

OECD Reviews of Health Systems

Finland



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Foreword

This review of the Finnish health system was undertaken at the request of the Finnish Ministry of Social Affairs and Health and was supported by the ministry with a financial contribution. It follows OECD reviews of the health systems of Korea (published in 2003) and of Mexico (published in 2005).

The review draws on an analytical framework developed during the OECD Health Project (2001-2004). It sets out the organisation of the Finnish health system and, in accordance with the analytical framework, evaluates its performance against three major goals of health policy: macroeconomic efficiency (or financial sustainability), microeconomic efficiency (or value for money) and equity (in the financing and utilisation of health care). After reviewing some recent reforms to the health system, the review offers an assessment of the challenges the system faces in the future. It concludes with a set of suggestions for further improvement to the system.

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Executive Summary

Introduction

The Finnish health system performs relatively well in international comparisons of many important dimensions of performance; the one notable exception is long waiting times for some services. But it also faces, in common with most other OECD countries, significant current and future challenges including: rapid and expensive technological change, an ageing population, and rising consumer expectations. These pressures threaten the ability of the system to continue to offer universal access to comprehensive health care in a way that remains both affordable and equitable in future, in the absence of continuing reforms.

This review of the Finnish health system assesses its performance against three main objectives: 1) financial sustainability; 2) value for money; and 3) equity. It reviews recent reforms to the health system and makes recommendations about future strategy and policy. Particular attention is paid to four specific issues of current concern to Finnish policy makers: 1) the growth of pharmaceutical expenditure; 2) the consequences for equity and efficiency of decentralisation; 3) the availability of enough qualified healthcare personnel; and 4) tackling lengthy waiting lists for elective surgery.

Performance assessment

Financial sustainability

In a notable achievement, total health expenditure as a share of GDP was brought under control in Finland in the 1990s. There is, however, a question mark over spending on drugs. The rate of growth of drugs spending *as a share of GDP* has been fairly typical for an OECD country but, *as a share of total health expenditure*, it has been growing faster than in other Nordic or in other OECD countries for over a decade. The latter draws attention to the relatively open-ended arrangements for National Health Insurance funding of prescribed medicines compared to the relatively tight constraints that were applied to municipal health expenditure in Finland in the 1990s. However, since 2000, there have been signs that municipalities have been finding it difficult, or undesirable, to maintain control over their health expenditure, particularly on hospitals. This has forced them increasingly to supplement tax funding with borrowing.

Value for money

International comparisons suggest that, despite a relatively low level of health spending, Finland manages to purchase an above-average level of some key inputs to its health system (with the exception of doctors and acute-care beds) – partly because relative wages are below the levels in other countries. These input levels do not always translate commensurately into utilisation rates because productivity (measured crudely) appears to be below average for some services. The latter may be related to the relative lack of

performance incentives for staff. Nevertheless, utilisation rates are above Nordic and OECD averages, respectively, for pharmaceuticals and for hospital discharges.

The technical quality of services is good, judging by some indicators of avoidance of public health risk and some indicators of health outcomes and appropriate procedures. The former may be due to policies which favour prevention and the latter to the strong professional skills of Finnish health care personnel.

In contrast, responsiveness to consumers is somewhat lacking, judging by the long waiting times for appointments with health centre physicians and the long queues for elective surgery. A combination of lack of patient choice and the lack of financial incentives facing providers may account for these characteristics. Given the prevalence of long waiting times, it is somewhat paradoxical that Finns, in general, report high satisfaction with their health system, but that might reflect, partly, low expectations.

On the topics of special concern to Finnish policy makers, cited above, there is some evidence of inappropriate prescribing for the elderly. Question marks can be raised over methods of regulating retail pharmacists. Although retail dispensing costs are about average for an OECD country, there may be opportunities to make savings.

There are reasons to suspect that the extreme decentralisation of governance of municipal services may be a hindrance to efficiency but it is difficult to find evidence to that effect – perhaps because measures have been put in place to require or encourage cooperation among municipalities and professionalism among providers may compensate for any weaknesses in municipal management.

On the human resources front, there are shortages of personnel in some staff groups. The skill mix among professional staff is rich in nurses, dentists and pharmacists but poor in doctors compared with other OECD countries. Shortages of health centre physicians may help to account for some of the long waiting times for appointments.

The long waiting times for elective surgery are likely to be due more to a set of incentives for providers which discourage appropriate management of demand than to a lack of surgical procedures – judging by the comparatively high surgical procedure rates in Finland.

Equity in the financing and use of health care

Payment for health care seems to be broadly proportional to income in Finland. However, international comparisons suggest that Finland offers less equitable access to GPs and specialists than many other countries. The former is likely to be due to the availability of free occupational health care combined with relatively tight rationing of access to, and charging for, health centre physicians. However, nurse consultation may compensate somewhat for the latter.

