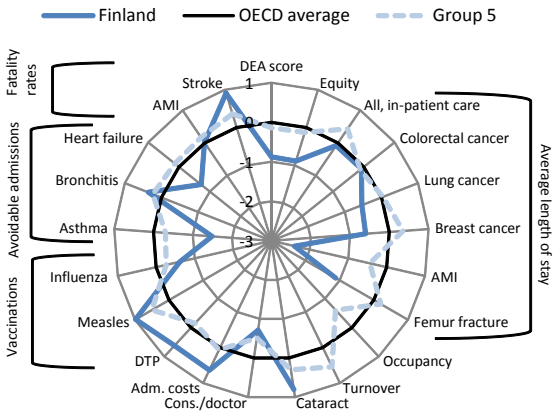
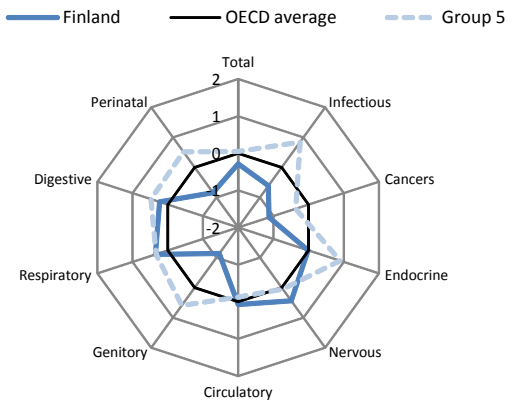
Finland: health care indicators

Group 5: Denmark, Finland, Mexico, Portugal, Spain

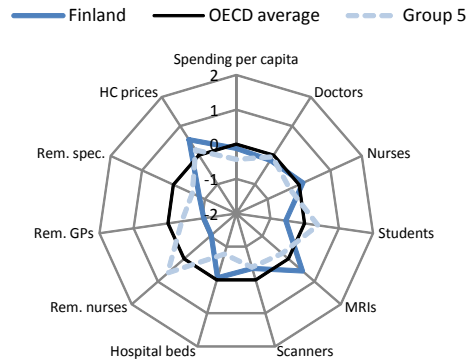
A. Efficiency and quality



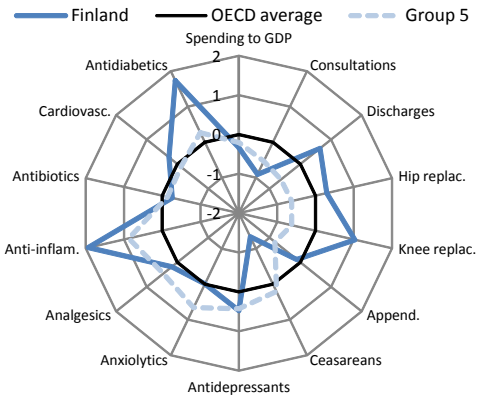
B. Amenable mortality by group of causes



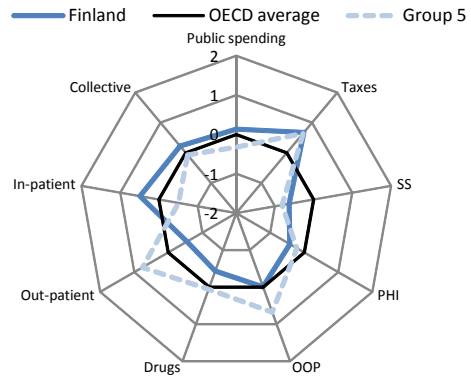
C. Prices and physical resources



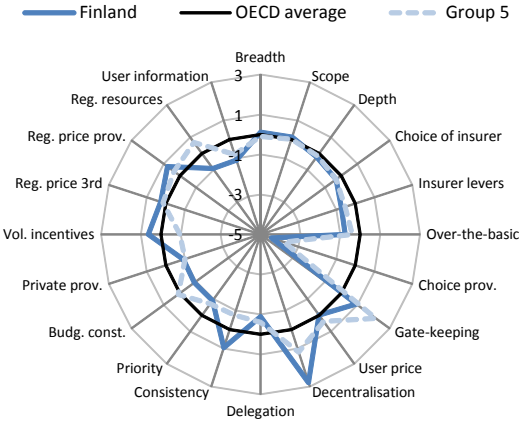
D. Activity and consumption



E. Financing and spending mix



F. Policy and institutions



Note: Country groups have been determined by a cluster analysis performed on policy and institutional indicators. In all panels except Panel A, data points outside the average circle indicate that the level of the variable for the group or the country under scrutiny is higher than for the average OECD country (e.g. Australia has more scanners than the OECD average country).
In Panel A, data points outside the average circle indicate that the group or the country under scrutiny performs better than the OECD average (e.g. administrative costs as a share of total health care spending are lower in Australia than on average in the OECD area).
In all panels except Panel F, data represent the deviation from the OECD average and are expressed in number of standard deviations.
In Panel F, data shown are simple deviations from the OECD average.

Source : OECD Health Data 2009; OECD Survey on Health Systems Characteristics 2008-2009; OECD estimates based on Nolte and Mc Kee (2008).

FINLAND

GROUP 5: Mostly public insurance. Health care is provided by a heavily regulated public system and the role of gate-keeping is important. Patient choice among providers is limited and the budget constraint imposed *via* the budget process is rather soft.

Efficiency and quality	Prices and physical resources	Activity and consumption	Financing and spending mix	Policies and institutions	Weaknesses and policy inconsistencies emerging from the set of indicators
Low DEA score and high inequalities in health status	About average health care spending *per capita*		Higher tax-financed shares	Less market orientation for the "over-the-basic" segment	Examine the reasons behind high inequalities in health status
Rather low output/hospital efficiency	More acute care beds *per capita*	More hospital discharges *per capita*	Higher in-patient share	Less gate-keeping and choice of provider	Reinforcing control on resources, priority setting and gate-keeping arrangements could contribute to shift resources from in-patient to out-patient care
Mixed scores on the quality of preventive and out-patient care		Less doctor consultations *per capita*	Lower out-patient share	Little private provision but more incentives to raise volume of care in the hospital sector. Out-patient physicians are paid on a salary basis	Assess whether reform of the compensation system for physicians could help to improve the quality of out-patient care
Low administrative costs	Much lower relative income level of health care professionals			Less regulation of resources, priority setting and budget constraint. More regulation of prices	