European Commission

# State of Health in the EU

# Finland

## Country Health Profile 2021

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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 Systems Performance Assessment (HSPA).

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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 27 Member States unless otherwise noted. These EU averages do not include Iceland and Norway.

This profile was completed in September 2021, based on data available at the end of August 2021.

### Demographic and socioeconomic context in Finland, 2020

| Demographic factors | Finland | EU |
|---|---|---|
| Population size (mid-year estimates) | 5 525 292 | 447 319 916 |
| Share of population over age 65 (%) | 22.3 | 20.6 |
| Fertility rate[1] (2019) | 1.3 | 1.5 |
| **Socioeconomic factors** | | |
| GDP per capita (EUR PPP[2]) | 33 949 | 29 801 |
| Relative poverty rate[3] (%, 2019) | 11.6 | 16.5 |
| Unemployment rate (%) | 7.8 | 7.1 |

*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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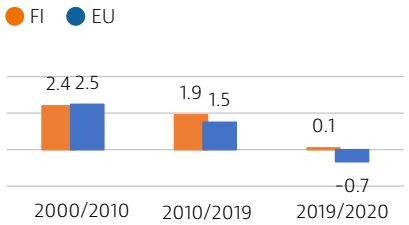
# 1 Highlights

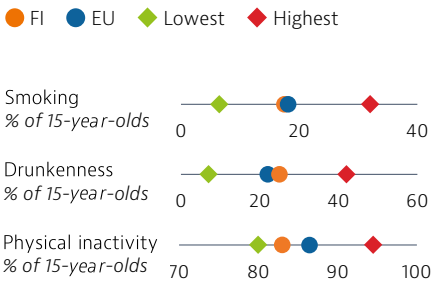
The Finnish population has seen improvements in life expectancy over the past two decades, and this positive development continued in 2020 despite the COVID-19 pandemic, as the government adopted a hybrid strategy to reduce the spread of the virus and protect high-risk people. However, an ageing society and high numbers of people with chronic diseases and disabilities will raise the demand on health and long-term care systems in the future. A recently approved major reform includes greater centralisation of responsibilities and resources at the regional level to improve access to care while controlling costs.




*Life expectancy gains, years*

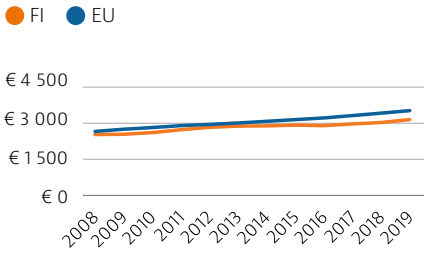
## Health Status

Over the past decade, life expectancy in Finland has increased at a faster rate than the EU average. Finland and Denmark were the only EU countries where life expectancy increased in 2020, although the gains were modest. Finland reported the lowest rate of COVID-19 cases and deaths among EU countries in 2020.




## Risk factors

Daily smoking among adults in Finland has halved since 2000. Alcohol consumption has also decreased over the past two decades, although heavy episodic alcohol consumption remains more common in Finland than the EU average. Among young people, smoking and drunkenness rates are near the EU average. While physical inactivity among adolescents is only slightly lower in Finland than in the rest of the EU as whole, over 80 % of adolescents are not doing sufficient physical activity every day.



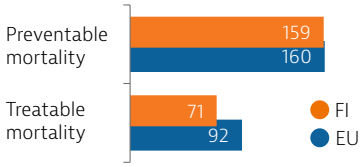

*Per capita spending (EUR PPP)*

## Health system

Health spending per capita in Finland increased at a very slow rate between 2013 and 2019. At EUR 3 150 in 2019, it was over 10 % lower than the EU average (EUR 3 520). Health spending accounted for 9.2 % of Finland's GDP – almost one percentage point below the EU average of 9.9 %. Public funding accounts for 78 % of all health spending, which is a slightly lower share than the EU average (80 %). In 2020 and 2021, the government provided additional funding of EUR 4 billion in response to the COVID-19 pandemic.

## Effectiveness

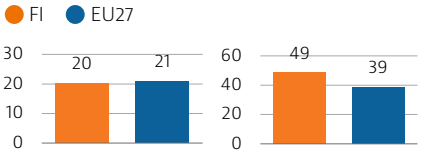
Mortality from treatable causes in Finland in 2018 was lower than the EU average, signalling that the health care system performs well in saving the lives of people with potentially fatal conditions. However, mortality that may be avoided through prevention policies was only close to the EU average.




*Age-standardised mortality rate per 100 000 population, 2018*

## Accessibility

During the first twelve months of the COVID-19 pandemic, 20 % of Finns reported unmet needs for medical care, which is close to the EU average. As in many other EU countries, the use of teleconsultations increased quickly during the pandemic to maintain access to care.

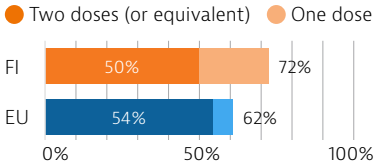



*% reporting forgone medical care during first 12 months of pandemic*

*% using teleconsultation during first 12 months of pandemic*

## Resilience

Finland followed a hybrid strategy to fight COVID-19, based on implementing targeted restrictions and a strong testing and tracing system. By the end of August 2021, more than 70 % of the population had received a first dose, but only 50 % had received two doses or the equivalent.




*Share of total population vaccinated against COVID-19 up to the end of August 2021*

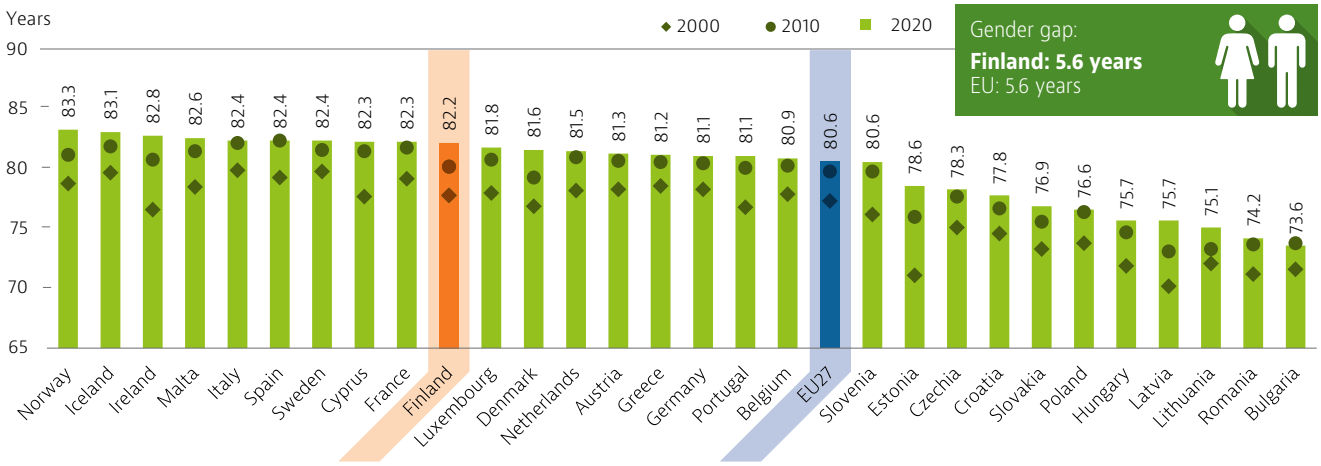
# 2 Health in Finland

## Life expectancy is higher than the EU average

Life expectancy in Finland increased by more than four years between 2000 and 2020, and is 1.6 years higher than the EU average (Figure 1). Finland and Denmark were the only two EU countries where life expectancy increased in 2020 despite the COVID-19 pandemic, although the increase in Finland was very modest (0.1 years for men and 0.2 years for women).

The gender gap in life expectancy remains large and equal to the EU average: women lived 5.6 years longer than men in 2020 (85.0 years versus 79.4 years). This is mainly caused by deaths from cardiovascular diseases and external causes (including accidents and suicides) among Finnish men aged under 65: these rates 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**



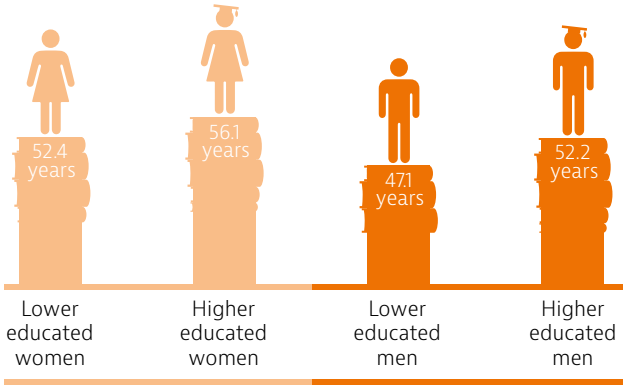

*Note: The EU average is weighted. Data for Ireland refer to 2019.*
*Source: Eurostat database.*

## Social inequalities in life expectancy are large

Inequalities in life expectancy in Finland exist not only by gender but also by socioeconomic status. In 2017, life expectancy for men at age 30 with the lowest level of education was more than 5 years lower than for the most educated. This education gap in longevity was smaller among women, at 3.6 years (Figure 2). However, the gap between the least and most educated women increased during the last decade (by nearly one year), while it narrowed slightly for men.

This gap can be explained at least in part 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 5.1 years for men and 3.6 years for women**




Education gap in life expectancy at age 30:

| | | | |
|---|---|---|---|
| Finland: | 3.6 years | Finland: | 5.1 years |
| EU18: | 3.4 years | EU18: | 6.9 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 2017).*

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

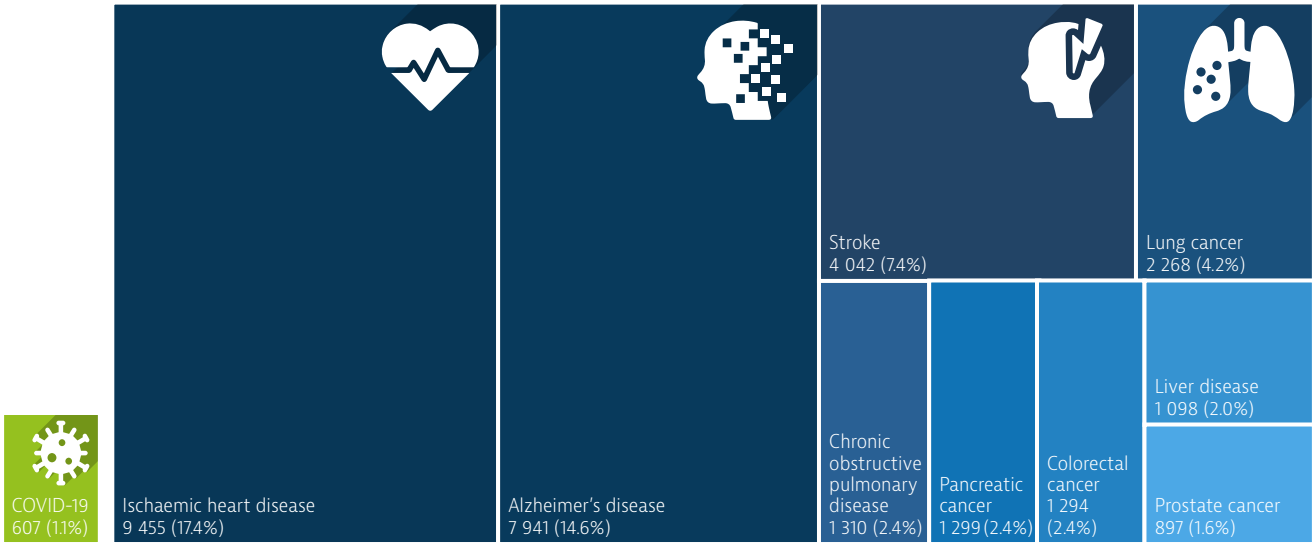
The increase in life expectancy in Finland since 2000 has been driven mainly by reductions in mortality rates from cardiovascular diseases – notably from ischaemic heart disease (which nonetheless remains the leading cause of death) but also from stroke.

