reimbursed proportion from the NHI directly. Fees for private services (both outpatient and inpatient care) are reimbursed by the NHI according to reference rates defined by the Government for every individual procedure. Since 2013 the rates are given as euros per procedure (and were specified as a share before 2013). Reimbursement covered on average 16% of practitioner's fees in 2017 (Kela, 2018d).

NHI also reimburses costs of travelling to a public or private health care provider due to illness, pregnancy, childbirth or rehabilitation. The costs which exceed the fixed co-payment of €25 are covered only for the nearest available place of treatment using the least expensive means of transport. In 2017, NHI covered 38% of the costs of outpatient prescription medicines, reimbursed 14–16% of private health services and 86% of travel and ambulance costs (Kela, 2018d).

In occupational health care there are no service fees for patients.

For prescribed outpatient medication three levels of reimbursement exist (basic at 40%, and special rates at 65% and 100%; see section 3.4.1 for further details). The special reimbursement rates are based on severity of condition. For example, medication for some chronic or long-term conditions, such as some cancers, is reimbursed at a 100% rate, while medication for diabetes is reimbursed at a 65% rate. The Pharmaceuticals Pricing Board decides upon the applications of pharmaceutical companies the reimbursement categories of the products. It can also restrict the special reimbursement to apply only for a certain or severe form of the disease. Finally, Kela decides the requirements and indications for special reimbursements.

There are few exemptions to user charges (see above for selected services and in some cases for children under the age of 18), and no exemptions

based on income. Instead, welfare benefits exist for low-income households to assist with meeting the cost of living, including health care costs. The payment of the benefit is stipulated by the Act on Social Assistance (1997, revision 563/2019) and is the responsibility of municipalities. Social assistance includes a basic sum of money and supplementary benefit which takes into account certain expenses (e.g. user charges for health services and outpatient medicines). Under this system, user charges can be paid directly to the health care unit or pharmacy, or they can be reimbursed to the patient.

High levels of user charges led to the introduction of annual ceilings in the beginning of 2000. Over the years the ceilings have gradually increased and in 2018–2019 they amount to €1 550 per year (see Box 3.1, section 3.4 and Table 3.3 for further details).

BOX 3.1 What are the key gaps in coverage?

In terms of population coverage, health coverage in Finland is comprehensive for residents. However, some population groups (e.g. undocumented migrants) only have access to urgent care (albeit fairly broadly defined).

In recent years, debates on the scope of public health care have addressed services, such as fertility treatment for female couples and single women and very expensive treatments of hereditary diseases and cancer. For instance, refusal to provide fertility treatment for female couples was considered discriminatory, therefore public providers now offer these treatments.

There is a relatively high degree of cost sharing in Finland, with 20% of health spending coming from out-of-pocket payments, corresponding to €759 per capita in 2017. User fees apply to a wide range of services provided by public health care (see section 3.4) and NHI reimbursement levels for medicines costs are relatively low, with patients on average paying 34% (in 2017) of the costs of prescription medicines. Due to annual cost ceilings for public health services charges (€683 in 2019), prescription medicines (€572) and travel costs (€300) the proportion of people affected by catastrophic out-of-pocket payments (over 40% of income) has been relatively low – around 1% on average and 3.6% among retired persons in 2015 (Vaalavuo, 2018). However, among older pensioners (over 85 years) and disabled people the incidence of catastrophic payments exceeds 10–14%.

This depth of coverage was reduced over recent years (along with the lowering of maximum reimbursement levels) due to the savings programme implemented by the Government in 2016 (see Chapter 6).

Health care service users are responsible for monitoring whether the payment ceiling is met. A certificate of reaching the ceiling can be issued by a health centre or other public health care provider. Patients may be asked to present original receipts. The payment ceilings for parents also cover the fees for their children under 18 years of age.

In 2009 the use of service vouchers (previously covering municipal social and home care) was expanded to non-acute health services provided by municipalities. This expansion of the voucher scheme to cover municipal health services has provoked a discussion about equity, as patients using service vouchers may have access to higher quality services than those who do not use vouchers.

■ 3.3.2 Collection

The financing of health care in Finland is collected mainly through six channels: state and municipal taxation, mandatory (national) and voluntary insurance fees and employer payments and out-of-pocket payments (see Fig. 3.6). This section discusses the state, municipal and social insurance collection mechanisms, while user charges are discussed in section 3.4.

Central government

Regarding state taxation, over half of the total revenue in 2017 came from two sources: income and wealth tax (24.2%) and VAT (31.8%). Due to the slow economic growth, public spending relies on borrowing. In the 2019 state budget, the increasing Government debt amounted to €1.4 billion (3.2% of total state revenues). State-level financing is mainly channelled to health care in the form of state subsidies to municipalities and as state contributions to NHI funding.

Municipalities

In 2017, 50.8% of overall municipal revenues came from municipal taxes. The taxation rate is decided every year by each municipal council. Municipalities levy municipal income tax, real estate tax and receive a share of the revenues from corporate tax, although income tax is by far the most important (84% of municipal tax income in 2017). Municipal income tax is a fixed proportion of gross wage, which in 2017 varied between municipalities from

16.5% to 22.5% of taxable income (in 2017 the average was 20.7%). This has resulted in considerable variation across municipalities in the amount of revenues raised from taxation.

National Health Insurance

The funding of the NHI scheme consists of two parts: sickness insurance and income insurance. The range of contributions is defined in the Health Insurance Act (2004) but adjustments are made through annual decree by the Council of State. Since 2016, employees and self-employed people pay income insurance contributions (1.54–1.77% of income), while the employers' contribution is 2.12% of gross wages. Other beneficiaries, such as pensioners, pay a sickness insurance contribution of 1.47% of income.

BOX 3.2 Is health financing fair?

As a source of health financing, the state taxation in Finland overall tends to be progressive due to progressive income tax. However, indirect taxes, such as VAT, are regressive. Municipal taxes and health insurance contributions are largely proportional with some exceptions. Out-of-pocket payments are highly regressive.

Klavus and Rissanen (2018) assessed the progressivity of health financing in Finland over 1990–2012, and found that progressivity of health care financing decreased steadily between 1990 and 2006, mainly due to an increase in the share of out-of-pocket payments. This trend has reversed in 2006, after which the share of financing from largely progressive income taxes has increased. The authors project that, should collection mechanisms remain the same as in 2012, progressivity of health financing would further increase. However, an increase in user charges and the planned termination of reimbursement scheme of private health service fees would by 2020 result in lower health financing progressivity than in 2012. Furthermore, Tervola et al. (2018) showed that increases in the maximum levels of all flat-rate user charges in municipal health services by 28% in 2016 have already contributed to decreasing the progressivity of health financing in recent years.

■ 3.3.3 Pooling and allocation of funds

Allocation from collection agencies to pooling agencies

Due to the complex financing and provision arrangements for health care, there is no predefined overall public budget for health in Finland. However, there are two main pooling mechanisms: municipalities act as pooling agencies for municipal health care services, and Kela pools funds for private and occupational health services as well as for health care costs related to services and benefits, such as outpatient drugs, transport and sickness allowance (see Fig. 3.6). This dual public financing creates challenges for overall efficiency of service production which are described in section 7.5.

Apart from organizing health services for their residents, municipalities are also responsible for many other public services, such as social care and primary and secondary education. The share dedicated to health is decided simultaneously with the budgets for other municipal services. As pooling agents, municipalities have two main sources of funding: municipal tax revenue described in section 3.3.2 and state subsidies.

Since 2010, subsidies are allocated for financing of the aforementioned primary municipal services. The purpose is to reduce differences in municipal tax revenues, cost structures and service needs. The subsidies are determined by a number of factors, such as population age structure, morbidity, unemployment rate, number of students at local schools and education-related unit costs. Depending on tax revenues, municipalities can also receive additional top-up payments or have their subsidies reduced. These balancing items comprise about a fifth of all central Government subsidies for municipalities. In addition, municipalities can receive general subsidies not tied to any specific functions, and discretionary grants in the case of serious economic problems. Therefore, the total state subsidy varies greatly between municipalities.

Besides collecting contributions (see section 3.3.2), Kela also pools health care financing, and runs the NHI scheme. The state participates in the financing of NHI by defining the level of contributions (overall, while the employers and employees shares are often negotiated with labour market organizations) and covering a considerable part of the expenditures of sickness and income insurance from the state budget. In 2017, the state share of the NHI funding was 42%. The remaining funding came from contributions from the population (employees, the self-employed and pensioners), amounting to 38%, and the employers (21%).

Allocating resources to purchasers

While NHI uniformly covers the whole population for services covered by the NHI scheme, municipal health care allocation is much more fragmented (see above). In the beginning of 2017 there were 295 municipalities in mainland Finland (excluding the Åland Islands with its own health care system), with populations ranging from 811 to 635 000 people. To purchase specialized health care, municipalities have formed 20 hospital districts, while for tertiary care the country has been divided into five special responsibility areas.

Municipalities running their own health centres usually use prospective budgets. In federation-owned health centres the budgets are built in a similar way, but sharing of costs between member municipalities is usually determined based on the volume of services provided. For specialist level care provided by hospital districts (federations of municipalities), the majority of funding is based on the volume of services provided.

Occupational health care is purchased by employers for their employees. Kela reimburses part of the cost of occupational health care for employers. The total estimated costs of occupational health care in 2016 were €809 million, of which €347 million (43%) were reimbursed to the employers by Kela. This amounted to 13.4% of all NHI reimbursements (Kela 2018, THL, 2018b).

■ 3.3.4 Purchasing and purchaser–provider relations

There are three different health care systems which receive public funding: municipal health care (primary and specialist), private health care and occupational health care. Kela operates nominally as a purchaser of services which are covered by NHI reimbursements. With an exception of rehabilitation and, since 2018, ambulance services (see section 3.4.1), Kela does not make any purchasing contracts with private providers; instead reimbursements are made directly to service users upon application.

Municipal health care

In municipal health care there is no formal purchaser–provider split. The most common way for municipalities to organize health care services is still to provide primary health care in municipal health centres and to purchase specialized care from their respective hospital districts. They can also purchase

services from other municipalities, other hospital districts, private providers or from the third sector. But, increasingly, municipalities establish integrated joint municipal authorities which provide primary and specialist health care as well as social services (Keskimäki et al., 2018).

Primary care

In the early 2000s, some large municipalities adopted a purchaser–provider split in their administration but since then most of these have departed from the model of somewhat artificially separating purchasing and delivery in their administration (Tynkkynen et al., 2013). However, municipalities can contract services from the private sector. For instance, in 2016, 27 health centres had contracted services from the private sector (Parhiala et al., 2016). In these cases, the contracts are signed after a procurement process, usually for up to 3 years with a potential option for extension. In the contracts, municipalities set criteria on content, staffing and quality of service. The payment mechanisms may vary but usually contracted providers are paid on the basis of capitation or, to a lesser extent, on the basis of global budget.

Municipalities' purchasing know-how has often been considered inadequate (Tynkkynen et al., 2013). In particular, municipalities have recognized that the skills required for strategic purchasing have been lacking. Nevertheless, purchasing has been used by municipalities as a means to benchmark their own provision against private providers. Some municipalities have claimed that they want to provide residents with more choice in terms of providers. However, this strategy has not gained much traction due to the lack of consistent payment arrangements and thus the lack of economic incentives for the providers.

Specialist care

There are different contractual and negotiation mechanisms between hospital districts and municipalities for agreeing target volumes and payments, which comprise elements of purchaser and provider separation. Overall, there has been a tendency for budgets to be too low, which sometimes results in revisions in the course of the year.

In addition to contracting specialized health care services from their hospital districts, municipalities can organize specialist level services themselves; for example, by using health centres as a base for specialist consultations. Municipalities can also purchase services from other hospital districts or from

private providers, normally on a case-by-case basis. However, the volume of such arrangements remains fairly minor.

Hospital district invoicing and pricing is in a continuous process of change, varying from district to district (Rättö et al., 2012) and the increasing tendency to establish the aforementioned joint authorities has further diversified the situation. Apart from some special arrangements for maintenance of readiness for catastrophes (such as large-scale traffic accidents or natural disasters) or pooling of exceptionally high costs, payments of municipalities have usually been based on price lists by either service item or a package of services (along the general principles of NordDRG (diagnosis-related group) pricing).

Occupational health care

In occupational health care services there is a purchaser–provider split, as employers contract private or municipal health service providers. In the contracts, employers define the level and scope of services purchased for their employees. Some larger companies may also have their own health units to provide services. Services are covered fully by employers, who are partly reimbursed retrospectively by the NHI, based on actual costs.

Private health care

For private sector patients, the NHI reimburses costs for some services and pharmaceuticals (see section 3.3.1). Kela is in general a passive purchaser and does not contract providers of health services, with the exception of rehabilitation services. Since 2003, the latter are contracted based on competitive biddings every fourth year. Kela defines the service standards (objective of a particular rehabilitation type, content of services, personnel qualification requirements, and outcome indicators). In addition, providers are being rated on quality (e.g. of premises, staff training and patient experience). This contracting system has been criticized for accepting nearly all tenders, which led to increasing costs and variations in provider charges (Aalto University, 2018). In the latest 2018 bidding round, Kela underlined price competition more than previously, prompting criticism regarding the omission of quality standards and overall cost-efficiency due to patients' longer distances to services.

For services funded by the VHI, the insurance companies have largely been passive purchasers (Alexandersen et al., 2016). Usually they do not have contracted providers in ambulatory care. However, they often have negotiated

prices with the largest private providers. For inpatient care and day surgery the private insurers may use contracting. Some insurance companies also have their own hospitals (see section 4.1).

■ 3.4 Out-of-pocket payments

As shown in Table 3.1, about a fifth of total health spending in Finland comes from out-of-pocket payments. This share has remained relatively stable since the mid-2000s and has varied between 19.0% and 20.4%. Out-of-pocket spending per person has doubled in Finland from PPP US\$ 423 in 2000 to PPP US\$ 837 in 2016. Before the financial crisis of 2008, per capita growth in public expenditure on health was overtaking growth in out-of-pocket payments (8% and 5% average annual growth between 2000 and 2008 respectively), whereas since 2009 out-of-pocket spending per capita increased at a faster pace (4% vs 3% growth in public spending) (WHO, 2018b).

User charges in municipal health centres were introduced in 1993, during the deep recession. Meanwhile, inpatient hospital care has traditionally been subject to cost sharing. In 2008, the legislation on user charges was reformed again, allowing MSAH to set maximum charges biannually, taking into account inflation. In the beginning of 2016 the user fees for municipal health care services were raised by 28% with the aim to increase the revenue collection from out-of-pocket payments by €150 million (Klavus & Rissanen, 2018). At the same time, NHI reimbursement for private services has decreased, mainly because the NHI levels of reimbursement have not followed increases in actual service fees.

In 2015, about half of the population in Finland incurred out-of-pocket spending for health and social welfare services. Among these, 36% paid flat fees (e.g. for primary or specialist care), amounting to €197 on average; about 5% paid income-related fees (e.g. for home-based, long-term or social care), amounting to €3 505 on average; and 22% paid for dental services, amounting to €104 on average (Vaalavuo, 2018).

Concerns that extensive user charges may lead to issues with accessing services and financial protection led to the introduction of an annual ceiling for health care costs in the beginning of 2000. The existence of separate ceilings for services, medicines and travel costs raised the total annual cap on out-of-pocket payments for health care services to €1 550 (see Table 3.3)

and service users may still incur further charges. In 2015, 6% of the population (about 330 000 people) reached at least one of the ceilings, while 0.1% reached all of them (Vaalavuo, 2018). There are no exemptions from user charges based on income.

■ 3.4.1 Cost sharing (user charges)

Table 3.3 shows maximum fees which municipalities can charge for health care services in 2018–2019, according to the latest Decree on User Fees in Social and Health Care (2017). Municipalities can set lower fees (e.g. some do not charge for GP visits), but this is not a widespread practice. According to a recent municipal survey, 70% of the population lived in municipalities charging the maximum fees for doctors' and nurses' visits in 2018 (Haaga, 2019). Usually user charges for services are not paid at the point of service use at the health care facility. Instead, patients are invoiced after the visit.

Health centre user charges

In health centres, patients can choose to pay per visit or by annual charge for appointments with a GP. People aged 15 years and older may be required to pay a penalty charge of €50.80 for not attending appointments. There is a charge for a visit to the health centre emergency clinic on weekdays between 8 p.m. and 8 a.m., on Saturdays, Sundays and bank holidays. A basic fee for dental care depends on the health professional's qualifications. On top of this, a fee for treatment from €8.40 (for a basic examination) to over €200 (dentures) can be charged. There is also a daily charge of inpatient care in a health centre inpatient ward. Several services, such as maternity and child welfare visits, laboratory tests and X-ray examinations and national programme vaccinations, are free of charge. In 2015, 12% of the population got health care centre outpatient treatment for free, 17% paid the annual fee of €32–42, and 70% paid according to use, up to €21 per visit (Vaalavuo, 2018).

Hospital user charges

Hospitals charge for a visit to an outpatient department, an outpatient surgery procedure, a daily hospital fee for inpatient care, a series of treatments and rehabilitation. Daily inpatient hospital charges cover examinations, treatment, medicines and meals. A maximum of 85% of a patient's monthly income

(for example, retirement pension) can be charged for long-term hospital or institutional care. At least €108 per month out of patient's income must remain available for the patient after paying the user charge.

Other specialist care charges

With regard to a series of treatments, €11.40 is charged for each appointment for up to 45 appointments a year. A series of treatments can consist of, for example, dialysis, radio- or chemotherapy and medical rehabilitation. A daily fee of €16.90 can be charged for rehabilitation of a physically or mentally disabled person. A fee of €61.00 can be charged for a medical certificate (for a driver's licence), but other certificates have a maximum charge of €50.80.

Home care charges

The fees for care provided at home depend on the nature of care/treatment. A maximum of €18.90 per visit is charged for occasional treatment by a physician or a dentist, while €12.00 is charged for a visit by other types of health care professionals. A monthly fee is applied for long-term care/treatment, which depends on the type and extent of service, as well as on household's composition and monthly income.

Ceiling for user charges in municipal health care

In 2018–2019, the ceiling for user charges in municipal health care is €683. The ceiling covers outpatient charges for most chargeable services, such as visits to the health centre, physiotherapy, and hospital care, but it does not include charges for dental care and ambulance services, and services with income-related charges. Dental care, certificates, diagnostic tests based on private sector referrals and patient transportation are excluded from the ceiling, but there is a separate cap for transportation. Once the ceiling is reached, service users can claim a certificate (based on receipts) from a municipal health care provider, relieving them of further user fees. After that, patients receive outpatient services free of charge, and pay for hospitalization at a reduced daily rate. The payment ceiling for parents also covers the fees for their children under 18 years of age.

Private health care services

In the private sector, patients pay all treatment costs themselves, but may claim partial reimbursement (according to the reimbursement tariff) from the

TABLE 3.3 User charges for health services in 2019 (maximum levels)

HEALTH SERVICE	TYPE OF USER CHARGE	EXEMPTIONS AND/OR REDUCED RATES	CAP ON OOP SPENDING			
Municipal health care services	Health centres	<ul style="list-style-type: none"> • GP visits • GP level emergency care 	<p>€20.60 per visit (max three times a year) or €41.20 annual fee</p> <p>€28.30 per visit</p>	<p>Children under 18 years are exempted from outpatient charges.</p> <p>Visits for maternity and welfare clinics, national vaccination programme and psychiatric outpatient care are free of charge</p>	<p>Annual €683 cap on service charges (except inpatient care daily charge).</p> <p>Parents ceiling includes fees for children under 18 years of age</p>	
	Specialist care	<ul style="list-style-type: none"> • Outpatient specialist visit • Ambulatory surgery • Treatment series 	<p>€41.20 per visit</p> <p>€135.10</p> <p>€11.40 per appointment</p>			
	Emergency outpatient visits		€41.20 per visit			
	Inpatient care	<ul style="list-style-type: none"> • Hospital and health centre inpatient stay • Psychiatric hospital inpatient stay 		<p>€48.90 per day; (€22.80 per day after ceiling for service charge has been reached)</p> <p>€22.50 per day</p>	<p>Children under 18 years pay only for 7 inpatient days per year. After that inpatient care is free of charge</p>	
	Dental care			€10.20–19.20 per visit plus cost of treatment	n/a	n/a
Occupational health care	Long-term institutional care		Income-based charges: maximum 85% of monthly income	Rehabilitation for disabilities in institutional care €13.40 per day	At least €108 per month left for patient's use	
			Free of charge	n/a	n/a	

	Billing according to provider costs	Partial retrospective reimbursement by NHI	
Private health care services			
Outpatient prescription drugs	€50 annual deductible; • 40% basic reimbursement rate; • 65% special (lower) reimbursement rate; • 100% special (higher) reimbursement rate + €4.50 flat co-payment per medicine	Children ≤18 years exempted from the deductible of €50	Annual €572 cap; then a fix deductible of €2.50 per prescription
Medical devices	Free of charge	n/a	n/a
Ambulance service and other patient travel costs	€25 flat co-payment per case	n/a	Annual €300 cap

Source: Act on User Fees in Social and Health Care 734/1992; Decree on User Fees in Social and Health Care 912/1992; both amended in 2017

NHI. Private providers set their price for services, which always exceeds the level of reimbursement. In 2017, the average reimbursement rate for private sector physician services was 16%, for dental services 14%, and for various examinations and treatments 13% (Kela, 2018). In case the provider has a direct reimbursement contract with Kela (e.g. for rehabilitation services), the payment up to reimbursement level is charged to NHI, while the patient pays the difference between the actual costs and the reimbursement tariff.

Ambulance and other transportation

For ambulance services the patient pays a flat fee of €25 with the rest (and up to €67) covered by NHI directly to the service provider. NHI also reimburses the cost of other forms of transportation for examination or treatment (for example, a taxi) if the sum exceeds €25. If the cost of transportation exceeds €300 per year, NHI reimburses all transport costs in excess of this limit.