Three main conclusions can be drawn about the impact of decentralisation on equity. First, the adjustments to the taxable capacity of municipalities and to the needs formula for state grants are incomplete. Secondly, local autonomy is a leading goal in the system and there is a trade-off between that goal and geographical equity. Thirdly, the decentralisation reforms of the early 1990s seem to have been followed by a reduction in inequity.

Recent reforms

There have been some significant reforms to the Finnish health system recently which have tackled some weaknesses and addressed some future challenges. In particular, the new targets for maximum waiting times for appointments and recommended treatments and care seem already to be reducing the long waits at health centres and the queues for surgery. The new guidelines for clinicians on what treatments should be offered and the new Pharmacotherapy Development Centre should help to reduce irrational variations in procedure and prescribing rates across Finland. The measures to encourage more regional co-operation among municipalities, in relation both to local services and to specialist services, and to develop national interoperability of IT systems, should enhance efficiency. The steps taken to stimulate the availability, skills and motivation of staff are already reducing staff shortages. Reforms to long-term care arrangements – such as the introduction of vouchers for home helps and the encouragement of informal care – seem to be appropriate adjustments to an ageing population with its growing demand for elderly people to make their own choices, often to remain in their own homes cared for by those close to them, wherever possible. Experience with change led from the bottom-up – that is, with local reforms – also seems to be a valuable feature of the Finnish health system.

By-and-large, these national and local reforms do not change significantly the incentives and structures underlying the Finnish health system. However, some of the latter were being addressed by the “Project to Restructure Municipalities and Services” at the time this report was completed.

Assessment and recommendations

The Finnish health system faces continuing challenges. Further improvements, in addition to the recent reforms now being implemented, are needed to secure its future. To ensure its fiscal sustainability, consideration should be given to: transferring the responsibility for the reimbursement costs of medicines from the KELA (the Social Insurance Institution) to the municipalities and employers; introducing physician-specific drugs budgets in health centres; developing improved post-marketing evaluation of the most important new drugs; and keeping under control the growth of municipal expenditure, especially on hospitals.

Fiscal sustainability of the system requires improvements in microeconomic efficiency. In particular, acute care should not be allowed to crowd out resources for health promotion and prevention. The operational efficiency of hospitals could be improved by: reducing the number of hospital districts, by separating the purchasing of specialist services from their provision; and by making hospitals self-governing, subject to good performance. National competition policy should apply to the health sector, but should be applied with an eye to public interest considerations. Market-testing should be made compulsory for hospital support services. To facilitate benchmark competition and market competition in the hospital sector, a uniform national method for pricing hospital services may also be necessary. Competition policy should also be applied to retail pharmacies: in particular, entry should be freed to allow retail margins to be set competitively, but the “pharmacy fee” should be retained.

Although waiting times for elective surgery have been falling in response to government policies, recently, it is not clear that these improvements will be sustained. It may require changes to financial incentives for surgeons and managers to maintain low waiting-times. Staff shortages loom over the next decade: to reduce them, further increases in intake to

training programmes are likely to be required. To free up more of the time of physicians in health centres, consideration should be given to the introduction of nurse-prescribing on a circumscribed basis, and to nurse-led telephone help services. Responsiveness to patients could also be encouraged by introducing more patient choice of physician and performance-related pay for staff in health centres.

Any savings on drug budgets could be used to improve equity of access by employing more health centre physicians. The large variations in needs-adjusted health and social service expenditure per capita across municipalities could be investigated, with a view to making adjustments to the state grant formulas for health and social services.

Résumé

Introduction

Le système de santé de la Finlande enregistre à de nombreux égards des résultats relativement satisfaisants selon les comparaisons internationales, si ce n'est le problème notable des longs délais d'attente imposés pour certains services. Mais tout comme la plupart des autres pays de l'OCDE, il a aussi aujourd'hui et aura dans l'avenir des défis importants à relever, dont l'évolution rapide et fort coûteuse de la technologie, le vieillissement de sa population et les attentes de plus en plus grandes des usagers. Faute d'un effort de réforme soutenu, ces facteurs de pression risquent dans l'avenir d'empêcher le système de continuer à assurer un accès universel à l'ensemble des soins de santé d'une façon qui reste à la fois abordable et équitable.

Cet examen du système de santé finlandais a consisté à évaluer ses performances à la lumière de trois grands objectifs : 1) la viabilité financière; 2) l'utilisation efficace des ressources; 3) l'équité. Les auteurs passent en revue les mesures de réforme récemment mises en œuvre dans le système de santé et formulent des recommandations au sujet de la stratégie et de la politique qui pourraient être appliquées dans l'avenir. Ils portent une attention particulière à quatre questions précises qui préoccupent actuellement les responsables finlandais de l'action gouvernementale: 1) la croissance des dépenses pharmaceutiques; 2) les conséquences de la décentralisation pour l'équité et l'efficience; 3) l'offre d'un nombre suffisant de professionnels de la santé qualifiés; 4) les moyens de s'attaquer au problème des longues listes d'attente pour les interventions chirurgicales non urgentes.