Mortality rates from Alzheimer's disease have increased greatly during the period, making it one of the leading causes of death (Figure 3). However, this is partly due to improvements in diagnosis and changes in death registration practices. Among EU countries, Finland has the highest mortality rate for Alzheimer's disease, but the lowest rate for pneumonia, following changes in death registration practices.[1]

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).

In 2020, COVID-19 accounted for about 600 deaths in Finland (1.1 % of all deaths). An additional 400 deaths were registered in the first eight months of 2021 (up to the end of August). Most deaths have been among older people. The mortality rate from COVID-19 up to the end of August 2021 was the lowest among EU countries (185 per million population compared with 1 590 for the EU average), although it was slightly higher than in Norway and Iceland.

**Figure 3. Ischaemic heart disease, Alzheimer's disease and stroke are the leading causes of death**




*Note: The number and share of COVID-19 deaths refer to 2020, while the number and share of other causes refer to 2018. The size of the COVID-19 box is proportional to the size of the other main causes of death in 2018.*
*Sources: Eurostat (for causes of death in 2018); ECDC (for COVID-19 deaths in 2020, up to week 53).*

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

More than two thirds of Finnish people reported being in good health in 2019 (68 %), a share similar to the EU average. However, as in other countries, people on lower incomes are considerably less likely to report being in good health: only 54 % of people in the lowest income group reported being in good health, compared to 81 % in the highest. This difference is greater than in other Nordic countries and the EU average reflecting larger socioeconomic differences in health behaviour in Finland.

## Nearly one in two adults in Finland has a chronic condition, with large inequalities

Nearly half of all adults (49 %) reported having at least one chronic condition in 2019 – a much greater proportion than in the EU as a whole (36 %), according to EU-SILC. As with self-reported health, there is a gap in the prevalence of chronic conditions by income group: 55 % of adults in the lowest income group reported having at least one chronic condition compared with 42 % of those in the highest.

In April 2021, the Ministry of Social Affairs and Health (2021) launched an action plan to reduce inequalities in health and well-being in Finland. The plan includes

*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.*

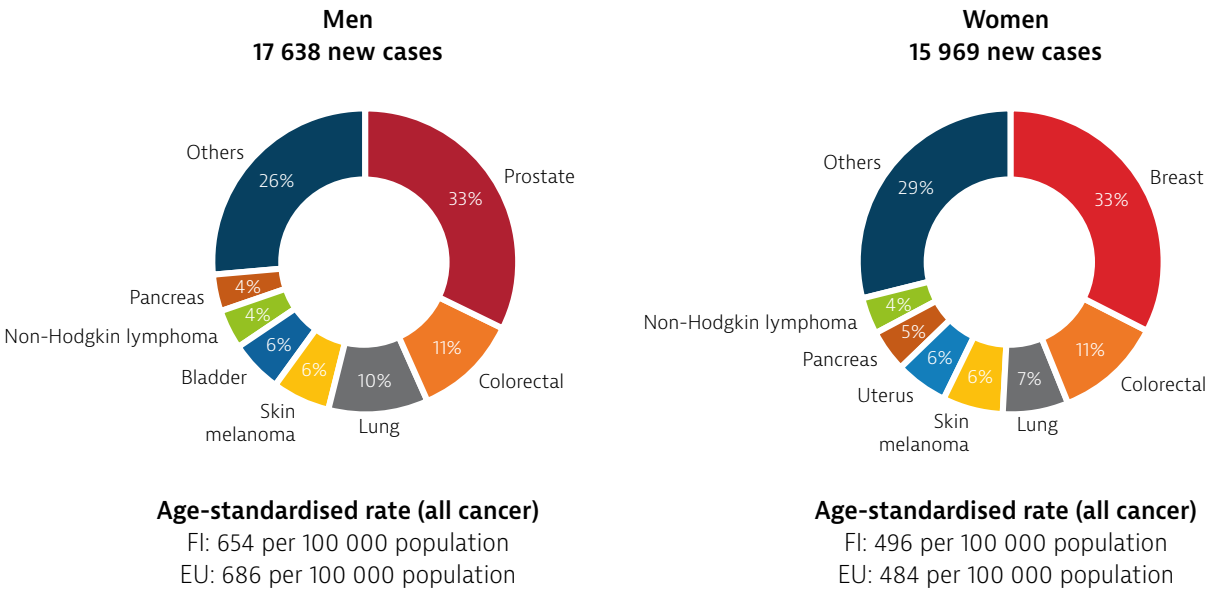
a total of 144 measures to be implemented by 2030. One of the key objectives is to support people's ability to work and study. The Advisory Board for Public Health will monitor the plan's implementation.

### The burden of cancer in Finland is close to the EU average

According to estimates from the Joint Research Centre based on incidence trends from previous years, around 33 000 new cases of cancer were expected in Finland in 2020, and about 13 000 people were expected to die of cancer during that year. The age-standardised rates of cancer were expected to be slightly lower than the EU average for men and slightly higher for women. In all ageing societies, cancer incidence has increased, but it seems to have remained stable in Finland over the last few years.

The main cancer sites among men are prostate, colorectal and lung, while among women breast cancer is the leading cancer, followed by colorectal and lung cancer (Figure 4). The national cancer screening programme is expected to be broadened in the coming years (see Section 5.3).

**Figure 4. About 33 000 people in Finland were expected to be diagnosed with cancer in 2020**




*Note: Non-melanoma skin cancer is excluded; uterus cancer does not include cancer of the cervix.*
*Source: ECIS – European Cancer Information System.*

# 3 Risk factors

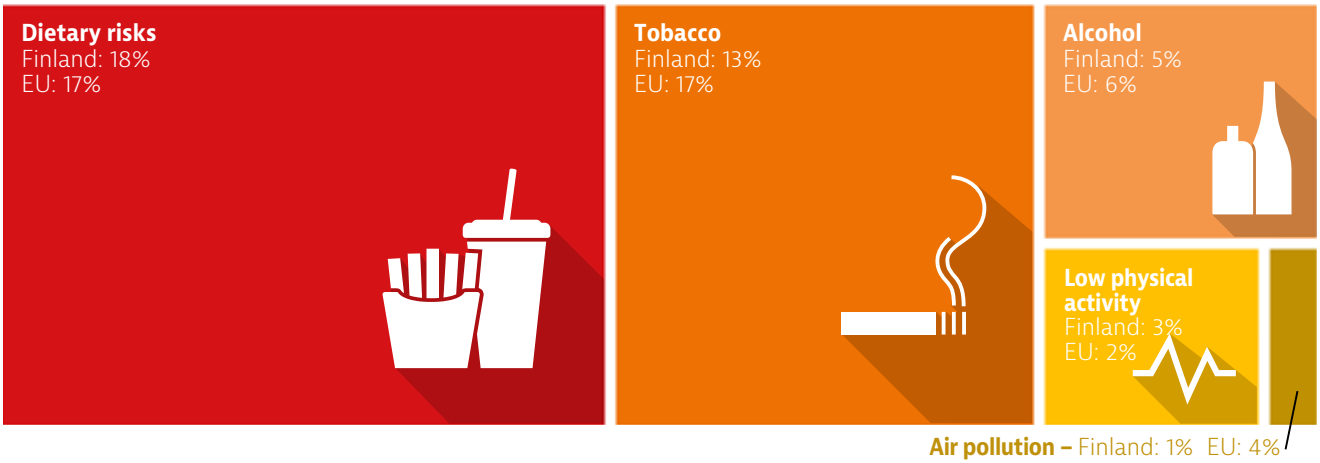
### Over one third of deaths in Finland can be attributed to behavioural risk factors

Estimates show that about 35 % 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 5). 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. Air pollution in the form of fine particulate matter (PM2.5) and ozone exposure alone accounted for about 1 % of all deaths in Finland in 2019 – a much lower share than the EU average.

### Smoking and alcohol have decreased

About 11 % of adults were smoking daily in 2019, down from 23 % in 2000, and the proportion of daily smokers in Finland is now much lower than the EU average (20 %). Alcohol consumption has also decreased since 2005, and was lower than in most EU countries in 2019 (Figure 6).

**Figure 5. Over one third of deaths can be attributed to behavioural risk factors in Finland**




*Note: The overall number of deaths related to these risk factors is lower than the sum of each one taken individually, because the same death can be attributed to more than one risk factor. Dietary risks include 14 components, such as low fruit and vegetable intake, and high sugar-sweetened beverages consumption. Air pollution refers to exposure to PM2.5 and ozone.*
*Sources: IHME (2020), Global Health Data Exchange (estimates refer to 2019).*

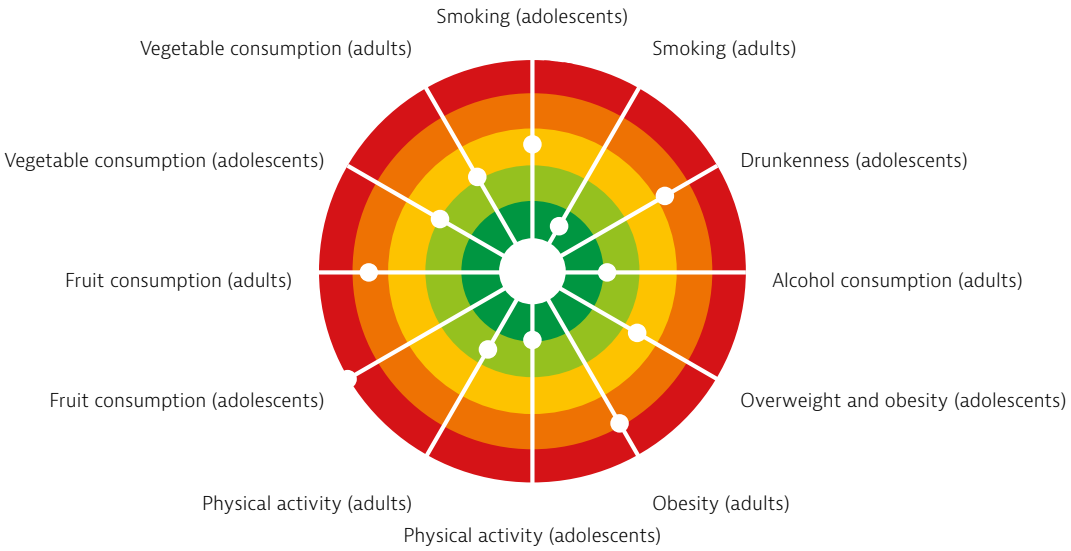
Among teenagers, 25 % of 15-year-olds reported having been drunk more than once in their life in 2018 – a lower proportion than a decade earlier, but still slightly higher than the EU average (22 %). Smoking and alcohol consumption among teenagers have decreased substantially over the past decade following improvements in health education in schools and the implementation of stricter age controls on sales.