Outpatient medicines

NHI reimbursements are paid for outpatient medicines, clinical nutrients and emollient creams prescribed for the treatment of an illness and included in the reimbursement list. Since 2017, reimbursement for adults can be received only for costs exceeding the initial deductible of €50 per calendar year. The rate of reimbursement (see also section 3.3.1) depends on the category of the product: 1) basic rate of reimbursement at 40%; 2) lower special rate of reimbursement at 65%; and 3) higher special rate of reimbursement at 100%. The latter still requires a co-payment of €4.50 per medicine per purchase. The reimbursement is deducted from the price of the medicine at the point of purchase. There is an annual ceiling on out-of-pocket payments for prescribed medicines (€572 in 2019), after which all costs are covered by the NHI with the patient paying a fixed deductible fee of €2.50 per prescription.

Medical devices

Medical devices, such as assistive devices for people with disabilities and devices for treating diabetes and monitoring blood glucose, are provided free of charge by municipal health services (a local health centre or a hospital district). The need for the device is assessed by a medical professional and registered in the patient's treatment plan.

■ 3.4.2 Direct payments

Direct payments apply for services not covered by the public financing schemes (e.g. private non-curative services, such as cosmetic surgery), and for pharmaceuticals not on the reimbursement list (e.g. hormonal contraception).

■ 3.4.3 Informal payments

No comprehensive evaluation has been carried out on informal payments, but there is no indication that these payments play any role in Finnish health care.

■ 3.5 Voluntary health insurance

The role of private voluntary health insurance (VHI) in Finland is complementary and it usually covers part of out-of-pocket payments not reimbursed by NHI (see section 3.4.1). Its volume has increased in recent years but in terms of total health care spending still remains fairly minor – below 5% in 2017 (Table 3.1). In national statistics VHI is often considered jointly with statutory private health insurance (e.g. for motor or occupational accidents).

VHI in Finland can be divided into the following categories: sickness insurance for children, sickness insurance for adults, leisure time accident insurance, sporting accident insurance (mainly for some specific sports), insurance for medical expenses during travelling and sickness insurance taken by the employer. These types of insurance can be combined or may form part of another type of insurance, for example insurance on private property.

VHI traditionally has not been very common in Finland, except for sickness insurance for children. In 2017, 467 000 children (44%) and 723 000 adults (16%) had VHI. For 30% of the adults with VHI, insurance policies were paid by the employers. In 2009–2018, the number of VHI policies taken for children increased by 25%, but the growth has been faster in adults – at around a 64% increase, while the share of policies paid by employers has more than doubled (Finance Finland, 2019).

The main reason for people to take out VHI is to reduce waiting times and out-of-pocket payments for private health care after NHI reimbursement (Tynkkynen et al., 2018). The relatively high number of VHI policies

bought for children is explained by the fact that they are not covered by occupational health care which is commonly used by the working adults as an alternative to municipal health care. Other reasons for buying VHI are to have greater choice of provider (including physicians) in the private sector and the perception that quality of care is higher in the private sector than in the municipal sector (Vuorenkoski, 2016).

The legislative framework for VHI is set out in the Insurance Contracts Act (1994), which covers all types of insurance. There is no special legislation for VHI. In general, VHI plans do not cover services that are not covered by NHI. Insurers are free to decide on eligibility criteria, premiums and benefit design. A wide range of options is therefore available and consumers can find it difficult to compare plans. The age limit for most plans is 60–65 years. Deductibles and maximum annual benefit limits usually apply. Not all VHI plans cover NHI cost sharing.

The VHI market is highly concentrated: the three largest insurers cover about two thirds of the market. All three are general insurers; one is owned by its members (a kind of cooperative) and the other two are commercial firms (Vuorenkoski, 2016). The insurers are not vertically integrated with providers and do not normally contract providers. Instead, people are free to go to any health care provider, including in the municipal sector, and are reimbursed afterwards. However, in 2013 one insurer has launched a chain of hospitals which first focused on orthopaedic surgery but has now a broader scope including occupational health services.

In addition to private health insurance, a number of relief funds still exists. Their membership is usually restricted to employees of a specific company. The relief funds are not companies but funds governed and owned by the members. The insurance premium (membership fee) depends on the salary of the individual. Employers may also fund these organizations. Coverage varies greatly between the funds.

■ 3.6 Other financing

■ 3.6.1 Parallel health systems

The impact of parallel funding systems for health services is minor in Finland. The Finnish Student Health Service (FSHS) provides primary, mental and

oral health care services for students of universities and institutions of higher education. The services for the Finnish Defence Forces including care for employees and conscripts are funded by the Ministry of Defence. Prisoners' health care was moved to THL and under the MSAH administration in 2016 (see section 2.2).

■ 3.6.2 External sources of funds

External sources have no role in the financing of the Finnish health system.

■ 3.6.3 Other sources of financing

Financing of occupational health services by employers plays a part in the Finnish health system. In 2016, 1.83 million employees (74% of the total), were offered occupational health care by their employers. In the same year, employers paid €464 million (57%) of the total expenditure on occupational health services, while the remaining share was reimbursed by the NHI (Kela, 2018a). Overall, occupational health care constitutes about 4% of all health care costs.

■ 3.7 Payment mechanisms

■ 3.7.1 Paying for health services

In primary health care, municipalities prospectively fund the budget of the health centres they maintain. Usually budgets are set based on previous years. In health centres run by joint health authorities, budgets are built in a similar way, but sharing of costs among municipalities is usually determined by the volume of services provided (see section 3.3.4).

Hospital districts providing specialized ambulatory and inpatient care are also mainly funded by the municipalities that they are composed of. Typically, municipal funding for hospital districts consists of a fixed part, based on the number of municipal residents, and a part based on services used. However, specified invoicing principles vary between hospital districts. Most hospital

districts use DRGs for municipal invoicing at least for a part of funding. In addition, bed day charges or treatment package pricing are used for assigning the costs to municipalities. Municipalities are charged prospectively but finances are balanced retrospectively according to actual services purchased. All hospital districts also have a funding pool to cover exceptionally high individual patient expenses (typically above €60 000–80 000 per patient or per episode).

When municipalities and hospital districts buy services from private providers, contracts and payment mechanisms vary considerably. These contracts must be arranged by open competition, due to anti-trust legislation.

Occupational health care services are paid for by employers according to contracts with providers (private or municipalities), using a variety of methods. Usually services are paid fully by employers who are then partially reimbursed retrospectively by the NHI. NHI reimbursement is based on actual costs of services following the guidelines of good occupational health care practices. The reimbursement level for services is usually 50%, but for preventive services it is possible to get the increased reimbursement of 60% if the employer and occupational health care provider have agreed on a supporting programme on employees' work ability. NHI also reimburses patients for costs of some services provided in the private sector, as well as pharmaceuticals (see section 3.3.1 and 3.4.1).

■ 3.7.2 Paying health workers

In the public sector health workers are salaried employees. In the private sector, doctors and dentists are entrepreneurs or work as salaried employees in clinics, while nurses mostly work as salaried employees. In the public sector, the salaries of municipal employees are negotiated at the national level between labour organizations (separate for doctors and nurses) and the Local Government Employers (association of municipalities and joint local authorities). Other groups of health professionals in the public sector have similar arrangements.

Physicians and dentists

Medical doctors and dentists in the public sector work usually as salaried employees, similarly to other public sector health care employees. However,

payment systems of GPs and dentists in municipal health centres are somewhat different from that of other employee groups and vary between municipalities. GPs' salary schemes vary according to specific work description and qualifications. In 2019, the most common salary scheme is a monthly salary with some extra fee-for-service payments for selected services or minor procedures, plus compensation for out-of-hours and overtime work. In those health centres where the personal doctor system has been introduced (see section 5.3), doctors are paid a combination of a basic salary, capitation payment and fee-for-service payment for visits. Physicians also receive some extra payments for issuing health certificates for various purposes. In 2018, the total monthly salary of a physician or dentist was around €6 300 (Table 3.4). The average monthly salary of public sector physicians and dentists, including extra payments, is usually substantially higher than the basic salary.

TABLE 3.4 Average income of health workers in Finland in 2018, € per month

	REGULAR WORKING TIME	TOTAL
Dentist	6 089	6 299
Physician	4 732	6 316
Nurse	3 081	3 159
Dentist at health care centre	6 057	6 383
Physician at health care centre	6 420	6 782
Medical specialist	5 325	8 866
Chief pharmacist	5 456	6 246
Pharmacist	2 644	2 960

Source: Statistics Finland (2019b)

Where municipalities outsourced health centre services to the private sector, physicians are employed by the contractors and their salary is negotiated with the company. Often contractors offer better salaries and more flexible working conditions than municipal health services.

Physicians in hospital districts are salaried employees. Their basic monthly salary depends on the physician's post and length of career. In addition, there are various compensations and bonuses (e.g. for working out-of-hours, being on-call, level of experience and training, additional responsibilities).

It is common that medical doctors working in public hospitals also work in private clinics during evenings on a fee-for-service basis. In the private

sector, physicians usually work as autonomous practitioners and are free to set their own rates. In recent years, many small private clinics have merged into larger provider organizations. In these cases, physicians tend to work there as salaried employees.

Nurses

Nursing staff have a basic monthly salary and compensation for working out-of-office hours (which is set at 15–45% extra). The basic salary depends on the competence and experience. The average monthly salary of nurses working in the public sector stood at about €3 100 in 2018, plus extra compensations. There are no major differences in nurses' salaries between public and private health care, and between primary and specialized health care.

Pharmacists and pharmacy workers

The salaries of pharmacy workers largely depend on the education level, work description and experience, and vary from €2 600 to €5 500 plus extras. A pharmacist with a Master's degree and sufficient work experience can apply for a pharmacy license and become an entrepreneur responsible for running their own pharmacy.

Physical and human resources

■ Summary

- Most health care facilities in Finland are owned by the public sector, although the number of privately or jointly owned hospitals is increasing. The public hospital network, consisting primarily of 15 central hospitals and five university hospitals, is owned by the country's 20 hospital districts. The municipalities and hospital districts also run and finance a network of primary and secondary care facilities, as well as separate psychiatric care institutions. A wave of hospital closures and mergers has substantially reduced the number of facilities and beds since 2000.
- Electronic patient records are used widely in both the public and the private sector. However, due to the decentralized health system, their interoperability is often deficient. Currently two major information system projects are ongoing, with one aiming to link health and social welfare services in the capital region and the other unifying information systems across the remaining 19 hospital regions.
- The shortage of physicians that previously affected the Finnish health system has been overcome by increased intake of students by Finnish faculties and an increase in students studying abroad. However, availability of doctors still varies more than twofold

across regions. At the same time, the ratio of nurses to population in Finland is one of the highest in the EU.

- Responsibility for specialist training has been shifted to MSAH in 2015, with a steering and planning function based on the current and future needs for specialists.

■ 4.1 Physical resources

■ 4.1.1 Capital stock and investments

Current capital stock

Data on hospital infrastructure are not collected systematically in Finland, and all information on inpatient care and procedures is aggregated at hospital district level when submitted to the National Care Register (HILMO). In addition, there is no regular data collection on the provision of private specialist care.

Hospital infrastructure has changed rapidly in recent years. Since the specialist care reform in the early 1990s, there have been 20 hospital districts on mainland Finland that run 15 regional hospitals and five university-owned teaching hospitals in Helsinki, Turku, Tampere, Kuopio and Oulu. These hospitals offer an extensive scope of secondary care services with tertiary level care provided mostly by the university hospitals. The Helsinki and Tampere University Hospitals have single-specialty hospitals as their subsidiaries, such as the Women's Hospital in Helsinki. In addition, the hospital districts and municipalities maintain smaller local general hospitals, which provide a narrower scope of services. There were 64 local hospitals in 2015 (Mikkola et al., 2015); however, some of them were closed, merged or re-profiled to a more limited scope of services, with only 21 local public hospitals registered in 2016 (Häkkinen & Matveinen, 2018).

Psychiatric inpatient care is currently mostly provided in the same facilities as other specialized care. However, in 2018 there remained 10 stand-alone inpatient psychiatric care facilities. Five of them are expected to be closed in the coming years.

The number of private for-profit hospitals that provide specialized (e.g. surgical, cardiac or ophthalmological) services was 45 in 2017 (THL, 2017).

Two of these hospitals are part of a corporation established by the Tampere University Hospital running separate for-profit units or satellite hospitals, e.g. units specializing in joint replacement operations (Coxa) and cardiac services (TAYS Heart Hospital). The Jokilaakso Hospital in central Finland is a small hospital jointly owned by a municipality, a hospital district and a private for-profit company that provides surgical services and a limited portfolio of other services. In addition, Helsinki University Hospital incorporates a previously private non-profit but now limited company provider (Orton Ltd) that specializes in musculoskeletal diseases. Another large and initially non-profit provider, which is now for-profit, is Diacor Ltd (now merged), established by the Deaconess Institute. In addition, the for-profit hospitals include four providers of orthopaedic surgery, founded by an insurance company. A private for-profit hospital Docrates offers cancer diagnostics and treatment.

Public hospitals in Finland have mainly been built in the 1950s and 1960s, and health centres followed about two decades later (Punnonen, 2013; Korhonen et al., 2017). Hospital districts owned in 2012 approximately 3.6 million square metres of real estate (Punnonen, 2013) and the value of all municipality-owned properties was estimated at €4.2 billion (Leskelä et al., 2016). Due to wear-out and changes to operational environments, a wave of renovations and construction of new buildings in hospital districts began in 2001 and by 2012 led to a cumulative national level investment of €3.3 billion, with overall need for investment estimated at €6 billion (Punnonen, 2013). Centralization has led to vacated hospital buildings that have been either sold or rented out, for example, for residential, day care or rehabilitation centre purposes. Some 2.5% of social welfare and health care properties are currently unused (Korhonen et al., 2018) and it has been estimated that up to 35% of municipality-owned inpatient facilities may be redundant (Leskelä et al., 2016).

The Counties' Service Centre for Facilities and Real Estate Management, founded in 2017, was aimed to be the first body to centrally maintain and monitor the public health care property stock; however, it has not started operation due to uncertainty over the health and social care reform (Chapter 6).

Regulation of capital investment

Since the early 1990s municipalities and hospital districts have been able to plan their health care capacity. However, due to the changes envisaged in the hospital network and the associated substantial costs, since 2016 decisions

on major capital investment (exceeding €5 million) have to be referred for appraisal by the MSAH until at least the end of the 2020. By September 2018, all submitted investment plans (63 plans) have been approved by the MSAH, albeit with some revisions. Approximately half of the tenders in 2017 concerned health care capital stock, with the other half being for social care (Rakennuslehti, 2017). Altogether, hospital districts received permission to invest in renovations or new buildings for a total sum of €2.2 billion, and municipalities for the sum of €336 million. On the whole, this approval process is considered as a positive step, as MSAH has been able to coordinate capital investments with national strategic planning.

Capital investment planning in the private sector rests solely with provider companies. National level data on the scale of investment are not available, but it can be noted that the structure of the private sector has markedly changed in the last decade and the market has consolidated with mergers of large private companies.

Investment funding

Typically, municipalities reserve funds for upkeep, maintenance and smaller repairs of buildings in their annual budget and allocate funds for larger renovations and development projects through separate capital funding. Private health and social care providers have increasingly acquired ownership of buildings to gain market access.

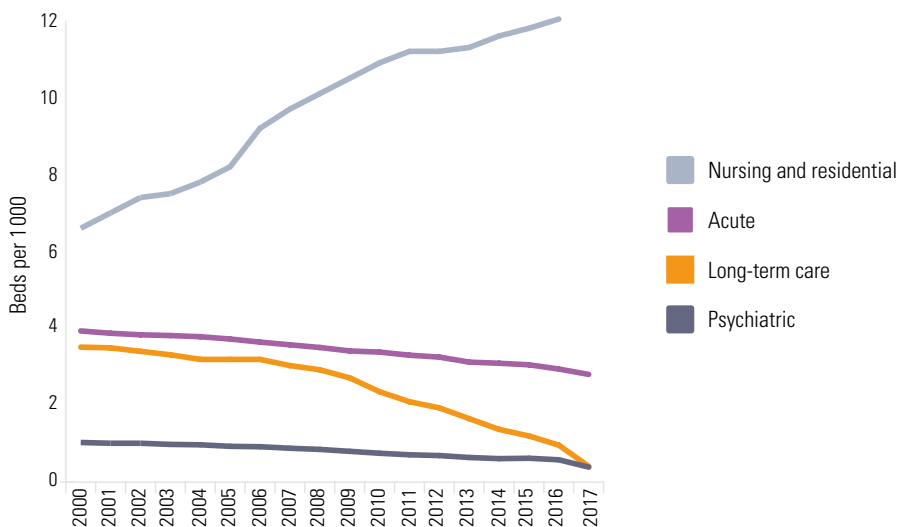
In the public sector, a new financing model was applied to the New Children's Hospital of the Helsinki University Hospital inaugurated in 2018. The hospital building was developed and owned by a private foundation, with capital investment coming partly from the state and the hospital district, but with a substantial top-up from private fundraising. Several other hospital districts are currently using alliance contracting models in their health care facility construction, including the districts of Kanta-Häme, Kainuu, Oulu, Kuopio and Vaasa (Rakennuslehti, 2018). The early collaboration between hospital district, designers and constructors is deemed to produce better quality while containing costs (Pekkala, 2016).

In the private sector, a model for a network of private hospitals established by an insurance company has been expanding in recent years. The first such hospital was established in 2013 to provide orthopaedic surgery services for insurance policy holders, but the number of providers has grown and services have broadened in scope.

■ 4.1.2 Infrastructure

In 2015, there were 330 public sector inpatient care facilities in Finland, such as specialist and primary care community hospitals (Mikkola et al., 2015). As in other EU countries, the number of acute and long-term care hospital beds has decreased markedly since 2000 (Fig. 4.1). In Finland the trend has been most pronounced in primary care hospitals, where the decrease between 2006 and 2013 was over 40% in some hospital districts. During the same period, specialist care beds decreased in some areas by 20–30% (Mikkola et al., 2015). Shortage of qualified health workers and limited finances played a role in this development, along with the centralization of emergency care services (MSAH, 2014b).

FIGURE 4.1 Hospital beds per 1 000 in Finland, 2000–2017



Source: OECD (2019); European Commission (2019)

The rapid reduction of inpatient care provided by health centres reflects a shift of care for older people towards home-based care and sheltered housing, which are under the remit of social care services (Mikkola et al., 2015). In some larger municipality-owned hospitals beds were re-profiled to provide selected services, such as cancer care and rehabilitation. Services that are now largely delivered at home include administration of intravenous antibiotics and changing of dressings.

Marked regional differences remain in the availability and use of hospital services. A nationwide study found that the population in the eastern parts of Finland used more hospital services between 1997 and 2013 than residents in other parts of the country (Mikkola et al., 2015). Furthermore, hospital districts in northeast Finland have more beds per population than other regions due to geographical factors. Since the 1990s, people living in the southern regions have constantly used less acute hospital services than those in other parts of the country (Keskimäki et al., 2014). A wide range of factors, such as population morbidity patterns, health care resources, and differences in medical practices have been put forward to explain these findings.

■ 4.1.3 Medical equipment

In Finland, public sector health care units fund medical equipment from their annual budgets. There is no state-level control over the acquisition of medical equipment, although, through their planning and coordination responsibility, the university hospitals and hospital districts have some steering control on purchases within their areas. The most expensive devices, such as magnetic resonance imaging (MRI) units, are located in hospitals but are increasingly found in mobile units as well. In 2016, the ratio of CT scanners to population was just above the EU average, while the ratio for MRI units and mammographs in Finland is among the highest in the EU (Table 4.1).

TABLE 4.1 Diagnostic equipment in Finland and the EU, per 100 000 population, 2016

EQUIPMENT	FINLAND	EU AVERAGE
Computed tomography scanners	2.4	2.2
Magnetic resonance imaging units	2.6	1.4
Mammographs	3.1	2.3

Source: European Commission (2019)

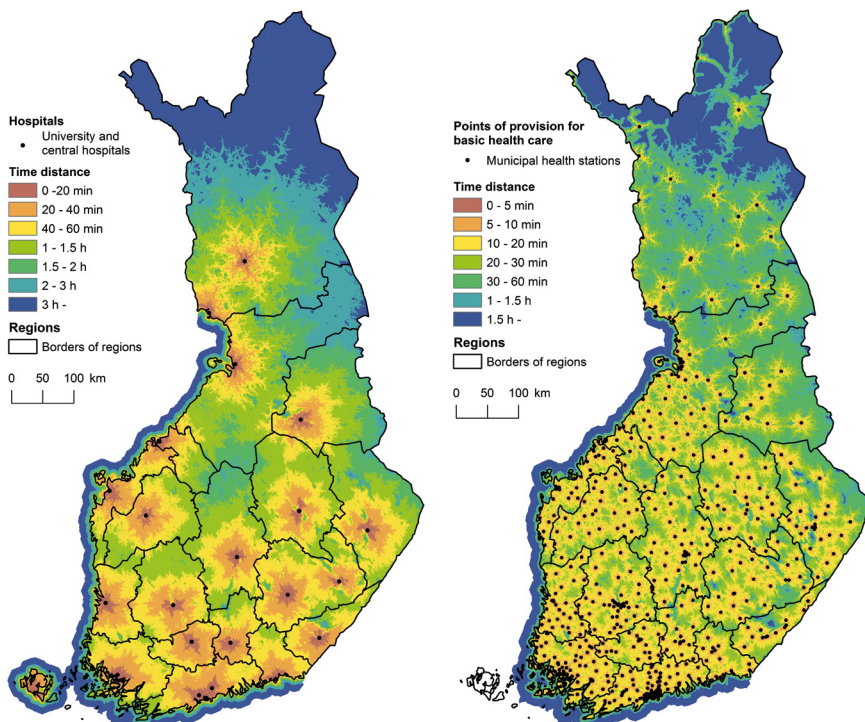
The Valvira and STUK are responsible for monitoring the compliance of medical devices with existing standards. HTA functions are currently the responsibility of the university hospitals and their coordinating centre FinCCHTA (Finnish Coordinating Centre for Health Technology Assessment). These assessments give advice on the cost–effectiveness of new equipment and are generally adhered to. Hospitals are increasingly using

mini-HTA methodology to determine the benefits and risks of their new technology, along with cost–effectiveness analyses (FinCCHTA).