Évaluation des performances

La viabilité financière

Dans un effort remarquable, la Finlande est parvenue à maîtriser ses dépenses totales de santé en pourcentage du PIB dans les années 90. Il existe cependant un point d'interrogation au sujet des dépenses afférentes aux médicaments. *En proportion du PIB*, celles-ci ont progressé à un rythme assez caractéristique des pays de l'OCDE, mais *en proportion des dépenses totales de santé*, leur croissance a été plus rapide que dans les autres pays nordiques ou les autres pays de l'OCDE pendant plus d'une décennie. Ce dernier constat appelle l'attention sur le caractère relativement illimité du financement des médicaments sur ordonnance par l'assurance maladie nationale, en comparaison des restrictions assez sévères auxquelles les dépenses de santé municipales ont été soumises dans les années 90. Toutefois, depuis 2000, certains faits donnent à penser que les communes jugent difficile, voire peu souhaitable, de continuer à contenir leurs dépenses de santé, en particulier celles qui se rapportent aux hôpitaux. Elles sont par conséquent de plus en plus contraintes de recourir à l'emprunt pour compléter le financement par l'impôt.

L'utilisation efficace des ressources

Il ressort des comparaisons internationales que, malgré le niveau relativement bas de ses dépenses de santé, la Finlande parvient à dépasser la moyenne pour l'acquisition de certaines ressources indispensables à son système de santé (exception faite des médecins et des lits pour soins de courte durée), en partie du fait que les salaires relatifs sont inférieurs à ceux des autres pays. Mais les taux d'utilisation de ces ressources ne sont pas toujours en rapport avec leur volume, étant donné que la productivité (mesurée de façon approximative) est apparemment inférieure à la moyenne dans le cas de certains services. Ce dernier problème tient peut-être à l'absence relative d'éléments propres à inciter le personnel à améliorer ses performances. Les taux d'utilisation des ressources sont néanmoins supérieurs à la moyenne des pays nordiques et à celle des pays de l'OCDE, respectivement pour les produits pharmaceutiques et les sorties d'hôpital.

La qualité technique des services est satisfaisante si l'on en juge d'après certains indicateurs afférents à la prévention des risques pour la santé publique, ainsi qu'aux résultats sur le plan de la santé et à l'utilisation de procédures appropriées. Cela tient sans doute, dans le premier cas, aux mesures prises pour encourager la prévention, et dans le second, aux solides compétences professionnelles du personnel finlandais de la santé.

En revanche, la prise en compte des besoins des usagers fait quelque peu défaut, étant donné les longs délais d'attente imposés pour les rendez-vous avec les médecins des centres de santé, ainsi que pour les interventions chirurgicales non urgentes. Ce dernier problème peut s'expliquer à la fois par le manque de possibilités de choix pour les malades et l'absence d'incitations financières pour les prestataires. Il est cependant assez paradoxal de constater que, malgré le caractère très fréquent du phénomène des long délais d'attente, les Finlandais se disent en général très satisfaits de leur système de santé, mais peut-être cela tient-il en partie à des attentes modestes de leur part.

En ce qui concerne les questions qui préoccupent particulièrement les responsables finlandais de l'action gouvernementale, énoncées ci-dessus, il y a lieu de penser que la prescription de médicaments aux personnes âgées se fait parfois de façon inappropriée. On peut s'interroger sur les modes de réglementation de la pharmacie de détail. Bien que les coûts afférents à la vente de médicaments au détail correspondent à peu près à la moyenne des pays de l'OCDE, il est sans doute possible de faire des économies.

Il y a des raisons de supposer que le caractère très décentralisé de la gestion des services municipaux fait obstacle à l'efficacité, mais il est difficile de le démontrer concrètement, peut-être parce que des mesures ont été prises pour imposer ou encourager la coopération entre les communes, et que le professionnalisme des prestataires compense les insuffisances qui peuvent affecter la gestion municipale.

S'agissant des ressources humaines, il existe des pénuries dans certaines catégories de personnel. Les infirmières, les dentistes et les pharmaciens sont nombreux parmi les professionnels de la santé, ce qui n'est pas le cas des médecins par comparaison avec d'autres pays de l'OCDE. Le manque de médecins dans les centres de santé contribue peut-être à expliquer en partie les longs délais d'attente pour les rendez-vous.

Quant aux interventions chirurgicales non urgentes, les longs délais d'attente tiennent probablement davantage à l'existence, chez les prestataires, d'un ensemble de motivations qui les dissuadent d'assurer une gestion appropriée de la demande, qu'à un nombre insuffisant d'actes chirurgicaux, la Finlande enregistrant dans ce dernier domaine des taux relativement élevés.

