HiT summary

Finland

Introduction

Government and recent political history

Finland has been an independent republic with its own constitution since 1917, when it became independent from the Russian Federation. It has been a member of the EU since 1995. The present government is a five-party coalition led by the Social Democratic Party and the conservative party National Coalition.

Population

The population in 2000 was 5 million. Although the average age of the Finnish population is slightly below the EU average, current projections suggest that the number of people aged 65 years or over will grow by over 50% in the next 20 years.

Average life expectancy

Since the 1960s life expectancy has grown considerably, and is now 74 years for men and 81 years for women in 2000. This is largely due to the rapid decline in coronary heart disease and other cardiovascular diseases.

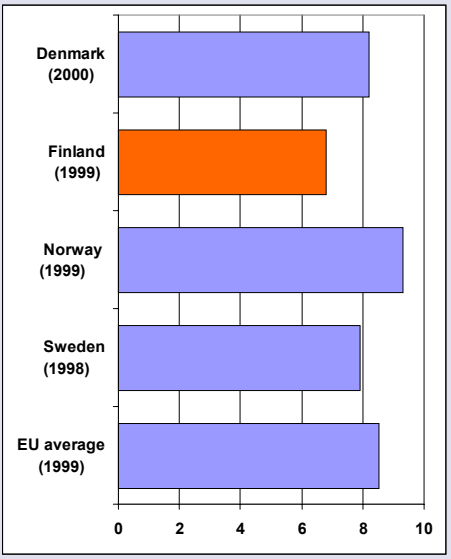
Leading causes of death

Circulatory diseases make up about half of all causes of death while the second most common cause is cancer. Suicides are a significant cause of death among men under 35. Since the mid-1990s, the rate of infant mortality has been less than 5 per 1000, one of the lowest in the world.

Recent history of the health care system

The origins of the public health care system can be traced back to the seventeenth century, when the municipalities started to hire primary care physicians to attend the health needs of their populations. The development of the modern hospital system dates from the 1950s, when it too was transferred to the municipalities. Perceived imbalances between primary and specialized health care led to the Primary Health Care Act 1972, which introduced a network of primary health care centres, publicly owned and staffed, in charge of delivering integrated preventive and curative services.

Fig. 1. Total health care expenditure as % of GDP, comparing Finland, selected countries and



Source: WHO Regional Office for Europe health for all database.

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In 1984 social services were brought into the same planning and financing system as health care. Since the late 1980s, regulation by the state has gradually decreased, increasing the autonomy of municipalities in organizing social services and health care.

Health expenditure and GDP

As GDP has grown rapidly after the economic recession in the first half of the 1990s, total health expenditure as a percentage of GDP has been constantly decreasing, reaching 6.8% in 1999 (which places Finland in the bottom group within the EU). Per capita health care expenditure in US $PPP was 1502 this same year (about 20% below the EU average). Public expenditure represented 76% of total health expenditure in 1999.

Overview

The health care system in Finland has changed and developed gradually over a long period of time. Tax-based funding, direct public provision of most services, and municipal governance have been long-standing features of the system. Since the 1970s there has been an increasing emphasis on the role of primary and community care. More recently, tighter cost-containment policies have been applied, mainly in the fields of social care and pharmaceuticals. Although the Finnish health care system has been in many ways successful, especially in surviving the economic crisis of the first half of the 1990s, there are still some areas that require further attention, such as patients' choice; equity problems arising from the system of financing; and the marked differences among municipalities in the delivery of public health care.

Organizational structure and management

Central government and the municipalities are the two main players in the organization of health care. The provinces, which constitute administrative divisions of the central state, also hold some monitoring power in the field. Hospital districts, comprising associations of municipalities, are in charge of some management functions in the hospital sector, and constitute critical instruments to overcome the efficiency and equity problems associated with the small scale of the main health care governing bodies, i.e. the municipalities.

At the national level, the Ministry of Social Affairs and Health issues framework legislation in health and social care policy and monitors implementation. Attached to the ministry is the Basic Security Council, which guarantees quality and equity in the provision of municipal health services. There are several agencies and institutions attached to the ministry, namely the National Research and Development Centre for Welfare and Health; the National Authority for Medico-legal Affairs; and the National Agency for Medicines.

Municipalities (448 in 2000) have responsibility for health promotion and prevention, medical care, medical rehabilitation and dental care. Decisions on the planning and organization of health care are made by the municipal health committee (sometimes merged with the social services committee), the municipal council and the municipal executive board. All are politically accountable to the citizens of the municipality. The country is divided into 20 hospital districts, which are federations of municipalities responsible for providing and coordinating specialized care within their area. Each municipality must be member of a hospital district.

Since 1995 there are have been five provinces (plus Åland Islands), which promote national and regional objectives of the central administration. They are responsible for the approval of capital investment plans and guide and supervise public specialized and primary health care.

