European Commission

State of Health in the EU

Finland

Country Health Profile 2019

OECD
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European Observatory on Health Systems and Policies
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The Country Health Profile series

The *State of Health in the EU*'s Country Health Profiles provide a concise and policy-relevant overview of health and health systems in the EU/European Economic Area. They emphasise the particular characteristics and challenges in each country against a backdrop of cross-country comparisons. The aim is to support policymakers and influencers with a means for mutual learning and voluntary exchange.

The profiles are the joint work of the OECD and the European Observatory on Health Systems and Policies, in cooperation with the European Commission. The team is grateful for the valuable comments and suggestions provided by the Health Systems and Policy Monitor network, the OECD Health Committee and the EU Expert Group on Health Information.

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Data and information sources

The data and information in the Country Health Profiles are based mainly on national official statistics provided to Eurostat and the OECD, which were validated to ensure the highest standards of data comparability. The sources and methods underlying these data are available in the Eurostat Database and the OECD health database. Some additional data also come from the Institute for Health Metrics and Evaluation (IHME), the European Centre for Disease Prevention and Control (ECDC), the Health Behaviour in School-Aged Children (HBSC) surveys and the World Health Organization (WHO), as well as other national sources.

The calculated EU averages are weighted averages of the 28 Member States unless otherwise noted. These EU averages do not include Iceland and Norway.

This profile was completed in August 2019, based on data available in July 2019.

To download the Excel spreadsheet matching all the tables and graphs in this profile, just type the following URL into your Internet browser: http://www.oecd.org/health/Country-Health-Profiles-2019-Finland.xls

Demographic and socioeconomic context in Finland, 2017

Demographic factors	Finland	EU
Population size (mid-year estimates)	5 508 000	511 876 000
Share of population over age 65 (%)	20.9	19.4
Fertility rate[1]	1.5	1.6
Socioeconomic factors		
GDP per capita (EUR PPP[2])	32 700	30 000
Relative poverty rate[3] (%)	11.5	16.9
Unemployment rate (%)	8.6	7.6

1. Number of children born per woman aged 15-49. 2. Purchasing power parity (PPP) is defined as the rate of currency conversion that equalises the purchasing power of different currencies by eliminating the differences in price levels between countries. 3. Percentage of persons living with less than 60 % of median equivalised disposable income.
Source: Eurostat Database.

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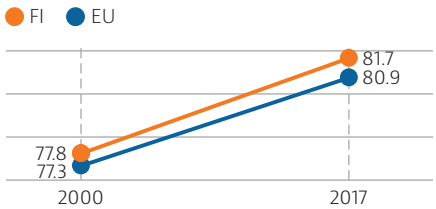
1 Highlights

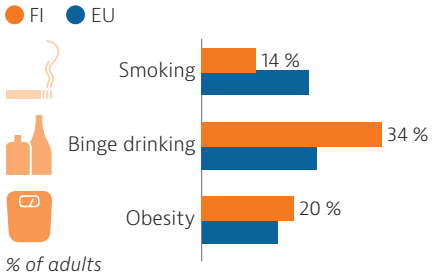
The Finnish population has seen encouraging improvements in life expectancy over the past two decades, but many of the additional years of life are spent with some chronic diseases and disabilities, raising demands on health and long-term care systems. The health system is complex, multi-tiered and decentralised. Comprehensive reforms of the health system have proved difficult to implement over the past 15 years. Proposed reforms include greater centralisation of responsibilities and resources at the regional level to improve equal access to care while controlling costs.



Life expectancy at birth, years

Health status

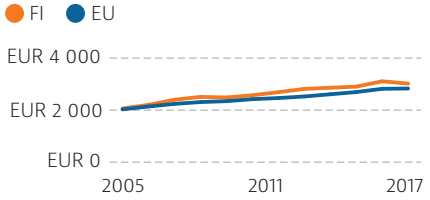
Life expectancy has increased by nearly four years since 2000, and the gender gap has narrowed slightly as gains among men have exceeded those among women. However, Finnish people report more activity limitations than other Europeans, resulting in a lower number of healthy life years than their EU counterparts.



% of adults

Risk factors

In 2018, 14 % of adults in Finland smoked tobacco daily – down from 23 % in 2000 and below the EU average of 19 %. Alcohol consumption has decreased, but over one-third of adults (34 %) still reported heavy episodic alcohol consumption in 2014, a proportion well above the EU average (20 %). The obesity rate among adults has gone up: at 20 % in 2018 it is higher than the EU average (15 %).



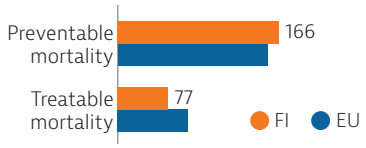
Per capita spending (EUR PPP)

Health system

Health spending per capita in Finland has increased at a moderate rate over the past 10 years. At EUR 3 036 in 2017, it is slightly above the EU average (EUR 2 884). Health spending accounts for 9.2 % of Finland's GDP, below the EU average of 9.8 %. Public funding accounts for 75 % of all health spending, a lower share than the EU average (79 %). Most of the remaining expenses are paid out of pocket by households.

Effectiveness

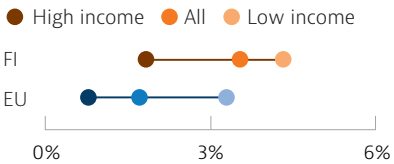
Mortality from treatable causes is lower in Finland than the EU average, signalling that the health care system performs well in saving the lives of people with potentially fatal conditions. On a less positive note, mortality that could be prevented through public health interventions is slightly higher than the EU average.



Age-standardised mortality rate per 100 000 population, 2016

Accessibility

People in employment have better access to health care through occupational health services than unemployed or retired people. The proportion of people reporting unmet needs for medical care is higher than the EU average, mainly because of long waiting times.



% reporting unmet medical needs, 2017

Resilience

Health and long-term care expenditure is expected to grow in the coming years because of population ageing, while there will be fewer working-age people to pay for these services. Progress has been achieved in improving efficiency in hospital care, but one of the main challenges is to strengthen access to primary care and achieve greater care coordination across sectors.

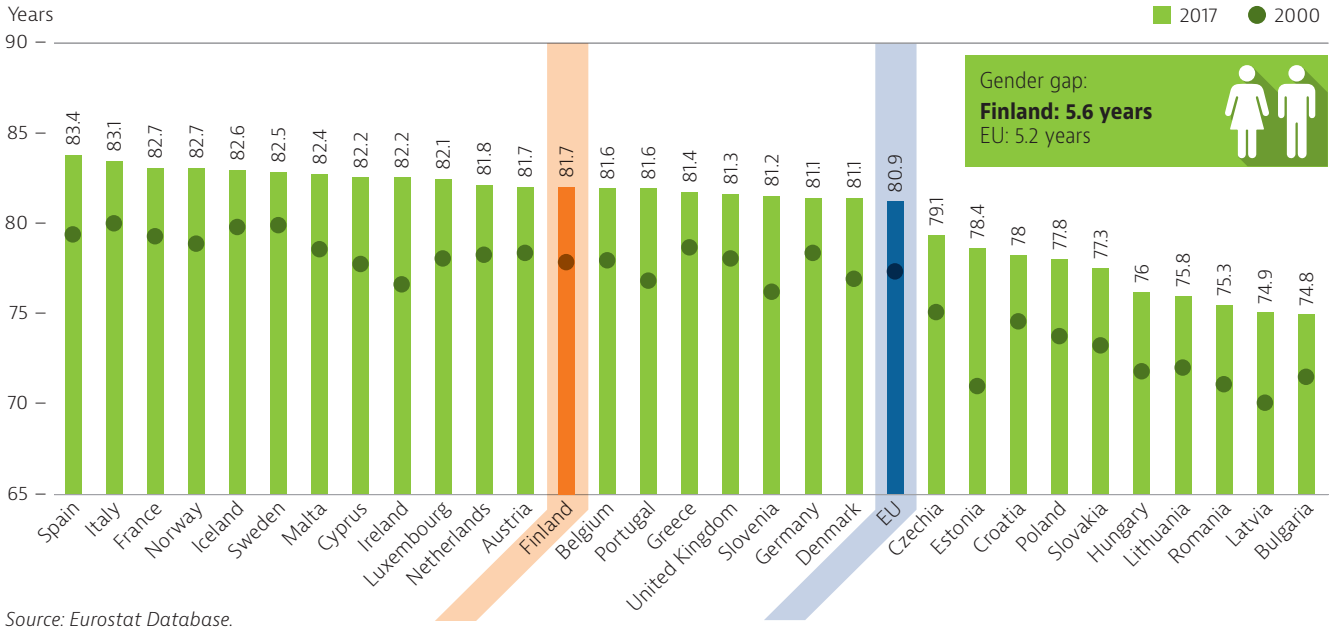
2 Health in Finland

Life expectancy is slightly higher than the EU average

Life expectancy in Finland increased by nearly four years between 2000 and 2017 and is almost one year higher than the EU average (Figure 1). However, it remains more than a year lower than in Spain and Italy, the two countries with the highest life expectancy in the EU, and about one year lower than in Sweden and Norway.

Although it has decreased, the gender gap in life expectancy remains large and above the EU average, with women living over five years more than men in 2017 (84.5 years and 78.9 years respectively). This is caused by the death rates from cardiovascular diseases and external causes (including accidents and suicides) among Finnish men aged under 65, which are more than three times higher than the rates among women in the same age group.

Figure 1. Life expectancy is higher than the EU average but the gender gap is still large



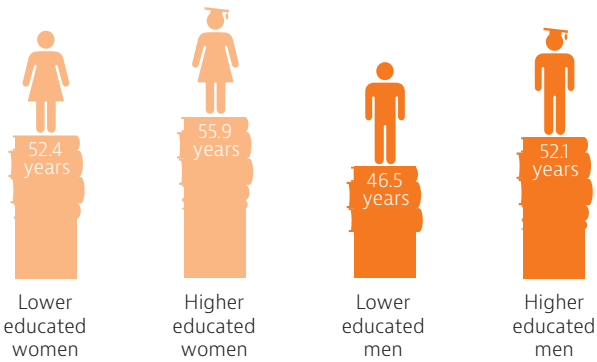
Source: Eurostat Database.

Social inequalities in life expectancy are large

Inequalities in life expectancy in Finland exist not only by gender but also by socioeconomic status. In 2016, life expectancy for men at age 30 with the lowest level of education was about 5.5 years lower than for the most educated. This education gap in longevity was smaller among women, at 3.5 years (Figure 2). However, the gap between the least and most educated women increased during the last decade (by 0.7 year), while it narrowed slightly for men.

This gap can be explained at least partly by differences in exposure to various risk factors and lifestyles, including higher smoking rates, poorer nutritional habits and higher obesity rates among men and women with low levels of education (see Section 3). The education gap in life expectancy is also related to differences in income level and living standards, which may affect both exposure to other risk factors and access to health care.

Figure 2. The education gap in life expectancy is 5.6 years for men and 3.5 years for women



Education gap in life expectancy at age 30:

Finland: 3.5 years
EU21: 4.1 years

Finland: 5.6 years
EU21: 7.6 years

Note: Data refer to life expectancy at age 30. High education is defined as people who have completed tertiary education (ISCED 5-8) whereas low education is defined as people who have not completed secondary education (ISCED 0-2).
Source: Eurostat Database (data refer to 2016).

National statistics have reported increased inequalities in life expectancy by income level among both men and women since the 1990s (National Institute for Health and Welfare, 2018a).