## Overweight and obesity are growing among Finnish adults and adolescents

One in five adults (20 %) in Finland was obese in 2019, based on self-reported data – up from 11 % in 2000. The current rate is higher than in most EU countries.

Among 15-year-olds, nearly one in five (19 %) were overweight or obese in 2018 – a rate equal to the EU average, based on the HBSC survey. National register-based sources reported high and increasing overweight and obesity rates between 2014 and 2019. In 2019, 24 % of boys aged 2-6 were overweight or obese, while the share was 15 % among girls in the same age group. Boys were also more overweight or obese than girls in the age groups 7-12 years and 13-16 years (Finnish Institute for Health and Welfare, 2020).

**Figure 6. Obesity is an important public health issue in Finland**




*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.*
*Sources: OECD calculations based on HBSC survey 2017-18 for adolescents' indicators; and OECD Health Statistics, EHIS 2014 and EHIS 2019 for adults' indicators.*

# 4 The health system

## The health and social care reform paves the way for more centralisation

The Finnish health system is currently governed at the national and local levels. At the national level, the Ministry of Social Affairs and Health is responsible for general steering, developing and implementing of health reforms and policies. It is supported by a large network of expert advisory bodies, which inform decision-making. At the local level, municipalities (293 in mainland Finland in 2021) are responsible for organising health and social care. For the provision of specialist care, municipalities have formed 20 hospital districts. All levels of government were involved in managing and implementing the country's response to the COVID-19 pandemic (Box 1).

Historically, high levels of decentralisation have allowed the health system to adapt to the needs of a dispersed population, but the setup was widely criticised for producing inequalities and inefficiencies. After many years of development, the major administrative reform was approved by parliament in June 2021. In total 21 well-being services counties (hyvinvointialue) will be established from September 2021. These counties and the City of Helsinki will take over the responsibility for organising health and social care services from 2023. This change in service provision arrangements seeks to reduce inequalities, improve the quality and availability of services and contain expenditure growth.

**Box 1. Finland's pandemic response allowed local and regional authorities to decide on measures**

A Coronavirus Coordination Group, comprised of representatives from various ministries, the Finnish Institute for Health and Welfare and the Prime Minister's Office, was appointed in February 2020 to plan, manage and coordinate measures in health care and social welfare. The regional state administrative agencies and municipal-level agencies for prevention of communicable diseases played a key role in implementation.

Since April 2020, the government has followed a "hybrid strategy" based on implementing targeted rather than blanket restrictions, as well as on a strong testing and tracing system. In line with the strategy, changes to the Communicable Diseases Act in February 2021 were approved to allow local and regional authorities to take additional proactive measures to prevent the spread of COVID-19. For example, authorities can introduce regional restrictions on business and leisure activities, and the measures can be implemented gradually and be further tightened or relaxed, depending on the epidemiological situation.

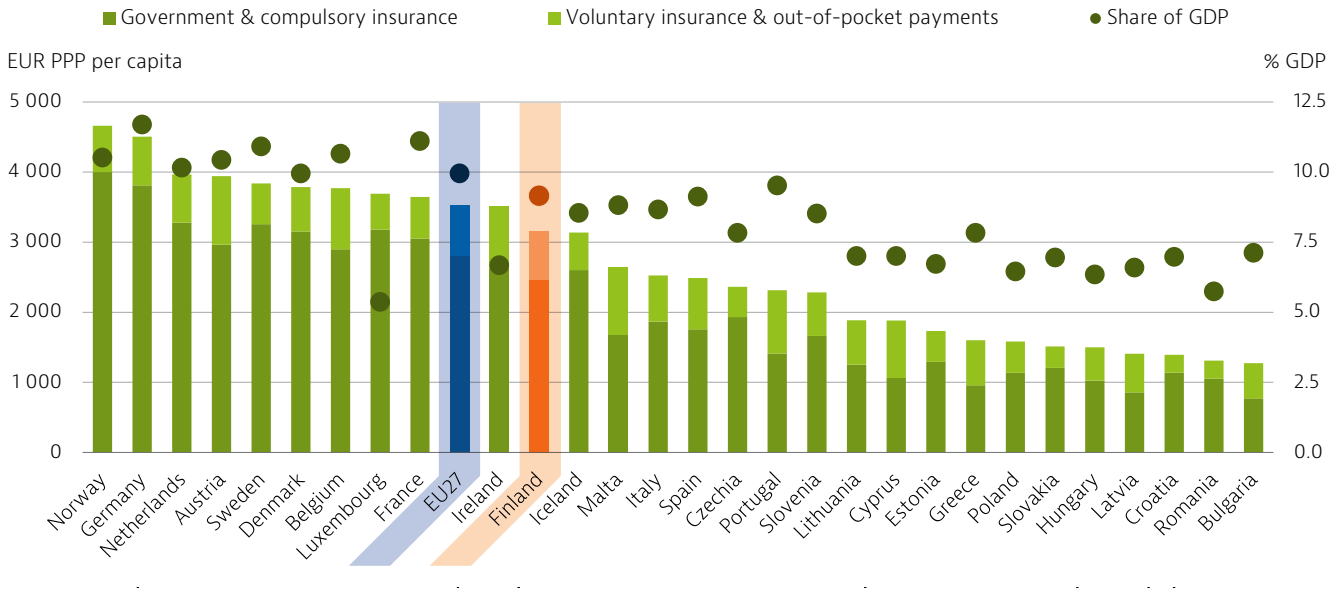
*Source: COVID-19 Health Systems Response Monitor.*

## Health spending was growing slowly before the COVID-19 pandemic

In 2019, 9.2 % of Finland's GDP was devoted to health, compared to 9.9 % across the EU as a whole. Expenditure on health per person (EUR 3 153, adjusted for differences in purchasing power) was also lower than the EU average (EUR 3 521) and in other Nordic countries (Figure 7). Between 2013 and 2019, health expenditure in Finland grew more slowly than in most EU countries.

More than one fifth of financing for health spending in 2019 came from private sources – mostly out-of-pocket payments (see Section 5.2). Voluntary health insurance plays a relatively minor role, accounting for less than 5 % of total health spending.

**Figure 7. Finland spends less than the EU average on health**




*Note: The EU average is weighted.*
*Source: OECD Health Statistics 2021 (data refer to 2019, except for Malta 2018).*

The national government provided additional funding to municipalities and hospital districts in 2020 and 2021 in response to the COVID-19 pandemic (Box 2).

## Outpatient care is the largest category of health spending

Outpatient care accounted for the largest category of health expenditure in the Finnish health system in 2019, at 39 % (Figure 8). Inpatient care made up nearly a quarter (24 %), followed by long-term care (17 %), pharmaceuticals and medical devices (15 %) and prevention (4 %). Although still low relative to total spending, spending on prevention per person in Finland is among the highest in the EU.



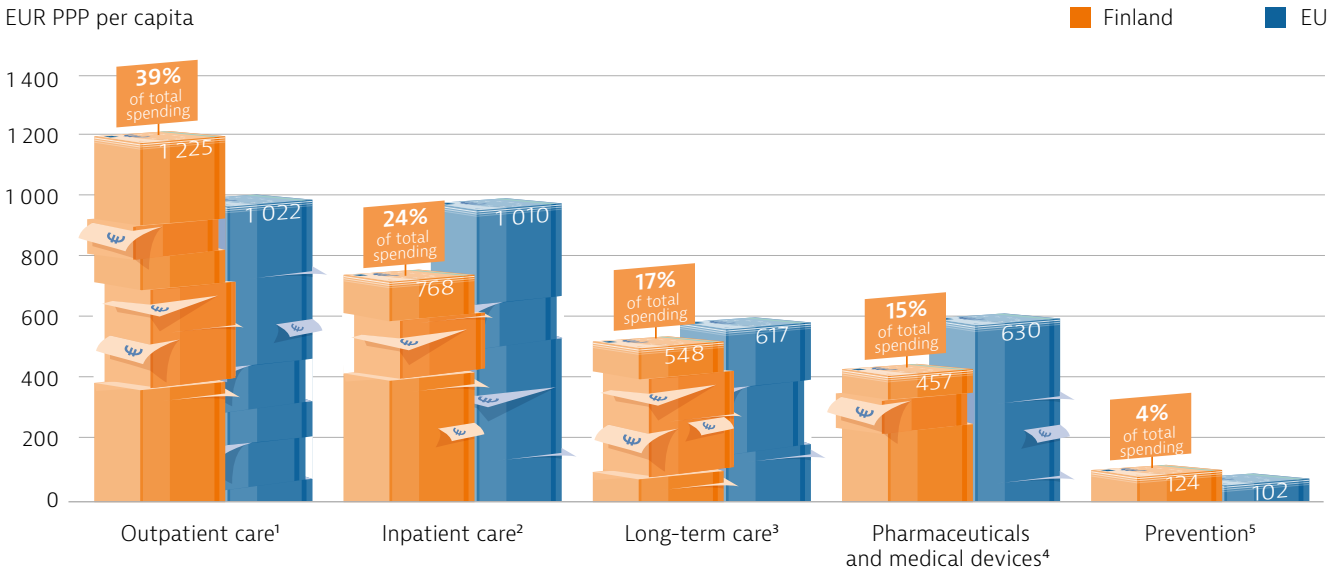
### Box 2. Additional spending in response to COVID-19 takes into account the impact on delayed care

Budgets for 2020 were adjusted to cope with the COVID-19 pandemic, including through the provision of economic support to municipalities of around EUR 1.5 billion to compensate for loss of taxes and to maintain the functioning of public services. In addition, the Finnish government channelled around EUR 2 billion to pay for costs directly related to COVID-19 in 2020 and 2021, and a further EUR 450 million is planned to be allocated over 2021-23 to cover the additional costs of treatment delayed due to the pandemic.

In 2020, state funding included compensation for municipalities and hospital districts for all COVID-19 related expenses, such as: the provision of services; procurement of personal protective equipment (PPE), diagnostic tools and medical devices, and medicines; testing and tracing; operational costs for expert agencies such as the Finnish Institute for Health and Welfare and the Finnish Medicines Agency (Fimea); and psychosocial support. In 2021, the municipalities will receive around 8 % more funding compared to the regular 2020 state budget.

*Source: COVID-19 Health Systems Response Monitor.*

**Figure 8. Finland spends considerably more on outpatient services than on inpatient care**




*Note: The costs of health system administration are not included.1. Includes home care and ancillary services (e.g. patient transportation); 2. Includes curative-rehabilitative care in hospital and other settings; 3. Includes only the health component; 4. Includes only the outpatient market. 5. Includes only spending for organised prevention programmes. The EU average is weighted.*
*Sources: OECD Health Statistics 2021, Eurostat database (data refer to 2019).*

## Coverage of health services is uneven

All permanent residents in Finland are covered for a broadly defined package of municipal health care services (primary and specialist care). Asylum seekers are not eligible, but can access care through reception centres. Undocumented migrants can access urgent care from public providers, but they may have to cover their costs. In addition to municipal services, the national health insurance scheme covers residents for part of the cost related to medicines, dental care and some private sector user charges. Employees are also covered through occupational health care for a set of services – usually at the primary care level – determined by their employers (with minimum standards set by law). Occupational health care creates a parallel system: it provides quicker and free-of-charge access to services for the employed population, while municipal health care users encounter co-payments and waiting times (Tervola et al., 2021).