Planning, regulation and management

In general, since the 1993 state subsidy reform, central regulation has become less detailed, in

order to allowing for different local solutions. In particular, central government's role was redefined, focusing in steering the system by means of information, framework legislation and experimental projects. However, some critical aspects, such as the ceilings on user charges, remain regulated centrally.

Municipalities negotiate annually on the provision of hospital services within their corresponding hospital district, which defines prices. The purchaser-provider split has not been introduced in Finland, and therefore hospital districts do not act as third-party purchasers. There is an equalization mechanism operating within hospital districts, which spreads the risk of high cost patients between the municipalities included within each district.

Finally, employers sometimes organize their own private plans. This builds on the 1979 Occupational Health Care Act, which obliged employers to provide preventive occupational health care for their employees.

Decentralization of the health care system

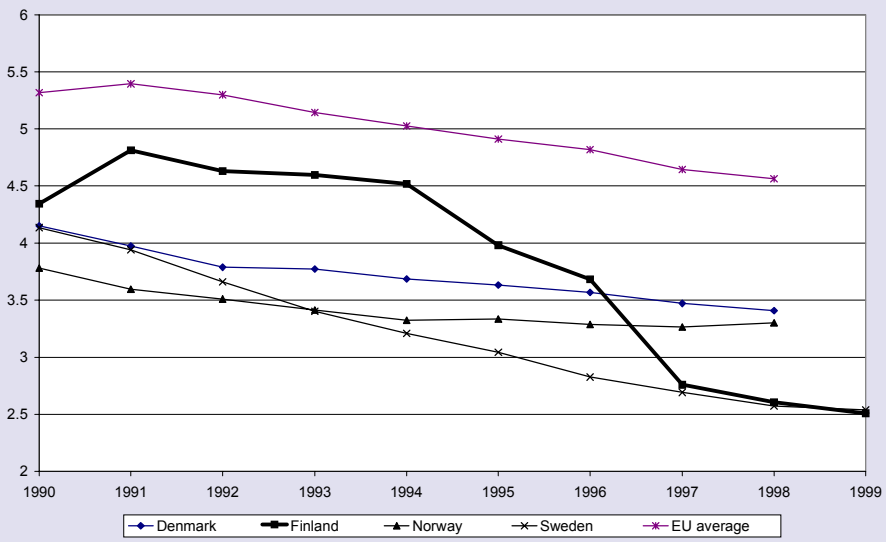
The Finnish health care system is very decentralized, as municipalities are responsible for regulation and management of health care. This results in significant variations among municipalities in clinical practice; delivery and per capita expenditure have been described.

Health care financing and expenditure

Health care financing and coverage

The Finnish health care system provides comprehensive coverage to all the resident population and it is mainly tax-financed. Both the state and municipalities have the right to levy taxes. In 1999 about 43% of total health care costs were financed by the municipalities, 18% by the state (mainly through state subsidies), 15% by

Fig. 2. Hospital beds in acute hospitals per 1000 population, Finland, selected countries and EU average



Source: WHO Regional Office for Europe health for all database.

the National Health Insurance (NHI), and about 24% by private sources (mainly households). During the 1990s, the state share in the financing has decreased (public expenditure was reduced in the context of economic recession in the early 1990s) while the NHI share has increased, mainly due to the growing use of new expensive pharmaceuticals. About half of the municipalities' income arises from tax revenues and they spend about 25% of their budget on health care. The existence of several public funding sources creates difficulties with coordination so that it seems the public financing system needs to be clarified and simplified.