*L'équité dans le financement et l'utilisation
des soins de santé*

Les paiements acquittés en Finlande pour les soins de santé paraissent dans l'ensemble proportionnels aux revenus. Cependant, les comparaisons internationales tendent à montrer que celle-ci assure un accès moins équitable aux médecins généralistes et aux spécialistes que beaucoup d'autres pays. S'agissant des premiers, cette situation tient probablement à l'offre de soins de santé gratuits en milieu de travail, associée à un rationnement relativement strict de l'accès aux médecins des centres de santé, pour lequel il faut de surcroît payer. Il se peut toutefois que ce dernier problème soit compensé dans une certaine mesure par les consultations qu'assurent les infirmières.

Trois grandes conclusions peuvent être tirées au sujet de l'impact de la décentralisation sur l'équité. Premièrement, les ajustements apportés à la capacité d'imposition des communes et à la méthode utilisée pour évaluer les besoins en vue du calcul des subventions publiques, sont incomplets. Deuxièmement, l'autonomie locale constitue un objectif de premier plan du système, qui est mis en balance avec l'équité géographique. Troisièmement, les mesures de décentralisation prises au début des années 90 semblent avoir fait régresser le problème du manque d'équité.

Réformes récentes

Le système de santé finlandais a récemment fait l'objet d'importantes mesures de réforme qui ont permis de s'attaquer à certaines de ses insuffisances et de se pencher sur certains des défis auxquels il sera confronté dans l'avenir. En particulier, les nouveaux objectifs concernant les délais d'attente maximums pour les rendez-vous et les traitements et soins recommandés semblent avoir déjà entraîné un raccourcissement des délais d'accès aux centres de santé et à la chirurgie. Les nouvelles lignes directrices destinées aux cliniciens sur les traitements qu'il convient de proposer et le Centre pour le développement de la pharmacothérapie récemment créé, devraient contribuer à réduire les fluctuations irrationnelles des taux d'actes chirurgicaux et de prescription dans l'ensemble de la Finlande. Les mesures visant à encourager l'intensification de la coopération régionale entre les communes, s'agissant tant des services locaux que des services de spécialistes, et à renforcer au niveau national l'interopérabilité des systèmes informatiques, devraient améliorer l'efficacité.

Les dispositions adoptées en vue d'accroître l'offre de personnel, de développer les compétences de celui-ci et de stimuler sa motivation ont déjà commencé à réduire la pénurie de ressources humaines. Les mesures destinées à réformer les dispositifs de prise en charge à long terme – en créant, par exemple, des chèques spéciaux pour l'aide à domicile et en encourageant l'aide informelle – paraissent bien adaptées à une population vieillissante dont les personnes âgées exigent de plus en plus d'avoir le choix et, dans bien des cas, de rester chez elles en s'en remettant, lorsque c'est possible, aux soins de leurs proches. Le fait que certains des changements qu'il a subis soient venus d'en bas – avec les réformes locales – semble par ailleurs constituer un aspect important du système de santé finlandais.

Globalement, ces mesures de réforme nationales et locales ne modifient pas sensiblement les éléments d'incitation et les structures sur lesquels repose le système de santé de la Finlande. Toutefois, au moment où s'achevait la rédaction de ce rapport, était mis en place le « Projet de restructuration des communes et des services » qui porte sur certaines de ces structures.

Évaluation et recommandations

Le système de santé finlandais a toujours des défis à relever. Outre les réformes en cours de mise en œuvre, d'autres améliorations doivent lui être apportées pour assurer son avenir. Afin de garantir sa viabilité budgétaire, il conviendrait d'examiner les mesures suivantes : transférer la prise en charge des coûts afférents au remboursement des médicaments du KELA (Institut d'assurances sociales) vers les communes et les employeurs; attribuer aux médecins des centres de santé des budgets pour les médicaments; améliorer l'évaluation des nouveaux médicaments les plus importants après leur commercialisation; contenir la progression des dépenses municipales, surtout celles qui concernent les hôpitaux.

La viabilité budgétaire du système exige une amélioration de l'efficacité microéconomique. En particulier, il faut éviter que les soins de courte durée absorbent les ressources au point qu'il ne soit pas possible d'en affecter à la promotion de la santé et à la prévention. Le fonctionnement des hôpitaux pourrait être rendu plus efficace par les moyens suivants : réduire le nombre de districts hospitaliers en séparant l'achat de services de spécialistes de leur fourniture; rendre les hôpitaux autonomes à condition que leurs résultats soient satisfaisants. La politique nationale de la concurrence devrait être appliquée au secteur de la santé, mais sans perdre de vue les considérations relatives à l'intérêt général. L'évaluation commerciale devrait devenir obligatoire pour les services de soutien offerts à l'hôpital. Afin de faciliter la concurrence par étalonnage et la concurrence par le marché dans le secteur hospitalier, il sera peut-être aussi nécessaire d'adopter une méthode nationale uniforme de tarification des services hospitaliers. La politique de la concurrence devrait en outre être appliquée à la pharmacie de détail : en particulier, l'entrée dans ce secteur devrait être libérée afin que les marges de détail puissent être fixées de manière concurrentielle, mais les droits payables par les pharmaciens devraient être maintenus.