## User charges are levied on a wide range of services

Substantial co-payments apply to most municipal services (primary, specialist outpatient and inpatient, as well as emergency care) and medicines. User fee limits are set by law and revised bi-annually, but municipalities can charge below the limits or define groups that are exempt. There are a few exemptions from co-payments (including primary care for children under 18, childhood vaccinations, maternity clinics, and diagnosis and treatment of certain communicable diseases) and three separate annual ceilings (EUR 683 for municipal services, EUR 580 for medicines and EUR 300 for travel costs in 2021).

## Hospital bed numbers have fallen, while specialist care has been centralised

In 2019, Finland had fewer hospital beds than the EU average (3.4 compared with 5.3 per 1 000 population), but this ratio is still higher than in other Nordic countries. The number of beds has more than halved since 2000. In recent years, hospital infrastructure has undergone restructuring focused on centralising an extensive array of specialised services, including multi-specialty 24/7 emergency care in five university clinics and a further eight major inpatient centres, with the remaining smaller hospitals providing a more limited range of services.

## Finland has relatively fewer doctors, but the highest number of nurses in the EU

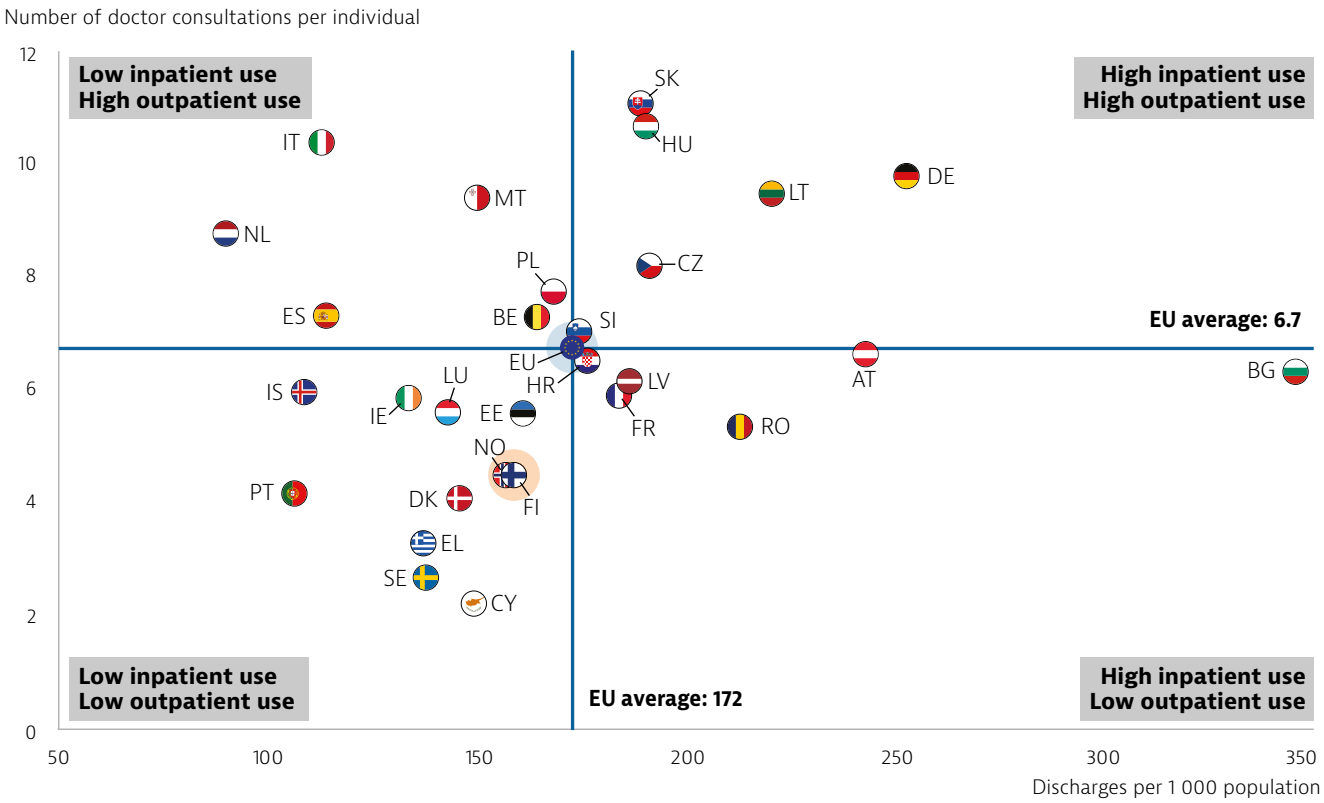
Finland has fewer doctors than the EU average (3.2 compared with 3.8 per 1 000 population), but the highest number of nurses in the EU (14.3 compared to 8.9 per 1 000), although the latest available data on health personnel for Finland are from 2014.

More recent data on education show that the number of medical graduates remained fairly stable between 2010 and 2019, while the number of nurse graduates increased by more than one third. The role of nurses has expanded in recent years to include patient consultations for acute and chronic health conditions, prescribing and care coordination in primary care, as well as outpatient consultations and advanced roles in operating theatres (Ensio et al., 2019).

### The use of outpatient and inpatient care in Finland is below the EU average

The Finnish population uses fewer health services than those in other EU countries. In 2019, the country recorded 4.4 doctor consultations per person compared to the EU average of 6.7 (although consultations with nurses partly substitute for consultations with doctors), and 158 hospital discharges per 1 000 population compared to the EU average of 172. However, these utilisation patterns are similar to those in other Nordic countries (Figure 9). Long waiting times persist in both primary and specialised care, particularly for people who are not eligible for occupational health care, such as unemployed and retired people (see Section 5.2). The health and social care reform aims to address issues of access, integration and coordination between primary and specialist care, and between health and social services.

**Figure 9. Finns are low users of health care services**




*Note: The EU average is unweighted.*
*Sources: OECD Health Statistics and Eurostat (data refer to 2019 or nearest year).*

# 5 Performance of the health system

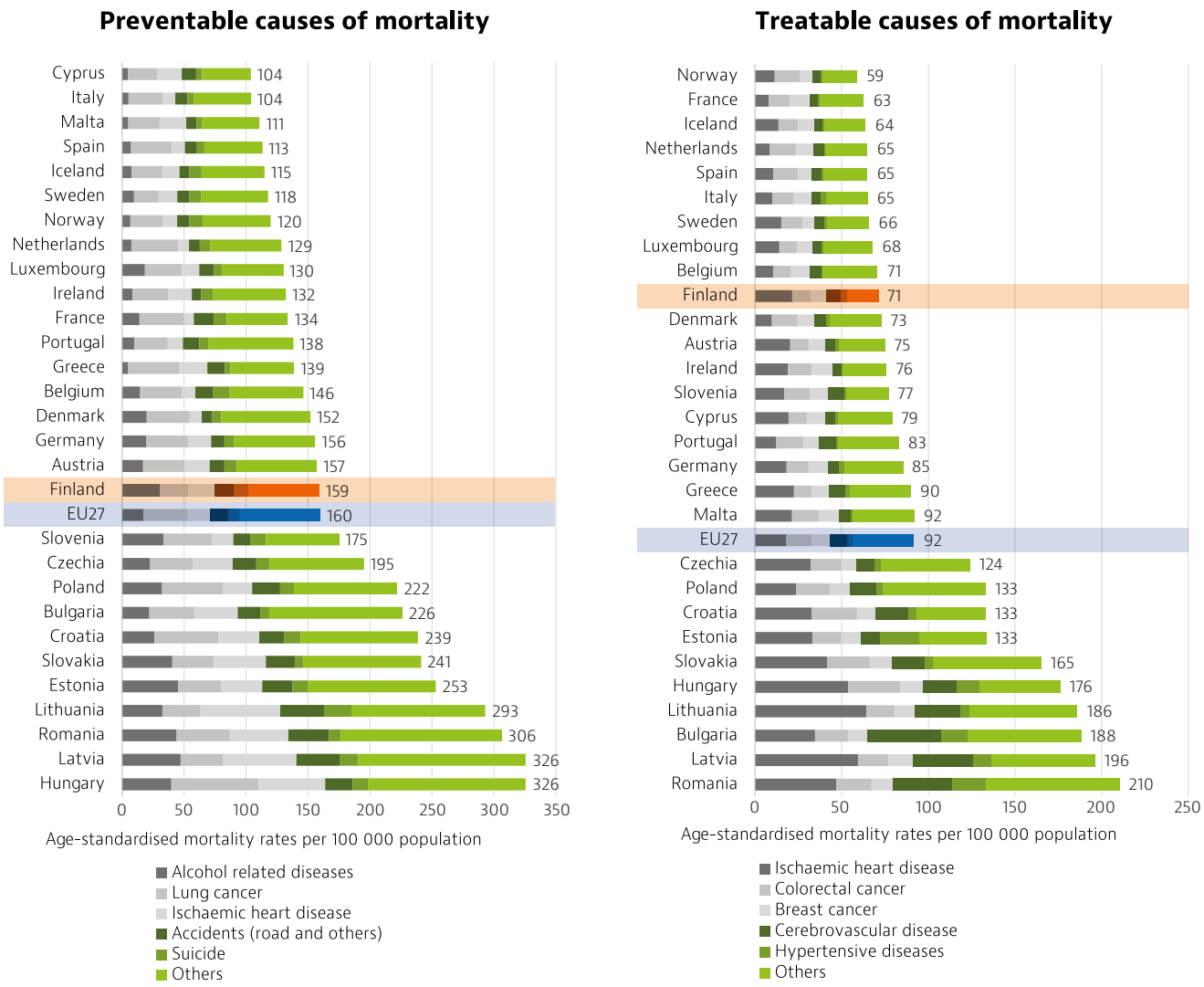
## 5.1 Effectiveness

### Preventable mortality is close to the EU average, but mortality from treatable causes is lower

Preventable mortality in 2018 was just below the EU average. The main causes of preventable mortality in Finland are alcohol-related deaths, lung cancer, ischaemic heart disease, accidents (including road accidents) and suicide (Figure 10).

Finland fared better in terms of mortality from treatable causes. This rate was over 20 % below the EU average, indicating that the health system is effective in saving the lives of people with life-threatening conditions through timely and high-quality care. The leading causes of treatable mortality rates are ischaemic heart disease, colorectal and breast cancer, and stroke. Between 2011 and 2018, mortality from preventable and treatable causes fell by about 15 %.

**Figure 10. 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. Treatable mortality is defined as death that can be mainly avoided through health care interventions, including screening and treatment. Half of all deaths for some diseases (e.g. ischaemic heart disease and cerebrovascular disease) are attributed to preventable mortality; the other half are attributed to treatable causes. Both indicators refer to premature mortality (under age 75). The data are based on the revised OECD/Eurostat lists.*
*Source: Eurostat database (data refer to 2018, except for France 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. The overarching goal of the current Tobacco Act is that Finland will become tobacco-free in 2030, and that less than 5 % of the adult population will consume tobacco or nicotine products on a daily basis (Tobacco-free Finland, 2021).

Overweight, obesity and diabetes are on the rise. A national programme to tackle obesity was put in place between 2012 and 2018, including information and communication campaigns to improve nutrition and physical activity and greater collaboration between national, regional and local actors. However, its results have not yet been evaluated (Finnish Institute for Health and Welfare, 2019).