BOX 4.1 Assessing the geographical distribution of health care resources

Traditionally, the central hospitals are located in the major cities and have been surrounded by a network of district and primary care inpatient facilities in the more sparsely populated areas. When evaluated in 2015, marked differences between regions were found; there was a preponderance of small municipality-owned primary care hospital buildings in the eastern and southwestern parts of Finland. Since then, seeking to improve efficiency, these regions have merged hospitals into larger entities and some facilities have been closed or premises rented out for other purposes. Figure 4.2 shows the estimated travel time to 1) central and university hospitals; and 2) health centres in all parts of the country.

FIGURE 4.2 Access time to health facilities in Finland



Note: a) All central and university hospitals in Finland with estimated accessibility in time using Digiroad calculations, 2015. District and municipality level hospitals are not shown. b) All health stations (point of provision for basic health care) in Finland and their accessibility, 2015c
Source: Rehunen et al., (2016)

■ 4.1.4 Information technology

Electronic patient records are widely used in all primary health care centres, hospitals and other specialized health care units. For private service providers the coverage of electronic patient records is widespread, although not obligatory. Paper-based documents are nowadays mainly used for the storage of historical data. The electronic patient record systems are multifunctional, and include administrative functions, continuous narrative documents of diagnostics, treatment and care, order entries for laboratory and radiological exams, tools for reviewing results, and inter-organizational data exchange. All specialized hospitals are filmless. The Evidence-based decision support tool (EBMeDS) is provided by the Finnish Medical Society Duodecim and is widely used. Information exchange between primary and specialized health care organizations takes place principally by electronic referrals and consultations. Electronic referrals and electronic consultations between primary and specialist care providers are the current standard. However, the usability of electronic records has been constantly criticized by physicians for being dense and time-consuming.

The development of health information systems in Finland has been uncoordinated due to the decision in the early 1990s to leave the acquisition of the systems to the discretion of municipalities. This resulted in a situation where non-interoperable information systems were used even within individual providers. Regionally integrated systems have succeeded in most hospital districts to overcome this challenge.

Two large information system projects with ambitious goals are currently ongoing: a joint enterprise of the Helsinki and Uusimaa hospital districts and most of the municipalities in the capital region is called Apotti. It aims to serve as an information system linking health care and social welfare service provider data with comprehensive patient and client services, as well as an operations management system. Apotti is being developed by end-users and promises more efficient use of knowledge and novel service provision methods for integrated care. The system was launched in November 2018. A parallel project called UNA developed by the Association of Finnish Local and Regional Authorities together with 19 hospital districts, aims to build a modular ecosystem of existing information systems. Other projects, such as the self-management platform Omaolo, launched by the Association of Finnish Local and Regional Authorities together with several municipalities,

and Virtual Hospital, a joint enterprise of all university hospitals, offer digitalized services across the country. The Virtual Hospital 2.0 consists of 30 different “houses” in a “health village” (Terveyskylä) representing different specialties or clinical entities, such as pain control and weight loss. These virtual houses provide visitors with advice regarding symptoms, medical conditions and procedures as well as actual services, such as psychotherapy.

In addition to regional approaches, a national information system called Kanta (National Archive of Health Information) was introduced gradually between 2010 and 2016 (see section 2.6). It is a collective name for several national medical information systems. These are e-Prescription and the national Pharmaceutical Database, the electronic repository of patient records (eArchive) and online access for patients to their personal prescription and medical data. The Kanta services are widely used and electronic prescription has almost eradicated paper-based prescriptions. Online access for patients has only recently been introduced but, in general, the Kanta system has gained widespread acceptance and in 2018 the My Kanta Pages had 2.1 million users. Requests for e-prescription are among the most common services and account for a quarter of all prescription renewal requests per year. However, there remains a lack of information on health care services’ availability and quality.

Social welfare services use digital services sparsely. The development of the Kansa archive for social services started in 2018, but is not expected to be fully operational before 2023. Electronic appointment booking systems exist, so far mostly in private clinics, but are increasingly available in publicly provided services.

■ 4.2 Human resources

■ 4.2.1 Planning and registration of human resources

There are few state-level mechanisms to steer the health care workforce geographically or in terms of skill-mix, except with regard to the education of health professionals (see below). However, MSAH and THL have issued several national recommendations for workforce sizing for care for the older people, and for preventive care (see MSAH, 2017a;

Klemetti & Hakulinen-Viitanen, 2013). Needs assessments and human resources planning have been conducted in the context of overall labour projections in collaboration with the Ministry of Education and Culture, the Ministry of Economic Affairs and Employment, MSAH, Statistics Finland and municipal organizations.

The Ministry of Education and Culture is responsible for regulating and supervising the training of health professionals. In theory universities are autonomous foundations and under public law can decide on the number of students to be enrolled. In practice the Ministry of Education and Culture together with the universities reach an agreement on the budget for and number of students. The universities of applied sciences (polytechnics), which provide training for nurses are public limited companies and mainly governed by municipalities. They are autonomous but operate under the guidance and financial support of the Ministry of Education and Culture.

The governance of specialist training of physicians and dentists has been a responsibility of MSAH since 2015. In practice the steering focuses on monitoring and securing collaboration between different actors, and it is carried out by an advisory expert group representing the main specialist training stakeholders (MSAH Coordination division for medical and dental specialist training and specific training in general medical practice). The intake of interns for physician and dentist specialist training was previously not covered by the MSAH steering mechanism at the national level, and instead determined through recruitment decisions by hospital districts and universities. However, since 2016 a new open selection procedure has been introduced following the national level regulation on the intake to specialist training based on current and future needs.

The National Supervisory Authority for Welfare and Health (Valvira) is responsible for licensing, registration and, together with the RSAAAs, supervision of health personnel. It also undertakes disciplinary procedures concerning health personnel.

There is no re-accreditation system in Finland; medical and other health care professionals are responsible for engaging in continuous education themselves. According to the legislation, employers are responsible for providing professional training, but the implementation varies across health care organizations.

■ 4.2.2 Trends in the health workforce

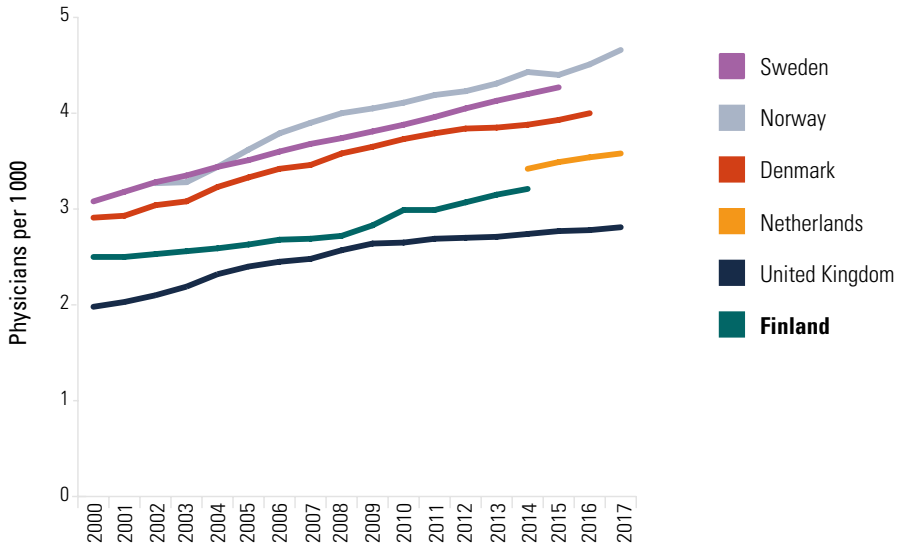
Most professionals working in the health sector are employed in municipally operated health services (health centres and hospital districts). In 2014, the health sector employed 180 724 employees, more than three quarters of whom were working in the municipal sector (THL, 2019d). Of all employees, just under 100 000 were working in hospitals and 66 000 worked for other providers, such as health centres. The total health workforce has increased by 15% since 2005.

As the public sector gradually recovered from the economic crisis in the late 1990s, a significant physician and dentist shortage developed in primary care. In order to rectify this situation, the yearly intake of medical students was doubled between 1995 and 2016, from 365 to 750. In addition to Finnish faculties, many students study medicine abroad (about 750 students in 2016), for example in Sweden, Estonia and Latvia, with an estimated 150 students graduating annually and returning to Finland (Finnish Medical Association, 2016).

After 2008 the shortage of medical doctors in health centres has decreased substantially – from 11% of unfilled posts to 6% in 2018 (Finnish Medical Association, 2018). However, there are significant variations in vacancies between regions. Currently the shortage is by far the largest in the north-eastern parts of Finland and in particular in Kainuu with one in five vacancies unfilled (Finnish Medical Association, 2018). In specialized care there were more than 9% unfilled positions in 2008 but by 2015 this share had decreased to 6% (Finnish Medical Association, 2016). The numbers of unfilled positions were highest in psychiatric fields, respiratory medicine and pathology.

Between 2000 and 2014 the number of practicing physicians in Finland increased by 28% (Fig. 4.3). According to national data, in 2016, 66% of physicians worked in the municipal sector with 44% working in hospitals and 22% in health centres; 18% of physicians worked in private medical centres or clinics. Over the past two decades (1996–2016), the number of physicians working in hospitals increased by 29%, compared with 21% increase in physicians working in primary care, while the number of physicians working in other places (mainly private and occupational health care) increased by 67% (Finnish Medical Association, 2016).

FIGURE 4.3 Practising physicians per 1 000 population in Finland and selected countries, 2000–2017



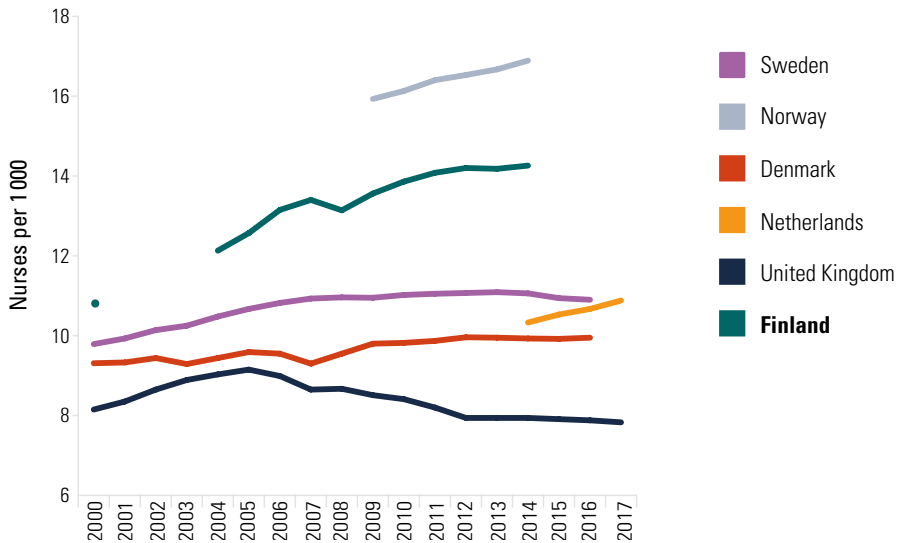
Source: OECD (2019)

In 2014, there were 14.3 nurses per 1 000 population, an increase of 33% compared with 2000 (Fig. 4.4). In comparison with other Nordic countries, Finland has a smaller physician to population ratio, while the ratio for nurses is higher than in Sweden and Denmark, but lower than in Norway. The nurse-to-doctor ratio in Finland is one of the highest among the OECD countries with 4.4 nurses per doctor in Finland in 2014. There is a movement towards a larger role of nurses in coordinating patient processes especially in terms of chronic, long-term and minor acute health conditions at primary care level. In 2018, nurse consultations covered 50% of the total number of non-urgent outpatient visits in health centres and they typically work in multidisciplinary teams or in pairs with physicians. After attaining a regulated postgraduate qualification the nurses have also been able to prescribe some drugs to patients suffering from common conditions (Keskimäki et al., 2018).

There were 0.7 dentists per 1 000 population in Finland in 2013, a ratio similar to Denmark but lower than in Sweden and Norway. The number of unfilled dentist posts in health centres has been relatively constant in recent years – 6% in 2018. About 37% of all dentists are working in the private sector (Finnish Dental Association, 2016a).

The ratio of pharmacists per population in Finland is higher than in other comparable countries – 1.1 per 1 000 in 2013, representing an increase

FIGURE 4.4 Practising nurses per 1 000 population in Finland and selected countries, 2000–2017



Source: OECD (2019)

of 12% from 2000. There are two university degrees in pharmacy in Finland: Master of Science and Bachelor of Science. In 2017, about 2 600 people had the degree of Master of Science in Pharmacy. About 600 of them ran their own pharmacy and about 750 were employed in a pharmacy owned by another person. Pharmacies additionally employ about 3 700 assistant pharmacists having the degree of Bachelor of Science in Pharmacy (Association of Finnish Pharmacies, 2018).

BOX 4.2 Evaluating the geographical distribution of health workers

There are major regional variations in the number of physicians in different parts of the country. The lowest density of physicians (less than two physicians per 1 000 inhabitants) is in Länsi-Pohja, which is a small hospital district in northern Finland. The highest physician ratio (around five physicians per 1 000 inhabitants) is found in regions where there is a university hospital. The shortage of physicians has led to health workers being contracted from the private sector or the outsourcing of entire health centres or even a central hospital to private companies.

■ 4.2.3 Professional mobility of health workers

Geographical mobility of health professionals in Finland is fairly limited, mainly due to the language barrier, with health professionals being required to speak sufficient Finnish (or Swedish in some areas). However, during the peak shortages of physicians in the 2000s there was a substantial influx of medical doctors from Estonia and the Russian Federation. In 2016 there were 935 physicians who were not Finnish citizens living and practising in Finland. The majority of foreign physicians are from Estonia (425 physicians) and the Russian Federation (183 physicians) (Finnish Medical Association, 2016). There has also been an active, but not very large-scale, recruitment of nurses, from abroad; for example, from the Philippines or Spain.

Migration of Finnish health professionals to other countries has been moderate. According to statistics of the Finnish Medical Association, about 2 060 Finnish physicians (including researchers), corresponding to about 10% of working-age physicians resident in Finland, were working abroad in 2016. The greatest proportion (41%) of them was working in Sweden. At the same time, 3 550 nurses from Finland were employed abroad, of which 37% were working in Sweden (THL, 2019d). Overall, migration of health professionals to or from Finland has not been a major issue, except for the impact on neighbouring Estonia, where the health workforce is consequently diminishing (Lai et al., 2013).

■ 4.2.4 Training of health personnel

Physicians are educated at five universities. University education leading to a degree is free of charge for EU/EEA citizens. However, tuition fees were introduced for students from other countries in 2017. Basic medical education lasts 6 years and contains a considerable amount of guided practical training. Dentists are trained in four university faculties and their studies last 5 years in total. Training of pharmacists takes place in three universities and takes 5 years (Master's level) for pharmacists or 3 years (Bachelor degree) for assistant pharmacists.

To become a specialist, physicians and dentists must register with the faculty of medicine for the relevant specialist training programme. Specialization lasts 5 to 6 years depending on specialty and includes theoretical studies,

clinical work and national examination. Specialization begins with the resident working as a junior hospital doctor at a central or district hospital under the supervision of an experienced physician. This is followed by working at a central university hospital, although at least half of the training must be done outside of central university hospitals. All specialization programmes require a 9-month residency at a health centre. Specialist training also includes compulsory management studies. Occupational care physicians, irrespective of the employer, can either be specialists in occupational health care (which is a medical specialty in Finland) or have additional training in occupational health care.

Nurses (including acute care, public health nurses and midwives) and other health professionals (e.g. dental hygienists, physiotherapists, laboratory personnel) have basic upper secondary level training lasting 3–4.5 years, which takes place at universities of applied sciences (polytechnics). The course for nurses covers general nursing. A separate specialist training includes, for example, surgery and internal medicine, paediatrics, geriatrics, anaesthetic and operating theatre, and psychiatric nursing. In addition, universities have programmes on nursing science and health sciences, leading to Bachelor and Master Degrees.

After graduation, continuous medical education for physicians and dentists is provided by employers, medical societies, universities and pharmaceutical companies. Health care professionals in Finland are licensed for their entire active careers, with no periodic revalidation. According to the Health Care Act, health centres and hospital districts are responsible for arranging continuous medical education for their personnel.

■ 4.2.5 Physicians' career paths

About 59% of working-age doctors have a specialist diploma and 20% of them are specialized in general practice. However, specialization in general practice is not a requirement for working as a GP in a health centre, although the salary is usually higher. Typically, medical graduates start their career from working at health centres for at least 9 months, often as part of their specialist training.

Health centres and hospital departments decide independently on the recruitment of doctors to junior and specialized doctor positions, and the

promotion of their staff. They also decide independently on the number of positions in each clinic.

■ 4.2.6 Other health workers' career paths

Dentists have similar career paths as medical doctors, except that specialization is rarer. Nurses are specialized already in their basic nurse training programme. Higher administrative positions in hospitals usually require for nurses to have a university degree in nursing or health sciences.

Provision of services

■ Summary

- Health promotion and disease prevention are the cornerstones of health care in Finland.
- There are three parallel systems for health service provision. The principal system is publicly financed and organized by the municipalities, for all levels of care. The others are private and occupational health care, mostly providing ambulatory primary and some specialist services.
- Municipal primary care is provided by health centres, providing a wide range of services, although waiting times can be long.
- Public specialist and inpatient care are provided through hospital districts; these provider networks have been undergoing centralization, as well as a shift from inpatient care to other settings.
- Centralization of specialized care is increasing. The numbers of district and specialist hospitals have decreased and their service provision has reduced markedly in the 2000s, largely through mergers with larger hospitals. A Government Decree on the further centralization of specialties has recently entered into force and is expected to reduce the number of surgical treatment centres.
- On-call services have undergone a shift towards emergency departments that provide primary and specialist care and are located mostly at hospitals. The array of services in larger hospitals

includes the availability of social welfare personnel at all hours.

- Long-term and mental health care are increasingly integrated with social services, and most care is provided closer to patients' homes. Mental health care is provided closer to somatic specialist care and substance abuse problems have been recognized as an important part of mental illness.

■ 5.1 Public health

Health promotion and the prevention of diseases have been a mainstay of Finnish health policy for decades. The main responsibility of MSAH is to protect and promote the health of the population. Health promotion is carried out both at the national and municipal level, and involves several agencies and institutions subordinated to the Ministry, as well as NGOs and other actors. The main sources of funding are municipal budgets, with separate allocations from the state budget determined by MSAH for specific projects. Since 2017, the Funding Centre for Social Welfare and Health Organisations (STEA) under MSAH has managed funding for NGOs from the state-owned Veikkaus Ltd which has an exclusive right to operate all gambling in Finland.

Environmental health services in Finland cover the health impacts of housing and public areas, noise pollution, the quality of drinking and bathing water, the assessment of adverse environmental health effects and waste management. Environmental health services also include the surveillance of gene technology, chemical control and protection from radiation. MSAH supervises health protection and is responsible for developing the principal legislation for environmental health services. MSAH carries the overall responsibility for tobacco control and has joint responsibility with the Ministry of the Environment for the control of chemicals and gene technology. The Ministry of the Environment has the responsibility for all other environmental issues. Other state bodies involved in environmental protection are the Ministry of Economic Affairs and Employment for radiation. The Finnish Food Safety Authority (Evira), a subsidiary of the Ministry of Agriculture and Forestry, ensures food safety and promotes animal health.

Municipalities (sometimes jointly) are responsible for the implementation of environmental health services, either within municipal health centres

or under the local municipal environmental protection authority. Municipal health inspectors ensure that environmental health legislation is complied with and provide consultation and guidance. Recent changes in legislation have shifted the responsibility for chemical surveillance from the municipalities to the Finnish Safety and Chemicals Agency (Tukes).

Prevention of communicable diseases is the responsibility of MSAH and THL. THL investigates infectious diseases, monitors their occurrence, provides guidance for professionals, and studies epidemics in collaboration with hospital districts and local authorities. Based on the recommendations from THL, MSAH decides on the national vaccination programme. Currently the programme includes free-of-charge vaccinations for children against 11 different diseases, and HPV vaccinations for girls. The 11 diseases are: rotavirus and pneumococcal infections, diphtheria, tetanus, pertussis, poliomyelitis, haemophilus b-infections, measles, mumps, rubella, and chicken pox. Also, children receive influenza vaccinations annually from 6 months to 6 years of age. MSAH is currently evaluating the administration of HPV vaccinations to boys according to THL recommendations. Adults receive a booster against diphtheria and tetanus every 20 years, influenza vaccinations for those aged over 65 years, and other supplementary vaccinations when needed or if they belong to specific risk groups (e.g. health and social care personnel, migrants, people living in areas with tick-borne encephalitis). All vaccinations are voluntary. THL has recently started a nationwide registry on vaccinations that collects information on vaccination status directly from patients' records.

The 2017 Government Decree on Infectious Diseases, based on the 2016 Infectious Diseases Act (1227/2016), redefined the classification of hazardous and monitored infectious diseases. It also aims to improve the collaboration and information exchange between physicians and authorities.

In terms of noncommunicable diseases, THL runs specific programmes to decrease the burden of chronic conditions and mental health problems. These include, for example, an online service that supports the planning and management of municipal and regional health promotion services (TEAvisari, <https://teaviisari.fi/teaviisari/en/>). THL regularly conducts a number of surveys, including the National Health, Well-being and Service Survey, FinSote.

According to the Occupational Health Care Act (1383/2001), the aim of occupational health care is to prevent work-related diseases and accidents and

to preserve the health and functional capacity of employees. According to this Act, every employee is entitled to occupational health care, regardless of the nature and duration of the employment relationship. Occupational health care is a service provided and paid for by the employer for the purpose of supporting the ability of employees to work. All employers are required to organize regular health examinations for their employees if the work involves special health risk factors defined in legislation (e.g. noise, flour dust or solvents) or is otherwise hazardous. Employees may ask for an opinion from occupational health care for health issues, and when confronted with, for example, physical or psychosocial overload at work. Besides early intervention when work capacity is compromised, occupational health care can assess the remaining work capacity of employees. Occupational health promotion is arranged by employers through their own, municipal or private service providers. Municipalities are obliged to organize occupational health services locally for employers who request them.