Ischaemic heart disease remains the main cause of death, but mortality from Alzheimer's disease is growing

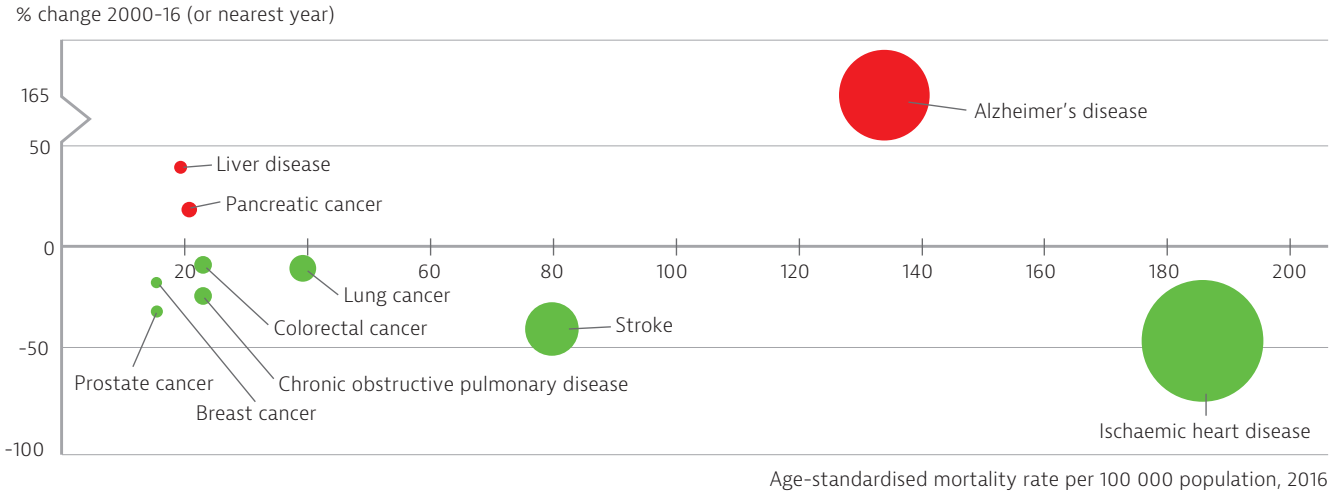
The increase in life expectancy in Finland since 2000 has been driven mainly by reductions in mortality rates from cardiovascular diseases – notably from ischaemic heart disease (which remains the leading cause of death) but also from stroke (Figure 3).

Mortality rates from Alzheimer's disease have increased greatly during the period, making it one of the leading causes of death. However, this is partly due to improvements in diagnosis and changes in death registration practices. Among EU Member States, Finland has the highest mortality rate for Alzheimer's disease, but the lowest rate for pneumonia, following changes in death registration practices.[1]

Mortality from chronic liver disease has also increased by more than one-third since 2000. Mortality from some cancers – including cancers of the liver, pharynx and pancreas, all linked to excess consumption of alcohol – also increased between 2000 and 2016, although the rates have started to drop in recent years.

Lung cancer remains the most frequent cause of death by cancer, although mortality rates have slightly decreased since 2000, following reductions in smoking rates over the past few decades, especially among men (see Section 3).

Figure 3. Mortality is decreasing from ischaemic heart disease and stroke, but rising from Alzheimer's disease



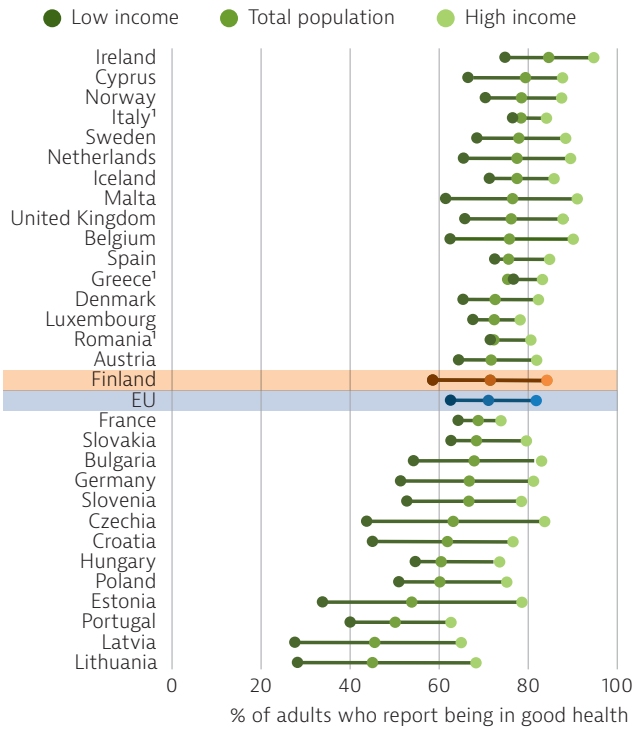
Note: The size of the bubbles is proportional to the mortality rates in 2016. The increase in mortality rates from Alzheimer's disease only covers the period 2006-16. It is largely due to changes in diagnostic and death registration practices.
Source: Eurostat Database.

Most Finns report being in good health, but disparities by income group persist

More than two-thirds of Finnish people report being in good health, a share similar to the EU as a whole (Figure 4). However, people on lower incomes are considerably less likely to report being in good health: less than 60 % in the lowest income group report being in good health, compared to over 80 % in the highest. This difference is greater than in other Nordic countries or the EU average.

1: Since 2005, a change in the WHO coding rules has reduced the use of pneumonia as an underlying cause of death. Any chronic disease mentioned in the death certificate is now recorded as the person's underlying cause of death instead of pneumonia. These cases mainly switched to Alzheimer's disease (and other dementias) and stroke

Figure 4. Inequalities in self-rated health by income level are relatively large



Note: 1. The shares for the total population and the population on low incomes are roughly the same.
Source: Eurostat Database, based on EU-SILC (data refer to 2017).

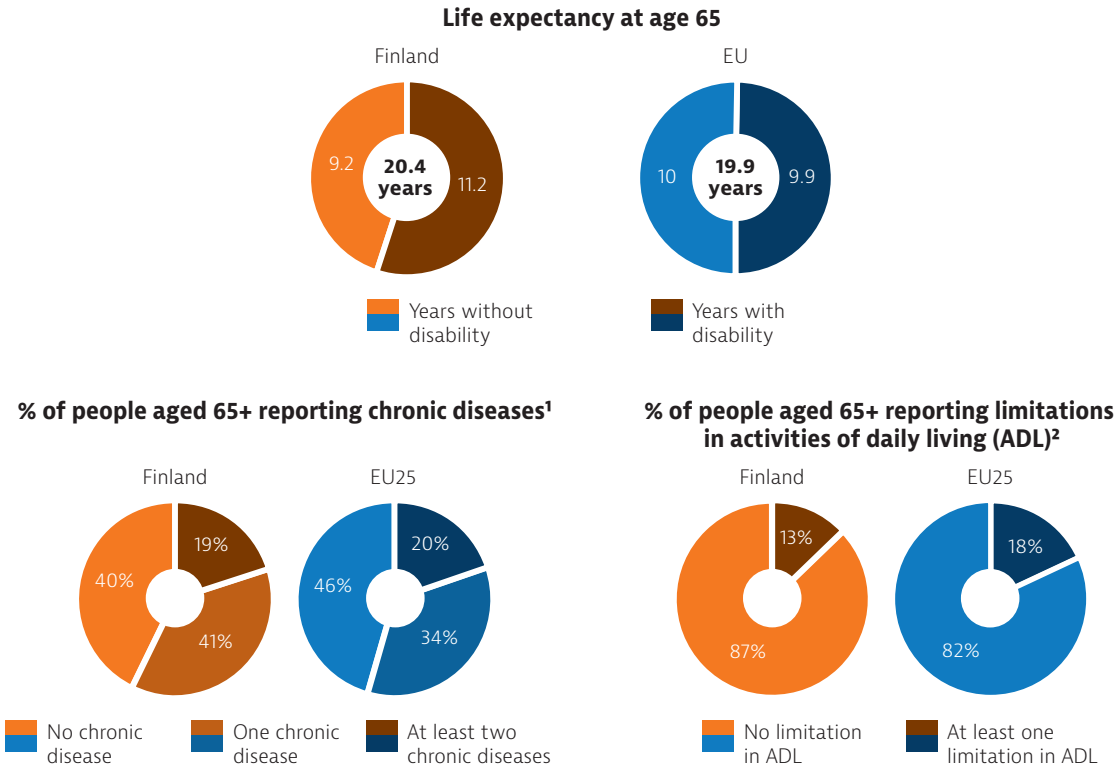
Many years of life after age 65 are lived with some chronic diseases and disabilities

The share of people aged 65 and over is steadily growing in Finland because of rising life expectancy and declining fertility rates. In 2017, more than one in five people were aged 65 and over (21 %), up from 12 % in 1980, and this share is projected to reach 26 % by 2030.

The life expectancy of Finns at age 65 now exceeds 20 years. However, more than half of these years may be spent with some chronic diseases and disabilities (Figure 5). While there is a gender gap of almost four years in life expectancy at age 65 in favour of women, there is almost no gap in the number of healthy life years,[2] as health issues and disabilities are more common among women than men in old age.

Three in five Finns aged 65 and over reported having at least one chronic condition in 2017, a higher proportion than the EU average. While most people are able to continue to live independently in old age, about one in eight reported some limitations in basic activities of daily living such as dressing and eating that may require assistance.

Figure 5. Many years of life of Finns after age 65 are lived with chronic diseases and disabilities



Note: 1. Chronic diseases include heart attack, stroke, diabetes, Parkinson disease, Alzheimer's disease and rheumatoid arthritis or osteoarthritis. 2. Basic activities of daily living include dressing, walking across a room, bathing or showering, eating, getting in or out of bed and using the toilet.
Source: Eurostat Database for life expectancy and healthy life years (data refer to 2017); SHARE survey for other indicators (data refer to 2017).

2: 'Healthy life years' measures the number of years that people can expect to live free of disability at different ages.

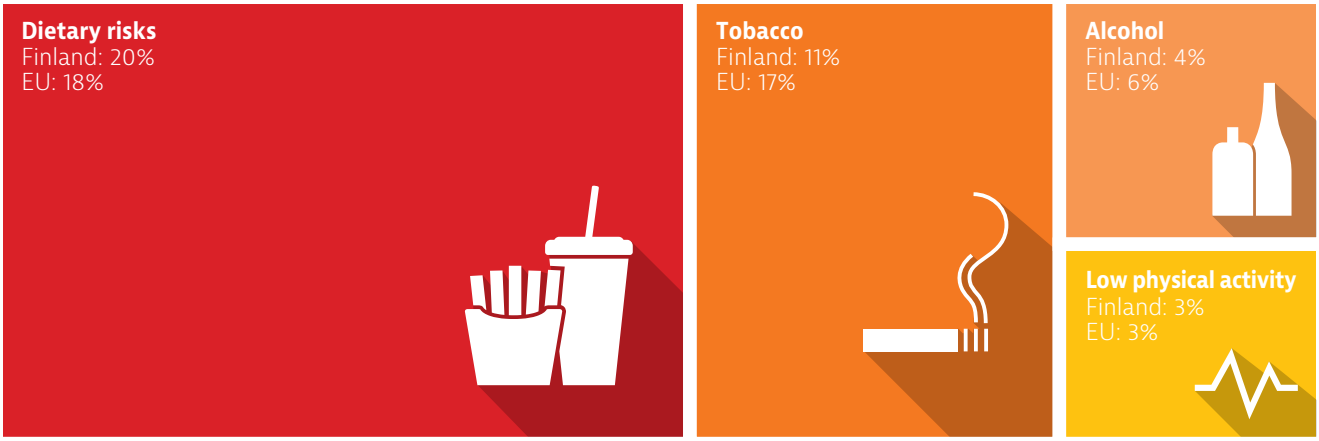
3 Risk factors

Two out of five deaths can be attributed to behavioural risk factors in Finland

Estimates show that almost 40 % of deaths in Finland can be attributed to behavioural risk factors, including dietary risks, tobacco smoking, alcohol consumption and low levels of physical activity (Figure 6; IHME, 2018). While this is below the EU average, the breakdown by cause shows differences in the relative importance of various behavioural risks compared to the EU as a whole.