Si les délais d'attente pour les interventions chirurgicales non urgentes sont en diminution sous l'effet des mesures prises par les pouvoirs publics, il n'est plus certain depuis peu que cette amélioration sera durable. Il sera peut-être nécessaire de modifier les incitations financières de façon à encourager les chirurgiens et les gestionnaires à faire en sorte que les délais d'attente soient courts. La prochaine décennie sera sans doute marquée par des pénuries de personnel : afin de les atténuer, il faudra probablement accroître encore le nombre de personnes admises à suivre les programmes de formation. Afin que les médecins des centres de santé puissent dégager du temps, il conviendrait d'envisager la possibilité d'accorder aux infirmières un droit de prescription limité, et de mettre en place des services d'aide téléphoniques assurés par des infirmières. La prise en compte des besoins des malades pourrait en outre être encouragée par l'adoption de dispositions qui leur permettent de choisir plus librement leur médecin, et l'instauration de la rémunération liée aux performances pour le personnel des centres de santé.

Les économies susceptibles d'être réalisées sur les budgets pharmaceutiques pourraient être utilisées pour l'emploi d'un plus grand nombre de médecins dans les centres de santé afin d'améliorer l'équité dans l'accès aux soins. Les fortes différences existant entre les communes quant aux dépenses par habitant afférentes aux services de santé et aux services sociaux telles qu'elles sont évaluées en fonction des besoins, pourraient être examinées, en vue d'apporter des ajustements aux méthodes de calcul des subventions publiques accordées au titre de ces services.

Introduction

The Finnish health system exhibits many achievements. It offers universal access to a comprehensive range of modern health services. It provides care that is financed in accordance with ability to pay and is provided broadly in accordance with need. It has been associated with very significant gains in the health status of Finns in the past four decades.

Yet, like health systems in other OECD countries, it faces significant current and future challenges including: expensive technological change, rising expectations and a rapidly ageing population. These pressures threaten the ability of the system to continue to offer universal access to comprehensive health care in a way that remains affordable in future.

This review of the Finnish health system was commissioned by the Ministry of Social Affairs and Health in Finland in 2004 with the following terms of reference,

“[To] describe the [health] system; assess its performance against three main objectives (adequacy and equity, macroeconomic efficiency and microeconomic efficiency); review recent reforms to the health system (especially the design and implementation of the National Health Care Project) and make recommendations about future strategy and policy, [taking] account of all aspects of the health system including preventive work and long term care. Attention [should] be paid also to the following issues: the growth of pharmaceutical expenditure; the consequences for equity and efficiency of decentralisation; human resources for healthcare (shortages of manpower inputs, the role of incentives, and skill mix of various manpower inputs), and tackling waiting lists for elective surgery.”

The structure of the report is as follows. Chapter 1 sets out the organisation of the Finnish health system. Chapter 2 contains an assessment of the performance of the system against the three main objectives specified in the terms of reference. Chapter 3 describes and comments upon recent reforms to the system. Chapter 4 contains an assessment of the remaining policy challenges facing the Finnish health system and makes recommendations for further reforms.

Chapter 1

Organisation of the Finnish Health System

1.1. Introduction

The Finnish health system resembles those in other Nordic countries in that it offers universal coverage of a comprehensive range of publicly funded health services paid for mainly out of general taxation and relies mainly on public provision of care.* Also, local government, in the shape of over 400 municipalities, plays a leading role both in the financing and provision of care. However, the system is both more decentralised and more mixed in its funding than in other Nordic countries. Some services are financed by a “parallel” social health insurance scheme, rather than by general taxation. Private finance accounts for almost 25% of total health expenditure and private providers play a significant role in the provision of some services. Figure 1.1 provides an overview of the main funding flows in the system.