Maternal and child health care has a strong tradition in Finland and these services form a comprehensive network covering all municipalities and include services that involve the well-being of the entire family. Maternity clinics provide family support, monitor the progress of pregnancy and offer screening tests and consultations when necessary. Expectant mothers normally meet with a nurse and doctor 11–15 times during pregnancy. Attending a maternity clinic is one of the preconditions for eligibility for maternity benefit. Both parents are expected to take part in family and childbirth preparation sessions. Child health clinics provide support to families by organizing home visits by public health nurses prior to and after birth. These clinics assess the physical, mental and social state of children below school age, provide vaccinations and support parents. A 2011 Government Decree (338/2011) requires all children below school age to have 15 visits at the child health clinic, five of them under the supervision of a physician. One of the main functions of the clinics is to promote healthy growing environments for children and to encourage healthy family lifestyles. Children below 18 years of age receive publicly funded free-of-charge preventive dental care.

Sexual and reproductive health is promoted by a national action plan (currently covering the period 2014–2020), which emphasizes sex education, good care at birth, an understanding of multiculturalism, as well as male sexual and reproductive health (Klemetti & Raussi-Lehto, 2013). In practice, municipalities provide family planning and related services free of charge. The largest cities have separate clinics for treatment of sexually transmitted

diseases, but otherwise treatment is provided as part of the general services of health centres. Comprehensive family planning services and health education targeting young people have resulted in the lowest number of pregnancy terminations in the Nordic countries. THL gathers and publishes data on sexual and reproductive health, including statistics on abortions and perinatal health in the Nordic countries and surveys on school children's health behaviour (School Health Promotion, every other year).

Taxation of harmful products, such as alcohol, tobacco and soft drinks, is the primary means of controlling the use of these substances in Finland. The sale of alcohol is a state monopoly (Alko Ltd) and only products that contain less than 4.7% of ethyl alcohol were available for sale outside the monopoly alcohol shops since the early 1990s until 2018. After a heated debate, the Alcohol Act was reformed in 2017 (1102/2017), with changes entering into force in the beginning of 2018. The main changes were that retail stores can sell all kinds of alcoholic beverages that contain up to 5.5% alcohol by volume and restaurants' and bars' opening hours are deregulated (but not the serving hours). The reform maintains Alko's retail monopoly and the existing licensing system. THL and a special committee of MSAH continue to monitor the public health consequences of these changes. Valvira and the RSAAs perform the licensing, supervisory and guidance activities as stipulated in the Alcohol Act.

Bans on tobacco advertising and gradually increasing restrictions on smoking in public places have been implemented in Finland since 1976. In 2007, restrictions were imposed on smoking in restaurants. The Tobacco Act was reinforced in 2016 (549/2016) to adhere to the EU Tobacco Product Directive and national objectives. The changes include a ban on cigarettes with characterizing flavours, such as menthol, restrictions on smoking on balconies in private apartment buildings and in vehicles transporting children, and certain safety and quality requirements for e-cigarettes containing nicotine. The sale of tobacco to children under 18 years is prohibited in Finland and products are not openly available in shops. Advertising of tobacco and strong alcohol products is banned. Other measures used to attain the goal of a completely smoke-free Finland by 2030 are education, research and the use of nicotine replacement therapy. The latter was made available outside of pharmacies in 2006.

The latest nutrition recommendations by the National Nutrition Council, an expert body under the Ministry of Agriculture and Forestry, were published in 2014 (National Nutrition Council, 2014). They follow the Nordic recommendations but allow for less intake of salt. Dedicated recommendations

have also been issued for specific population groups, such as school children, young adults, older people and pregnant and breastfeeding women (Finnish Food Authority, 2019). As the Finnish adults are more often overweight than their Nordic counterparts, THL has launched a nationwide programme for 2016–2018 to decrease the prevalence of obesity (Box 5.1). In addition, MSAH has introduced a national strategy for physical activity that emphasizes the dangers of sedentary lifestyles (MSAH, 2013). Special attention has been paid to the nutrition and physical activity in older people and to the prevention of obesity in children. The Ministry of Education and Culture is responsible for creating favourable conditions for sports and physical activity.

BOX 5.1 Are public health interventions making a difference?

Overall the public health interventions that address risk factors for disease in Finland can be deemed to be effective although some setbacks have been seen lately; for example, the programmes that sought to fight obesity seemed to be successful at the turn of the century, but unsuccessful since the early 2010s. The weight of the working-age population has risen again and approximately a quarter of the population are obese (BMI over 30 kg/m²) (Koponen et al., 2018). Also, the prevalence of raised blood pressure and psychological distress, including depression, are worrisome. On the positive side, daily smoking has decreased, abstinence from alcohol use and the levels of physical activity have increased, and blood glucose and cholesterol values show trends that indicate less cardiovascular disease in the future.

The coverage of vaccinations is registered and published by THL (<https://thl.fi/roko/rokotusrekisteri/raportit2018/>). These reports can be used to evaluate the geographical variation in the coverage of the national vaccination programme for children. Typically this has been excellent, i.e., reaching 99% for the first DTaP-IPV-Hib vaccination at the age of 3 months. There has been more geographical variation in the coverage of rotavirus (93%) and pneumococcal infection (96%) vaccinations. The coverage of the first MMR vaccination is currently around 96%, but for the second at the age of 6 it is only 92%. There are geographical pockets particularly on the west coast where the coverage for MMR is below 90%. THL's interactive maps (<https://thl.fi/roko/rokotusrekisteri/atlas/atlas.html?show=influenza>) can be used to evaluate the coverage of influenza vaccinations in different parts of the country. In general, the percentage of children aged 6–35 months receiving these vaccinations has been quite low, less than 20%, but during winter 2017–2018 rose to 34.5%. For those aged more than 65 years, the respective number was 47.6%.

Municipalities are obliged by a 2011 Government Decree (Governmental Decree on Screening 336/2011) to provide the following screening tests for their residents: 1) breast cancer screening for all women between the ages of 50 and 69 years, or for those born in 1947 or after, every 20 to 26 months; 2) cervical cancer screening for women aged between 30 and 60 years every 5 years; 3) ultrasound examinations and screening for chromosomal abnormalities for pregnant women. In addition, there is newborn screening for hypothyreosis and specific inherited metabolic disorders. Municipalities may also offer other screening services, but are obliged to assess cost–effectiveness and ethical considerations. Screening for colorectal cancer was started in some municipalities in the beginning of 2019 and will become a nationwide programme in the 2020s.

■ 5.2 Patient pathways

The Finnish health system is characterized by a strong gatekeeping system by GPs for specialist level services (OECD, 2010). A patient's first point of contact for all non-urgent elective care is typically the local municipal health centre. The Health Care Act stipulates (1326/2010), in section §51, that patients must be able to get in contact with their health centre either by phone or visit without delay during opening hours when the need arises. If the health centre is reached by phone, a health professional, usually a nurse, will answer the call to make the first assessment or the system will register the call and the patient will be called back as soon as possible. A nurse will, according to need, give the patient home care instructions, an appointment to see a nurse, physical therapist or doctor, or a telephone appointment with a nurse or doctor. Patients may have a predetermined nurse–doctor team and can then call their nurse directly. A chronic care model (Wagner, 2004) with assisted self-care and multiprofessional teams is used in some health centres to care for patients with persisting morbidities. Also, many health centres currently use electronic services to give advice and assess patients' need for care or even artificial-intelligence-based algorithms to make correct appointments. When the initial assessment cannot be done by phone the patient has to be seen at the health centre within three office days and if further primary care is needed, this has to be provided within 3 months (or 6 months

for dental care) (2010 Health Care Act). Alternatively, occupational care is an option for employed persons. Patients can also consult private services provided by for-profit companies and receive a reimbursement from Kela, with approximately 16% of the cost being reimbursed in 2018 (Kela, 2018b).

From the first point of contact patients can be referred to specialist level public hospitals or – less often – to private specialists clinics. The referral itself is currently mostly in electronic format. The public route can also be a contractual consultation arrangement for selected specialists, typically for diagnostic procedures or interventions in complex situations. Private physicians and occupational health services can refer the patient to public outpatient clinics without limitations. Patients who have started their pathway in the private sector often ask for referral to public sector investigations, as they hope to avoid the high expense of private diagnostic investigations.

Waiting times for specialist outpatient clinics vary from 1–2 weeks to 2–3 months, depending on specialty and urgency of the condition. According to the national waiting time policies, established in the 2004 Care Guarantee legislation (1019/2004) and corroborated by the 2010 Health Care Act, the specialist clinic has to evaluate the need for care within 3 weeks and begin relevant specialist examinations within 3 months after receiving a referral. If the patient needs in-hospital care, this has to be provided within 6 months after the initial evaluation. Timelines are stricter in child psychiatric care.

Waiting times for both health centres and hospitals are routinely monitored and published by THL as well as by municipalities and hospital districts. The data on primary care outpatient visits are submitted to THL electronically daily or monthly, and the data on inpatient care are submitted once a year in accordance with definitions and guidelines provided by THL. Data for specialist care are collected every 4 months from all hospital districts and primary care units that provide specialist care services. Valvira and the RSAAs can impose monetary sanctions when waiting times exceed the specified limits, but typically issues are resolved before the imposition of fines.

Emergency care is defined as care that typically has to be given within 24 hours and cannot be postponed without adverse effects or deterioration of patient's condition (the Government Decree on Emergency Care in the Health Care Act (1326/2010) §50, 1516/2016). Patients can receive care for urgent complaints at the nearest point of service and all municipalities have to provide this at all hours either at specific joint (GP and specialist care)

on-call clinics or, if accessibility and patient safety issues necessitate, elsewhere. A dedicated national Medical Helpline has been recently established to assist patients seeking urgent care, 116 117, in addition to the emergency number 112 (Box 5.2).

BOX 5.2 Example of a patient pathway

In Finland, a woman in need of an elective hip replacement due to arthritis undergoes the following steps:

- She contacts the health centre of her resident municipality, most likely by phone. If she does not succeed in getting through, she will receive a call during the same day from a nurse or a receptionist.
- She will receive an appointment to see a GP at the health centre in the next few weeks.
- Depending on the municipal health authority, she may pay a small fee per visit (see section 3.4).
- The GP evaluates the patient's clinical condition, orders an X-ray of the hip, lab exams and medications when necessary. The diagnostic examinations are free of charge if performed by a public provider or partly reimbursed by NHI if the patients want to minimize their waiting time and seek help from private service providers. NHI reimburses around 13.7% of these costs.
- The GP may also order physiotherapy that is usually provided by a private therapist. NHI will reimburse approximately 13.7% of the cost of 15 1-hour sessions.
- The patient takes the prescription her GP wrote for analgesics to the nearest pharmacy. NHI will reimburse the costs of these drugs for up to 40% of total cost (basic level of reimbursement) if her deductible share for the year (€50) has been exceeded. If her medicine costs have, however, reached her annual payment cap of €572 she will only pay €2.50 for any prescription drug.
- The second appointment is scheduled to evaluate the results of the X-ray and a possible deterioration or improvement of her clinical condition.
- After jointly deciding on the potential need for operative treatment, the GP writes a referral to orthopaedic care. Some health centres may have a visiting orthopaedic surgeon to consult.

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- The patient has free access to any public hospital in Finland and her GP advises her which hospital to go to. Typically, the referral is to a hospital with orthopaedic services run by the hospital district of which her resident municipality is a member. The patient may have to wait for a specialist outpatient hospital appointment for 3 months or more, and incur further waiting time if other examinations (e.g. MRI) have been prescribed.
- The need for operative care is assessed by a hospital-based orthopaedic surgeon who also advises the patient on choosing the operating hospital if non-surgical measures, such as weight loss, have not eased the symptoms. The patient then has to wait for inpatient admission and surgery.
- If the patient does not want to wait at all, she can choose to go to a private hospital. She must pay for treatment out of pocket, and will receive a small reimbursement (approx. 16% of total costs) from NHI. A minority of patients chooses this option.
- Following surgery and primary rehabilitation at the hospital, the patient is discharged.
- Prior to discharge a physiotherapist may, depending on the municipality, check her home for necessary changes, such as removal of thresholds and insertion of aids.
- After discharge she will receive a bill from the hospital for typically €48.90 per care day. Care may be free of charge if she has reached the in-hospital payment cap of €683 during the same calendar year. If she has paid for a private health care insurance, she will receive all examinations, medications and most of the care for free.
- If the patient is employed, she will receive the occupational care visits for free of charge and depending on the contract between her employer and the care provider, at least some of the examinations for free.
- The physiotherapy that started at the hospital continues after discharge and other home care (assistance or nursing) prescribed by the hospital is provided by the municipality for a small fee determined by the patient's income.
- The GP receives a discharge summary from the hospital and primary care nurse removes the sutures and checks the wound when instructed by the surgeon.

A follow-up hospital visit is likely to take place to check the outcome of the procedure.

■ 5.3 Primary care

Primary care is provided through three overlapping health systems, i.e. the public municipal health centre-based system, occupational health care and private for-profit care. Also, the Finnish Student Health Service (FSHS), a not-for-profit organization provides primary health care services, including mental and oral health care services for students of universities and other institutions of higher education (Hetemaa et al., 2018).

Municipal health centres

The ground-breaking Primary Health Care Act of 1972 (77/1972) outlined the current system of delivering municipal primary health services through health centres which provide primary curative, preventive and public health services to its population. The health centre is an administrative body and its activities can be organized at several locations, i.e., at health stations or clinics and increasingly at patients' place of domicile. Municipal health centres or stations usually denote GP group practices which employ nurses, public health nurses, and other professionals depending on the size and needs of the population. Furthermore, remote services are developing, and digitalization plays an increasing role in health care.

Municipalities (of which there are 311 in 2019) can organize primary care services on their own (about 60%), form a joint authority with other municipalities (about 20%), or transfer the responsibility to a host municipality (also about 20%).

During recent years, smaller municipalities typically have either not been able to organize these services due to, for example, a workforce shortage, or have anticipated increased productivity with cost savings and therefore outsourced the provision of all or some of the services to for-profit companies (Junnila & Fredriksson 2012; Junnila et al., 2012). The latest analysis of this trend showed that 13 of the 151 organizing bodies had outsourced all of their primary care functions, and 14 some functions, to private companies (Parhiala & Hetemaa, 2017). Some 6.8% of the population and 50 health stations were thus in 2017 covered by private provision, with half of these stations having only private providers. Two large for-profit companies had 62% of the overall market and three, 96%. Private staffing companies started to lease physician workforce to health centres at the end of the 1990s. Currently, approximately one in 10 health centre physicians are employed by these companies and other salaried employees (Finnish Medical Association, 2016).

Legislation does not stipulate in detail how services should be provided, and in most cases this is left to the discretion of municipalities. For some services, such as maternity and child health clinics, as well as school health care, there are national guidelines. Typically, health centres provide the following services: 1) ambulatory curative care, both for acute and chronic patients; 2) preventive services, including maternity and child clinics; 3) home nursing for older people or for selected groups of chronic patients; 4) dental health services; 5) rehabilitation in various forms; and 6) mental health services and substance abuse services (Hetemaa et al., 2018). Health centres typically have a stock of medications for their own use. Other services, such as physiotherapy, psychotherapy, speech and language therapy, occupational therapy and medical specialist consultations may be available, depending on the municipality. Larger health centres are usually well equipped with staff and medical technologies. They have routine access to other specialties; for example, for interpreting radiological examinations. In addition to consultation rooms, larger centres may provide radiological facilities, laboratories for taking samples (analysis is typically outsourced to larger entities owned by hospital districts), other diagnostic equipment (such as for undertaking electrocardiogram and ultrasound examinations), and even facilities for minor surgery and endoscopic examinations. The array of services provided in these facilities is in most cases wider than that seen in GP practices in other countries.

The personnel of larger health centres consist of a wide range of health professionals: GPs, nurses, public health nurses, midwives, social workers, dentists, physiotherapists, psychologists, nutritionists, speech and language therapists, occupational therapists and administrative personnel. The number of inhabitants per health centre physician varies and is not officially defined. GPs and nurses play a key role in coordinating services, particularly for patients with chronic conditions.

A team model of care of complex patients is more and more prevalent, and a nurse may function as a case manager. Nurses in primary care have adopted increasingly advanced roles, particularly in the care of chronic conditions, and retain the responsibility for many parts of acute care; since 2010, nurses have had limited rights to prescribe medications (Pasternack et al., 2018; Keskimäki et al., 2019). Smaller remote health stations may have a nurse or a physician intermittently present, as there has been a chronic shortage of physicians in more remote rural areas. A recent Finnish study

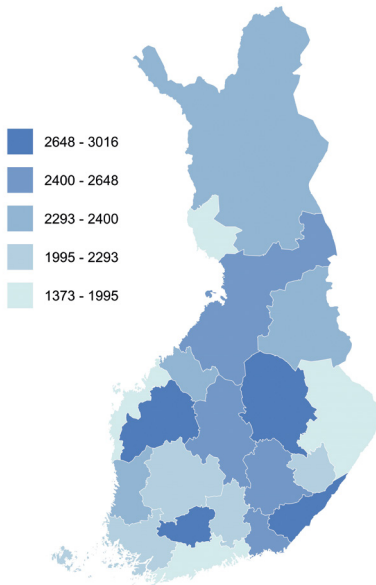
showed that approximately 50% of acute cases can be handled by a nurse without the physician's intervention (Parhiala et al., 2016). In addition, nurses provide telephone consultations and they also coordinate care of patients with chronic or multiple illnesses. The number of patient contacts using electronic consultations is on the rise (Hetemaa et al., 2018) and such consultations are typically handled by a nurse, with physician back-up.

Inpatient departments in health centres are a specific feature in Finnish primary care. There were 226 of these inpatient hospital-type wards staffed with nurses and overseen by a permanent or visiting GP, or specialist in geriatrics in 2015 (Mikkola et al., 2015). These units account for about 20–25% of all acute admissions. A typical health centre inpatient facility has 30–60 beds, but, in bigger cities, such as Helsinki, they are even larger and include medical specialists among the permanent staff. These wards have for a long time been used for the long-term treatment of older people with chronic diseases. During the last decade, due to the centralization of specialist care and changes in the care for older people (see section 5.8), these GP-run facilities have in some areas taken a more active role in rehabilitation and some parts of specialist care, such as cancer care. Currently these wards are often used in equal parts for acute and chronic care, with some beds reserved for patients suffering from dementia or otherwise needing intermittent care. This arrangement contributes to the high overall number of hospital beds in Finland (Mikkola et al., 2015).

All health centres offer acute emergency services during office hours, provided by either GPs or nurses. In exceptional circumstances, and with permission from MSAH, municipalities can organize 24/7 emergency care, but since 2013 the responsibility for most out-of-hours services has been transferred to hospital clinics, where primary and specialist on-call services take place in the same premises, making specialist consultation more accessible.

Health centre-based home nursing is provided together with home help services, which originate from the social sector, forming a new entity called “home care”. Many health centres also provide other social services for their population and disseminate information on, for example, social welfare benefits.

In 2017, there were on average 4.6 visits for any type of public primary care service and 2.2 GP contacts per inhabitant (Sotkanet.fi). There were marked regional differences in the number of visits per population (Fig. 5.1).

FIGURE 5.1 Number of all GP contacts including phone calls per 1 000 population, 2017

Source: THL; Sotkanet.fi

Routinely, citizens are registered with the health centre closest to their place of residence. According to the provision of the 2010 Health Care Act implemented in 2014, patients can choose their health centre once a year from all centres in the country. However, they cannot choose the treating physician and have to notify the health centre they wish to choose in advance of their plans to use its services. If they do not exercise this right to choose, they are listed to the health centre closest to their place of residence.

Occupational health care services

Employers organize mandatory preventive occupational health care for their employees (Occupational Health Care Act 1383/2001). To a varying extent, employers also organize curative services. Occupational care reimbursed by NHI covered 87.6% of the workforce in 2017 (Kela, 2018c). These clients received occupational care services from private for-profit companies (60%), from municipal health centres (22.8%) or from dedicated occupational care centres (15%). The total number of occupational care visits has been around 6 million annually, i.e. approximately 3 per person and year. These include visits to physicians, nurses, psychologists and physiotherapy for preventive check-ups and medical indications. Other services such as nutritionist and specialist consultations may be available, depending on the contract the employer has made with the service provider.

The occupational health care costs constitute approximately 20–30% of primary care costs but vary considerably by region (Hujanen & Mikkola, 2013). These costs are highest in the Helsinki-Uusimaa region (31%) and lowest in Eastern Savo (17%). There is an inverse correlation between total primary care costs and occupational care costs. This arrangement into two separate health care systems depending on employment status has been criticized for its overall inequity implications and for its potential attraction of physicians to shift away from municipal primary care services, but political support to retain the current arrangement is broad.

Private health care services

Altogether, in 2017, NHI reimbursed 707 000 visits to primary care level private providers and there were 12.8 visits per 100 inhabitants (Kela, 2018b). The reimbursement was on average 16% of the cost of the visit (Kela, 2018b). The patient fee can typically be determined by the practising physician and is often time-dependent, with costs of any diagnostic examinations and medical certificates billed separately.

BOX 5.3 What are the key strengths and weaknesses of primary care?

The role of primary care in Finland differs from the solo GP practice model of many other European countries – a GP in Finland is expected to and is able to diagnose and treat patients independently to a degree typically seen in specialized care in other EU countries (Parkkila-Harju, 2018). Many traditionally in-hospital services are now taken care of by health centres and thus their duties have expanded rapidly. Moreover, the population base in health centres is biased towards the socially and medically demanding, i.e., the very young and the aged, and those of lower socioeconomic or educational level (Kestilä & Karvonen, 2019). This is due to the co-existing occupational and private health care systems. Primary care is in theory the backbone of the Finnish health care service system. In reality, primary care services are plagued particularly by accessibility problems. According to THL follow-up of waiting times, 45% of the population waited a week for elective GP appointment and 3% more than 3 months (THL, 2019a). On the other hand, almost 70% of patients were able to see their nurse within 3 days. The protracted waiting times for GP consultation are at least partly due to the increased financial and physician resource investments into specialized care at the expense of health centres.