About 20 % (11 000) of all deaths in 2017 can be attributed to dietary risks (including low fruit and vegetable intake, and high sugar and salt consumption), a slightly higher share than the EU average. Tobacco smoking (including direct and second-hand smoking) is estimated to account for about 11 % (almost 6 000) of deaths – a markedly smaller share than the EU average. About 4 % (2 300) of deaths can be attributed to alcohol consumption and 3 % (nearly 2 000) to low levels of physical exercise, respectively below and in line with the EU average.

Figure 6. Almost 40 % of deaths can be attributed to behavioural risk factors in Finland



Note: The overall number of deaths (20 000) related to these risk factors is lower than the sum of each one taken individually (21 000), because the same death can be attributed to more than one risk factor. Dietary risks include 14 components such as low fruit and vegetable consumption, and high sugar-sweetened beverages and salt consumption.
Source: IHME (2018), Global Health Data Exchange (estimates refer to 2017).

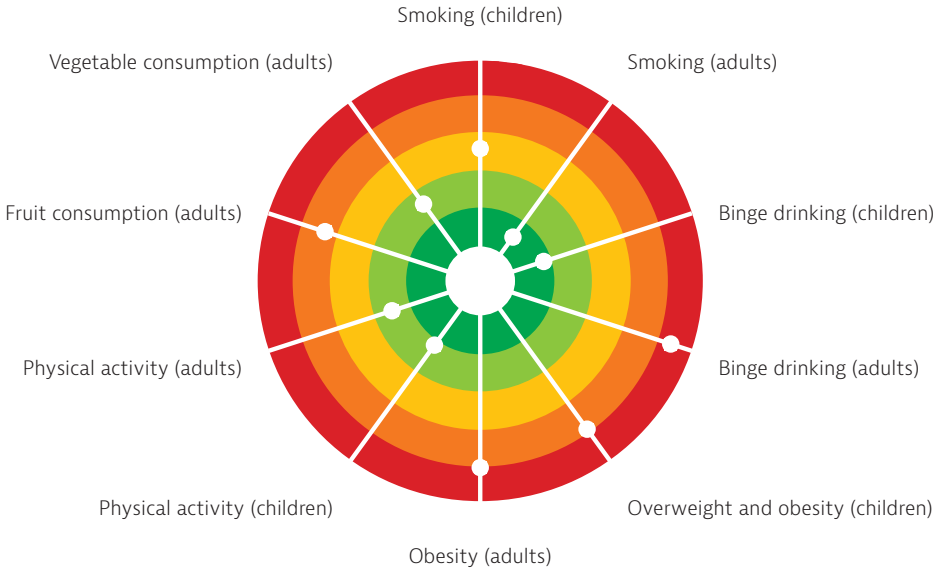
Smoking has decreased, but excessive alcohol consumption remains a public health issue

About 14 % of adults were smoking daily in 2018, down from 23 % in 2000, and the proportion of daily smokers in Finland is now lower than the EU average (19 %). However, one-third of adults reported heavy episodic alcohol consumption (binge drinking[3]) at least once a month in 2014, a higher proportion than in most EU countries (Figure 7). Excessive alcohol consumption is twice as frequent among men than women, a pattern common in other EU countries. Overall alcohol consumption has decreased since the mid-2000s, but it increased slightly in 2018 after the legislation on alcohol sales was liberalised (see Section 5.1).

Among teenagers, 23 % of 15- and 16-year-olds reported binge drinking at least once in the past month in 2015. This proportion was greater among boys (25 %) than girls (20 %), but nonetheless lower than in most EU countries. Smoking rates and alcohol consumption among teenagers have decreased substantially over the past decade (National Institute for Health and Welfare, 2019a) after improving health education in schools and implementation of stricter controls on teenagers trying to buy tobacco or alcohol.

3: Binge drinking is defined as consuming six or more alcoholic drinks on a single occasion for adults, and five or more alcoholic drinks for teenagers.

Figure 7. Obesity and excessive alcohol consumption are important public health issues



Note: The closer the dot is to the centre, the better the country performs compared to other EU countries. No country is in the white 'target area' as there is room for progress in all countries in all areas.
Source: OECD calculations based on ESPAD survey 2015 and HBSC survey 2013-14 for children indicators; and EU-SILC 2017, EHIS 2014 and OECD Health Statistics 2019 for adults indicators.

One in five adults is obese, and one in five teenagers is at least overweight

One in five adults (20 %) in Finland was obese in 2018 based on self-reported data, a higher rate than the EU average (15 %). According to the 2017 Health Examination Survey that took measures of height and weight, an even greater proportion of adults were obese: 26 % of men and 28 % of women.

Among 15-year-olds, nearly 20 % were defined as overweight or obese in 2013-14, a rate also higher than the EU average (17 %), based on the HBSC survey. National sources report alarming increases in overweight and obesity rates between 2013 and 2017: from 16 % to 19 % among students aged 16-18 years in upper secondary school, and from 22 % to 26 % among students aged 16-18 in vocational school (National Institute for Health and Welfare, 2019a).

Social inequality contributes to health risks

Many behavioural risk factors in Finland are more common among people with lower education or income. In 2017-18, one in six adults (18 %) who had not completed secondary education smoked daily, compared to only one in sixteen (6 %) among those with tertiary education. In the same vein, 24 % of people without secondary education were defined as obese, compared to only 17 % among those with higher education. This higher prevalence of risk factors among socially disadvantaged groups contributes significantly to inequalities in health and life expectancy (National Institute for Health and Welfare, 2018b).

4 The health system

Finland's health system is complex, decentralised and fragmented

The Finnish health system is governed at national and local levels. At the national level, the Ministry of Social Affairs and Health is responsible for developing and implementing health reforms and policies, with extensive support from a large network of expert and advisory bodies.

Local authorities (over 300 municipalities) play a key role in purchasing and providing health services. They fund and organise (often jointly) the provision of primary care, and form 20 hospital districts to fund and provide hospital care.

The national Social Insurance Institution runs the statutory national health insurance (NHI) scheme. The NHI funds outpatient pharmaceuticals, health care related travel costs as well as sickness and maternity allowances. In practice, the NHI also subsidises occupational health care: in Finland employers are required to provide health services for their employees, and the NHI covers about half of employers' health care costs. In addition, the NHI reimburses part of the services provided in the private sector – mainly outpatient (or ambulatory) care.

The NHI is financed through compulsory employment contributions, while primary and hospital care are funded through taxes collected by the municipalities as well as subsidies from the national government.

While high levels of decentralisation allow the health system to adapt to the needs of a dispersed population, it generates some inequalities and inefficiencies. Agreement has been broad on the need to reform the Finnish health system for over a decade, but reaching policy consensus on how the reform should be implemented has proved very difficult. A number of factors have made it impossible so far to implement a fundamental reform, including the lack of a clear vision, difficulties in reaching political consensus, the weak position of the central government, decentralised decision-making and a number of vested interests in the system.

The reforms that have taken place over the past decade have largely been incremental and mainly focused on modifying existing features without fundamentally changing the structure of the health system (Table 1). However, the three main aims of a major reform remain relatively the same. These include recentralisation of the organisational structure from the local to the regional level, containment of costs and increasing patient choice (Keskimäki et al., 2019). The new government elected in 2019 has proposed to pursue some of these reform directions (see Section 5.3).

Table 1. Policy measures and attempts at major health reforms in Finland, 2007 to 2019

2007	Law on Restructuring Local Government and Services
2008	Law on User Fees in Social and Health Care
2009	Amendments to the Medicines Act (reference pricing)
2009	Law on Vouchers in Health Care and Social Services
2010	Health Care Act
2013-17	Pharmaceutical cost containment and changes to pharmaceutical coverage
2014	Cross-border Health Care Act
2014	All-party proposal on reforming health care and social services (failed)
2015	Decree on User Fees in Social and Health Care
2017	Decree on the Centralisation of Specialist Services
2017	Decree on Emergency Care Services
2017	New Alcohol Act
2015-19	Government proposals for regional government and health and social services reform (failed)

Source: adapted from Keskimäki et al. (2019).

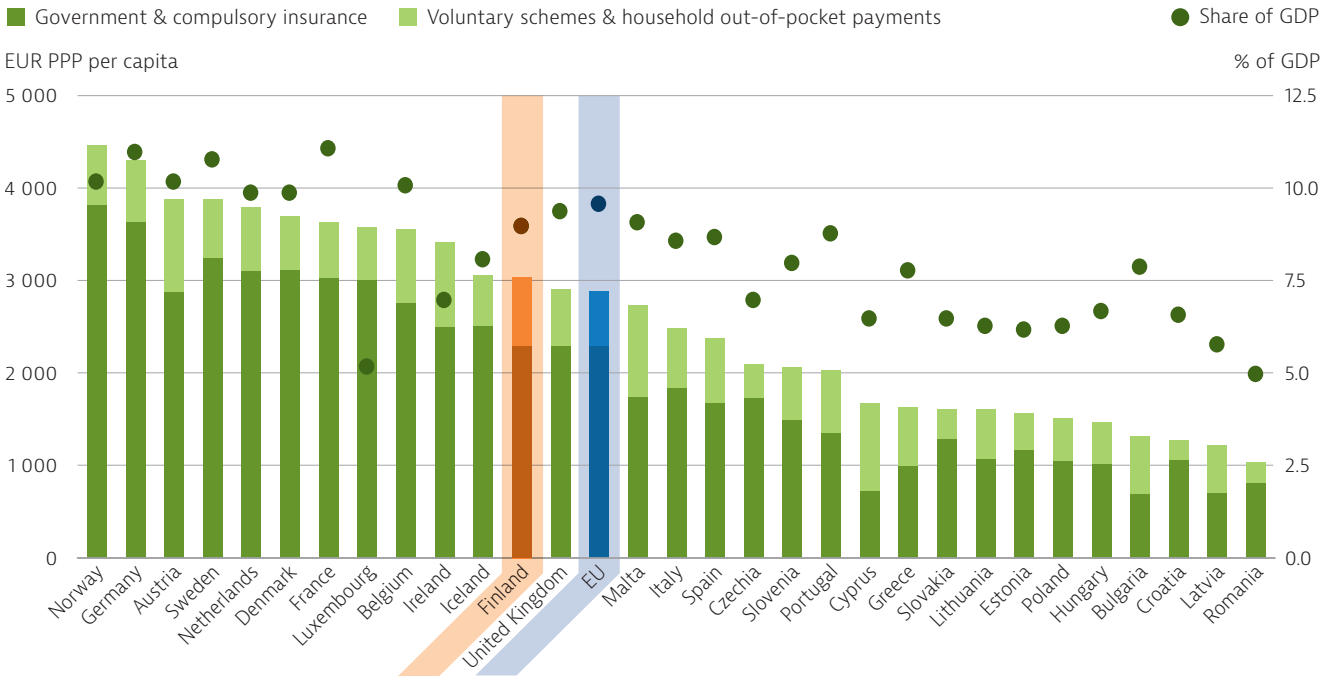
Finland spends less on health than other Nordic countries

In 2017, Finland spent EUR 3 036 per person on health (adjusted for differences in purchasing power), slightly more than the EU average (EUR 2 884), but substantially less than Denmark, Sweden and Norway (Figure 8). As a share of GDP, it amounted to 9.2 %, which is lower than both the EU average (9.8 %) and the share in Denmark, Sweden and Norway (all above 10 %).