1.2. Sources of finance

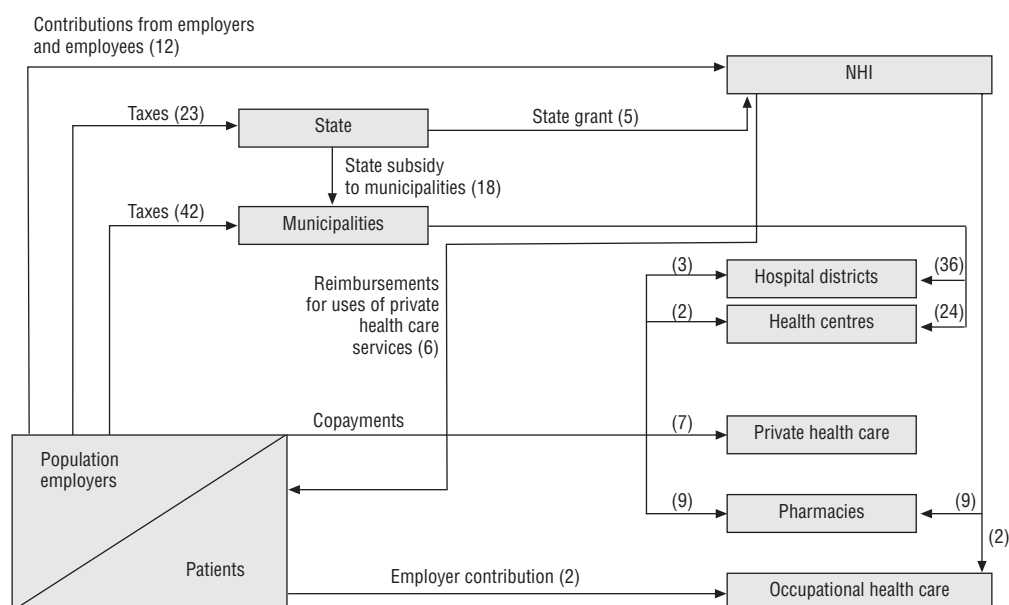
Public funding accounts for more than three quarters of total health expenditure and flows down two different or “parallel” channels. The widest channel is municipal health expenditure on primary care in public health centres and specialist care in public hospitals which are funded by municipal taxation (42% of total health expenditure in 2003) and the state subsidy to the municipalities (18% of health expenditure in 2003). Municipal taxation takes the form of an income tax which is a fixed proportion of income and varies between municipalities. The average rate was 18.3 % in 2005. The rate varied from 16% to 21% across municipalities. Municipalities also have the right to set the level of cost-sharing by patients for their services, up to a maximum decided by the Parliament.

Most of the relevant national taxation is passed on to municipalities in the form of non-earmarked block grants. These block grants are allocated to municipalities according to a weighted capitation formula which is designed to adjust the grants, at least partly, for differences in the need for services. The formula takes account of the age structure of the population, an indicator of morbidity (the age-standardised index of invalidity pensions for people under 55) and geographical remoteness. In addition, the Ministry of Interior provides grants which help to bring about convergence in the taxable capacity of municipalities. Any municipality with revenue-raising capacity below 90% of the per capita average in Finland receives equalisation payments to bring it up to that threshold. Any municipality above the threshold pays into a central pool 40% of the differential above the 90% figure (OECD, 2003c). As a consequence, state transfers are low in rich, urban areas and high in poor, rural and remote areas. Although the grants are not earmarked, it can be estimated, indirectly, that the state’s share of municipal health expenditure varied across municipalities from a low of 10% to a high of 60%.

The second channel carrying public funding into the Finnish health system is the KELA, the Social Insurance Institution of Finland, which provides a National Health Insurance (NHI)

* A recent detailed description of the Finnish health system can be found in Järvelin (2002).

Figure 1.1. Main funding flows in the Finnish health system, 2003



Note: The figures in parentheses against funding flows indicate percentages shares of “total health expenditure”, in 2003. The sums of percentages of arrows starting from population/employer and patients equal 100. The arrows ending at providers equal 94 since NHI reimbursements for users of private health care services are paid to patients. “Total health expenditure” excludes expenditure on some smaller items such as administration, public investments, environmental health care and medical equipment and appliances. In order to keep the diagram simple, it does not identify some smaller financing flows. For example the contributions to private insurance (about 2% of total expenditure) are included in patients’ payments to private health care. NHI reimbursements for rehabilitation (about 2% of total expenditure) are included in reimbursement from NHI to patients. State subsidies to hospitals for research and teaching (about 1% of total expenditure) are included in state subsidies to municipalities. Currently, expenditure on long term care is not included in OECD data on Finnish “health expenditure” and so is excluded from this diagram. Source: Häkkinen, U. (2005), “The Impact of Changes in Finland’s Health Care System”, *Health Economics*, Vol. 14, No. 51, pp. 5101-5118.

scheme which covers all Finns for part of the cost of a range of health services (17% of total health expenditure in 2003). The services covered include: prescribed drugs for ambulatory patients, private medical and dental consultations, private diagnostic tests and treatments, patient transportation services, some rehabilitation services and student health services. For all of these services, the patient pays the provider and can seek reimbursement for part of the cost from NHI. In the case of doctors’ and dentists’ fees, examination charges and treatment charges, reimbursements are based on a fixed scale of charges defined by the Ministry of Health and Social Affairs. If the actual fee exceeds the fixed charge, the patient is responsible for paying the full excess. NHI also helps to fund about half the cost of occupational health services, which are otherwise funded by employers (see below). In addition, NHI offers sickness, maternity and special care allowances. All of the health care services covered by NHI are provided by the private sector. NHI expenditure was previously financed mainly by employer and employee contributions and contributions from other insured persons, such as pensioners. However, in the past two or three years there has been an increasing transfer of funds from VAT revenues to the KELA which by 2004 accounted for nearly 18% of NHI expenditure. In addition, there has been a deficit of about 22% of NHI expenditure over the same period (5% of total health expenditure) which has been covered by the national budget. Consequently, contributions now account for only about 60% of NHI expenditure.