The continuity of care has been the focus of many projects financed by MSAH during the 2000s (Raivio, 2017). The tools used in these projects have been, for

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example, care plans and Chronic Care Models (Wagner, 2004). According to THL customer satisfaction surveys, patients are very satisfied with their services (4.6 on a scale of 0–5) in health centres, but slightly less so with the communication between different care providers (4.4/5).

The reputation of health centres is not always impeccable as they are sometimes called “guessing centres” (Tiirinki, 2014). However, repeated studies show that the Finnish population retains trust in health care services – 80% of the Finns trusted the health services and 83% the personnel in 2018 (Kestilä & Karvonen, 2019).

The quality of Finnish primary care is generally considered to be good (see Chapter 7.6), hospital admissions for people with chronic conditions are generally avoided and the survival rates are high for patients admitted following a heart attack or stroke, and for different types of cancer. On the downside, the unmet medical needs in Finland are large, regional disparities exist and patients have limited freedom to choose their care provider.

■ 5.4 Specialized care

Specialized care, both ambulatory and inpatient, is provided by five types of public organization. Four of these are owned by the hospital districts and one is owned by one or more municipality:

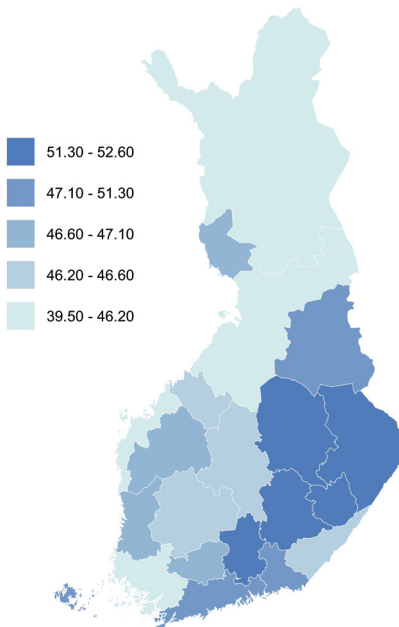
1. Five university/tertiary hospitals that are attached to medical schools and serve as central hospitals for their immediate population. Their tertiary service catchment populations range from 741 807 (Oulu) to 2 148 143 (Helsinki) (Kuntaliitto, 2018a). For selected treatments and population groups, their responsibilities may be nationwide.
2. Central hospitals (15 overall, in addition to the abovementioned university hospitals). These hospitals provide the traditional range of medical specialties with some subspecialization in surgery and internal medicine. They all maintained emergency and surgery services on a 24/7 basis until 2018, but government centralization efforts have reduced the number of central hospitals that provide a broad spectrum of services to eight,

located in Lappeenranta, Lahti, Jyväskylä, Joensuu, Rovaniemi, Vaasa, Seinäjoki and Pori. The catchment populations for these central hospitals ranges from around 100 000 to 200 000. Central hospitals with a more limited variety of on-call services are in Hämeenlinna, Kemi, Kokkola, Kajaani, Kotka, Mikkeli and Savonlinna. These hospitals have population bases ranging from 43 000 to approximately 170 000. The Government is currently preparing to change the Vaasa central hospital back to a broad spectrum hospital.

3. Hospital districts previously operated smaller local hospitals, but many of them have either been shut down or merged into university or central hospitals. Examples of such hospitals are located in Turku, Tampere and Oulu University Hospital catchment areas. These previously fairly independent hospitals are currently run as university clinic departments. Typically, the range of inpatient care is limited to the largest specialties, such as surgical day care, and out-of-hours services are variable. Catchment populations may range from 20 000 to 100 000. As well as the main hospitals located in Helsinki (Helsinki University Central Hospital, HUCH), Helsinki University Hospital district operates four, at least nominally, independent hospitals and two subsidiary hospitals of HUCH in Espoo and Vantaa. The overall number of hospitals in this category is currently 13 and their population bases range from 43 000 to more than 200 000. Their profiles are, in some cases, shifted to primary care or rehabilitative service provision with closure of specialist on-call services.
4. Hospital districts own psychiatric inpatient facilities located at a distance from the central or other somatic care hospitals. These hospitals have either been closed (11 since 2012), or there are plans to close them (six hospitals). Their current number is 10. Some of them have outpatient departments, but ambulatory psychiatric care is mostly provided by departments at central or university hospitals.
5. Specialist-run health centre hospitals (14 overall), owned and run by single municipalities (in larger cities) or jointly by several municipalities, mostly provide primary care but with some basic internal medicine and surgical services in ambulatory and day surgery settings. Their future is uncertain, as some may be undergoing conversion into inpatient health centre units, and some have rented part of their premises to private companies.

The number of patients treated in specialized somatic and psychiatric care has increased steadily in recent years. In theory, all patients admitted to secondary or tertiary care need a referral from primary care. In 2015, 41% of all inpatient care episodes were referred from the health centres, with a further 18% referred by private providers. However, a large share of patients bypass initial referral through directly accessing hospital-based emergency care units (THL, Sotkanet.fi). The percentage of in-hospital care periods beginning through emergency departments is particularly high in the north-eastern parts of Finland (Fig. 5.2).

FIGURE 5.2 Care periods for patients treated in hospitals with admission through emergency departments as a percentage of all care periods by hospital district, 2017



Source: THL; Sotkanet.fi

Since 2014, patients have been able to choose where they want to receive specialist services (Health Care Act 2010). The referring physician must discuss the options with the patient and offer information regarding, for example, waiting times. Waiting times for specialist services can be lengthy (see section 5.2), particularly for orthopaedics, gynaecology and ophthalmology.

The quality, outcomes, performance and efficiency of the Finnish hospital system has been studied extensively (EuroHOPE Study Group 2014;

Kittelsen et al., 2015). Recommendations to develop a focus on quality was an MSAH priority when the 2010 Health Care Act (1326/2010) was issued with a section (§8) on quality and patient safety. The Association of Finnish Local and Regional Authorities published guidance on the implementation of this legislation (Koivuranta-Vaara, 2011). The University Hospitals employ dedicated chief medical officers to supervise the development of quality and patient safety in their catchment area.

■ 5.4.1 Specialized ambulatory care

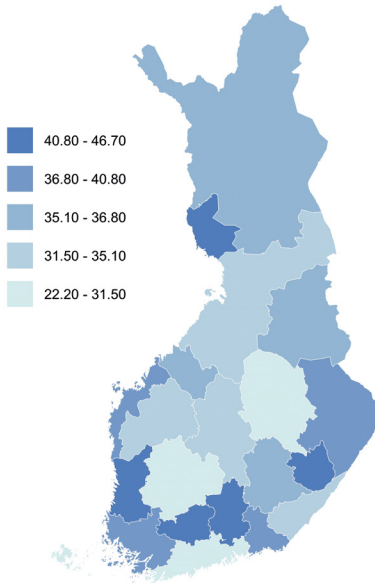
Specialized ambulatory care is mainly provided in outpatient departments of public hospitals, or, for minor treatments and where expertise is available, in larger health centres. The latter may collaborate with their local or central hospitals for the acquisition of consultative services and small procedures, such as endoscopy and stress ergometry. Over time, the total number of outpatient appointments per 1 000 population has increased from 1 022 in 2006 to 1 401 in 2016.

Private clinics offer services, particularly in the areas of gynaecology and ophthalmology, but also for other specialities depending on regional demand. The clinics can be partly or wholly owned by a publicly financed hospital district or a private insurance company, but for-profit companies prevail. The NHI reimburses part of the cost when patients use private ambulatory specialist services. The number of privately provided visits in 2017 was 2.7 million, corresponding to a ratio of 0.5 per inhabitant. The reimbursement covered on average 16% of the total cost (Kela, 2018b).

■ 5.4.2 Day care

Finland had a somewhat slow start in developing day care in specialized health services, due to the topographical remoteness of some areas. Nowadays, day surgery is more established and day care procedures currently account for slightly less than half of all surgical operations, although with major variations between hospital districts (Fig. 5.3). Most hospitals and some larger health centres provide day care, mainly for minor surgeries, endoscopies and cardiac procedures.

FIGURE 5.3 Day care surgery patients per 1 000 population in Finnish hospital districts, 2017



Source: THL; Sotkanet.fi

■ 5.4.3 Inpatient care

Inpatient care is provided largely by hospital districts, but there are also large private hospitals specializing in orthopaedic surgery (2 hospitals), cardiology (1), cancer care (1) and some smaller units (see Chapter 4). Inpatient care has been transformed since the early 1990s towards more centralized services, as well as a shift into other settings. This is reflected in a reduced number of hospitals, a decreased number of inpatient care periods, a shortened average length of stay, and an increase in day surgery. Many inpatient wards have been closed or combined with other general-purpose wards, as outpatient care caters for most needs. This is especially true for some specialities, such as pulmonology, rheumatoid diseases and dermatology.

Several publications have shown that there have been unacceptable levels of regional variation in surgical procedure rates and medical care in Finland (Keskimäki et al., 2000; Vuorma et al., 1998; Mikkola et al., 2005; Nguyen et al., 2003). Together with the long waiting times for elective surgery, the persisting rates of variation resulted in the instigation of a national project called “Care Guarantee”. Based on this project, the Primary Care Act 66/1972 and the Act on

Specialized Medical Care 1062/1989 were supplemented with a Governmental Decree on Access to Care and Regional Cooperation (1019/2004). In addition to maximum waiting times, this Decree specified that the joint municipal boards of hospital districts have the responsibility for providing the specialized medical care prescribed in the Act in accordance with uniform medical principles and in collaboration with other hospital districts. The National Health Care Project was initiated in 2004 in order to secure access to treatment on equal grounds irrespective of the place of residence. In 2010, MSAH published the uniform criteria on access to non-urgent care (MSAH, 2010). Other guidance for health care personnel has been available in the widely used Current Care Guidelines published by the Finnish Medical Society, Duodecim.

Despite these measures, the geographical variation in medical practices persists in Finland (Keskimäki et al., 2014). This report showed that, for example, the rates for coronary revascularization and diagnostic tests are around two times higher in high activity areas than in low activity areas. The variations observed for caesarean sections and knee replacements were less pronounced. Over time these variations had increased for coronary procedures. In 2018 MSAH initiated an updating of the uniform criteria, and the work is ongoing.

There has not been a systematic national level follow-up of medical practice variation until the recent reform plans established a new unit within THL to evaluate the performance of the new organizing entities, counties. Although the plans for reform have been deferred, THL will continue its analyses on care practices together with MSAH.

BOX 5.4 Are efforts to improve integrated care working?

Health centre-based home nursing is provided together with home help services originating from the social sector forming an integrated service (“home care”) targeted for those unable to cope. These professionals offer practical assistance with everyday tasks that extend to a range of medical nursing tasks, such as treating chronic ulcers or administering medications and injections.

Patient specific care plans have been developed as a tool for integrating different care providers’ contributions, particularly for complex cases and when social welfare services are needed. However, the format and use of the plans are not yet fully established.

continues

continued

Primary and secondary levels of care have designed regionally adapted recommendations of patient pathways that are published on the hospital districts' Internet pages and the national physicians' Internet portal, Terveysportti (<http://www.terveysportti.fi>). These recommendations usually reflect the national Care Guidelines (Nuutinen, 2017). More generic pathways have been adapted across several hospital districts; for example, in northern Finland.

Despite these recommendations, there is often a lack of continuity of care between different parts of the system. A specific bottleneck is the point of discharge from hospital care for patients who no longer need specialist care but lack suitable follow-up care at their place of residence. Consequently, dedicated teams of nurses have been established in many municipalities and hospital districts to ensure patients' safe return home. In some municipalities, teams also include physiotherapist and occupational therapist. After discharge, patient might have a short intensive home rehabilitation period. All of this care is coordinated by the patient's primary care physician.

BOX 5.5 What do patients think of the care they receive?

Increasing patient involvement in their own care and their input for the development of services has been one of the key improvement goals of the Finnish health care system (Linnanmäki, 2017). The use of patients' viewpoints on their care continues using different methods such as:

- specific patient satisfaction surveys on user experience;
- population surveys that include questions on patients' opinions of care and public satisfaction with the health system. The FinSote National survey operated by THL produces follow-up and evaluation data on the views of the population on the social welfare and health care service system, and the availability, quality and use of services. The project develops different indicators for national level follow-up and results can be found in the Terveystemme (Our health) online service (<http://www.terveystemme.fi>);
- municipalities' checklists of different means to involve patients;
- patient-reported outcome measures (PROMs) that are piloted in at least one hospital district.

■ 5.5 Urgent and emergency care

In Finland, emergency care refers to all services and interventions related to the first response to urgent and potentially life-threatening situations including emergency transportation of patients and emergency response teams.

In 2011, the Health Care Act of 2010 supplemented by MSAH Decree (340/2011) transferred the responsibility for prehospital ambulance services from the municipalities to the hospital districts. Currently, the service can be either under the direct management of hospital districts, be integrated with the fire and civil rescue service systems, or be contractually purchased from another public or private service provider. The latter arrangement expanded with MSAH Decree (585/2017) and is to be applied particularly for non-urgent patient transfers (MSAH, 2019a). This Decree also centralized the responsibility for organizing these services to the five university hospitals. Data on emergency care services has not been collected at national level, but a database is under construction. There are currently six helicopter service units maintained by the five tertiary care districts and financed by the state. The day to day operations are run by a non-profit company (FinnHEMS Ltd) owned by the university hospitals.

Primary health care and specialized services have traditionally had their own systems of on-call emergency care, and 60% of health centres continue to offer some type of care for urgent cases during office hours (Parhiala et al., 2016). Increasingly the out-of-hours services of both primary and specialist levels are provided through a more consolidated network of sites. This progress was hastened by the 2014 MSAH Decree on Emergency Care Services (782/2014). This decree and the 2017 Governmental Decree (583/2017) shifted the focus of all, both primary and specialist, care on-call services to jointly organized emergency care units located typically at hospital premises and operated by doctors from health centres and specialized care. These Decrees also specified the requirements for key medical specialties including the minimum acceptable total number of deliveries annually per hospital and the presence of key specialists in hospitals with on-call units or that perform any type of surgery. These Decrees changed emergency care services considerably as, in the 2012 THL assessment, 10% of the population received their 24/7 on-call services at health centres (Reissell et al., 2012), but only 5 % in the 2015 assessment (Parhiala et al., 2016). The number of hospital-based joint on-call units has decreased as smaller hospitals have

BOX 5.6 Patient pathway in emergency care

On a Sunday morning, a man in a Finnish community with suspected acute appendicitis would take the following steps:

- He checks (in most cases this is well-known) for an open primary care out-of-hours service in his municipality. He may call the telephone service (national number 116 117 in development), check the municipality website for instructions or go directly to the service site. If his general condition is not good, he may call the national emergency number 112 that dispatches an ambulance to evaluate his health status at home.
- Depending on his place of residence and time of day, the man would first be examined at a health centre or hospital-based on-call department. Regardless of the location, typically a GP, or increasingly a trained nurse, would examine him and would decide whether he needs to be transferred to hospital or be seen by a surgeon. The GP or nurse may order some preliminary tests, such as blood and urine analysis. If his clinical picture is clear, he would usually be referred for surgical consultation.
- The surgeon examines the patient again and orders further lab tests, if this was not done by other members of the staff, and writes referrals when needed for radiological examinations, such as ultrasound or CT-scans. He/she determines the next steps based on his/her clinical examination and the test results, or the surgeon may use diagnostic score calculators (Sammalkorpi et al., 2014).
- If the suspicion of appendicitis remains, the surgeon may operate on the patient that day (Sunday). If the patient is deemed to be at low risk of complications, the operation may be delayed until Monday morning.
- Travel costs by public transportation, private car, taxi or ambulance from the patient's home to the GP service and from there to the hospital and later back home, are largely reimbursed by the NHI. The patient will need to get a certificate from the service provider and has to pay a personal liability of €25.
- The patient will receive a bill of €48.90 per care day, and typically nothing else as the polyclinic fee is waived due to admission.

closed since 2014 or, as in Varsinais-Suomi and Pirkanmaa hospital districts, large university hospitals have merged local hospitals under their jurisdiction into one hospital and concentrated most of the on-call services into

the main unit. The centralization is continuing with a recent revision of the 2010 Health Care Act that was implemented in January 2017. This amendment centralized all on-call surgical services offering 24/7 care to 12 major hospitals (5 university and 7 central hospitals), and included social welfare services as an integral part of joint emergency care departments.

Tertiary level hospitals may have several, separately located specialty focused on-call hospitals.

■ 5.6 Pharmaceutical care

After several mergers and takeovers, Finland has only one major domestic pharmaceutical company, Orion Ltd, with the main part of its 2018 market share (10%) covered by generic products. The second largest seller is Merck Sharp & Dohme, with a market share of 7%. Due to the existence few production facilities in Finland, the great majority of pharmaceuticals are imported. Because of this, pharmaceuticals companies, importers, health care units and THL are legally obliged to maintain relatively large crisis preparedness stocks (mandatory reserve supplies).

In Finland, mainly two wholesalers provide nearly all pharmaceuticals to the community and hospital pharmacies. The pharmaceutical manufacturer makes a sole-distribution contract with the wholesaler and the products are available only through that wholesaler (a so-called one-channel system). Certain products may be delivered through an alternative route directly from the manufacturer to hospital pharmacies, mainly for inpatient care. Fimea publishes information on specific medicine shortages.

Community pharmacies are privately owned by pharmacists. There were 616 privately owned pharmacies in Finland in 2017, and a further 196 subsidiary pharmacies run by pharmacists in addition to their main pharmacy (Association of Finnish Pharmacies, 2019). Fimea grants permissions to run subsidiary pharmacies in areas where it is not economically viable to run an independent pharmacy. In rural areas, where even a subsidiary pharmacy is not economically viable, Fimea can give permission to a pharmacist having a pharmacy in the same region to run a service point for over-the-counter and pre-ordered prescription medicines.

In addition to this, the University of Helsinki and the University of Eastern Finland have their own outpatient pharmacies (18 in total). Hospitals

and health centres also have their own pharmacies and medicine dispensaries, but they can dispense medicines only to their own wards and departments. On special occasions, a patient who is discharged may be issued medicines from the hospital to ensure the continuation of the medication.

Electronic prescription has been in use in Finland since 2013. In 2017, e-prescription became the only method of prescribing except in case of technical failure and emergency cases. Prescriptions are usually valid for 2 years except in cases when the physician has restricted it for shorter period.

In outpatient care, physicians do not have any financial incentives, such as holding a budget to assess costs, and Kela as a payer has limited options to directly influence physicians. However, in principle, according to the legislation, the physicians are obliged to take account of cost-efficiency in prescribing. Prescription patterns have also been somewhat regulated by limiting reimbursement for defined patient groups. In inpatient care, the physicians need to assess costs more closely as expenditures are included in the departmental budget in hospitals. Pharmaceutical expenses have been a

BOX 5.7 Is there waste in pharmaceutical spending?

Price regulation conducted by the Pharmaceutical Pricing Board is strong so wholesale prices are rather low in Finland. In addition, reference pricing and compulsory generic substitution have induced strong price competition among pharmaceuticals with generic alternatives.

The weak point in the Finnish system in terms of rational pharmacotherapy is the structure of the retail price in outpatient care. Pharmacies are private monopolies in their catchment areas and there is hardly any competition among them. The payer (Kela) of outpatient medicines does not have any means to steer prescribing. There are some national level steering by the Current Care Guidelines but cost-effectiveness is not in the primary focus of these guidelines. A timely topic is how to increase the use of biosimilars in outpatient care. These medicines are used widely in inpatient settings as hospitals have strong economic incentives to increase their use. Due to this lack of effective steering mechanism, and despite the fact that the use of the cheapest pharmaceutical product is obligatory, the use of biosimilars has been negligible in outpatient care.

MSAH has recently initiated a project to renew the financing, distribution, and guidance at national level of the entire pharmaceutical field with the use of e.g., digital tools (MSAH, 2019a).

target of state budget cuts for a long time. Several measures have been attempted, such as reimbursement rates, and introducing deductibles and different measures to increase price competition.

The most recent measures have come into effect in 2017. These include restricting the dispensing of expensive drugs for a period of up to 1 month at a time, issuing a new batch of regular medication only after the previous batch has almost been consumed, and lowering the reimbursement for type 2 diabetes medicines from 100% to the 65%.

The total sales of pharmaceuticals was €3.1 billion in 2017, amounting to €558 per person. Outpatient prescription medicines accounted for 68% of this, OTC drugs for 11% and hospital sales for 20% (Fimea & Kela, 2018).

■ 5.7 Rehabilitation/intermediate care

MSAH defines rehabilitation to consist of the following categories: medical rehabilitation, rehabilitative work experience for long-term unemployed, vocational rehabilitation, rehabilitative psychotherapy, social rehabilitation for the severely socially excluded, rehabilitation in the event of workplace or traffic accidents, rehabilitation under the Military Injuries Act, disability services, and discretionary rehabilitation.

The responsibility for organizing and paying for rehabilitation services is shared between several organizations. In addition to Kela, rehabilitation services are provided by public sector health care providers, such as health centres and hospitals, and paid for by municipalities. The public health authorities also provide assistive devices needed with daily activities, such as mobility and communication aids. Insurers are involved when rehabilitation is needed after traffic or workplace accidents. Private payers and employers can acquire supplementary services, but most of the statutory services are provided free of charge.

Rehabilitation in health care is provided in hospitals, health centres, and sheltered housing facilities or as outpatient care, depending on the patient's need for care. Many activities of the municipalities in rehabilitative care have been outsourced to not-for-profit organizations or private providers. Service vouchers are often used to provide services, such as physiotherapy.

Kela both funds rehabilitation services and provides income security (Rehabilitation Allowance) during participation in rehabilitation. In 2017,

the total number of beneficiaries was 120 165 and the overall costs were €453 million (Kela, 2018b). Recipients of psychotherapy services were the single largest group of patients and their number has markedly increased during the 2000s (Kela, 2019). The rehabilitation services provided by municipalities and hospital districts are typically not reported separate from medical diagnoses and interventions.