In terms of public spending priorities, the share of government spending allocated to health is also lower in Finland than in the EU as a whole and in other Nordic countries, at 13 % in 2017 compared to 16 % (EU average and Denmark) and 18 % (Sweden and Norway).

Three-quarters of health spending is financed through public sources (compared to an EU average of 79 %), with the remaining 25 % paid by private sources (higher than the 15-18 % share in other Nordic countries and the 21 % EU average). Most of this private expenditure comes from out-of-pocket (OOP) payments, of which outpatient medical care, dental care, pharmaceuticals and long-term care account for the majority. Private insurance plays a relatively minor role in health financing, with a share of only 2 % of total health spending.

Figure 8. Total spending on health is similar to the EU average but less than other Nordic countries



Source: OECD Health Statistics 2019 (data refer to 2017).

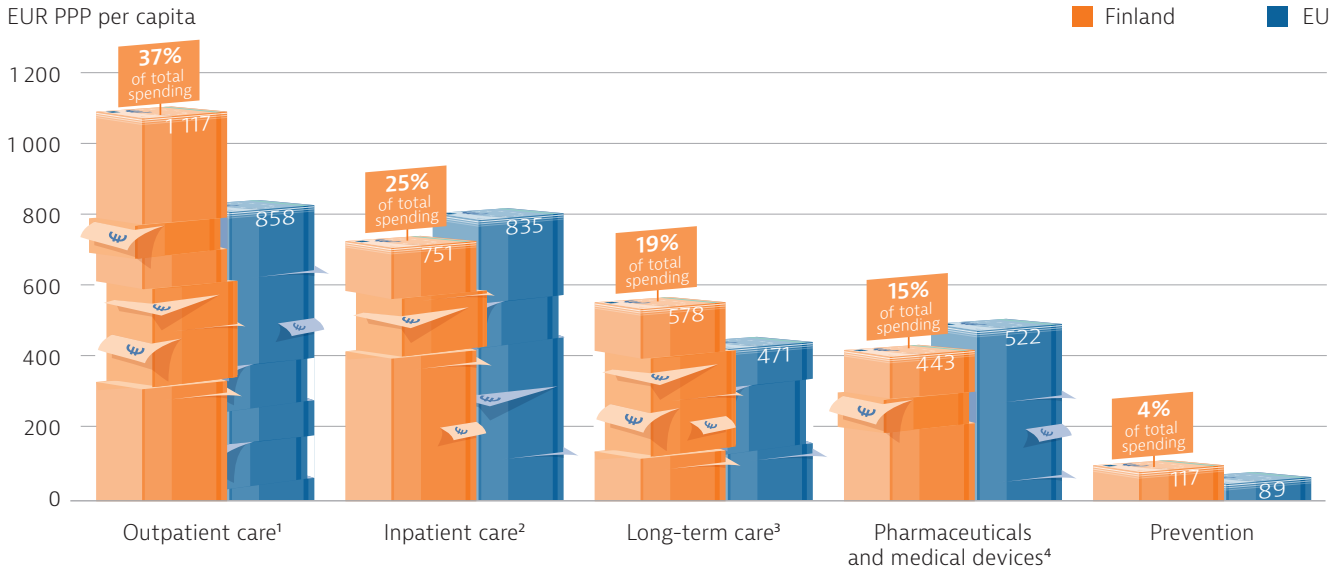
Outpatient services take up the largest share of health spending (37 %), followed by inpatient care (25 %) and long-term care (19 %). Pharmaceuticals and medical devices account for 15 %, although this does not include those used in hospitals (which are reported as inpatient or outpatient care). The inclusion of such hospital spending would increase the total amount by one-fifth. Only about 4 % of health spending is allocated to prevention programmes, although this is slightly higher than the 3 % EU average (Figure 9).

Population coverage is broad, but benefits are fragmented

All residents of Finland, as long as they are registered as living in one of the municipalities, have access to publicly funded health services. The only people without health coverage are irregular immigrants and asylum-seekers who have not been granted asylum and may have therefore lose their right to health services.

The benefit package is broad and covers all services provided by the municipal health system, although waiting times to services vary. Services covered by the NHI are often reimbursed afterwards, up to the reimbursement limit. The occupational health care scheme covers some further benefits for those in employment – about two-fifths of the total population. A growing share of the population (about 21 %) has complementary and/or supplementary private health insurance, mainly to cover the costs of private services and outpatient medicines.

Figure 9. Outpatient care is the main category of health spending



Note: Administration costs are not included. 1. Includes home care; 2. Includes curative-rehabilitative care in hospital and other settings; 3. Includes only the health component; 4. Includes only the outpatient market.
Source: OECD Health Statistics 2019; Eurostat Database (data refer to 2017).

Finland has high levels of user charges

User fees are extensive and involve the majority of services, including primary and emergency care. Two forms of protection from excessive user fees are in place: caps on annual payments and exemptions. There are separate annual caps on services (EUR 683 in 2019), prescribed outpatient medicines (EUR 572) and transportation costs (EUR 300). Medicines included in the reimbursement list are reimbursed at 40 %, 65 % or 100 %, depending largely on the severity of the condition.

Exemptions involve specific services (e.g. treatment of certain infectious diseases, immunisations, maternity and child health clinics, provision of medical aids), and most services are free for children under 18. However, this type of health coverage design, with substantial out-of-pocket spending and unequal distribution of available services across municipalities, raises concerns about barriers to accessing health services (see Section 5.2).

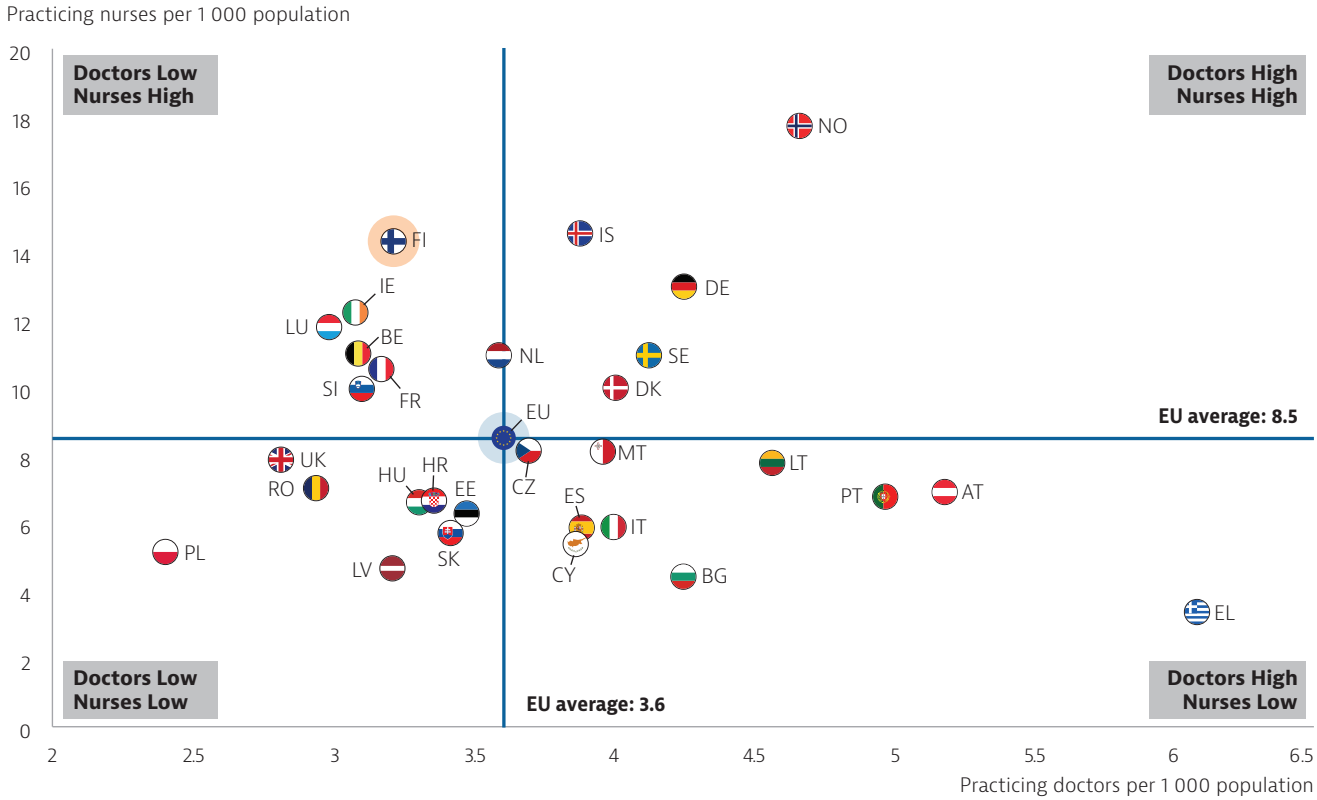
Secondary care centres are more centralised

The hospital infrastructure is currently undergoing major changes. Besides the five university hospitals, seven or eight large inpatient centres are expected to provide an extensive range of specialist services. The remaining regional and local hospitals are also expected to be restructured, and some of these may be closed or merged. More generally, the number of hospital beds has been cut by almost half since 2000. In 2017, Finland had just over three beds per 1 000 population, compared to five in the EU on average (see Section 5.3).

Finland has a high ratio of nurses and their role is gradually expanding

Most professionals working in the health sector are employed in municipally operated health services. Since the 2000s, the shortage of doctors has eased, but the ratio of physicians to population in Finland (3.2 per 1 000 population in 2016) remains below the EU average (3.6; Figure 10). The ratio of nurses to population (14.3 per 1 000 population) is the highest among EU countries, but lower than in Norway and Iceland. The role of nurses in primary care has gradually expanded and now includes limited prescribing and care coordination (see Section 5.2).

Figure 10. Finland has one of the highest numbers of nurses in the EU, but relatively fewer doctors



Note: In Portugal and Greece, data refer to all doctors licensed to practice, resulting in a large overestimation of the number of practising doctors (e.g. of around 30 % in Portugal). In Austria and Greece, the number of nurses is underestimated as it only includes those working in hospital.
Source: Eurostat Database (data refer to 2017 or the nearest year, 2014 for Finland).

Long waiting times and lack of coordination remain key challenges in service provision

Primary care offers a range of services in health centres and occupational health units. These include prevention and ambulatory care, dental care, maternity and child health care. Health centres also often have inpatient units run by general practitioners (GPs) for chronic and long-term care patients. Secondary (specialist outpatient and inpatient) care is usually provided by regional hospitals, while tertiary care is delivered in five university hospitals. Patients need a referral to access specialist care, but not for emergency cases.