Capital expenditure on health centres and hospitals, formerly funded partly by central government grants, is now funded mainly by the municipalities, which are allowed to borrow. The national government still makes grants for selected projects which are aimed to raise efficiency or which demonstrate innovative ways to provide services.

User charges and cost-sharing play a prominent role in funding health services (see Box 1.1). Cost-sharing is lower for municipal services than for the privately provided services and products, particularly prescribed medicines, eligible for NHI reimbursement. For example, user charges represent about 10% of the total cost of services provided by health centres, about 5% of the cost of hospital services but about 35% of the cost of drugs prescribed outside hospitals. If patients need long-term care in a health centre ward or an “old peoples’ home”, up to 80% of their income will be charged for their accommodation, provided a (low) minimum amount is available for their own use. A voucher scheme was started in 2004 which empowers municipalities to grant vouchers to clients such as elderly people, allowing them to choose private providers, such as home helps, and pay for part of the cost.

Box 1.1. User charges

The user charges for health services and prescribed medicines are as follows:

Publicly provided (municipal) services. There is a fee of EUR 11 for a visit to a health centre but municipalities can decide whether it is charged for a maximum of three visits per year or for only two visits per year, paid in advance. People under the age of 18 are exempt. There is a fee of EUR 22 for a visit to an outpatient department but patients attending the psychiatric unit are exempt. There is a fee of EUR 26 per day for inpatient care in a health centre or hospital (EUR 12 per day in the psychiatric unit) but people under 18 may be charged only for a maximum of seven days per year. Day surgery is charged at EUR 72 per procedure.

Privately provided services covered by NHI. Cost-sharing is generally much higher for the privately provided services covered by NHI. In the case of doctors’ services, the patient can seek reimbursement for 60% of an established tariff (which may not cover the full charge). In the case of laboratory tests or x-rays, the patient is reimbursed 75% of the established tariff after paying a deductible of EUR 13.46. In the case of transportation, the reimbursement rate is 100% after a deductible of EUR 9.25. The reimbursement is based on the cost of reaching the nearest doctor or place of examination by the least expensive mode of transportation. There is an annual ceiling on transport costs of EUR 157.26 after which all further transportation costs are fully reimbursed.

Prescribed medicines. For medicines prescribed either by health centres or by private physicians, there are three reimbursement categories: a basic refund category and two special refund categories, one lower and one higher. Assignment to the lower special refund category depends on whether the patient is suffering from one or more of a list of ten chronic illnesses, such as asthma and hypertension, where drug treatment is necessary to maintain the patient’s health status. Assignment to the higher special refund category depends on whether the patient is suffering from one or more of a list of 34 severe or life-threatening chronic illnesses such as cancer and diabetes. Most drugs fall into the basic category where cost-sharing is 50% after a deductible of EUR 10 per purchase has been paid. One purchase may include one or more prescription. Under the lower special refund category cost-sharing is 25% after a deductible of EUR 5 per purchase has been paid. Under the higher special refund category there is no further cost-sharing, after a deductible of EUR 5 per purchase has been paid. In 2005 there was a ceiling of about EUR 607 per person per year on all cost-sharing for drugs.

Private health insurance accounts for only about 2% of total health expenditure in the Finnish health care system.

1.3. Provision of services

1.3.1. Municipal health centres

Approximately 270 municipal health centres provide a wide range of primary, preventive, inpatient and community health services throughout Finland. Viewed from the perspective of primary health care arrangements in many other countries, they are large units. Municipalities often cooperate to provide health centre services. The health centres, depending on their size, can be staffed by general practitioners, sometimes specialists, nurses, midwives, social workers, dentists, physiotherapists and psychologists. They are generally furnished with X-ray and pathology testing equipment, with facilities for minor surgery and with endoscopy equipment. As well as providing basic primary care, they offer maternal and child health care, cancer screening services, community nursing, school health care, dental care, physiotherapy and occupational health care. In addition, they usually have inpatient departments, with typically 30-60 beds, which are occupied mainly by elderly and chronically ill patients. They also provide occupational health services, under contract, for some employers. General practitioners in health centres act as gatekeepers for municipally-funded specialist care, except in cases of emergencies.

1.3.2. Occupational health services

Employers in Finland are required by law to provide occupational health services (covering prevention and first aid) for their employees and insurance for industrial diseases and accidents. About a third of the Finnish population is covered by such schemes. In addition, employers can offer, on a voluntary basis, additional primary (and even some specialist) health care for their employees. Employers can provide these services themselves, or can contract out the responsibility to private providers or to municipal health centres. In either case, this care is free of charge to the employee and the employer can be reimbursed by NHI up to a limit per employee. Up to 50% of the total costs approved by NHI are reimbursable by the KELA. The rest of the costs are borne by employers. Small employers may not offer these additional services.