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 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, together with multiple increases of alcohol tax levels, contributed to an 18 % reduction in overall alcohol consumption among adolescents and adults between 2007 and 2019. In 2020, recorded alcohol consumption increased slightly to 8.2 litres per person aged 15 years (a rise of 0.4 %), but unregistered consumption declined by one third to 1.1 litres due to reduced imports (Finnish Institute for Health and Welfare, 2021a).

In addition, use of illicit drugs (such as LSD, ecstasy and amphetamines) is generally higher in Finland than in many EU countries, and is increasing. The rate of drug-related deaths is among the highest in the EU (72 per million people aged 15-64 compared with an EU average of 24 in 2018) (European Monitoring Centre for Drugs and Drug Addiction, 2020). However, tackling the use of illicit drugs has not been a key focus in recent public health debates.

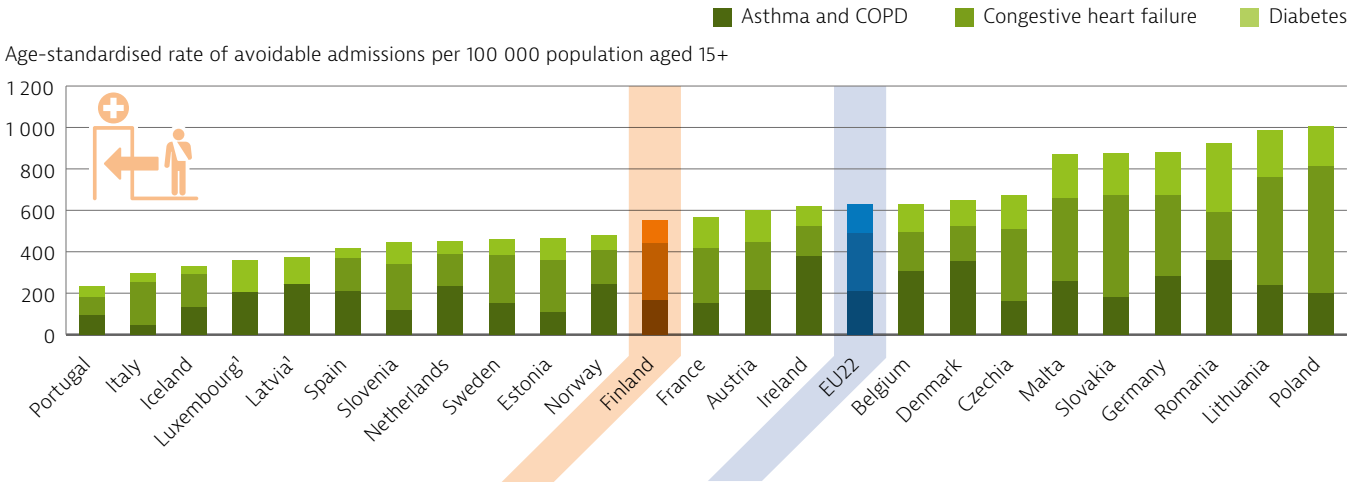
## Vaccination coverage improved during the pandemic

The number of Finns aged 65 and over who were vaccinated against influenza has been below 50 % over the last decade up to 2019, but the number of vaccinated elderly people increased by five percentage points to 52 % in 2020-21 during the COVID-19 pandemic (Finnish Institute for Health and Welfare, 2021b). The rate is still, however, well below the WHO recommended target of 75 %.

## 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 congestive heart failure and diabetes (Figure 11). This indicates that there is room to improve management of chronic conditions outside hospitals.

**Figure 11. Avoidable admissions for chronic conditions could be reduced further**




*Note: 1. Data for congestive heart failure is not available in Latvia and Luxembourg.*
*Source: OECD Health Statistics 2021 (data refer to 2019 or nearest year).*

## Cancer care is generally effective

Owing to early diagnosis and effective treatments, people diagnosed with different types of cancer (such as breast, cervical and colon) in Finland have higher survival rates than in most EU countries (Figure 12), and overall mortality from cancer is among the lowest in the EU (OECD/EU, 2020).

Finland has well-established national screening programmes for cervical cancer (covering over 80 % of eligible women) and breast cancer (covering over 70 %) – both well above the EU average (58 % for these two cancer screenings). Finland also offers the human papillomavirus (HPV) test for the early identification of cervical cancer. A colorectal cancer screening programme was initiated regionally in the 2010s and nationally in 2022 (for ages 60-68) and becoming fully implemented in 2031 (for ages 56-74).

Finland has also promoted specialisation of health professionals in cancer care through licensing and certification systems. A new National Cancer Centre, active since 2018, is expected to promote greater coordination in cancer research and treatment and equal access to cancer care.

**Figure 12. Cancer survival rates are above the EU average for most cancers**

| Prostate cancer | Childhood leukaemia | Breast cancer | Cervical cancer | Colon cancer | Lung cancer |
|---|---|---|---|---|---|
| Finland: 93 % | Finland: 95 % | Finland: 89 % | Finland: 67 % | Finland: 65 % | Finland: 13 % |
| EU23: 87 % | EU23: 85 % | EU23: 82 % | EU23: 63 % | EU23: 60 % | EU23: 15 % |

*Note: Data refer to people diagnosed between 2010 and 2014. Childhood leukaemia refers to acute lymphoblastic cancer.*
*Source: CONCORD Programme, London School of Hygiene and Tropical Medicine.*

### A new strategy for mental health was launched in 2020

Depression and other mental illnesses continue to be widespread in Finland, and suicide rates have historically been high. National suicide prevention programmes with a focus on early access to mental health services – particularly for young men and people with severe depression or substance misuse – proved effective in reducing suicide rates by one third between 1990 and 2005 and a further one quarter between 2005 and 2019. Crisis phone lines for people experiencing suicidal thoughts were established several decades ago, along with guidance for the media on reporting suicides.

In 2020, the Ministry of Social Affairs and Health launched a new 10-year mental health strategy. It includes five key priority areas: mental health as human capital, mental health for children and young people, mental health rights, broad-based services that meet people's mental health needs and good mental health management. In its first years, implementation will focus on developing services, launching a new suicide prevention programme and promoting mental health in people's everyday environments as part of a wider effort to promote well-being and health (Finnish Institute for Health and Welfare, 2021c).

## 5.2 Accessibility

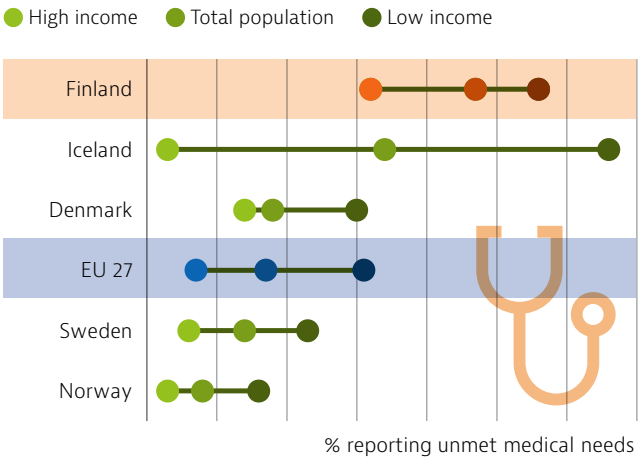
### The Finnish health system covers nearly all the population, but co-payments can be high

As described in Section 4, all permanent residents are entitled to access publicly financed health services, although coverage is better for those with access to occupational health care. A wide range of health services and goods are publicly covered, but user fees apply to most of these. In 2019, out-of-pocket payments accounted for 17.4 % of current health expenditure in Finland, a higher share than the EU average (15.4 %). More than one quarter of out-of-pocket payments are used to purchase pharmaceuticals, while the rest are mainly used to pay for outpatient medical care, dental care and long-term care. Looking at health expenditure by type of service, public funding covers a higher share of costs for inpatient care and outpatient care than the EU average. For pharmaceuticals and dental care, the share of public funding is much lower and is identical or close to the EU average.

### 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 the rate in most other Nordic countries. In 2019, almost 5 % of the Finnish population reported unmet medical care needs for financial reasons, geographical barriers or waiting times, compared to below 2 % on average across the EU (Figure 13). By far the main reason reported was waiting times. The proportion of people reporting unmet needs for medical care in the lowest income quintile was almost twice that in the highest.

**Figure 13. Many Finns on low incomes report unmet medical care needs, mainly due to 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 2019, except for Iceland 2018).*

According to a Europe-wide survey carried out in February and March 2021, unmet medical care needs during the first twelve months of the COVID-19 pandemic were reported by 20 % of Finns – a share close to the EU average of 21 % (Eurofound, 2021).[2]

## Waiting times to access care have increased following the COVID-19 pandemic

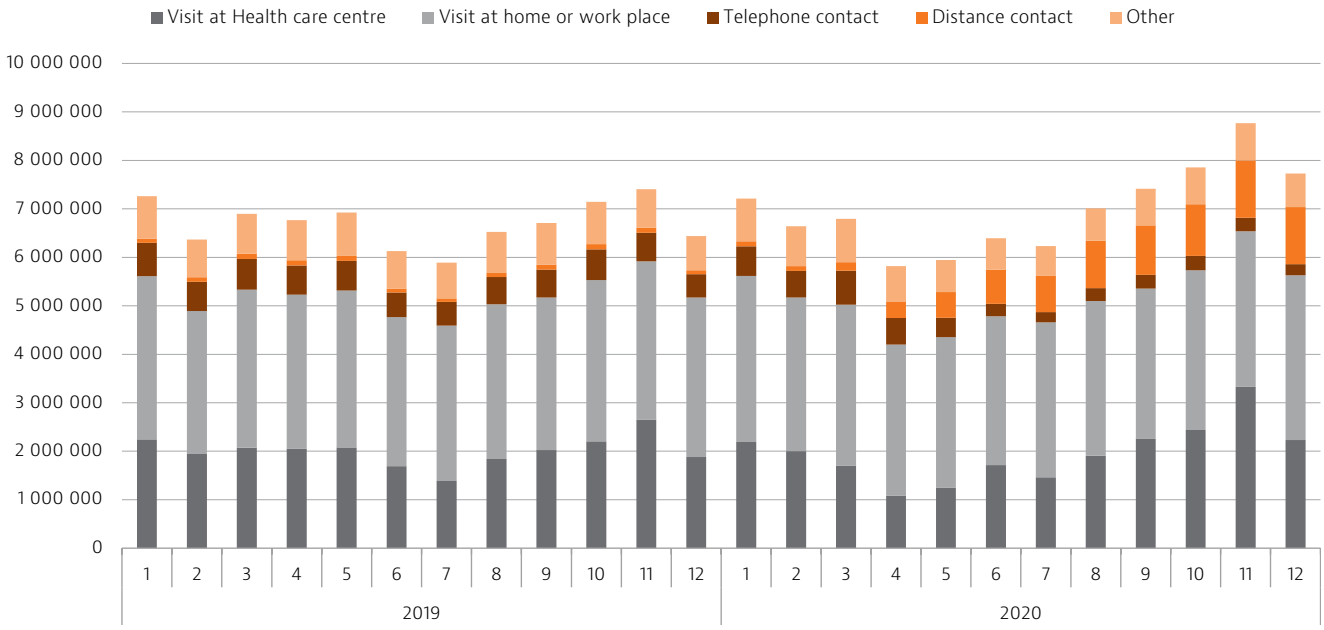
The 2010 Health Care Act states that patients in Finland should be able to access primary care within a day during office hours, and specialised medical care within three weeks of a referral. Treatment has to be provided within six months of the assessment. For mental health services for children and young people aged below 23, the limits are six weeks for primary care and three months for specialist care.