Many aspects of publicly provided rehabilitation services have improved over the past few years. In many areas, GP-run inpatient facilities in health centres have shifted their focus from long-term care to active rehabilitation. Under the auspices of hospital districts, many local hospitals have been converted into units providing mainly active rehabilitation. Particular attention has been paid to multiprofessional care of patients with neurological diseases, such as strokes and dementia. Project-based interventions have improved continuity of care for patients, such as those discharged from hospitals after hip fractures. Patient associations have an active role in the rehabilitation of, for example, coronary heart and cerebrovascular disease patients. However, there are large regional variations in the availability and accessibility of services and lack of data to assess their quality. Moreover, the organization of Finnish rehabilitation services has been criticized to be fragmented, the responsibilities of different actors involved are considered to be blurred and rehabilitative interventions are not pre-emptive (Lith, 2014).

■ 5.8 Long-term care

Institutional long-term care in Finland is provided mainly for older people and people with disabilities, for children in need of custody and for substance abuse patients. The grounds for admission into long-term institutional care have been stipulated in the Social Welfare Act of 2014 (1301/2014), in the Act on Care Services for Older People dating from 2012 (980/2012) and in the Act on Disability Care from 1987 (380/1987).

There have been significant changes in the provision of long-term care in Finland for older people in the 2000s. Depending on the municipality, institutional care was previously provided in health centre wards and nursing homes. In the early 2000s the nursing homes were largely converted into living in sheltered housing with or without 24/7 assistance. In the last

decade, the role of the private sector, and particularly for-profit services, has increased. In 2017, about half of the sheltered housing services for older people were provided by the private sector. There is large regional variation in the availability of different types of long-term facilities and the quality of care. Most older patients requiring institutional care suffer from dementia (Kehusmaa et al., 2018).

MSAH and the Association of Finnish Local and Regional Authorities have published recommendations on the quality of care for older people in 2001, 2008, 2013 and 2017 (MSAH, 2017a). The strategy for the future, outlined in Finnish policy for care for older people, is to further increase the number of those living at home with adequate home care and to decrease the proportion of those aged over 75 years living in institutions to below 2–3%. The ratio of nursing staff per patient was recommended to be over 0.5 in institutions. According to a 2018 evaluation, 95% of institutions adhere to this standard (Kehusmaa et al., 2018). In 2017, 1.2% of those aged more than 75 years were in institutional long-term care (Sotkanet.fi).

People with disabilities are offered special residential services and other services by municipalities and their federations (“special welfare districts”). The guiding principle in disability care has been the right for self-determination and participation in society with no discrimination. The national plan to change the living conditions from institutional care to regular home environments (VAMPO 2010–2015) stated as its goal that no people with disabilities should be living in institutions in 2020 (Sjöblom, 2016). Although the development of independent living or moving from institutional care to sheltered housing began in the early 2000s and has continued successfully, there remain mainly centralized facilities that provide long-term care. As for other services, regional variation is large (Tanhua, 2017). Most of these facilities are owned by municipality federations, and approximately 10% by NGOs or for-profit companies. In 2015, there were 962 long-term residents in institutions and 105 severely disabled living in sheltered housing (Nurmi-Koikkalainen et al., 2017).

Long-term care for patients with chronic substance abuse is mostly provided in specialized facilities run by NGOs or municipalities, and the services are financed by municipalities. There were altogether 7 713 patients receiving rehabilitation in 2017 (Sotkanet.fi), some still in health centre wards.

■ 5.9 Services for informal carers

The importance of informal carers for long-term care is well recognized in the Finnish social and health services. Legislation on informal care was decreed in 2005 (Act on Compensation for Informal Care 2005/937). It states that an informal carer can be a family member or otherwise closely connected to the patient and that the local municipality may offer compensation to the caregiver if the overall setting and arrangements are adequate. In essence, the disabilities or functional limitations of the receiver of care and the capability of the caregiver must be in reasonable reciprocal proportion. The interpretation varies considerably between municipalities.

The local municipality and the caregiver sign a care contract supplemented with a care plan. The caregiver is then entitled to a monetary monthly fee, which depends on the estimated burden of care. The fee ranges from €380 to €761 per month (MSAH, 2014a). The caregiver is also entitled to a respite of 2 to 3 days per month. The caregiver may also receive services that support their own capability for the task of caring. These may, for instance, include physiotherapy and training courses.

The informal care givers are typically spouses for older people in home care or parents for persons with severe physical or learning disabilities. Altogether, in 2017, there were 46 132 registered care givers (Sotkanet.fi).

■ 5.10 Palliative care

In recent years, palliative care has been developed. All five university hospitals and some other central hospitals have units for palliative care, but, according to an MSAH working group survey published in 2017, none of the hospitals satisfied the specialist level criteria for palliative care centres (Saarto et al., 2017). Basic-level palliative care in the public sector is provided primarily by municipalities, more precisely by the home care services (an integrated service combining home nursing and social services-based home help). These services are mainly targeted for older people and, in some regions, for end-of-life cancer care. In many areas palliative care is underdeveloped and consists primarily of care within the GP-run inpatient wards located at health centres.

In addition to public services, there are non-profit facilities specialized in palliative care, located in in the southern parts of the country. These services

are run by non-profit foundations supported by the regional cancer societies and the Cancer Foundation. Usually, the patients in these units pay a user fee comparable to public sector payments and the costs are mainly covered by the patients' municipalities of residence. Patients are referred to palliative care by specialists and care is provided together with patients and families.

The Act on the Status and Rights of Patients (785/1992) stipulates that patients have a right to determine when care changes from curative to palliative treatment. Patients can sign a document stating their wishes concerning medical treatment in case of becoming legally incapacitated.

■ 5.11 Mental health care

The care for psychiatric conditions and substance abuse problems in Finland has undergone fundamental changes during the last decades both in terms of the type of services provided and the attitude of society and legislators. Since the 1991 Act on Mental Health (1116/1990) the system no longer relies on institutional care but mostly on outpatient services.

Further restructuring of mental and substance abuse services got into full swing in 2009 with the national plan for mental health and substance abuse work (Partanen et al., 2010), which defined the core principles and priorities in this area. The plan and the subsequent Health Care Act (2010) emphasized the client's status, acknowledged the role of alcohol and drug abuse problems as part of mental health issues, and strived to strengthen integration of outpatient services and social care. Outpatient care includes the principle of low-threshold access to care with a single point of entry (for mental and substance abuse problems) and the expansion of preventive services. Legislation concerning involuntary treatment was also revised.

Outpatient psychiatric services are provided by mental health offices and outpatient departments of psychiatric hospitals, as well as by health centres, when there is the expertise. Social services, parishes, and NGOs also play an important part in the provision of care, as well as private and occupational care services for employees. An NGO, A-Clinic Foundation, provides a substantial share of outpatient and rehabilitative substance abuse services.

The role of psychiatric nurses has increased in outpatient care, particularly in the detection of depressive disorders. The latest development in outpatient care is the introduction of remote care, including Internet-based

psychotherapy by the Helsinki University Central Hospital. This service has a part tailored specifically for adolescents. The improvement of child and youth psychiatry has been the focus of many policies of late (MSAH, 2016a). In mental health, the age limit of adulthood is considered to be 23 years.

Due to the expansion and strengthening of outpatient care and other care settings, the percentage of patients needing in-hospital care has decreased substantially since the early 2000s. The reorganization of psychiatric emergency care services initiated by the 2014 Decree on emergency care services has led to the closure of several psychiatric institutions and the establishment of new inpatient wards in general hospitals with somatic emergency services.

■ 5.12 Dental care

The municipalities have organized dental services for their residents since a major oral care subsidization reform in the early 2000s. Previously, the municipal services were reserved for children and some other population groups (e.g. those with certain chronic conditions). The 2010 Health Care Act extended services to dental and follow-up checks, as well as to the dissemination of relevant information. In addition, municipalities now have to organize prevention and care for oral diseases with referrals to specialist level care when necessary. Dental services are located within health centres and over half of all dentists work in those as salaried employees (Finnish Dental Association, 2019).

Patients have the option to use private services and receive a small reimbursement (14.9% of the total cost in 2017) from the NHI (Kela, 2018b), with the exception of orthodontic or prosthetic treatments. There is no price regulation for private services. The basic cost for a dentist visit in a health centre is currently €13.30, with additional costs for procedures ranging from €8.40 for a check-up to over €200 for prosthetics (MSAH, 2019b). Private providers charge on average €63 for a basic check-up (range €60–70) (Kela, 2018b). Occupational health care is not obliged to provide dental services for employees, but some do. Dental nurses and oral hygienists may perform some of the check-ups instead of dentists. All subsequent interventions are based on individualized care plans.

In 2017, there were 697 dentist and 203 oral hygienist visits per 1 000 population in municipal oral care. NHI reimbursed 444 visits

per 1 000 inhabitants in private care (number includes all professional groups) (Sotkanet.fi).

Regular dental check-ups for children and adolescents have been provided by health centres since 1972. The Government Decree on Preventive Oral Health Care (338/2011) outlines the check-up schedule, with three visits before school age, and one visit during the first, fifth and eighth school years, as well as one visit for students.

For the adult population, waiting times within public dental health care are long and in many areas exceed the specified maximum limit of 3–6 months (Mölläri & Kovanen, 2018). Service vouchers and dental hygienists are used to shorten the queues in municipal health care. On-call services are provided by municipalities mainly during office hours and are otherwise available in hospital districts and, for more complex cases, at university clinics.

Oral health in Finnish adults has improved during the last decades, but caries and periodontal conditions are more prevalent than in other Nordic countries and the differences between socioeconomic groups are more pronounced (Linden et al., 2017). The lack of resources in public care and the cost of private dental services have been implicated. Fluoride is no longer added in drinking-water in Finland.

6

Principal health reforms

■ Summary

- There has been a broad agreement on the need to reform the Finnish health system towards centralization of the organizational structure, containment of costs and integration of health and social care, but reaching a feasible policy consensus on how the reform should be implemented has been challenging.
- The reforms that have taken place in the past decade have largely been incremental and mainly focused on modifying existing features, without fundamentally changing the structure of the health system.
- A series of measures were taken to reduce the share of public spending on health. Some of these translated into reduced levels of reimbursement for medicines and increased user fees.
- The attempts to pursue major health and social care reform are likely to continue and focus on some form of centralization of service provision to the regional level and integration of health and social care. Preparations undertaken over the past few years mean that some aspects of these changes have already been implemented on a small scale.

■ 6.1 Analysis of recent reforms

Over the past 20 years, the expert, political and public criticisms of the Finnish health system have grown stronger. According to the analysis performed by a working group appointed by MSAH in 2012, the main weaknesses of the system were: inequitable service structure; poor performance of primary health care; a fragmented system; lack of overall responsibility in care management processes; weak stewardship; inefficient cost containment; and incompatible and poorly used ICT applications (MSAH, 2011).

While there have been several attempts to implement a fundamental reform of the municipal health system, several factors, such as the lack of a clear vision, difficulties in forming political consensus, the weak position of the central Government, decentralized decision-making, and a number of vested interests in the health system, have delayed the envisaged reform. Proposals have been heavily influenced by party objectives and political power, which is divided between the Centre Party (with its main support base in small, mainly rural, municipalities) and the National Coalition Party, the Social Democrats and the Greens (with more support in large urban municipalities).

The reforms that have taken place in the past decade have largely been incremental and mainly focused on modifying existing features without fundamentally changing the structure of the health system (Box 6.1). These included changes in the social insurance system to achieve incremental inflation of reimbursement rates, which currently cover around only about one sixth of the costs for the use of private services. However, a more fundamental reform has been high on the political agenda, with three core aims: centralization of the organizational structure, containment of costs and integration of health and social care.

Centralization as a key aim in reforming health services and administration

After a deep economic recession of the early 1990s, municipalities displayed wide differences not only in terms of economic development, but also in terms of health and welfare services provision. Differences in access to GP services were particularly tangible, especially as health centres in rural areas struggle to recruit doctors. In response, soft policy measures were initially introduced. These included a national programme to develop health services in 2001, which was followed by a more assertive policy instrument, a law guaranteeing access to specific health services within defined maximum time limits (see Vuorenkoski (2008) for more details).

By the mid-2000s, the focus of concerns shifted from the health system to broader structural issues that posed challenges to municipalities. The Government at that time (comprising the Centre Party, the Social Democrats, and the Swedish People's Party) focused specifically on demographic changes and resulting regional disparities. Rural areas were rapidly ageing while the working-age population was getting more concentrated in the region around the capital, Helsinki, and other growing cities. There were concerns about the increasing financial difficulties faced by many municipalities and the growing need for health and social services because of the ageing of the population in many areas.

Resulting from these concerns, two major reform attempts followed. In 2005, the Government set up the Project to Restructure Municipalities and Services (Vuorenkoski, 2008). The purpose of the planned public sector reform was to create a firm structural and financial basis within municipal services so that the organization and provision of services would also be secured in the future. The project concerned all services organized by municipalities, not only health care.

BOX 6.1 Major health reforms and policy measures in Finland, 2007–2019

Year	Reforms
2007	Law on Restructuring Local Government and Services
2007	Public Procurement Act
2008	Law on User Fees in Health and Social Care
2009	Amendments to the Medicines Act (reference pricing)
2009	Law on Vouchers in Healthcare and Social Services
2010	Health Care Act
2013	MSAH Decree on Criteria for Acute Care and Specialty-specific Prerequisites for Emergency Services
2013–2017	Pharmaceutical cost containment and changes to pharmaceutical coverage
2014	Cross-border Healthcare Act
2014	All-party Proposal on Reforming Healthcare and Social Services (failed)
2015	Decree on User Fees in Social and Health Care
2017	Decree on the Centralization of Specialist Services
2017	Decree on Emergency Care Services
2015–2019	Government Proposals for the Regional Government and Health and Social Services Reform (failed)

In 2007, the Parliament approved the Act on Restructuring Local Government and Services (169/2007), which defined the implementation of the Project to Restructure Municipalities and Services (Kokko et al., 2009). The act stated that organizational responsibility for primary health care and social services closely related to health services should be organized by entities covering at least 20 000 inhabitants (only a quarter of entities at a time). This, however, did not result in merger of small municipalities, but rather in a joint mechanism to provide health and social welfare services. At the same time, the funding still remained the responsibility of individual municipalities.

After the parliamentary elections in 2011, a broad majority Government was formed, comprising parties from the centre-right National Coalition Party, and five centre and left-wing parties (the Christian Democratic Party, the Swedish People's Party, the Green Party, the Social Democratic Party and the Left Alliance). The new Government included the municipal and health and social care reforms among its main objectives and drew up a plan to strengthen municipalities to enable them to organize all health and social services, including basic specialized health care, for their residents.

While the major objectives for the planned reform remained the same as in the earlier reform attempts (i.e. balancing the service structure by strengthening services particularly in health care, integration of health and social services in terms of administration, budgeting and provision, and strengthening national stewardship) the means anticipated to achieve these objectives were different. The focus of the reform was changed from an attempt to boost collaboration between municipalities to a more or less radical reform and mergers of municipalities as a platform for establishing a new and more centralized structure for public services.

The new blueprint for health and social care reform was based on the establishment of five overarching regional units for organizing health and social services (thus reducing the number of authorities responsible for organizing health and social services from 170 to five). However, the funding system would have remained the same, without any major changes to municipal finances in terms of health and social services. The proposal was rejected by the Constitutional Law Committee due to conflicts with the Finnish Constitution regarding the autonomy of municipalities in terms of decision over their finances.

Due to the very decentralized organization of health and social care as well as most other public services, it has been challenging to implement any

major reforms without implications for the role of the local governments. Such arrangements, together with the constitutionally very strong position of the municipalities, means that finding a consensus on feasible policy solutions has proved very difficult. This has resulted in a series of failed reform attempts (Box 6.2).

BOX 6.2 An example of the challenges in reforming health and social care in Finland

One of the key programme actions of the Government formed after the election in 2015 (the Centre Party, the National Coalition Party and the Finns Party) was to reform health and social care. The main objective of the reform was “to narrow health disparities and contain costs”, in the light of the so-called “sustainability gap” of the public economy. The Government aimed to contain increases of overall public spending by €10 billion by 2029, of which approximately €3 billion would have been covered through reforms led by MSAH. The target was strict and entailed keeping the annual growth rate of health and social care expenditure below 1%.

The key tenet of the proposed reform was to integrate primary care, specialist care and social services under the same administrative structure and budget. In addition, the Government aimed to strengthen the centralized steering of the system, centralize the financial responsibility for organizing health and social services and increase patient choice and provider competition in the system. Initially, the aim was to proceed step-wise: by first centralizing and integrating the organization of the services to larger areas (counties) with democratically elected councils; and, second, by simplifying the existing multichannel financing system. In the third stage, the idea was to increase choice and competition in the system.

However, early on in its term, the Government was already on the brink of collapse due to disagreements on the step-wise process and the actual number of the administrative units that would take the responsibility for health care and social services. This “Government crisis” led to a framework, in which health and social service reform was put together with a reform of regional administration and reforms in which choice and competition were to be radically increased in the system.

The plan was that 18 newly-formed administrative units (counties) with democratically elected councils would be responsible for a wide range of tasks, including health and social care, rescue services, economic development, transport

and the environment, as well as the current functions of the regional councils. Municipalities would have remained responsible for the promotion of health and well-being. Through a separate process it was later decided that the counties would get all their funding from the central government, i.e. they would not have the right to levy taxes. The change in the funding structure also included the element of cost-containment measures with which it was aimed to reduce the Government expenses. The budget constraint for the counties was planned to be extremely tight and allowing only 0.9% of the growth in annual health and social service costs.

The creation of the regional governments has been commonly interpreted as the Centre Party's will to strengthen the role of regional administration since it has its main electorate in the rural areas and small towns. The National Coalition Party, in turn, had previously stated that the regional administration should not be based on more than "a handful" of entities responsible for health services. This indicates that the solution of 18 counties was politically challenging. But in return, during the negotiations the National Coalition Party was able to get through its long-term pledge of introducing more choice and competition in health services. In 2015, this political deal on trading off larger number of regional governments for choice and competition also included an agreement that all these reforms would be enacted simultaneously. Plainly, this meant all or nothing.

The proposed choice and competition model was extensive and included the choice of a primary care provider and freedom to establish practices for any qualified provider. The service packages and reimbursement rates were already defined in the law which would have left the counties very little room to determine the optimal composition of services. In addition, the proposal would have also introduced compulsory choice and competition model in some parts social care and specialist care services. In these services, choice would have operated through using personal budgets (social services) and service vouchers.

The two key bills (on regional government and on choice and competition) became the central pieces of the proposed legislation package, but contained major challenges. Among those were the very tight budget constraints for the financing of the counties, conflicts of the freedom of choice model with the Finnish Constitution, and the process of integration of services – especially for the vulnerable groups – within the complex system of multiple providers. In combination, these proposals were strongly controversial even within the coalition parties. However, it was the conflict with the provision of the Constitutional Law that, after several revision rounds with the Constitutional Law Committee, formally made the proposal to fail in March 2019, resulting in the Government's resignation 5 weeks before the general elections in April 2019.

Patient choice

One of the means believed to promote patient empowerment and patient-centredness has been the introduction and further expansion of choice and competition policies. In 2009, the Act on Service Vouchers in Social and Health Care introduced the choice of provider in publicly financed health and social services (vouchers have been used in social services since 2004). The Act enabled municipalities to produce vouchers for patients, which could then be used to purchase a health care service from a selection of private providers. The value of a voucher is determined by municipality. Providers can set their prices; however, municipalities determine the maximum price providers can charge, or select providers through public tender. The overall aim of the Act was to provide patients with a choice between public and private providers. In addition, it aimed at improving private providers' ability to deliver publicly funded services. Data on the use of vouchers are limited. However, it seems that vouchers have been used mostly in home care and home help services for older people, while their use in health care has been marginal (Sotkanet, 2019). Service vouchers were also piloted in preparation for the health and social care reform in 2017–2019. However, it is difficult to draw any general conclusions on the applicability of vouchers in the Finnish health and social care from the results of these pilots (Owalgrou, 2019).

The 2010 Health Care Act broadened patients' ability to choose primary care provider and hospital in the municipal health care system. The Act enabled residents to change their primary care provider within or between municipal primary care authorities and to choose a hospital for treatment. Each municipal resident is registered with a primary care unit based on where they live, but the 2010 Act allowed to change primary health care unit once a year. Patients can choose between municipal health centres and private primary care provider contracted by the municipality. Still, in primary care choice remains fairly limited by the availability of providers and one change per person per year. Choices are not restricted geographically, i.e. patients can also choose a primary care unit outside of their municipality of residence. In hospital care the choice is also not restricted geographically, but the decision has to be made jointly with the referring doctor.

Public procurement and competition

In Finland, public procurement policies have been stricter than requirements set by EU regulations. The Public Procurement Act was revised in 2010

and again in 2016 to allow for more flexibility for social and health service contracts. As a result, procurements of up to €400 000 in value are now more flexible, but this threshold is still lower than that of EU regulations, and exceptions for NGOs do not apply.

Due to the complicated public procurement obligations, municipalities often struggled to ensure sufficient knowledge and expertise on the process itself, and on dealing with court cases and complaints. Therefore, they called for to change in the implementation of the procurement law and return to public provision of municipal services (Eronen et al., 2013).

Containment of pharmaceutical costs

Generic substitution in Finland was introduced in 2003. Since then, pharmacies are obliged to substitute a prescribed medicinal product that costs more than a defined maximum price (reference price) with a product with the same active substance that costs less than the limit (see section 2.7.4). In 2009 another cost-containment measure – reference pricing for pharmaceuticals – was introduced in health insurance reimbursements. E-prescription has been implemented in stages since 2012. By 2017, all health care providers had to join the e-prescription system and provide prescriptions electronically, except for emergency situations or technical issues. In 2013–2017, a series of measures were introduced to lower the public share of pharmaceutical expenditure (see below), together with piloting a clawback system (see section 2.7.4) and lowering of reference prices.