Despite waiting time guarantees for primary health care and specialised services, long waiting lists are a persistent feature of the Finnish health system. Access is worse for people who are not eligible for occupational health care, such as unemployed and retired people (see Section 5.2). Lack of coordination between primary and secondary care settings is another issue, as well as variation in the availability, standards and quality of services. The same is true for coordination between health services and social welfare services, although these services are increasingly merged in the municipalities. The proposed health care reforms have aimed to integrate primary health care, specialised hospital care and social welfare services in the regions.

5 Performance of the health system

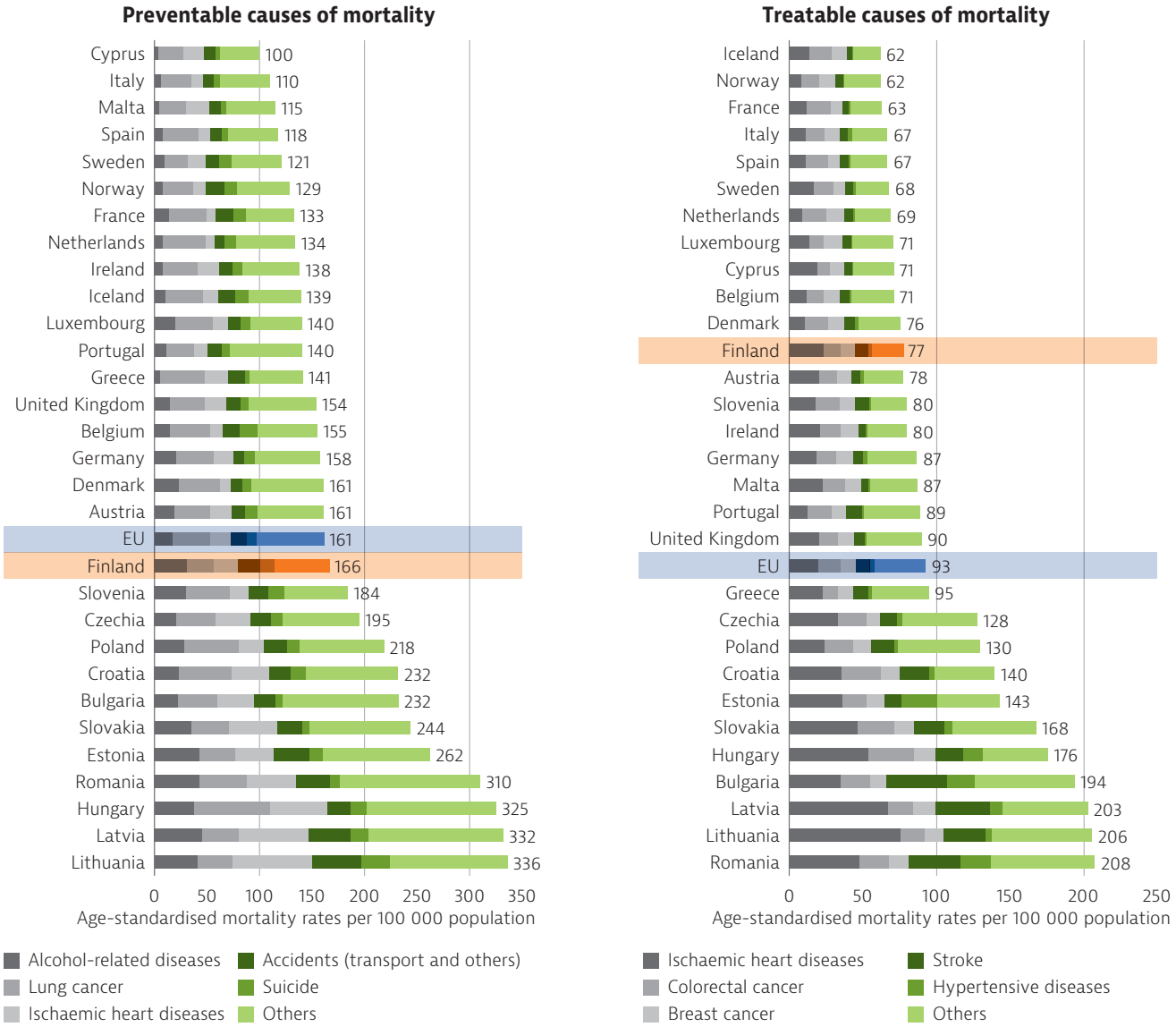
5.1. Effectiveness

Preventable mortality is higher than average, but mortality from treatable causes is low

Preventable mortality is slightly above the EU average, suggesting that investing more on prevention might reduce premature deaths. The main causes of preventable mortality in Finland are alcohol-related deaths, lung cancer, ischaemic heart disease, accidents (including road accidents) and suicide (Figure 11).

On a more positive note, Finland fares better in terms of mortality from treatable causes. This rate was over 15 % below the EU average in 2016, indicating that the health system is effective in saving the lives of people with life-threatening conditions. The leading causes of treatable mortality are ischaemic heart disease, colorectal and breast cancer and stroke. Between 2011 and 2016, mortality from treatable causes fell by 10 %.

Figure 11. Rates of mortality from treatable causes are low but higher for preventable causes



Note: Preventable mortality is defined as death that can be mainly avoided through public health and primary prevention interventions. Mortality from treatable (or amenable) causes is defined as death that can be mainly avoided through health care interventions, including screening and treatment. Both indicators refer to premature mortality (under age 75). The data is based on the revised OECD/Eurostat lists.
Source: Eurostat Database (data refer to 2016).

Prevention policies have been effective in reducing smoking

As noted in Section 3, smoking rates have reduced greatly in Finland over the past 15 years and are now among the lowest in the EU. Finland continues to implement a range of tobacco control policies and programmes, including tobacco cessation programmes, health warnings on cigarette packages, public awareness campaigns through mass media and high taxation of tobacco products.

Overweight, obesity and diabetes are on the rise. These issues were addressed under a national obesity programme that was put in place between 2012 and 2018. A healthy nutrition and physical activity programme aimed to curb the growth in obesity through information and communication campaigns and greater collaboration between national, regional and local actors, but the results have not yet been evaluated (National Institute for Health and Welfare, 2019b).

Alcohol-related harms and deaths are much higher than in most other Nordic and EU countries. A number of regulations have been introduced to reduce alcohol consumption, such as advertising restrictions, granting a monopoly to a government-owned company (Alko) for retail sales of alcohol products exceeding 5.5 % alcohol by volume and restricting opening hours for both retail sales and sales of alcohol in bars and restaurants. These measures contributed to a 20 % reduction in overall alcohol consumption among adolescents and adults between 2007 and 2017.

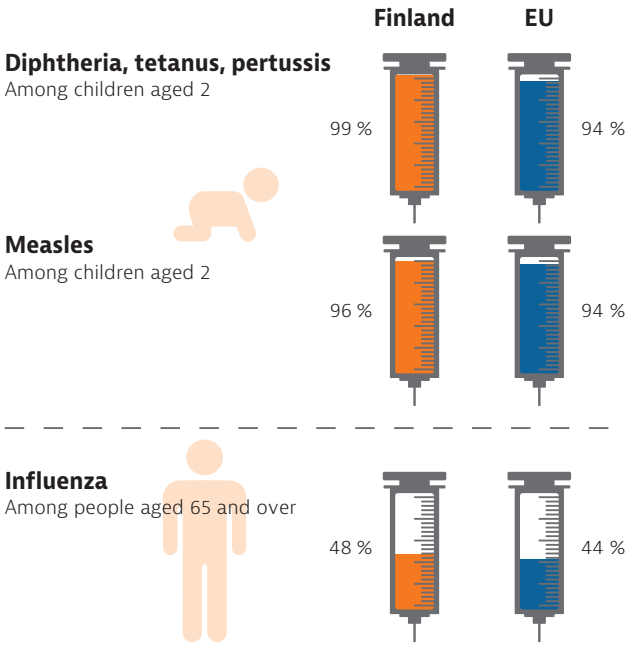
In 2017, however, the government adopted the New Alcohol Act, which deregulated sales of alcohol by loosening the rules governing the advertising of alcoholic beverages, allowing sales of a greater range of alcoholic drinks outside the government monopoly stores and extending opening hours for both retail sales and sales in bars and restaurants. This liberalisation of the alcohol control policy raised serious concerns that it might reverse recent progress in reducing alcohol consumption. Consumption increased by 0.4 % in 2018, which was less than expected but nonetheless reversed the decreasing trend of the previous decade (National Institute for Health and Welfare, 2019c).

In addition, the use of illicit drugs (e.g. cannabis, ecstasy and amphetamines) is generally higher in Finland than in many EU countries (EMCDDA, 2018). However, tackling the use of illicit drugs has not been a key focus in recent public health debates.

Vaccination coverage is lagging in some regions

Nearly all children (99 %) are vaccinated against diphtheria, tetanus and pertussis, and 96 % are vaccinated against measles – above both the EU average and the WHO recommended target of 95 % (Figure 12). However, some regions have coverage rates below 85 %, which substantially increase the risk of outbreaks. Even though the number of measles cases has remained low (below 20 in 2017-18), measles is re-emerging in Finland, as in many other countries (National Institute for Health and Welfare, 2019d).

Figure 12. Vaccination coverage is high among children, but low among older people



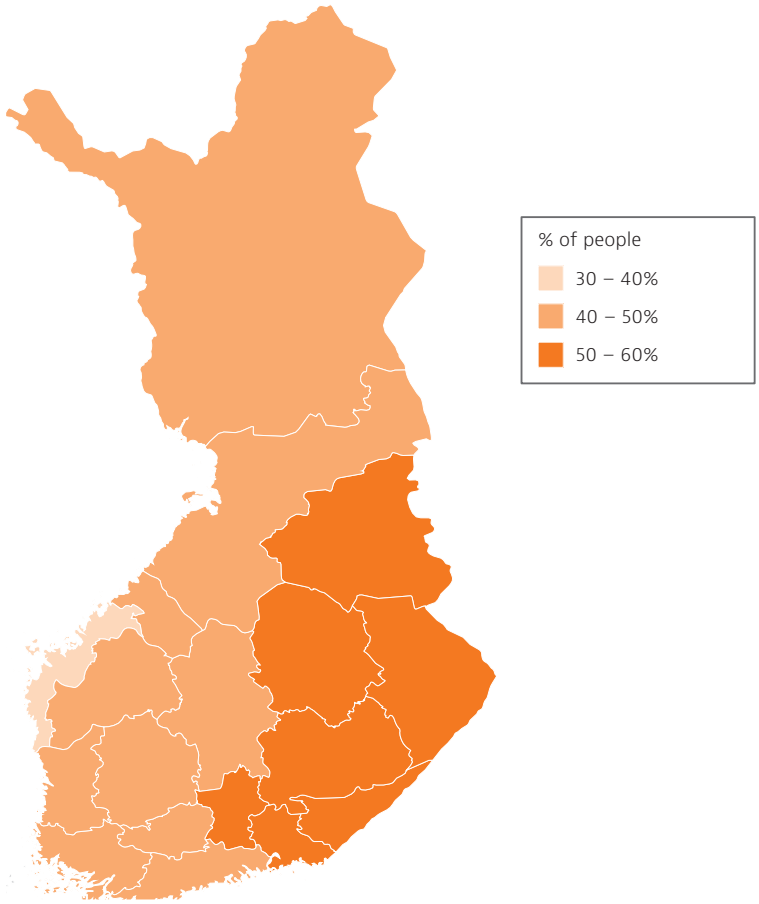
Note: The data refer to the third dose for diphtheria, tetanus and pertussis, and the first dose for measles.
Source: WHO/UNICEF Global Health Observatory Data Repository for children (data refer to 2018); OECD Health Statistics 2019 and Eurostat Database for people aged 65 and over (data refer to 2017 or nearest year).