Most providers have been able to follow these rules, although around 1 500 patients were on a waiting list for non-urgent specialised care for more than six months at the end of 2019. In March 2020, the government relaxed the rules for maximum waiting times because of the need to mobilise additional resources in response to the pandemic. As a consequence, the number of patients on waiting lists for more than six months increased from 1 500 to almost 18 000 (12.9 % of all patients) in August 2020. At the end of April 2021, the number had declined to around 6 100 (4.6 %).

When implementing health reforms in the coming years, the government will shorten the mandatory limits for non-urgent treatment in primary care from three weeks to one week. During the pandemic, the number of patients waiting for treatment in primary care halved, but many (7 % in March 2021) had waited for more than 30 days.

The number of primary health care visits declined from 6.9 million per month in January-February 2020 to 5.8 million in April-May 2020 (Figure 14). After the summer, the number recovered quickly and exceeded 8 million visits per month at the end of 2020. There was a substantial increase in the use of distance services. The number of teleconsultations increased from 0.1 million to 1.2 million per month during 2020 (Finnish Institute for Health and Welfare, 2021d).

**Figure 14. The number of teleconsultations in public primary health care increased rapidly in 2020**




*Source: Finnish Institute for Health and Welfare (2021d).*

## Uneven distribution of resources, combined with employer-based schemes, causes access inequalities

The uneven geographic distribution of health care resources reinforces disparities in access to care in Finland. The density of doctors is much greater in the capital region of Helsinki and in other major cities, owing 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

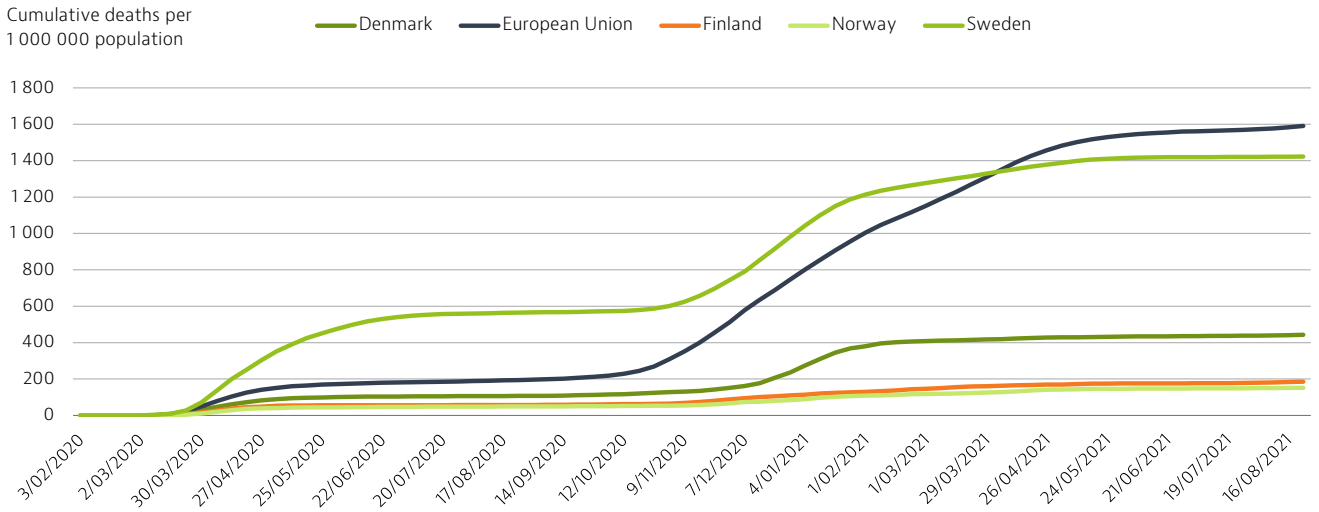
2. *The data from the Eurofound survey are not comparable to those from the EU-SILC survey because of differences in methodologies.*

access through wider provider choice. Meanwhile, people from lower socioeconomic groups and older people have to wait longer and incur larger co-payments to access services. The proposed centralisation of health and social care at the regional level (see Section 4) aims to achieve more balanced resource allocation and reduce waiting times. Access to primary care may also be improved by expanding the role of nurses further, particularly in areas where there are shortages of GPs.

## 5.3 Resilience

This section on resilience focuses mainly on the impacts of and responses to the COVID-19 pandemic.[3] As noted in Section 2, unlike in many other EU countries the COVID-19 pandemic did not have a major impact on mortality in Finland in 2020. At the end of August 2021, the total number of registered cases relative to the population size (2 280 per 100 000 population) was the lowest among all EU countries and Iceland and Norway, and less than one quarter of the EU average. The total number of deaths (18.5 per 100 000 population) was the lowest among EU countries, although slightly higher than in Iceland and Norway (Figure 15).

**Figure 15. Finland registered the lowest number of COVID-19 deaths among EU countries up to end of August 2021**




*Note: In many countries, the number of registered COVID-19 deaths under-estimates the real number, mainly because of limited testing (see section 2 for a discussion of the gap between registered COVID-19 deaths and excess mortality).*
*Source: ECDC*

This relatively good performance in managing the pandemic can be seen at least in part as a result of effective action taken by government and other authorities to contain the initial spread of the virus, but also to the country's remote location, low population density and Finnish people's cultural preference for maintaining social distance even in normal times. A similar pattern was seen during the 1918-19 influenza pandemic, when excess mortality was also remarkably low in Finland (Ansart et al., 2009).

### Following a strict first lockdown, Finland applied a hybrid strategy to tackle the COVID-19 pandemic

The first case of COVID-19 was detected at the end of January 2020. The government, in co-operation with the President of the Republic, declared a state of emergency in Finland due to COVID-19 on 17 March 2020. The Emergency Powers Act, adopted in 1991, was used for the first time. This aims to ensure the safety of the population and the functioning of society in exceptional circumstances.

Following the declaration of the state of emergency, gatherings of more than 10 people were prohibited. Public services such as schools, libraries and swimming pools were closed, with schools switching to remote education. Day care for children remained open for workers deemed to be essential. All workers were required to work from home, if possible. People over the age of 70 were recommended to avoid social contacts (self-quarantine). Visits to nursing homes, health care and other at-risk facilities were largely prohibited.

*3. In this context, health system resilience has been defined as the ability to prepare for, manage (absorb, adapt and transform) and learn from shocks (EU Expert Group on Health Systems Performance Assessment, 2020).*

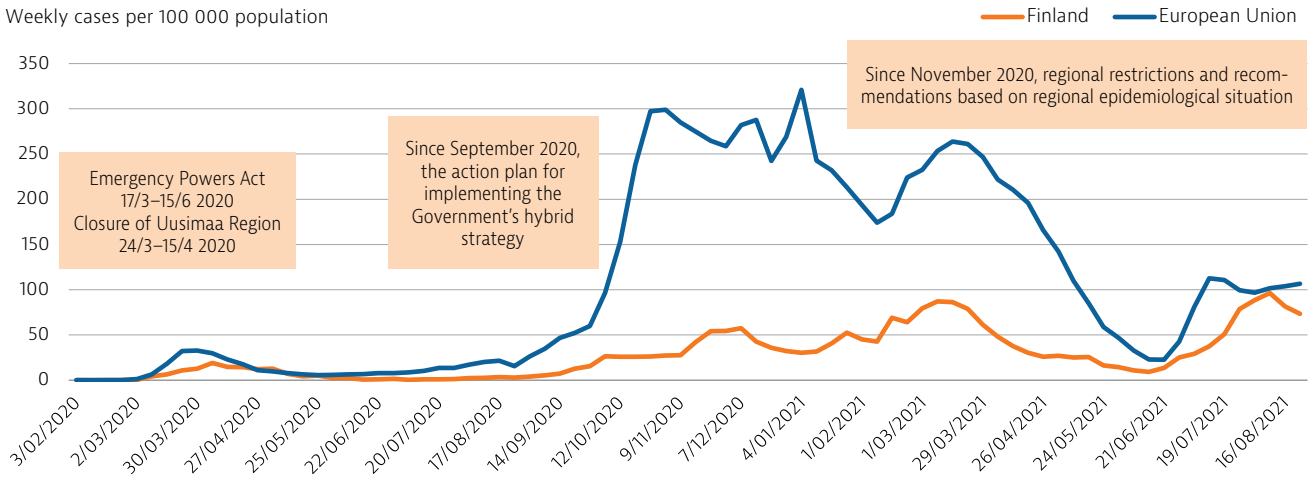
During the first wave, the capacity of health and social care services was increased, and non-urgent activities were reduced. Private sector capacity was pooled as needed. As noted above, statutory ward guarantees and obligations on waiting times for non-urgent interventions were relaxed. Coronavirus laboratory testing capacity was increased. Provisions in the Working Hours and Annual Leave Act were suspended temporarily for critical personnel. Professionals trained in social and health care and internal security were obliged to work if required.

The first wave of the pandemic mostly hit the capital region. The government restricted movement between the southern region of Uusimaa (including the capital region of Helsinki) and other parts of the country between 24 March 2020 and 15 April 2020 to prevent the spread of the pandemic. Crossing the regional border was allowed only under specific circumstances, including work or urgent family affairs.

On 4 May 2020, the government announced that the restrictive measures during the first wave would be relaxed throughout the country. Schools opened on 14 May 2020 for two weeks before the summer holiday. Restaurants opened on 1 June 2020, having been closed since 4 April 2020.

On 6 May 2020, the government adopted a resolution on a plan for a hybrid strategy to manage the COVID-19 crisis: test, trace, isolate and treat. A more detailed plan was presented in September 2020. It aimed to prevent the spread of the virus in the society, to safeguard the capacity of the health care system against excessive pressure and to protect people – especially those in high-risk groups (Figure 16).

**Figure 16. The number of COVID-19 cases remained low because of effective containment measures and other contextual factors**




*Note: The EU average is unweighted (the number of countries included in the average varies depending on the week). The number of COVID-19 cases in EU countries was underestimated during the first wave in spring 2020 due to more limited testing.*
*Source: ECDC for COVID-19 data and authors for containment measures.*

The action plan for implementing the government's hybrid strategy divided the COVID-19 pandemic into three phases. This classification was used to assess the need for recommendations and restrictions to control the spread of the virus and to ensure that they were appropriately targeted.

- Baseline phase: The pandemic is at a low and stable level.
- Acceleration phase: The spread of the pandemic is beginning to speed up; regional incidence of cases is higher than at the baseline level; and there are several local and regional transmission chains.
- Community transmission phase: The pandemic continues to accelerate, and cases are spreading regionally or more widely throughout the population. Tracing is becoming more difficult because there are too many cases.

The epidemiological situation was monitored at regional and national levels, while decision-making concerning the tier of prevention measures to implement was decentralised to regional and local authorities (municipalities or regional state administrative agencies).