Several other measures have been implemented in recent years to contain medicine reimbursement costs for the NHI. However, these shifted the financial burden on households, by increasing the share of out-of-pocket payments. In 2013, basic reimbursement level was lowered from 42% to 35%, and was increased to 40% in 2016; the lower special reimbursement level from 72% to 65%. At the same time, the wholesale price of drugs not belonging to the generic substitution system was lowered by 5%. The ceiling for annual out-of-pocket spending on reimbursable medicines was lowered over several stages in recent years – from €720 in 2013 to €572 in 2018–2019. In 2016, the initial annual deductible of €50 was introduced into the reimbursement system. Alongside, the co-payment in the 100% reimbursement category was increased from €3 to €4.50 and the co-payment beyond the annual ceiling was increased from €1.50 to €2.50. In 2017, the reimbursement level of oral diabetes drugs was lowered from 100% to 65%, but insulin products stayed within the 100% category.

From January 2017, a prescription can be valid for a maximum of 2 years (previously 1 year). The prescribing physician can, however, decide that prescription is valid for a shorter time. Very expensive drugs (over €1 000 per package) can be prescribed for a maximum treatment duration of 1 month at a time.

Increase in user fees for health services

Two major changes concerning user fees have taken place over the past decade. First, in 2008, the Law on User Fees in Health and Social Care was changed to allow an automatic biannual increase to reflect health and social care service price index. This led to a steep (17% on average) increase in user charges in 2008, and ongoing increases every 2 years. In 2015 and 2016, user fees were further increased by 9% and 28% respectively, in addition to the index increases. User fees for 2019 are shown in Table 3.3.

Tackling efficiency

In 2013, MSAH issued the Decree on Criteria for Acute Care and Specialty-specific Prerequisites for Emergency Services as a measure to improve quality and efficiency through centralizing services in larger units. The Decree defined, among other things, a minimum number of cases for providers of emergency services. In 2017, this was followed by the Decree on the Centralization of Specialist Services and an amendment of the Health Care Act regarding 24/7 on-call surgical services. These changes centralized full emergency services covering all specialities in only 12 hospitals (five university clinics and seven central hospitals) and set the requirements for the availability of key personnel, such as anaesthesiologists, radiologists and midwives. In addition, the Decree sets the minimum number of deliveries (1 000), which is quite high: in 2018 this number was not reached in central hospitals of five hospital districts. Hospitals that do not reach the minimum volume requirements are not permitted to provide 24/7 on-call surgical services; therefore, they have to shift provision towards less demanding, typically conservative secondary level and rehabilitative services covering a limited number of specialties. In a fairly dispersed country such as Finland, this may have adverse access implications for people living far away from major centres.

Relaxing alcohol control

The New Alcohol Act (2017) was a step towards liberalizing the Finnish alcohol policy. The law increases the limit of volume of alcohol in beverages

sold in retail stores to 5.5% (from 4.7% previously). The legislation also relaxed many other restrictions aimed at decrease the availability of alcohol, such as allowing discount advertisements, liberalizing licensing, extending opening hours for restaurants, bars and small breweries. The law was criticized by public health experts due to the anticipated impact of increasing alcohol consumption on population health. In the first year after the reform, there was a 0.4% increase in alcohol consumption, reversing a decade-long decreasing trend (THL, 2019a).

■ 6.2 Future developments

After the failure of the health and social care reform (see Box 6.2), a new Government was formed after the general election in April 2019.

A new Government programme was issued in June 2019. The Government has stated that it aims to achieve a socially, economically and ecologically sustainable Finland by 2030. The programme emphasizes key pillars of the Nordic welfare state, including well-functioning health and social services. The Government has started preparations for restructuring health and social services, taking into account the work done during previous electoral terms and making sure that relevant constitutional requirements are met. The central objectives of the anticipated health and social services reform will be to reduce inequalities in health and well-being, safeguard high quality health and social services for all, improve the availability and accessibility of skilled health and social care workers, respond to changes in society, and curb the growth of costs.

Since 2017 municipalities in several regions have established joint authorities for health and social care, which follow the early example of the South Karelia Social and Health District and aim to achieve comprehensive integration of health and social services (Keskimäki et al., 2018). According to the Government programme, the anticipated health and social services reform will transfer the responsibility for organizing health and social services to 18 self-governing regions (counties). Decision-making power in the regions is anticipated to rest with directly elected councillors. The counties will receive most of their funding from the central government. Five collaboration areas for specialized services are planned to be created, based on existing catchment areas for highly specialized health care.

The public sector is anticipated to be the primary service provider in the counties, with the private and third sectors serving as supplementary service providers. Health and social services centres are anticipated to provide both social services and primary care services, with the range of services including at least primary care, oral health, social work, home care, basic-level mental health and substance abuse services, outpatient rehabilitation services, chronic disease prevention, maternity and child health clinics, and other preventive services.

Assessment of the health system

■ Summary

- Finnish health policy seeks to incorporate Health in All policies into all aspects of public decision-making. The main goals are to promote population health and welfare, reduce health inequalities, ensure universal access to services and improve quality, as well as to increase the responsiveness of the system.
- In terms of health outcomes, Finland performs relatively well in international comparisons. Mortality from causes related to public health and intersectoral policies is also relatively low, although little progress has been achieved in recent years, partly reflecting a weakening of alcohol control.
- In terms of access to care, waiting times and high levels of cost sharing result in relatively high levels of unmet need. Although the incidence of catastrophic payments is low, it accumulates in more vulnerable groups. Mechanisms for financial protection of people with lower income or higher need are weak, and largely reliant on annual ceilings for out-of-pocket payments, which are set to a combined total of over €1 500.
- Overall, Finland compares favourably to many EU countries in terms of efficiency and quality of services, despite high levels of fragmentation in financing and service delivery. A lot of progress

has been achieved in the past two decades in terms of strengthening primary care (particularly around optimizing skill-mix), improving the effectiveness of specialist and hospital care, and containing pharmaceutical spending.

■ 7.1 Monitoring health system performance

A number of national and regional organizations in Finland supervise and monitor adequacy of services delivered by health care professionals and providers (see section 2.2). In addition, THL runs and maintains several systems for assessing different aspects of health system performance, but they are usually specific to a particular area, such as waiting times, vaccination rates and hospital efficiencies (see section on Information systems below). However, national or regional systems providing a comprehensive health system assessment have been missing until recently.

In 2018, MSAH piloted the assessment and guidance activities related to the organization of regional social and health care services in 18 regions (counties). To complement this, THL compiled a national expert evaluation for the first time. The evaluation was designed to help national and regional level authorities and decision-makers in their steering and financing of health and social care. For this purpose, THL established a Unit for Health Care and Social Services Evaluation, which has, in 2019, published a draft of the first national level evaluation (Rissanen, 2019).

Information systems

Finland has a range of data available for population health and health care monitoring (see section 2.6), which are also used for evaluation and policy-making. In addition, THL runs a monitoring system for hospital care performance – based on the Performance, Effectiveness and Cost of Treatment Episodes (PERFECT) project, launched in 2004. The system aims to measure treatment costs and effectiveness of hospital districts in major disease groups (including stroke, very low-birth weight infants, hip fracture, hip and knee replacements, acute myocardial infarction, breast cancer, etc.) in specialized health care. In addition to the traditional outcome measures, it also contains information on self-reported health using general and disease-specific quality-of-life indicators.

A uniform performance measurement framework (KUVA) that includes multiple indicators for assessing the health and welfare needs of the population and monitors quality, impact, costs and efficiency of services has been published in March 2019. These are the key indicators for national and regional monitoring, evaluation and guidance.

Stated objectives of the health system

The basis of the Finnish health care system is laid down in the Constitution of Finland (1999), which emphasizes the right of everyone to income and to care:

Everyone shall be guaranteed the right to basic subsistence in the event of unemployment, illness, and disability and during old age, as well as at the birth of a child or the loss of a provider. The public authorities shall guarantee for everyone (...) adequate social, health and medical services and promote the health of the population.

Finnish health policy seeks to incorporate health into all policies and all aspects of public decision-making. The Health Care Act (2010) aims at: 1) promoting and maintaining population health and welfare, work ability and functional capacity, and social security; 2) reducing health inequalities between different population groups; 3) ensuring universal access to services and improving quality and patient safety; 4) promoting client-orientation in the provision of health care services; and 5) improving the effectiveness of primary care and strengthening cooperation between providers and bodies responsible for delivery of health and social care services.

The Act has also introduced a wider element of choice in the system (see section 2.8.2) since 2014. According to survey studies and observations from the municipalities, so far about one in 10 people have used their right to change their primary care unit. The current choice system has been criticized for its lack of competition and incentives for providers to attract patients, and for limited information on services (Sinervo et al., 2016; Aalto et al., 2018).

Another aim of Finnish health policy is to strengthen the vertical integration of different levels of services, such as primary and specialist care levels, and the horizontal integration of services from different sectors, such as health and social services. Integration plans have been put forward nationally in 2000s, in the form of structural reform attempts (e.g. the Project to Restructure Municipalities and Services) as well as in the form of the National Development Programs for Social Welfare and Health Care. The

latter introduced policy guidelines to develop integrated care at the local level and also funded local projects to develop integrated service models.

All in all, the most topical issues in the Finnish health system currently include long waiting times, in particular for people with no access to occupational health care services, a lack of coordination between primary and secondary care settings, and variation in standards and quality of services (OECD, 2017). These findings are corroborated in the recent THL evaluation (Rissanen, 2019). This publication shows that in particular, access to primary care and child protection services are plagued by regional differences in workforce availability, and care practices for older people vary considerably. Moreover, the results show that in the regions where organization for different types of services is integrated, cost containment can be achieved. The integration of services and further increases in the productivity of specialized care surfaced as the main development goals.

■ 7.2 Health system impact on population health

Amenable mortality (i.e. mortality from causes that can be avoided in presence of timely and quality care) in Finland has almost halved since 2000 and in 2015 was 79 per 100 000 (compared with 143 per 100 000 in 2000) (Fig. 7.1). However, Finland has not been able to reduce the differences in amenable mortality between various socioeconomic groups during the past few decades (Lumme et al., 2018). Despite this, the health system performs relatively well overall in international comparisons of performance (Fullman et al., 2018).

In the long run, cardiovascular mortality has decreased substantially from its peak in the 1970s. This has affected particularly middle-aged men and, for instance, among men aged 35–64 IHD mortality decreased over 80% between the early 1970s and 2010s. Most of this improvement has considered to be related to changes in risk factors supported by health policy measures, such as comprehensive nutritional policies, leading to changes in the population's health habits inspired by the North Karelia project (Laatikainen et al., 2007; Puska et al., 2016). However, in recent decades, treatment of cardiovascular diseases has improved. Secondary medicinal prevention of IHD and hypertension, as well as hospital care for cardiovascular diseases, has become more effective and follow clinical guidelines. In particular, a wider use of coronary angioplasties for IHD, as well as streamlining of emergency care processes

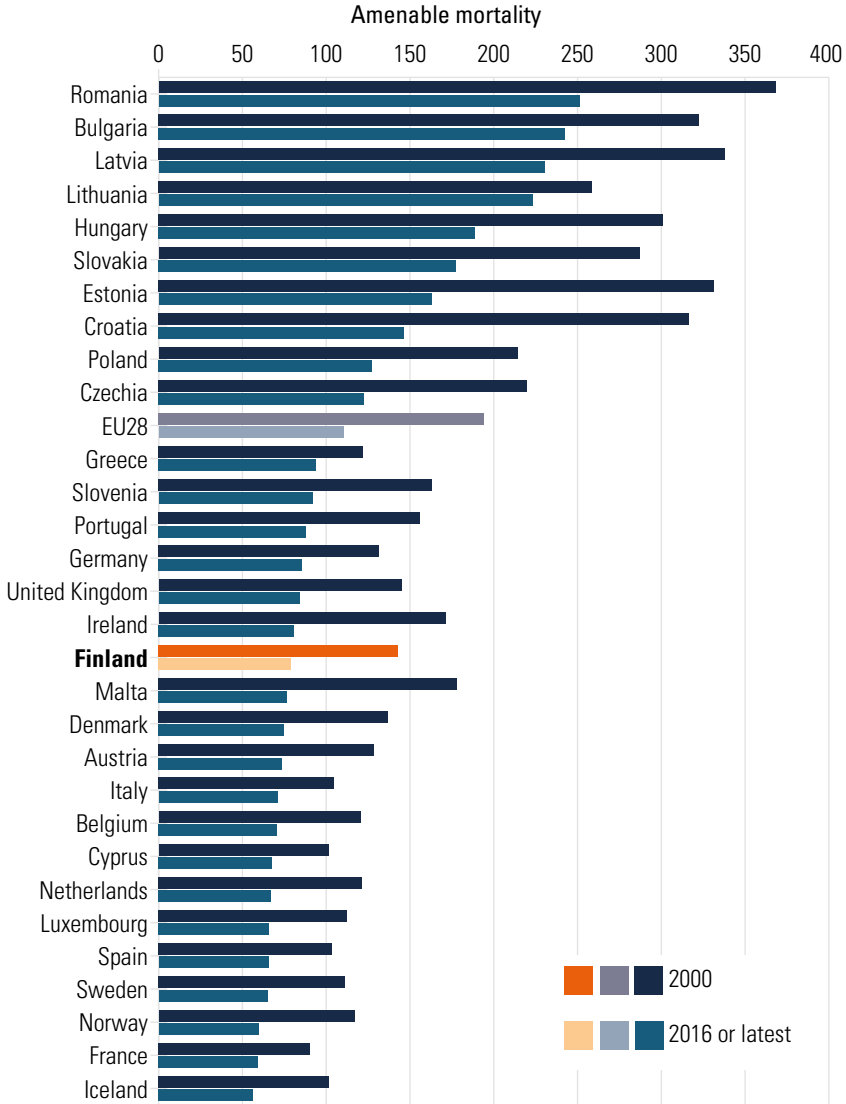
and better treatments (notably a greater use of thrombolysis) for ischaemic stroke have made a substantial impact (OECD, 2017). As a result, progress has been achieved over the past decade in reducing mortality rates for people admitted to hospital for myocardial infarction and stroke (see section 7.5). In cancer treatment, due to early diagnosis and access to effective treatments, survival rates for breast, cervical, colon and rectal cancers in Finland are higher than in most EU countries (OECD, 2017).

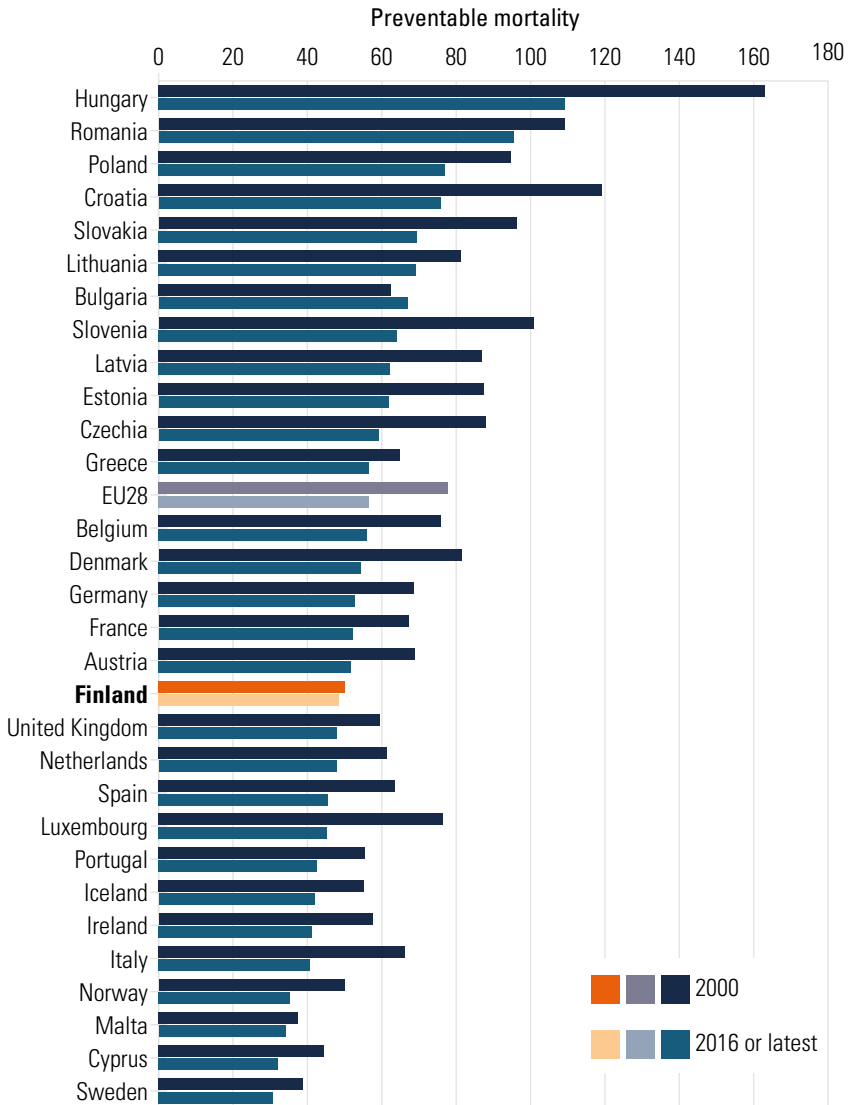
In terms of mortality from three causes preventable through wider public health policies (lung cancer, chronic liver disease, road traffic accidents), Finland's rates are below the EU28 average; however, little change has happened since 2000 (Fig. 7.1). But there are varying trends among these causes. The lung cancer mortality rate has gradually reduced since 2000, reflecting the reduction in smoking. This improvement can at least partly be attributed to the range of tobacco control policies and programmes which are still ongoing. Tobacco control measures include tobacco cessation programmes, health warnings on cigarette packages, restriction on the visibility and availability of the tobacco products in stores, public awareness campaigns through mass media, and high taxation of tobacco products. Deaths from chronic liver disease and cirrhosis have, on the other hand, increased from 12 per 100 000 in 2000 to a peak of 21 per 100 000 in 2007 and, while these figures have since fallen, they are still among the highest in the EU28 and above the level of 2000 (17 per 100 000 in 2015) (WHO, 2018a). Transport accidents, in the meantime, have almost halved, reflecting improvements in road safety.

The decrease in suicide rate has been substantial over the past three decades, although the rates are still above the EU average (European Commission, 2019). This decrease at least partly may be linked with better awareness of mental health problems, national and local mental health promotion and suicide prevention programmes, as well as some improvements in mental health care over the past years.

Vaccinations under the national vaccination programme (a range of communicable disease for children and adolescence and influenza vaccination for people over 65 years) are free of charge. Coverage for childhood vaccinations on average is close to 95% of the population, but there are variations in across the country and also in terms of the vaccines. There are some areas with 85% and 90% coverage. For the influenza vaccination, the coverage is close to 50%, but there are also variations across the country. However, the influenza vaccination rates have steadily increased during the 2010s (THL, 2018d).

FIG. 7.1 Amenable and preventable mortality in Finland and the EU28 (age-standardized rate per 100 000 population), 2000 and 2016





Notes: Age-standardized mortality rates for all persons. Latest data for Finland for 2015. Amenable causes as per list by Nolte and McKee (2004); preventable causes: chronic liver disease, lung cancer and road traffic deaths.

Source: WHO (2018) Detailed mortality files; calculated by European Observatory for Health Systems and Policies

BOX 7.1 Equity of outcomes

Risk factors seem to play a key role in the mortality gap between various socioeconomic groups. In 2011–2014, cardiovascular diseases accounted for nearly one third of the gap in life expectancy between people from the highest and lowest income quintiles. Among men, alcohol-related mortality contributed to 20%, and among women to 16%, of the gap in life expectancy, while cancer mortality accounted for 14% in men and 18% in women. However, in comparison with 2006–2009, there was a decrease in the socioeconomic gap in mortality. Reduction in alcohol-related mortality and suicides in men of working age with lower incomes played a substantial role in the increase in life expectancy in this group, thus reducing socioeconomic disparities (Tarkiainen et al., 2017).

7.3 Access

Finland lags behind many EU countries in having a relatively high share of the population reporting unmet need for medical care due to either cost, waiting time or travel distance – 4.7% in 2018 (Fig. 7.2). Waiting lists are the main reasons for unmet need for medical care in Finland, and are especially encountered by unemployed people (8.3%), a group that does not have access to occupational health care.

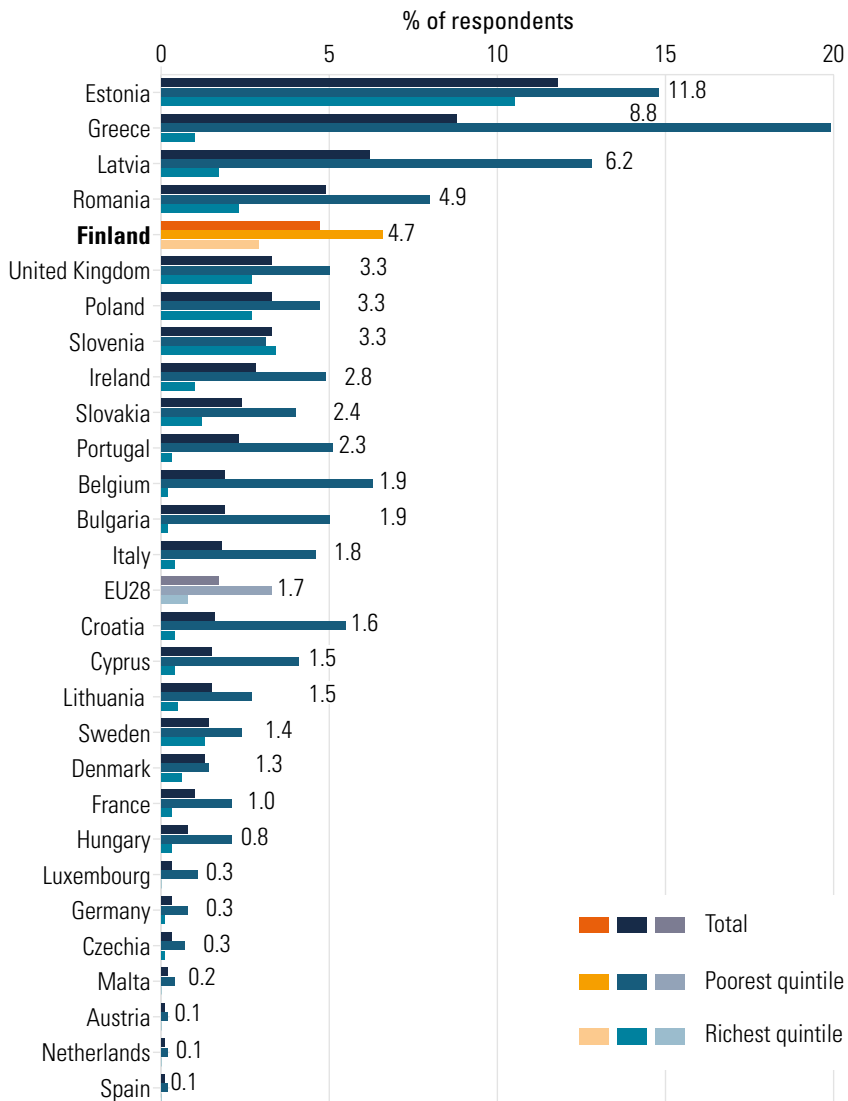
Although the availability of health and social services has improved, there are regional differences for some types of services. For example, while access to maternity and paediatric services is fairly equal, there are considerable regional differences in access to primary care.