Less than half of Finns aged 65 years and over are vaccinated against influenza, well below the WHO recommended target of 75 %. No region reached a vaccination coverage of 60 % in 2018; the lowest vaccination rate, in Western Finland, was a mere 33 % (Figure 13).

Potentially avoidable admissions for chronic diseases are close to the EU average

For several diseases, admissions to hospital can be avoided through accessible and effective primary care. While admission rates for asthma and chronic obstructive pulmonary disease (COPD) are below the EU average, rates are close to the EU average for diabetes and slightly above it for congestive heart failure (Figure 14). This indicates that there is room to improve chronic disease management outside hospitals.

Figure 13. Vaccination rates against influenza among people aged 65 and over vary across regions

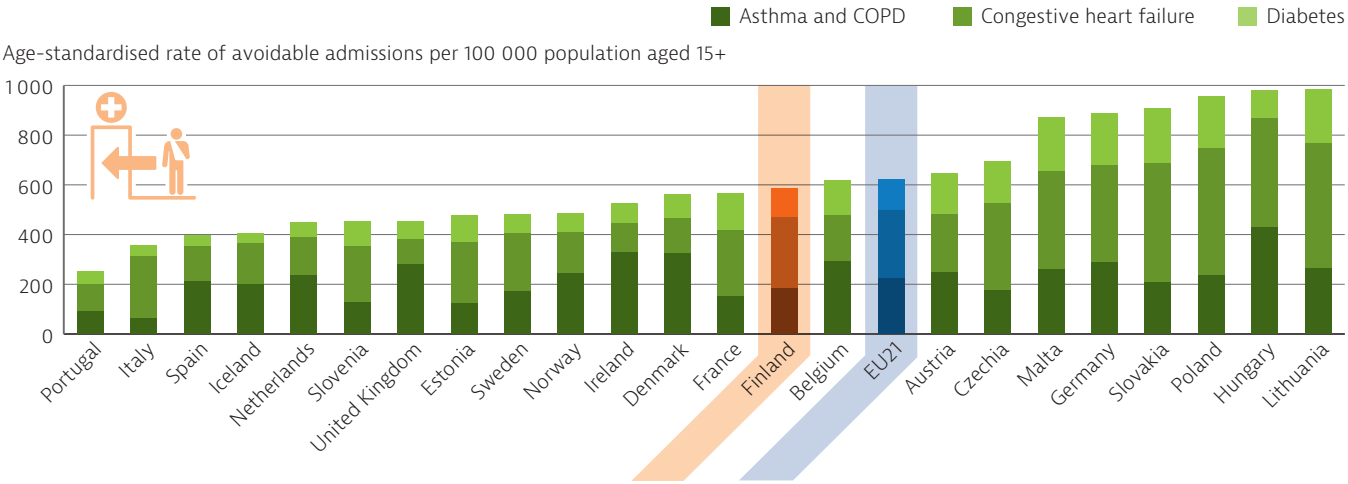


Source: National Institute for Health and Welfare (data refer to 2018).

Hospitals provide high-quality treatment to people requiring acute care

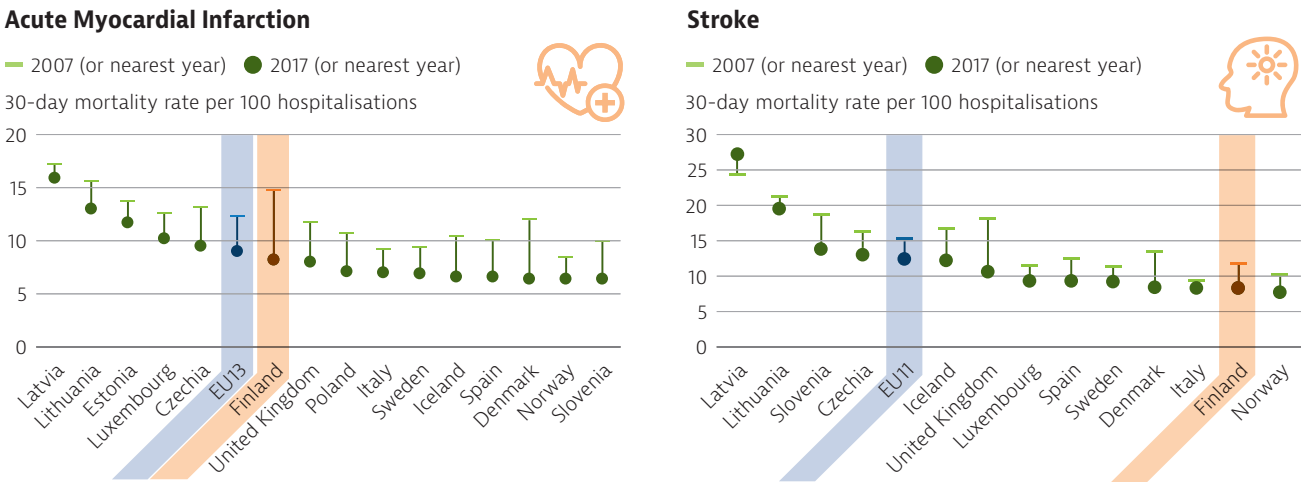
Hospitals in Finland deal very effectively with patients requiring acute care following acute myocardial infarction (AMI) and particularly stroke. Substantial progress was achieved over the past decade in reducing mortality rates for people admitted to hospital for these life-threatening conditions. The 30-day mortality rate is now one of the lowest among EU countries with available data for ischaemic stroke (Figure 15), whereas the mortality rate after AMI has decreased faster than in any other EU country with available data.

Figure 14. Avoidable admissions for chronic diseases could be reduced further



Source: OECD Health Statistics 2019 (data refer to 2017 or the nearest year).

Figure 15. Mortality following hospital admission for acute myocardial infarction and stroke has dropped



Note: Figures are based on patient data and have been age-sex standardised to the 2010 OECD population aged 45+ admitted to hospital for AMI and ischaemic stroke.
Source: OECD Health Statistics 2019.

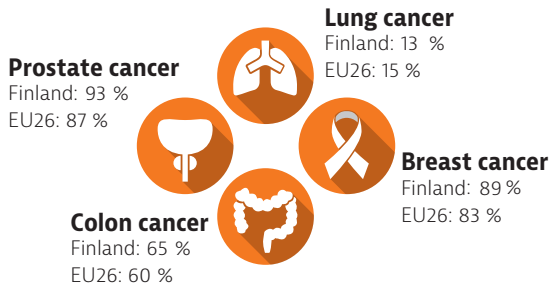
Cancer care is generally effective

Cancer care in Finland is generally good. Owing to early diagnosis and effective treatments, people diagnosed for different types of cancer (such as breast, cervical and colon) have higher survival rates than in most EU countries (Figure 16), and overall mortality from cancer is among the lowest in the EU (OECD/EU, 2018). The survival rate for lung cancer is, however, low and below the EU average.

Finland established national cancer screening programmes earlier than most EU countries – in 1968 for cervical cancer and 1987 for breast cancer. Screening rates in these cancers' target group of women have been relatively high for many years (such as over 80 % in recent years for breast cancer screening). Finland also offers the human papillomavirus (HPV) test for the early identification of cervical cancer.

While planning and delivery of treatments for rare cancers and some of the most serious cancers are centralised, treatment of most other cancers is carried out close to the patient's home. Finland has also promoted specialisation of health professionals in cancer care through licensing and certification systems.

Figure 16. Cancer survival rates are above the EU average for most cancers



Note: Data refer to people diagnosed between 2010 and 2014.
Source: CONCORD programme, London School of Hygiene and Tropical Medicine.

In 2016, the Ministry of Social Affairs and Health announced the establishment of a new National Cancer Centre, responsible for coordinating treatment and research, ensuring equal access to cancer care and promoting quality of care and cost-effectiveness of treatments. It started its activities in 2018.

A new strategy for mental health is planned

Depression and other mental illnesses continue to be widespread in Finland, and suicide rates have historically been high. Over the past few decades, Finland has implemented national suicide prevention programmes, involving cross-sector collaboration and a range of stakeholders, which have proved effective in gradually reducing suicide rates. These programmes aim to identify people facing severe depression or with substance and alcohol abuse problems as early as possible, to improve access to mental health services and to reduce access to lethal means. Crisis phone lines for people experiencing suicidal thoughts have been established, along with guidance to the media on reporting suicides. Specific interventions have also targeted young men, who carry the highest suicide risk (OECD/EU, 2018).

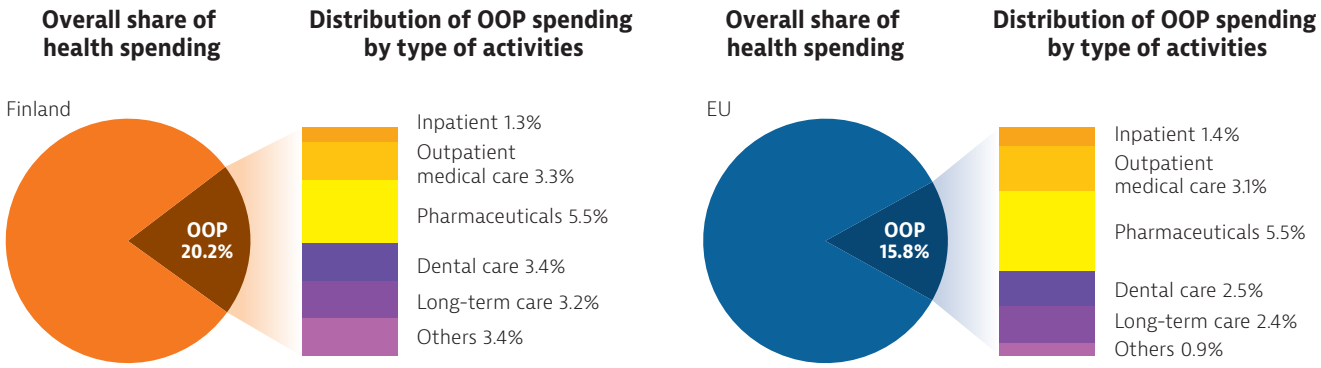
In 2018, the Ministry of Social Affairs and Health began to develop a new mental health strategy until 2030. Suicide prevention will be part of this broader strategy, under which each government level will be responsible for preparing a mental health action programme, defining the priorities and targets and the means to implement the mental health policy (Ministry of Social Affairs and Health, 2018).

5.2. Accessibility

The Finnish health system covers nearly all the population, but co-payments can be high

As described in Section 4, all permanent residents are entitled to health insurance coverage, although coverage is better for those under occupational health schemes who have access to services free of charge and same-day access to a doctor or nurse, as well as for those with private insurance. A wide range of health services and goods are publicly covered, but user fees apply to most of these – notably to pharmaceuticals and dental care. In 2017, out-of-pocket payments accounted for 20 % of current health expenditure in Finland, a higher share than the EU average (Figure 17). These payments averaged EUR 756 per person, up from EUR 417 in 2000. More than one-quarter of out-of-pocket payments are used to purchase pharmaceuticals (in line with the EU average), while the rest are mainly used to pay for outpatient medical care, dental care and long-term care.