As in many other EU countries, mobility restrictions were relaxed in the summer months of 2020 as a result of the steep decline in the number of reported

cases. However, they were reintroduced in autumn 2020 as the number of cases started to rise again, with some regions reaching the third phase of community transmission. In October 2020, more severe restrictions were imposed across the country, for example for restaurants and bars. The teleworking recommendation was repeated for the whole country, and strict limits were again imposed on public events and gatherings. Secondary schools and universities switched to distance education again. Use of a mask was recommended, if possible.

On 22 February 2021, an amendment to the Communicable Diseases Act came into force, which allowed the Finnish government to significantly tighten restrictions whenever the epidemiologic situation requires it without resorting to the Emergency Powers Act.

On 1 March 2021, the government set out exceptional circumstances for Finland and immediately imposed further restrictions on areas in the acceleration phase, which included virtually the entire country. From 8 March 2021, closure of public spaces for areas in the acceleration phase was put in place – similar to the closure of spring 2020. The government also proposed a new law that would make face masks compulsory and could include further restrictions on movement. However, the Constitutional Law Committee of the Parliament did not approve this proposal.

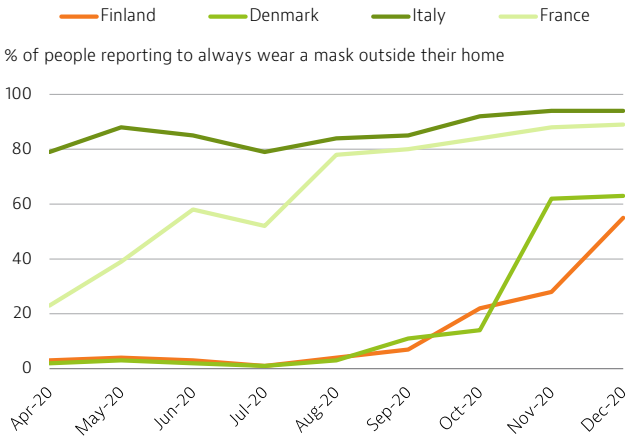
## Use of face masks was more limited than in countries where mask-wearing was compulsory

Adoption of mask recommendations in Finland was slow compared to other European countries. This can partly be explained due to poor availability of face masks during the first months of the pandemic, and the results of a systematic literature review commissioned by the Finnish Ministry of Social Affairs and Health (2020), which showed that there was not much research data demonstrating the effectiveness of widespread use of face shields in preventing the spread of COVID-19 in society.

On 13 August 2020, the Finnish Institute for Health and Welfare issued the first official recommendation on the use of face masks, recommending their use on public transport, on the way to a coronavirus test and for people entering Finland on the way from a coronavirus risk country to the quarantine location. In autumn 2020, the recommendation was tightened in those areas where the COVID-19 pandemic was accelerating, recommending the use of face masks in most public spaces, as well as for public events taking place in locations where the incidence of COVID-19 cases exceeded a minimum threshold. A recommendation to wear face masks was also extended to secondary schools.

Use of masks in public spaces in Finland increased in autumn 2020, but always remained well below utilisation rates in western European countries where they were compulsory (Figure 17).

**Figure 17. Use of face masks was relatively low in Finland**




*Source: YouGov data (http://www.coviddatahub.com/).*

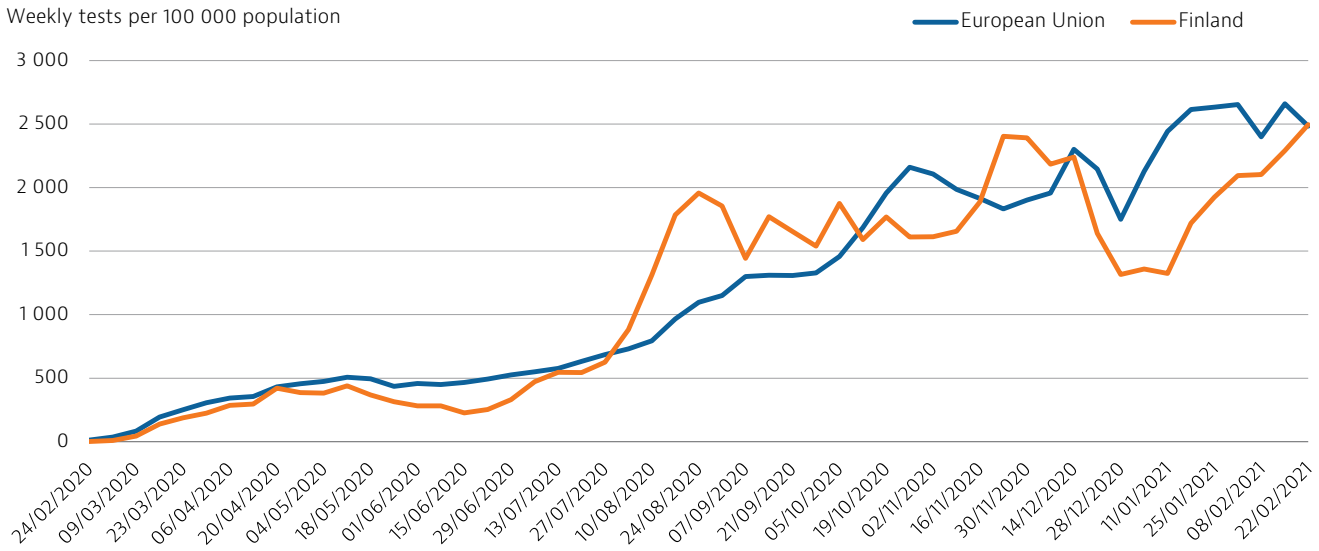
## The beginning of the pandemic showed problems in preparedness to deal with a public health emergency

Finland's crisis preparedness measures were based on a national preparedness plan for an influenza pandemic from 2012, but the country faced some delays in its initial response to the COVID-19 pandemic.

A major problem was obtaining sufficient PPE for health workers. Following cost-saving measures in the 2010s, the necessary equipment was in short supply in hospitals at the beginning of the pandemic. Temporary shortages of PPE such as visors, top-level face masks and protective jackets were reported until June 2020, when sufficient import of PPE and domestic production resolved the shortage.

At the beginning of the pandemic, the limited testing capacity could not effectively cover all people with COVID-19 and the difficulties to start contact tracing activities led to an underestimation of registered cases. The number of weekly tests progressively increased in summer 2020 and exceeded 1 000 per 100 000 population in mid-August 2020. It then remained around the EU level until the end of February 2021, excluding the Christmas holiday period (Figure 18). Given that the number of cases was several times lower than the EU average, this indicates that testing was very broad.

**Figure 18. Following a slow start, testing capacity increased in the second half of 2020**




*Note: The EU average is weighted (the number of countries included in the average varies depending on the week).*
*Source: ECDC.*

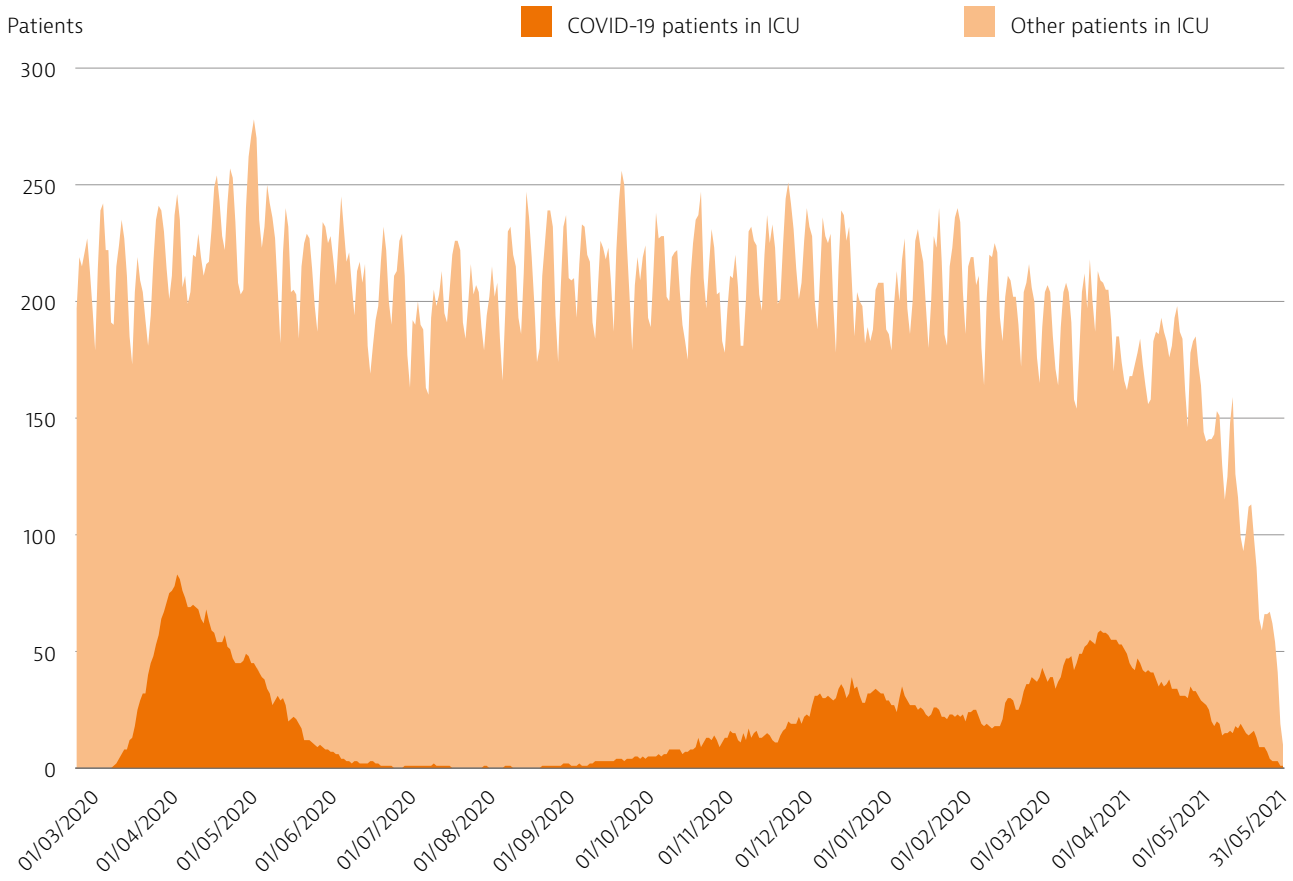
## Uptake of the contact tracing application was high

The Finnish Institute for Health and Welfare released Koronavilkku/Coronablinkern, a COVID-19 contact tracing app to facilitate contact tracing efforts. It collects information about users who have reported being infected and other users of the app who have been near them. By November 2020, the app had been downloaded more than 2.5 million times, which is around 45 % of the Finnish population. In March 2021, 14 000 users had reported their diagnoses and 10 000 users had reported symptoms after exposure, out of 60 000 cases from mid-August 2020 to mid-March 2021.

## The number of hospital and intensive care unit beds was sufficient to handle the peak in demand for care, but staff shortages were more of a constraint

As of June 2020, the Finnish health care system had a total capacity of 11 000 hospital beds for COVID-19 patients, including 300 fully equipped intensive care unit (ICU) beds and 200 respiratory-assisted beds (with oxygen). According to the national preparedness plans, ICU bed capacity could be doubled in a short time if required. However, available capacity was far from being exhausted due to COVID-19 patients during the first wave in spring 2020 (Figure 19). During the second wave (up to the end of March 2021), the number of patients treated in ICUs remained below the maximum level reached during the first wave.