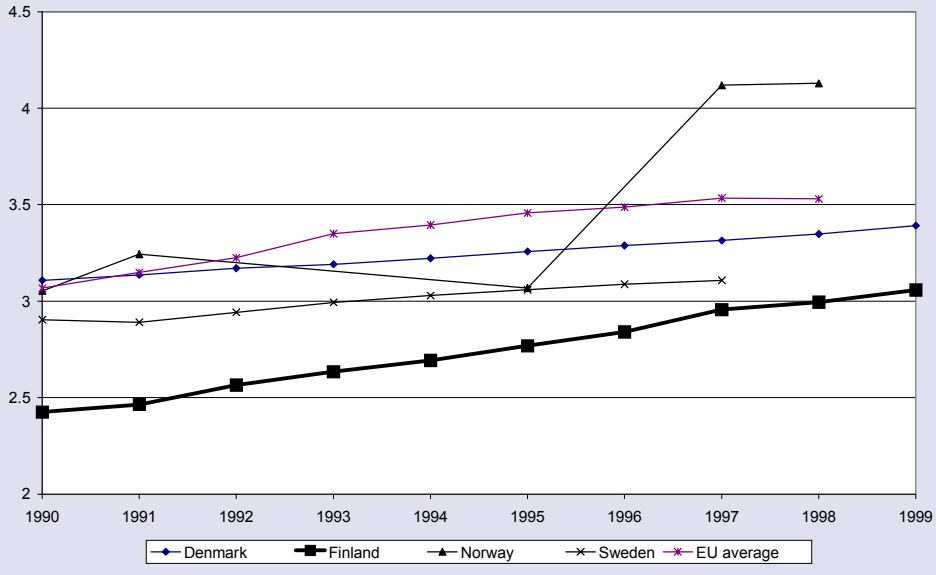
Health care benefits and rationing

There are no plans for an explicitly stated basic package of benefits to which people are entitled. Some services are excluded from the statutory health system such as dental care for certain groups (although it is foreseen that by the end of 2002 the entire population would be offered publicly funded dental care). Spectacles are generally not publicly financed but *in vitro* fertilization and surgery for varicose veins are not excluded from the public system.

Complementary sources of finance

The increase in out-of-pocket payments has led to an increase in the total share of private financing. There has been an overall increase in private financing in absolute and relative terms (since there has been a reduction in public spending). This is accounted for by increases in user charges for municipal services; the abolition of tax deductions for drug and other medical treatment costs; and reductions in the reimbursement of pharmaceuticals by the NHI. Exemptions from user charges are not available to low-income or any other groups so they have to seek subsistence through the social welfare system. An annual ceiling for health care costs was introduced at the beginning of 2000.

Fig. 3. Physicians per 100 population, Finland, selected countries and EU average



Source: WHO Regional Office for Europe health for all database.

Voluntary health insurance

The role of private health insurance is still relatively insignificant in Finland, and has grown only recently. In 1980 it accounted for about 0.8% of total health care expenditure, and in 1990 for about 1.7%. The recent increase up to 2% is mainly due to the recent increase in the rehabilitation services offered by private insurance companies.

Health care expenditure

Total health expenditure as a percentage of GDP decreased from 7.5% in 1995 to 6.8% in 1999. On the other hand, total health expediture in US $PPP per capita increased from 1421 in 1995 to 1547 in 1999. The distribution of expenditure by levels and categories of care has however changed. For instance, total pharmaceutical expenditure has grown rapidly during the 1990s while public expenditure on inpatient care has decreased.

Health delivery system

Primary health care and public services

The 1972 Primary Health Care Act created a newly-built network of primary health care centres, within which multidisciplinary teams provide primary curative, preventive and public health services to their assigned populations. They are publicly owned and run. Legislation does not define in great detail how the services should be provided, and in most cases this is left to the discretion of the municipalities. Nurses have an essential role in health centres, especially in maternal and child care. The choice of health care doctor or hospital is in practice very limited, although reforms to increase freedom of choice are currently under discussion.

The personal doctor system was introduced in the 1980s, focusing on improving continuity and family care and this improved access to general practitioners and reduced waiting times. This system was later developed so that overall responsibility for the health status of assigned and territorially defined populations lay with the multidisciplinary primary care teams.

Health centres provide most preventive services, including maternal and child care as well as school health care. Public health policy has been particularly successful in reducing mortality and risk factors related to cardiovascular diseases. However, primary and secondary care are not always very well coordinated and there is a need to improve continuity across levels of care.

Secondary and tertiary care

They are provided in public hospitals, through outpatient and inpatient departments. During the 1990s the number of all hospital beds declined by one third (specially in short-term acute care) to 7.6 per 1000 in 1999, and the average of stay fell by around 40%. In contrast, admission rates rose during the same period by about 20% on average. Reductions in length of stay reflect the increased efficiency of clinical management, achieved through the introduction of new medical technologies, the development of day surgery, and the increasing resort to community versus institutionalized care.

In particular, many long-term psychiatric patients have been transferred from institutionalized care to outpatient care, housing care or the primary care system. However, beds have been decreasing at a faster pace than non-institutionalized care has been expanding. Accordingly, psychiatric services are now a priority area in the Finnish health care system. State subsidies to municipalities for the improvement of psychiatric services were increased in 2001; and the Ministry of Social Affairs and Health and the Association of Finnish Local and Regional Authorities have recently published guidelines for psychiatric care.

Social care

Provision of social services is the responsibility of the municipalities and it mainly comprises

child day care, child welfare, and care for the elderly, the disabled and substance abusers. Care for the elderly and disabled suffered greatly from the severe economic crisis of the 1990s. As a result, there have been cuts in resources and thereby reductions in services, which is especially worrying given rapid population aging. As a consequence, new measures have been launched (i.e. the publication of national quality guidelines for elderly care). Supplementary care insurance is being considered as an option for financing the future costs of elderly. No measures have been taken to promote private long-term care insurance.