Figure 17. The share of out-of-pocket payments in health expenditure is high in Finland

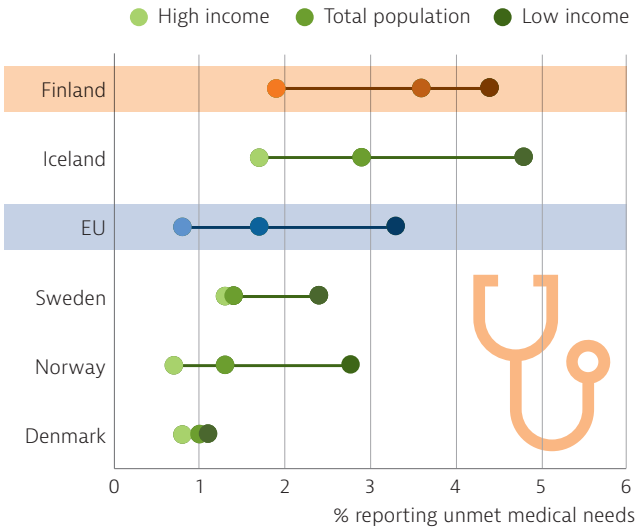


Source: OECD Health Statistics 2019 (data refer to 2017).

Unmet medical care needs are relatively high, mainly due to waiting times

The proportion of people in Finland reporting unmet needs for medical care is higher than the EU average and most other Nordic countries. In 2017, almost 4 % of the Finnish population reported unmet medical care needs for financial reasons, geographical barriers or waiting times, compared to just over 3 % on average across the EU (Figure 18). By far the main reason reported for unmet needs was waiting times. The proportion of people reporting unmet needs for medical care in the lowest income quintile was more than twice that in the highest.

Figure 18. Many Finns on low income report unmet medical care needs, mainly because of waiting times



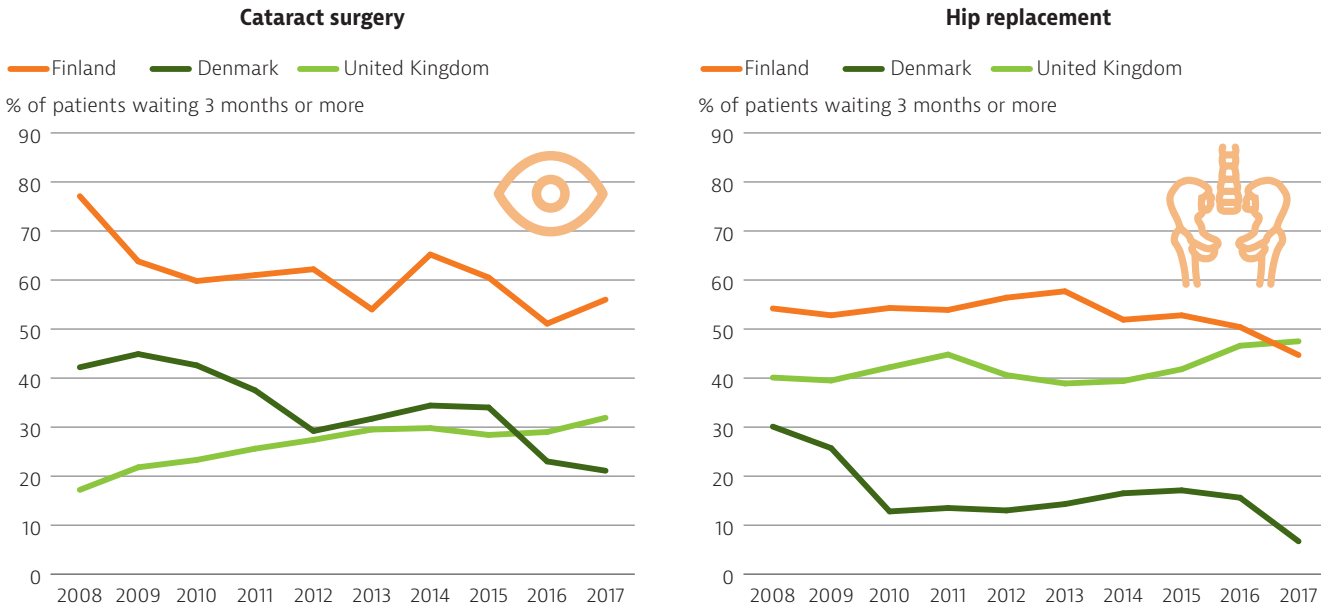
Note: Data refer to unmet needs for a medical examination or treatment due to costs, distance to travel or waiting times.
Source: Eurostat Database, based on EU-SILC data (data refer to 2017).

Waiting time guarantees were introduced to reduce waiting times

The 2010 Health Care Act states that local authorities must ensure patients are able to reach a health centre or other health care unit on the same day during weekday office hours, and that a health professional should assess need for treatment no later than the third working day after the patient first contacts the health centre. For specialised medical care provided following a first assessment from primary care, an assessment of the need for treatment should occur within three weeks of a patient referral. Any treatment deemed necessary has to be provided within three months following the assessment. The maximum period is six months for specialised medical care if such treatment can be postponed on medical or other grounds without jeopardising the health of the patient.

Most municipalities and hospital districts are able to follow these rules, even though almost 2 % of all patients with non-urgent specialised care were on a waiting list for more than six months in August 2018 (National Institute for Health and Welfare, 2018c). More than half of Finnish patients waited over three months from specialist assessment to receiving treatment for cataracts or having a knee replacement in 2017. For hip replacement the share was slightly smaller, but 45 % waited for at least three months in 2017 (Figure 19). These proportions are much higher than in Denmark.

Figure 19. Many Finns still have to wait several months to receive elective surgery



Source: OECD Health Statistics 2019.

The uneven distribution of resources, combined with employer-based schemes, causes access inequalities

The uneven distribution of health care resources reinforces disparities in access to care. The density of doctors is much greater in the Capital region and other major cities due to the concentration of hospitals and specialised care units in urban areas, compared to relatively few doctors working in remote and sparsely populated regions. Occupational health care and private health insurance – mainly covering people from higher socioeconomic groups – also reinforce inequalities in access to care, as they facilitate faster access through wider provider choice. Meanwhile, people from lower socioeconomic groups and older people have less provider choice and have to wait longer to access services. The proposed regionalisation of health and social care (see Section 4) may help achieve a more balanced resource allocation across regions and reduce waiting times.

An important challenge to address is the limited coordination between hospital districts and municipal primary care authorities, and the slow increase in primary care funding. Access to primary care may also be improved by expanding the role of nurses further (Box 1), particularly in areas where there are shortages of GPs.

Box 1. The role of nurses in Finland is expanding in primary care and home care

Since 2010, many primary care centres have changed the delivery of services to improve access and address shortages of doctors. These mainly involve the expansion of nurses' roles – in particular the ability to prescribe some medications, make referrals or interpret X-rays. Nonetheless, there are still restrictions on prescribing by nurses: the range of medications is limited for both initial prescribing (for example, to medicines for pharyngitis and contraceptives) and continued prescribing (for example, to medicines to manage some chronic conditions like hypertension, diabetes and asthma). To be able to prescribe, a nurse has to be employed by a municipal health centre, have at least three years of work experience and a postgraduate qualification, and be registered as a prescriber.

Beyond prescribing, the role of nurses has mostly been strengthened in chronic care, including through involvement in multi-professional care coordination teams, management of chronic diseases and conducting patient consultations.

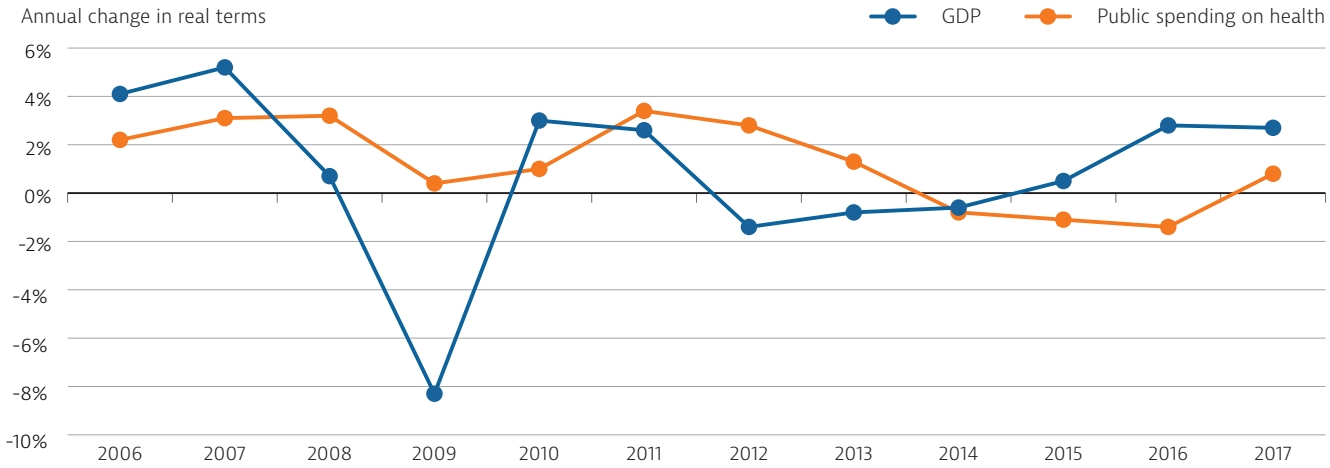
Sources: Keskimäki et al. (2019); Maier, Aiken and Busse (2017).

5.3. Resilience[4]

Spending on health has been constrained by slow GDP growth

As noted in Section 4, health expenditure in Finland accounted for 9.2 % of GDP in 2017, a share lower than in the EU as a whole and lower than in other Nordic countries. Following the economic crisis in 2009 and a further recession during 2012-14, public spending on health declined slightly in real terms between 2014 and 2016 (Figure 20).

Figure 20. Public expenditure on health slowed sharply in recent years following two recessions



Source: OECD Health Statistics 2019.

Looking ahead, population ageing and modest economic growth are projected to add pressures to public spending on health and long-term care in the coming years and decades. Public spending on health is projected to increase by 0.8 percentage point of GDP between 2016 and 2070 (from 6.1 % to 6.9 %), but budgetary pressures are expected to be greater for long-term care expenditure, which may rise by 2.0 percentage points of GDP during the same period (from 2.2 % to 4.2 %), contributing to fiscal sustainability risks in the long term (European Commission-EPC, 2018).

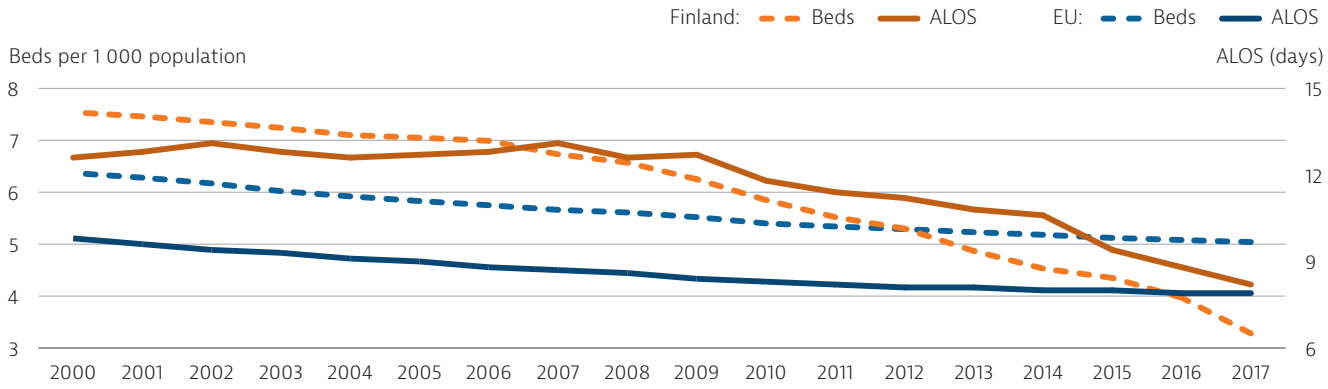
The hospital sector is functioning more efficiently

Finland now has a lower number of hospital beds per population than the EU average. The rapid reduction in the number of beds over the past decade has been accompanied by a rapid reduction in the average length of stay (ALOS) (Figure 21), and these do not seem to have resulted in any discernible reduction in access or quality.