**Figure 19. Finland had enough intensive care unit capacity for COVID-19 patients during the pandemic**




*Source: National Coordinating Office for Intensive Care, Kuopio University Hospital (unpublished data)*

According to weekly monitoring reports, the number of trained healthcare staff was perceived to be more of a limiting factor than the number of ICU beds. Staff shortages were filled by relocating non-urgent care, reorganising work and inviting retired health workers back to work. In specialised care, the pandemic resulted in a deficit of some 170 000 care episodes caused by shortages of hospital personnel and reallocation of the resources. In primary care where staff shortages existed before the pandemic, service providers reported shortages of personnel from March 2021.

## The societal consequences of the COVID-19 pandemic are high

Although the pandemic had a lesser impact on GDP in Finland than in many other European countries, unemployment in 2020 was over one percentage point higher than in 2019. The number of business bankruptcies did not increase, however, owing to temporary legislation that restricted creditors' rights to file for bankruptcy.

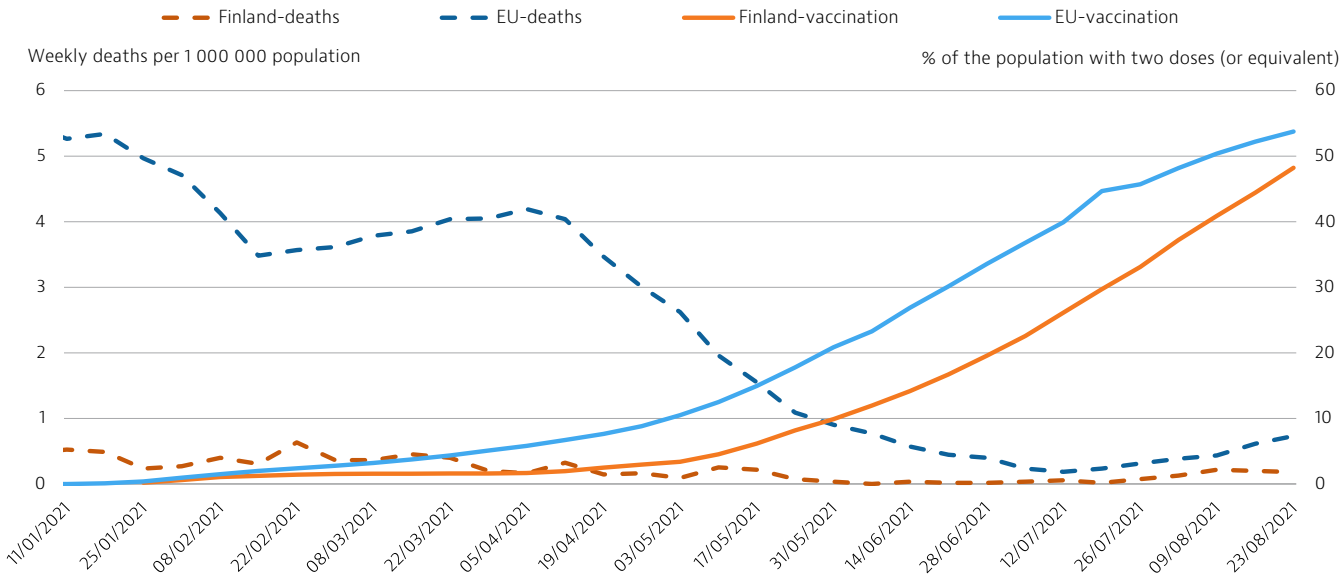
The social impacts of the pandemic have been substantial. One in three people in Finland reported having experienced increased loneliness during the pandemic – this was particularly the case among single people, elderly people and young adults. Higher rates of loneliness were reported by people living in those areas where restrictive measures related to COVID-19 were most severe. The effects of the pandemic and its restrictive measures on the mood of the adult population were clear – including, for example, a decline in hope for the future and increased stress. Mental stress increased towards the end of 2020, while this was not the case during the first wave. Recovery from the pandemic may improve the situation, but the Finnish Institute for Health and Welfare will continue to monitor its burden on mental health and access to mental health services to prevent problems from worsening (Finnish Institute for Health and Welfare, 2021e).

Reductions of mental health and substance use support and switching to remote services caused problems, especially among the most vulnerable groups. Alcohol and amphetamine use was estimated to have increased (Kestilä et al. 2020). According to surveys, older people did not receive enough support during the COVID-19 pandemic – especially those needing assistance at home.

## The rollout of the COVID-19 vaccine started in late December 2020

Municipalities are responsible for arranging vaccinations in Finland. Based on the recommendation of the National Vaccine Expert Group, the vaccination priority order was divided into three groups: health care personnel dealing with COVID-19 patients and personnel and residents in long-term care facilities; elderly people and those with underlying conditions that predispose them to severe COVID-19 (five subcategories) and social welfare and other health care personnel; and all other adults (Finnish Institute for Health and Welfare, 2021f). The interval between the first and second dose of the vaccines was extended to 12 weeks, which explains the large gap between the share of the population who had received a first dose at the end of August (over 70%) and those who had received two doses (about 50 %) (Figure 20).

**Figure 20. The percentage of the Finns who had received two doses of vaccine against COVID-19 was still relatively low at the end of August 2021**




*Source: ECDC for COVID-19 deaths and Our World in Data for vaccination rates.*

## The government increased public spending on health in response to the crisis

The government substantially increased public spending on health in 2020 and 2021 to cover the direct costs related to COVID-19 and the indirect costs of dealing with delayed care. The initial spending plan included a total package of about EUR 4 billion to provide direct support for local government – including hospital districts, joint municipalities and municipalities – and for the provision of basic public services.

Finland's Recovery and Resilience Plan was published in May 2021. This Plan forms part of the Sustainable Growth Programme for Finland, including investment projects and reforms that the government has selected to achieve a long-term positive impact. Health and social services are one of the priority areas with funding of EUR 400 million. The largest investments are related to reducing the care backlog arising from the COVID-19 pandemic and structural measures to speed up access to care, introducing digital innovations that promote the care guarantee, improving the knowledge base to support cost-effectiveness of health care and social welfare, and strengthening prevention and mobile services (Ministry of Finance, 2021).

# 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. Finland was one of the only two EU countries where life expectancy continued to increase in 2020 despite the COVID-19 pandemic, although the gains were fairly small.

- Substantial progress has been achieved in reducing important risk factors for health such as smoking and alcohol consumption. The aim of the current Tobacco Act is that Finland should become tobacco-free in 2030, with a smoking rate of less than 5 %. Alcohol consumption has decreased fairly steadily since 2005, and this reduction continued during the COVID-19 pandemic in 2020. 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.

- Health spending in Finland is slightly lower than the EU average both per person and as a share of GDP (9.2 % compared with 9.9 % for the EU average in 2019), and is much lower than in Sweden, Norway and Denmark. Public spending accounts for 78 % of health spending, which is below the EU average (80 %) and the rates in other Nordic countries (all above 82 %). The rest is paid mainly out of pocket by households, especially for pharmaceuticals and dental care.

- 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. For the post-pandemic recovery plan it is important to tackle unmet needs due to lack of services, which have emerged in primary health care, specialised care and social welfare services. This aim may be complicated by a lack of funding and limited availability of qualified staff.

- A particular concern is that both occupational health care 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.

- Health and social care services, funding mechanisms and the regional governance structure will be reformed from 2021 onwards. The 21 self-governing counties and the capital Helsinki will be in charge of social and health care services, and most services will be delivered by public providers.

- Finland applied a hybrid strategy against COVID-19, which focused on testing, tracing, isolating and treating confirmed cases. Until August 2021, Finland had the lowest rate of registered COVID-19 cases and deaths among EU countries. The country's positive outcome in managing the pandemic has been seen as a result of the government's and public authorities' effective actions to contain the spread of the virus with this hybrid strategy, as well as contextual factors including the remote location of the country, low population density and the population's cultural preference for maintaining social distance.

# Key sources

Keskimäki I et al. (2019), *Finland: health system review, Health Systems in Transition, 21(2):1-166.*

OECD/EU (2020), *Health at a Glance: Europe 2020 – State of Health in the EU Cycle.* Paris, OECD Publishing, https://doi.org/10.1787/82129230-en.

# References

Ansart S et al. (2009), *Mortality burden of the 1918-1919 influenza pandemic in Europe, Influenza Other Respiratory Viruses*, 3(3): 99-106.

Ensio A et al. (2019), Finland. In: Rafferty AM et al., eds. *Strengthening health systems through nursing: evidence from 14 European countries.* Copenhagen, WHO Regional Office for Europe.

EU Expert Group on Health Systems Performance Assessment (HSPA) (2020), *Assessing the resilience of health systems in Europe: an overview of the theory, current practice and strategies for improvement.* Luxembourg, Publications Office of the EU.

Eurofound (2021), *Living, Working and COVID-19 data,* 11 May 2021.

European Monitoring Centre for Drugs and Drug Addiction (2020), *European drug report 2020: trends and developments.* Luxembourg, Publications Office of the EU.

Finnish Institute for Health and Welfare (2019), *The National Obesity Programme 2012-2018.*

Finnish Institute for Health and Welfare (2020), *Child and adolescent overweight and obesity 2019: one in every four boys and almost one in every five girls is overweight or obese.* Statistical report 31/2020

Finnish Institute for Health and Welfare (2021a), *Alcoholic beverage consumption in 2020*. Statistical report 7/2021.

Finnish Institute for Health and Welfare (2021b), *Annetut influenssarokotukset kaudella 2020-2021* (Influenza vaccination in season 2020–2021).

Finnish Institute for Health and Welfare (2021c), *National Mental Health Strategy 2020-2030.*

Finnish Institute for Health and Welfare (2021d), *AvoHilmo: Käynnit viikoittain ja kuukausittain* (Primary health care register: The number of visits per month and week).

Finnish Institute for Health and Welfare (2021e), *Koronaepidemian vaikutukset hyvinvointiin, palveluihin ja talouteen* (The effects of COVID-19 epidemic to well-being, services and economy).

Finnish Institute for Health and Welfare (2021f), *Vaccination order and at-risk groups for COVID-19.*

Kestilä L et al. (2020), *Covid-19-epidemian vaikutukset hyvinvointiin, palvelujärjestelmään ja kansantalouteen: Asiantuntija-arvio, syksy 2020* (The effects of the COVID-19 epidemic on well-being, the service system and the national economy. Expert assessment, autumn 2020), Raportti 14/2020. Tampere, PunaMusta Oy.

Ministry of Finance (2021), *Health and social services – Recovery and Resilience Plan.*

Ministry of Social Affairs and Health (2020), *Selvitys väestön kasvosuojusten käytöstä COVID-19-epidemian leviämisen ehkäisyssä* (Review on the use of face masks in the population to prevent the spread of the COVID-19 epidemic).

Ministry of Social Affairs and Health (2021), *Reducing differences in wellbeing by 2030.*

Tervola J, Aaltonen K, Tallgren F (2021), *Can people afford to pay for health care? New evidence on financial protection in Finland.* Copenhagen, WHO Regional Office for Europe.

Tobacco-free Finland 2030 (2021), *Towards a tobacco-free Finland.*

WHO Regional Office for Europe, *European Commission, European Observatory on Health Systems and Policies (2021)*, COVID-19 Health Systems Response Monitor - Finland.

**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 | | |

European Commission

# State of Health in the EU
## Country Health Profile 2021

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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