Human resources and training

Most health care professionals are employed by municipalities. In 1999 the number of physicians per capita was slightly below the EU average, while the ratio of nurses was the highest in western Europe. As a consequence of population aging, demand is expected to rise, which will increase the current shortage of doctors and other health personnel.

Pharmaceuticals and health care technology assessment

Pharmaceutical products enter the market by permission of the National Agency of Pharmaceuticals. The Pharmaceuticals Pricing Board regulates the prices of those drugs that are reimbursed by the NHI. The majority of drugs are reimbursable. Pharmacies are privately owned but require a licence from the National Agency of Pharmaceuticals.

Although pharmaceutical costs grew by 10% every year from the beginning of the 1990s to 1998, mainly due to new expensive drugs, the use of generic prescribing is modest. Since 1997 a number of measures have been launched to contain rising costs, such as a programme to change doctors' prescribing practices. Drug expenditure and reimbursement costs started growing faster in 1999, so it seems that further measures are needed. Finally, an independent Centre for Health Care Technology Assessment, established in 1995 within the National Research and Development Centre for Welfare and Health, regulates the effectiveness and cost-effectiveness of care.

Financial resource allocation

In 1993, the resource allocation system to municipalities which channels state subsidies was reformed so that funds are prospectively set (and paid in advance) and cease to be earmarked. Municipal allocations are calculated mainly according to the number of inhabitants, age structure and morbidity, under a weighted capitation system. As regards capital investments, future prospects point to a gradual reduction of state subsidies (to 25% of the costs from the year 2002 onwards). Municipalities are allowed to borrow money to finance capital investments or for other purposes.

Payment of hospitals

As a consequence of the reform of the state subsidy system, since 1993 hospitals have received their revenue from the municipalities according to the services used by their inhabitants. Although services are defined and prices calculated in very different ways, hospitals and hospital districts have become increasingly interested in using diagnostic related groups (DRGs) as the basis for billing municipalities.

Payment of physicians

Hospital physicians and most doctors in municipal health centres are salaried employees. They usually have a basic monthly salary and an additional remuneration for being on call or for certificates of health status. Under the personal doctor system, physicians are paid a combination of a basic salary (approx. 60%), a capitation payment (20%), fee-for-service (15%) and local allowances (5%).

The Commission for Local Authority Employers, and the trade unions autonomously negotiate the wages, salaries and fees of health personnel.

Health care reforms

Reform regulation issued by the central government during the 1980s and 1990s was not intended to promote major structural change, but rather to solve specific problems with a number of sectoral programmes. Some examples are the introduction of a personal doctor system in the 1980s as an attempt to address increasing waiting times; the activation of a set of cost-containing measures from 1997 onwards in response to a rising pharmaceutical bill; and the negotiation and approval of quality guidelines for mental health care services in 2001 to facilitate the development of community care in parallel with rapid reductions of capacity in the hospital sector. A new national programme of health promotion was approved in May 2001. It sets guidelines for the next 15 years based on the WHO health for all policy.

Finally, a recent development is the emergence of a number of local projects and pilots around the country along the lines of the purchaser-provider model, as well as experiments promoting the real or virtual integration between primary and secondary providers.

Conclusions

The health care system in Finland has been in many ways successful. It survived the severe economic crisis of the first half of the 1990s fairly well and despite the resulting cuts in health budgets, the quality and quantity of service provision have been largely maintained. However, there are still some problems that require further attention, namely the marked variations in per capita expenditure and activity rates between different municipalities. In addition, it is not clear whether the reduction in lengths of stays and capacity in hospitals has been compensated by expanded community services. Personnel shortages are already an important problem, and will be more acutely felt in the near future, as a result of a rapidly aging population. There are also some constraints on patients' freedom of choice either of primary care doctor or of hospital. Finally, the financing of health care contains a number of unusual features that undermine equity, such as the rising proportion of health funding from out-of-pocket payments.

Table 1. Inpatient utilization and performance in acute hospitals in the WHO European Region, 2000 or latest available year

Country	Hospital beds per 1000 population	Admissions per 100 population	Average length of stay in days	Occupancy rate (%)
Denmark	3.3[a]	19.2[e]	5.5	79.9[a]
Finland	2.4	19.3[d]	4.3	74.0[e]
Norway	3.1	14.5[d]	6.0	85.2
Sweden	2.5	15.9[d]	5.5[a]	77.5[d]
EU average	4.2[a]	17.1[e]	8.2[b]	77.0[b]

Source: WHO Regional Office for Europe health for all database.
Note: [a] 1999, [b] 1998, [c] 1997, [d] 1996, [e] 1995, [f] 1994, [g] 1993.

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The Health Care Systems in Transition (HiT) profiles are country-based reports that provide an analytical description of each health care system and of reform initiatives in progress or under development. The HiTs are a key element that underpins the work of the European Observatory on Health Care Systems.

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