4: Resilience refers to health systems' capacity to adapt effectively to changing environments, sudden shocks or crises.

The hospital infrastructure will be further centralised, with five university hospitals and seven or eight large inpatient centres providing an extensive range of specialist services. The Ministry of Social Affairs and Health has also introduced minimum volumes of activities – for example, for orthopaedic surgery and births – for other hospitals, which has led to the closure of smaller units.

Figure 21. Numbers of hospital beds and average length of stay have fallen over the past decade



Source: Eurostat Database.

Strengthening primary care and care coordination remains a challenge

One important challenge in Finland is to strengthen access to and efficiency in primary care, alongside promoting greater coordination among primary care providers and hospitals. Owing to shortages and long waiting times in some municipalities, primary care providers do not always function as gatekeepers and patients sometimes seek specialist and emergency care directly, even if these visits may be unnecessary.

In addition, although various efforts have been made to promote more integrated care and some innovative local models have emerged, care coordination is still problematic, particularly between private and public providers. This is partly related to accountability being assigned separately to providers delivering primary care, specialist care and long-term care. Furthermore, the current funding mechanisms do not embed adequate incentives for strengthening care coordination among providers.

eHealth is expected to improve care coordination

To promote greater care coordination, Finland invested substantially in eHealth. It introduced a nationwide harmonised electronic patient record – the national Patient Data Repository. This information system includes all public and private health care providers and features mandatory electronic prescriptions (ePrescriptions) and a health portal allowing citizens to review their own information. Since September 2016, electronic patient records have covered the entire population in the health sector. For social welfare services, the archive was launched for public and private services in 2018, but the system is not expected to be fully operative before 2023.

A series of measures have helped to contain pharmaceutical costs

A number of policies have been implemented over the past 15 years to control growth of pharmaceutical spending, including price controls, more appropriate prescribing and promotion of generics. The share of pharmaceutical spending in overall health expenditure (excluding pharmaceuticals dispensed in hospitals) has decreased considerably over the past decade, from 16 % in 2005 to 12 % in 2017.

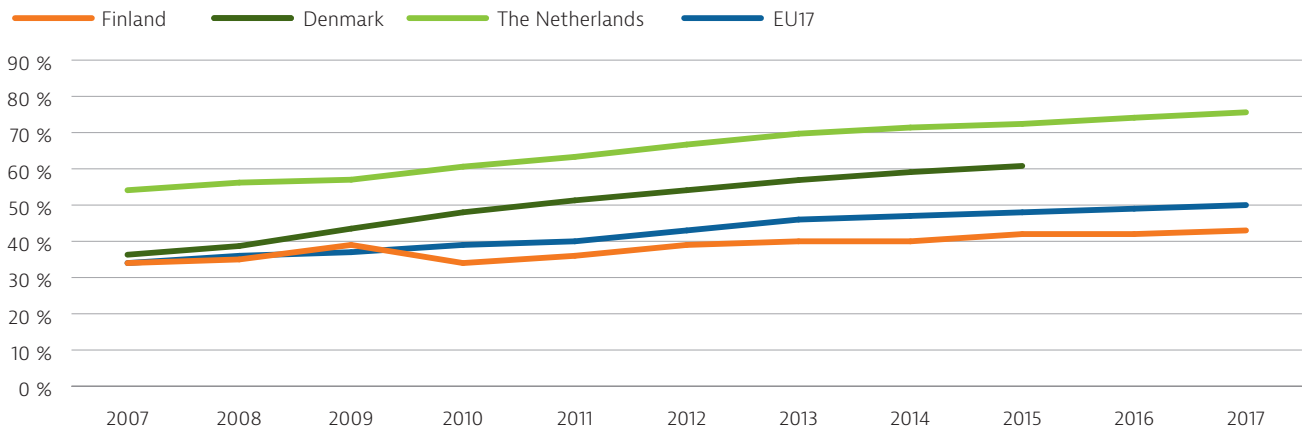
Generic substitution was introduced in Finland in 2003. Since then, pharmacists have been obliged to substitute a prescribed pharmaceutical that costs more than a defined maximum price with a cheaper product with the same active substance. While the share of generics has increased over the past decade, it has nonetheless grown at a slower rate than in Denmark and several other EU countries (Figure 22).

ePrescriptions have been implemented progressively since 2012. By 2017, all health care providers had to join the ePrescription system and provide prescriptions electronically except in the case of emergency situations or technical issues (Keskimäki et al., 2019).

Since 2017, a prescription can be valid for up to two years (previously one year), with the exception of very expensive drugs (over EUR 1 000 per package) that can only be prescribed for one month at a time.

Finland began participating in a new Nordic collaboration to assess the relative effectiveness of new pharmaceuticals and to carry out economic analyses in 2018 (Box 2).

Figure 22. The share of generics has increased but remains lower than in many other EU countries



Note: Data refer to the share of generics in volume.
Source: OECD Health Statistics 2019.

Box 2. Finland joined a collaboration on health technology assessment of new pharmaceuticals

The Finnish, Norwegian and Swedish health technology assessment authorities agreed in 2018 to strengthen their collaboration in assessing new pharmaceutical products under the FINOSE initiative. The overall objective of the collaboration is to pool resources to assess the relative effectiveness of new pharmaceuticals and to carry out joint economic analysis. Following these joint assessments, each country will still have the flexibility to make final decisions regarding reimbursement and prices of new pharmaceuticals, in accordance with their national context and regulations.

In practice, this collaboration means that companies only have to submit a single dossier to all three countries simultaneously and agree to sign a waiver on data sharing. A joint team across the three countries is then appointed to undertake the joint assessment. The outcome is the adoption of a single assessment report by the three agencies.

FINOSE is currently a pilot project and will be assessed to determine whether it contributes to achieving its objectives.

Overview of new reform proposals

After the failure of the health and social care reform proposal between 2015 and 2019, the new government programme following the April 2019 general election includes some reforms of health and social services, with the aim of reducing inequalities in health and well-being, ensuring equal and high-quality health and social services for all Finns, securing access to a skilled workforce and curbing cost growth.

The new 2019-23 reform programme will bring together the organisation of social and health care services into self-governing areas. There will be 18 such self-governing counties, and their activities, finances and administration will be regulated by a separate law. Decision-making in the counties will fall under the responsibility of elected councils, and the democratic involvement of residents will be strengthened.

Unlike the previous reform proposal, which envisaged a greater role for private providers, most services will continue to be delivered by public providers. The private for-profit and not-for-profit sectors will be complementary service providers. The role of non-governmental organisations in promoting health and well-being will be strengthened, while the ability of organisations to provide these services will be secured.

County funding will mainly be based on state funding, but the government will start to prepare implementation of county taxes.

The government has also promised to take action to strengthen the language rights for minority languages, especially Swedish, Sami and sign languages, in health and social welfare services.

6 Key findings

- Life expectancy in Finland has increased steadily since 2000, reflecting the positive impacts of public health policies and health care interventions in reducing mortality from preventable and treatable causes. While disparities in life expectancy by socioeconomic status are below the EU average, they remain important: the least educated men can expect to live 5.5 years less than the most educated, while this education gap among women is 3.5 years.

- Substantial progress has been achieved in reducing important risk factors to health such as smoking. However, obesity rates have increased among both children and adults, and most interventions aimed at curbing this growth have shown only modest results so far. The inequalities in health status are to a large extent due to the greater prevalence of risk factors among people with the lowest level of education and income, as shown by higher smoking and obesity rates among the least educated. An important challenge for public health policies is to find effective ways to reach these disadvantaged groups.

- Alcohol consumption remains an important public health issue in Finland, with more than one-third of adults reporting regular binge drinking. The liberalisation of alcohol sales in 2017 resulted in a slight increase in alcohol consumption in 2018, reversing a previous decade-long reduction, although the increase was more modest than anticipated.

- Health spending per person in Finland is slightly higher than the EU average, yet slightly lower as a share of GDP (9.2 % compared with 9.8 % for the EU average in 2017) and much lower than in Sweden, Norway and Denmark. Public spending accounts for 75 % of health spending, below the EU average (79 %) and other Nordic countries (all above 83 %). The rest is paid mainly out of pocket by households.

- Public expenditure on health and long-term care as a share of GDP is projected to increase in the coming decades due to population ageing and slower economic growth. These projections reinforce the need to achieve efficiency gains in health and long-term care delivery to ensure the long-term sustainability of these services.

- An important challenge is to strengthen access to primary care and promote greater coordination between primary care providers and hospitals, as well as with social welfare services. More timely and effective access to primary care could help reduce unnecessary visits to specialists or hospital emergency departments, especially for the growing number of people with chronic conditions. The role of nurses has been expanded to improve access to primary care, but so far the implementation of these new roles has been limited.

- A particular concern is that both occupational health care directly funded by employers and primary care provided through private providers reinforce inequalities in access to care. These mainly facilitate faster access for people from higher socioeconomic groups, while those from lower socioeconomic groups and retired people have to wait longer. The overcapacity in occupational health care also raises issues about allocative efficiency in the system.

- The new government has proposed to reform the organisation of health and social care services, the funding mechanisms and the regional governance structure. There will be 18 self-governing counties in charge of social and health care services. Most services will, however, continue to be delivered by public providers.

Key sources

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National Institute for Health and Welfare (2019d), *Tartuntatautirekisterin tilastotietokanta* [Statistical database for infectious diseases].

Country abbreviations

Austria	AT	Denmark	DK	Hungary	HU	Luxembourg	LU	Romania	RO
Belgium	BE	Estonia	EE	Iceland	IS	Malta	MT	Slovakia	SK
Bulgaria	BG	Finland	FI	Ireland	IE	Netherlands	NL	Slovenia	SI
Croatia	HR	France	FR	Italy	IT	Norway	NO	Spain	ES
Cyprus	CY	Germany	DE	Latvia	LV	Poland	PL	Sweden	SE
Czechia	CZ	Greece	EL	Lithuania	LT	Portugal	PT	United Kingdom	UK

European Commission

State of Health in the EU
Country Health Profile 2019

The Country Health Profiles are an important step in the European Commission's ongoing *State of Health in the EU* cycle of knowledge brokering, produced with the financial assistance of the European Union. The profiles are the result of joint work between the Organisation for Economic Co-operation and Development (OECD) and the European Observatory on Health Systems and Policies, in cooperation with the European Commission.

The concise, policy-relevant profiles are based on a transparent, consistent methodology, using both quantitative and qualitative data, yet flexibly adapted to the context of each EU/EEA country. The aim is to create a means for mutual learning and voluntary exchange that can be used by policymakers and policy influencers alike.

Each country profile provides a short synthesis of:

- health status in the country
- the determinants of health, focussing on behavioural risk factors
- the organisation of the health system
- the effectiveness, accessibility and resilience of the health system

The Commission is complementing the key findings of these country profiles with a Companion Report.

For more information see: ec.europa.eu/health/state

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