In principle, health care benefits are the same for everyone using public health care services, but in practice the range of services available depends on the capacity of municipalities to deliver them. A waiting-time guarantee for elective surgery, introduced in 2005, resulted in an overall reduction of waiting times, which is now around 100 days for cataract surgery and hip replacement (OECD, 2017). Preliminary THL data for 2019 show that waiting times for specialist care have worsened, and the average time is currently 1 to 2 months with large regional variations. However, variations in municipalities for primary care and in hospital districts for secondary care remain and reflect the availability of services as well as staff. As a response,

the roles of nurses are gradually changing to include more tasks and improve access to services, at least in primary care (see section 4.2).

Faster access to some (mainly ambulatory) health services can be obtained via occupational health care, or from private providers. However, these service delivery channels either do not cover the entire population or require extra out-of-pocket spending.

FIG. 7.2 Unmet medical need due to cost, waiting time or travel distance, 2018 or latest



Source: Eurostat (European Commission, 2019)

■ 7.4 Financial protection

As mentioned above, co-payments are common in Finnish health care and charges apply to most municipal health care services, including primary and emergency care. The share of out-of-pocket payments on final household consumption was 3% in 2015 which is similar to the OECD average, with nearly half of population paying health or social care user fees (Vaalavuo, 2018). Pharmaceuticals (33%), dental care (21%) and outpatient care (26%) form the main types of services and goods the co-payments are paid (European Commission, 2017).

According to a recent report commissioned by the Government (Vaalavuo, 2018), there is a remarkable variation in the frequency and amount of user fees paid by different population groups. For example, in 2015 some 3.6% of the population paid almost half of all user charges. A further breakdown shows that one-tenth of people affected by flat fees for health services paid almost half of the total volume, with the same proportion of those paying income-related fees (largely for long-term and social care) covering 44% of the total volume. At the same time, the incidence of catastrophic payments (over 40% of disposable income) was deemed “rare”, but nevertheless constituted about 1% on average. Furthermore, catastrophic payments were concentrated in more vulnerable population groups; for example, reaching 2% for people in the lowest income quintile, and 5% among those aged 75 and over (Vaalavuo, 2018).

In addition to causing impoverishment, excessive user fees present a barrier to accessing services. EHIS survey data (2014) show that among people who needed health services, 20% were not able to access them due to costs, with the highest levels for dental care (15%), followed by medical care (12%), prescription medicines (11%) and mental health services (7%) (European Commission, 2019). Among the households that reported problems in access to health services or care due to costs, 34% had applied for social assistance and 17% received it (Aaltonen, 2017).

■ 7.5 Health system efficiency

In international rankings, the Finnish health system overall appears to be fairly efficient, due to comparatively lower levels of absolute spending and

good overall health outcomes (European Commission, 2017). In many respects, the structure of the Finnish health care system supports efficiency. Primary care services provided by municipal health centres are generally well developed and offer a wide scope of primary services (see section 5.3). On the other hand, high levels of decentralization and fragmentation undermine allocative efficiency of the Finnish health care (see below). Nevertheless, there is no comprehensive framework for evaluating the efficiency of the entire system, and, beyond the hospital sector, performance assessment is not systematic and there is no regular follow-up for unwarranted geographical variations in health care.

Comparative information on efficiency in hospital care has been published as part of the official national statistics since 2007. The national hospital information system is managed by the THL and contains data on use, costs and productivity of hospital activities by hospital district, hospital, municipality, specialty and DRG. Provider-specific data contain information on all public hospitals that provide specialized somatic health care, while regional level data also include private hospitals. These data are based on the information from the Care Register (HILMO), reported to THL annually by providers. The data on hospital costs and specialties are collected separately on an annual basis. Hospital efficiency analysis is then done both over time and cross-sectionally at the provider and regional levels. Statistical reports on hospital productivity are published annually, while electronic reports with benchmarking data are available for hospital districts to use for their annual planning (Häkkinen & Matveinen, 2019).

■ 7.5.1 Allocative efficiency

Despite coordinated planning of services, primary and specialist care services are provided in most regions by separate organizations: municipal health centres and hospital districts respectively. Although municipalities govern both, incoherence in local policies together with the dominant role of hospital districts in decision-making have led to imbalance in the development of resources between the primary and hospital care sectors. For instance, the number of doctors in public hospitals increased by 23% in 2000–2014, while their number in health centres increased by less than 10%. At the same time, the number of physician outpatient consultations in health centres decreased

by around 30%, and increased in hospitals by nearly 50% (Ailasmaa, 2015; Finnish Medical Association, 2016). While these trends reflect changes in service delivery patterns, expansion of hospital outpatient care and changing skill-mix with broadening tasks for nurses in health centres, they also highlight the differing development in these sectors, which is in contrast to the stated national priority of strengthening primary care.

Another challenge for allocative efficiency related to the multichannel financing and provision of services raises from the existence of occupational care, arranged separately by employers (see section 2.2). The number of physicians working in occupational health care in 2016 was around 2000, which corresponded to about a half of the number of physicians working for municipal health centres (Finnish Medical Association, 2016). The functions of occupational health services are broadly similar to those in primary care, but the former are only available to population groups who are on average healthier and better off. Therefore, this arrangement partly contributes to socioeconomic disparities in access to care; it also reduces allocative efficiency, as resources are directed to populations with lower level of health care needs.

■ 7.5.2 Technical efficiency

Finland has been particularly active in improving efficiency of the health care system in two areas: hospital care and pharmaceuticals. In primary care, the initiatives have focused on developing integrated care arrangements and skill-mix in health centre work. So far many initiatives, such as joint integrated care joint authorities (see section 6.1) have been local, and although some experiences suggest it is possible to improve efficiency in this way, it is still too early to generalize these results.

A number of indicators show improvements in technical efficiency in the hospital sector since 2000. The number of hospital beds per capita reduced by 40%, and the average length of hospital stay by 25% in 2000–2015. The latter, however, is still above the EU average, which may partly be explained by a substantial volume of services in inpatient wards of health centres. For specific conditions, such as normal delivery or myocardial infarction, length of stay is shorter in Finland than in the EU countries on average (OECD, 2018).

The volume and share of day surgeries have also increased for many procedures. In 2016, virtually all cataract surgery and majority of procedures,

such as inguinal hernia repair (68%) and tonsillectomy (87%) were carried out on a day surgery basis. However, further progress can be achieved for some conditions. Only 38% of laparoscopic cholecystectomies were performed in day surgery in 2016 (OECD, 2018).

In terms of inappropriate care, although the volume of some procedures (hysterectomy, back surgery) has decreased, large geographical variations remain (Keskimäki et al., 2014). In addition, caesarean section rates have remained stable since the mid-2000s, albeit among the lowest in the EU countries. The share of potentially avoidable hospital admissions due to five chronic conditions (diabetes, hypertension, heart failure, chronic obstructive pulmonary disease and bronchiectasis, and asthma) has been lower in Finland than on average in the EU (OECD, 2018).

Recent initiatives, which may have a further impact on hospital productivity, are centralization of hospital care and emergency services (see section 6.1). The main motivation for these measures was to improve quality and patient safety, but cost containment was also an important objective. Centralization measures were only started to be implemented in 2018; therefore, the results are not yet available.

Several policies have been implemented to contain growth of pharmaceutical spending, including price controls and promotion of generics (see section 6.1). As a result, the share of pharmaceutical spending in overall health spending decreased considerably (from about 16% in 2000 to 12.5% in 2016). This was substantially lower than the current EU average of 16.8%. Spending on pharmaceuticals per capita in Finland was also lower – €380 in 2016 compared with the EU average of €425. However, compared with other measures, promoting use of generic products has not been as successful. In 2016, market share of generics was 42% of volume and 18% of value – both below the EU average (OECD, 2018). The use of biosimilars has been boosted in 2010 by obliging doctors to prescribe the cheapest comparable biological product.

■ 7.6 Health care quality and safety

The first Finnish patient safety strategy was outlined by MSAH in 2009 and this has been recently updated as the Patient and Client Safety Strategy for 2017–2021. The Health Care Act (2010) and subsequent legislation,

such as the Decree on Quality Control and Patient Safety Plan (2011) and the Social Welfare Act (2014), the Act on Supporting the Functional Capacity of the Older Population and on Social and Health Services for Older Persons (2012), have emphasized patient safety and quality of care as part of the responsibility of care organizers and providers. Since 2010, all health care providers are obliged to adhere to a quality control plan. The Finnish Patient Safety Association and other stakeholders have been closely involved in this work, emphasizing prevention of adverse incidents and the fostering of safety-prone cultural change. Increasingly detailed and up-to-date patient safety and care quality-related data are currently collected by THL and assessed by relevant authorities (MSAH, Ministry of Finances) as financing of organizing bodies and providers will increasingly depend on their overall performance.

The quality of primary care is reflected in avoidable hospital admissions: for asthma plus COPD these were substantially below the EU average in 2016 (174 vs 237 per 100 000, respectively). For congestive heart failure, however, the rates were substantially higher (312 vs 285 per 100 000). Diabetes-related hospital admissions have decreased markedly since 2000 and were in 2016 close to the EU average (141 vs 138 per 100 000, respectively) (OECD, 2019). In secondary care, the share of 30-day mortality from ischaemic stroke was 7.7% in 2015 – the lowest among the 14 EU countries with comparable data available. It was also fairly low for 30-day mortality for myocardial infarction (8.3%), but above the rate for Sweden (8.1%), Norway (7.7%) or Denmark (7.6%) (OECD, 2019)

Indicators reflecting prescription practices in Finland show differences with other Nordic countries. The share of diabetic patients with at least one prescription for cholesterol-lowering drugs was 65% in 2015 (Sweden 70% and Denmark 79%), and the prescribing of antihypertensive agents was even lower (59%) in Finland compared with the OECD average of 84%. This, however, may at least partly be attributed to novel and not yet comprehensive data collection methods in Finland. Prescribing of long-acting sedatives, such as benzodiazepines, for older people and the total volume of antibiotics for systemic use is moderate in Finland when compared with OECD countries. However, the use of second-line antibiotics as a share of the total antibiotic use is of concern as it amounts to 19% of all antibiotics prescribed in Finland. In other Nordic countries, the corresponding percentages range from 3% in Denmark to 5% in Sweden (OECD, 2019).

Specific OECD patient safety indicators for Finland show good results, i.e. below the OECD average in the following areas: foreign body left in during procedure and obstetric trauma in vaginal delivery with instrument. The indicators for postoperative pulmonary embolism or deep vein thrombosis after hip or knee replacement and postoperative sepsis after abdominal surgery show, on the other hand, results that are around the OECD average or slightly worse. However, data registration and collection for all these indicators may yet be incomparable between countries.

■ 7.7 Transparency and accountability

Accountability for service provision is set out in the Constitution (1999), which obliges local governments to provide health and social services. Specifically, Article 19 of the Constitution not only obliges public bodies to provide adequate health and social services, but also to promote population health. Further accountability has been outlined by the Act on the Status and Rights of Patients (1992). Key patient rights include the right to good quality health care and fair treatment, access to treatment, access to own medical records, patient autonomy and complaints mechanisms.

Valvira is responsible for the ex-post monitoring of individual cases and complaints after serious patient injuries, plan-based supervision, guidance and advisement related to health and social care, maintaining registries of professionals. Valvira has oversight on both public and private sector professionals and providers and deals with professional practice rights. Complaints can also be made directly to the Parliament ombudsman if a public authority or an official has not observed the law or fulfilled a duty, or if fundamental and human rights have not been appropriately implemented.

A bill on expansion, limits and potential for enhancing transparency in health data has come into force in May 2019 (Act 2019/552). In addition to streamlining the administration on regulating the access to health and social care data, the new law is also extending the use of these data beyond statistics and research to other purposes, such as supervision, planning, innovation and knowledge management. The implementation of the new law has just started and most of its implications and related administrative practices are unclear. However, the implementation poses several challenges, such as how to ensure transparency while protecting personal data and how

to enact the legislation in a way, which applies to both public and private sector providers. Potential further challenges relate to quality and value of data gathered as well as their ethical and cost-effective use, including the scope for personal profiling, protection of commercial secrets and access to knowledge. Related to the extended use of health and social care data allowed by the Act, and as a means to assess performance of the health system and improve transparency, Finland has established six pilot disease-based quality registries learning from practices in other countries, in particular, countries in the Nordic region (THL, 2018d).

Conclusions

- Population health has improved but inequalities in health remain

The Finnish health system performs relatively well in international comparisons, and according to national surveys that indicate high levels of satisfaction with the quality of services and high trust in health care providers. Nevertheless, mortality amenable to health care is higher than in other Nordic countries, although it almost halved since the early 2000s. The gender gap in health, as well as socioeconomic inequalities, have declined but remain substantial; they can be largely attributed to a greater prevalence of risk factors in men, particularly those with lower levels of education. In addition, there are persistent geographical inequities in health, to the detriment of people living in the northern and eastern or central regions.

- Fragmented organization and soft governance at the national level leave municipalities with varying abilities to deliver health services

At the national level, soft governance measures, such as the provision of information, are used, while the administration of the health system is highly decentralized. This weak position of the central Government, together with multiple co-existing financial flows and three overlapping provision channels for statutory services (the municipal system, the national health insurance system, and occupational health care) has led to weak stewardship of the health system and inefficient cost containment. There is also fragmentation

within health services, between primary and specialist services, and between the health and social welfare sector. At present, the responsibility to organize all health and social welfare services rests with the municipalities, many of which are too small and financially weak to carry it out effectively. Moreover, as municipalities are obliged to provide health services to their populations, in many cases they have been forced to outsource part or all of service provision to private companies, adding a further layer to an already complex health system. Examples of successfully integrated services have been developed in particular within home care for older people, psychosocial services for children and adults and hospital-based emergency care.

■ High cost-sharing has implications for financial protection

There has been no overall budget for health services in Finland, due to the complex financing arrangements. The dual public financing system via municipalities and the NHI creates challenges for the overall efficiency of service provision. Nonetheless, current health expenditure in Finland is below comparable countries, including other Nordic countries, the United Kingdom and the Netherlands. Roughly one fifth of total health spending comes from out-of-pocket payments. Private expenditure on outpatient prescription medications is particularly high, amounting to about one third of total pharmaceutical spending. User fees exist also in all other areas of health services, with occupational health care being the only exception. Although there are payment caps for medication and service costs, these are set at high levels, particularly affecting people with lower incomes.

■ Infrastructure has been improved, but matching service provision to population needs remains a challenge

The infrastructure and facilities for health care provision have undergone marked changes in the 2000s. For example, the lack of inter-operable ICT-systems limited the degree of continuity and coordination of care. In order to address this, several tools, including the national data repository, Kanta, have been developed. In terms of facilities, hospital districts invested heavily in new buildings, as the previous structures were considered outdated. With the aim of improving quality of care, in 2014 a set of care requirements

were established for specialist emergency care providers. As a result, smaller hospitals have been closed or merged with larger units.

Nevertheless, capacity to deliver services that match population needs has weakened in the past decade. This is reflected in long waiting times in primary care (up to several weeks for a non-urgent GP appointment in some health centres), but also in elective specialist care. The relatively high rates of unmet care needs in Finland have been associated with long waiting times for the first appointment. This is particularly the case for those outside employment who do not have access to occupational health care. However, in several health centres the adoption of nurse consultations and enhanced roles of nurses have improved access to health services, particularly in primary care.

■ Achieving greater centralization remains the main goal of health reforms

There is broad consensus that the Finnish health system has inherent flaws, such as weak stewardship and a large degree of fragmentation. The separate organization of primary and specialized care and social services, particularly in the context of an ageing population, is seen as an obstacle to improving health system performance. Over the past two decades, several governments have attempted reforms, with three core aims irrespective of political profiles: 1) centralization of organizational structures; 2) improving access to primary care; and 3) integration of services (both horizontal and vertical). The implementation of these reforms, however, has yet to succeed. The vast legislative package, which envisaged the establishment of 18 regional governments and an expansion of privatization, failed to overcome constitutional and parliamentary hurdles in spring 2019, leading to the Government's resignation. Nevertheless, some aspects of the reform attempts have been achieved, such as a larger degree of centralization of emergency care and specialist services, as well as the creation of a functioning example of joint health authorities. The new Government nominated in June 2019 has decided to continue with the health and social services reform based on 18 self-governing counties, which have a responsibility to organize and provide all health and social services.

Appendices

9.1 References

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■ 9.2 HiT methodology and production process

HiTs are produced by country experts in collaboration with the Observatory’s research directors and staff. They are based on a template that, revised periodically, provides detailed guidelines and specific questions, definitions, suggestions for data sources and examples needed to compile reviews. While the template offers a comprehensive set of questions, it is intended to be used in a flexible way to allow authors and editors to adapt it to their particular national context. The latest version of the template (2019) is available

on the Observatory website http://www.euro.who.int/__data/assets/pdf_file/0009/393498/hit-template-eng.pdf?ua=1

Authors draw on multiple data sources for the compilation of HiTs, ranging from national statistics, national and regional policy documents to published literature. Furthermore, international data sources may be incorporated, such as those of the OECD and the World Bank. The OECD Health Data contain over 1200 indicators for the 34 OECD countries. Data are drawn from information collected by national statistical bureaux and health ministries. The World Bank provides World Development Indicators, which also rely on official sources.

In addition to the information and data provided by the country experts, the Observatory supplies quantitative data in the form of a set of standard comparative figures for each country, drawing on the European Health for All database. The Health for All database contains more than 600 indicators defined by the WHO Regional Office for Europe for the purpose of monitoring Health in All policies in Europe. It is updated for distribution twice a year from various sources, relying largely upon official figures provided by governments, as well as health statistics collected by the technical units of the WHO Regional Office for Europe. The standard Health for All data have been officially approved by national governments.

HiT authors are encouraged to discuss the data in the text in detail, including the standard figures prepared by the Observatory staff, especially if there are concerns about discrepancies between the data available from different sources.

A typical HiT consists of nine chapters.

1. Introduction: outlines the broader context of the health system, including geography and sociodemography, economic and political context, and population health.
2. Organization and governance: provides an overview of how the health system in the country is organized, governed, planned and regulated, as well as the historical background of the system; outlines the main actors and their decision-making powers; and describes the level of patient empowerment in the areas of information, choice, rights and cross-border health care.
3. Financing: provides information on the level of expenditure and the distribution of health spending across different service areas,

sources of revenue, how resources are pooled and allocated, who is covered, what benefits are covered, the extent of user charges and other out-of-pocket payments, voluntary health insurance and how providers and health workers are paid.

4. Physical and human resources: deals with the planning and distribution of capital stock and investments, infrastructure and medical equipment; the context in which IT systems operate; and human resource input into the health system, including information on workforce trends, professional mobility, training and career paths.
5. Provision of services: concentrates on the organization and delivery of services and patient flows, addressing public health, primary care, secondary and tertiary care, day care, emergency care, pharmaceutical care, rehabilitation, long-term care, services for informal carers, palliative care, mental health care and dental care.
6. Principal health reforms: reviews reforms, policies and organizational changes; and provides an overview of future developments.
7. Assessment of the health system: provides an assessment of systems for monitoring health system performance, the impact of the health system on population health, access to health services, financial protection, health system efficiency, health care quality and safety, and transparency and accountability.
8. Conclusions: identifies key findings, highlights the lessons learned from health system changes; and summarizes remaining challenges and future prospects.
9. Appendices: includes references and useful web sites.

The quality of HiTs is of real importance since they inform policy-making and meta-analysis. HiTs are the subject of wide consultation throughout the writing and editing process, which involves multiple iterations. They are then subject to the following.

- A rigorous review process.
- There are further efforts to ensure quality while the report is finalized that focus on copy-editing and proofreading.
- HiTs are disseminated (hard copies, electronic publication, translations and launches).

The editor supports the authors throughout the production process and in close consultation with the authors ensures that all stages of the process are taken forward as effectively as possible.

One of the authors is also a member of the Observatory staff team and they are responsible for supporting the other authors throughout the writing and production process. They consult closely with each other to ensure that all stages of the process are as effective as possible and that HiTs meet the series standard and can support both national decision-making and comparisons across countries.

■ 9.3 The review process

This consists of three stages. Initially the text of the HiT is checked, reviewed and approved by the series editors of the European Observatory. It is then sent for review to two independent academic experts, and their comments and amendments are incorporated into the text, and modifications are made accordingly. The text is then submitted to the relevant ministry of health, or appropriate authority, and policy-makers within those bodies are restricted to checking for factual errors within the HiT.

■ 9.4 About the authors

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(2001^e, 2006^c, 2013^a, 2018^e)

Azerbaijan

(2004^a, 2010^a)

Belarus

(2008^a, 2013)

Belgium

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(1999, 2003^b, 2007^a, 2012, 2018^b)

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(1999, 2006, 2014)

Cyprus

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(2000, 2005^a, 2009, 2015)

Denmark

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Estonia

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HiTs are in-depth profiles of health systems and policies, produced using a standardized approach that allows comparison across countries. They provide facts, figures and analysis and highlight reform initiatives in progress.