1.3.3. Hospital and specialist services

Because of their small size (on average), municipalities are required to join federations to fund and manage specialist services. There are 20 hospital districts throughout Finland. Municipal hospital and specialist services are provided by five university hospitals, 15 central hospitals and about 40 smaller specialised hospitals.

1.3.4. Pharmaceutical services

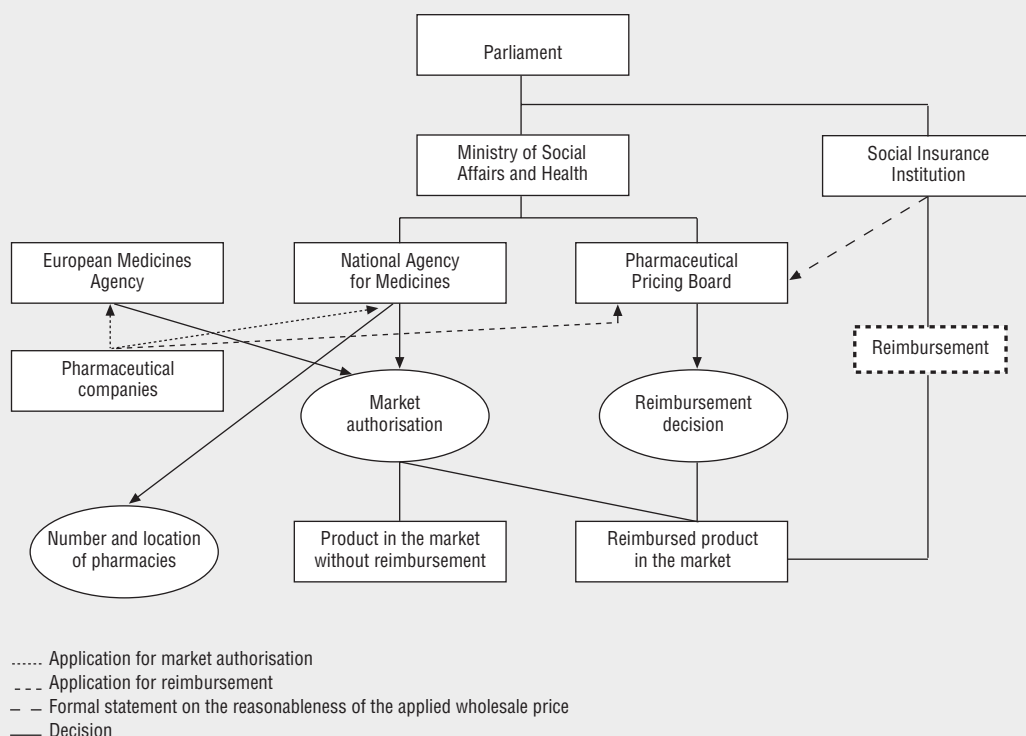
Prescribed drugs and over-the-counter (OTC) medicines for ambulatory patients are supplied by (and, for the most part, only by) about 800 independent pharmacy outlets. However, in sparsely populated areas, post offices and grocers are allowed to stock some OTC medicines. There is a wide array of other regulations which affect the pharmaceutical market, detailed in Box 1.2.

Box 1.2. Regulation of the pharmaceutical market

On the demand side, as has been detailed in Box 1.1, Finns share in the cost of prescribed drugs in ambulatory care. The rest of the cost can be reimbursed by NHI. Significant increases in the rates of cost-sharing were imposed in the early 1990s as a result of the economic crisis. The average out-of-pocket share of the cost of prescribed drugs was 35.5% in 2003, having fallen from 40% in 1995.

On the supply side, Finland has a number of institutions and arrangements intended to ensure that only safe and cost-effective drugs are eligible for reimbursement, that prescribed and over-the-counter medicines are widely available throughout Finland, that their wholesale and retail prices are reasonable, and that prescribing is rational. Key aspects of these arrangements are summarised in Figure 1.2.

Figure 1.2. **Decision making in the Finnish pharmaceutical sector, a simplified presentation**



Source: Pekurinen, M. and U. Häkkinen (2005), "Regulating Pharmaceutical Markets in Finland", CHESS/STAKES Discussion Papers 4/2005.

The National Agency for Medicines or the European Medicines Agency, approve drugs for safety, quality and effectiveness before they can be marketed in Finland. For a drug to qualify, additionally, for reimbursement by NHI, a "reasonable wholesale price" has to be agreed by the Pharmaceutical Pricing Board. The Board's assessment of "reasonableness" is based on four factors: i) an economic evaluation of the product, based on information supplied by the drug company concerned, comparing it to major alternatives or prevailing treatment practices; ii) the proposed wholesale price compared to major competitors and the price of the product in other EU countries; iii) the likely budgetary consequences for NHI; and iv) the clinical judgement (Pekurinen and Häkkinen, 2005).

Box 1.2. Regulation of the pharmaceutical market (cont.)

Once a reasonable wholesale price has been agreed, the drug qualifies automatically for reimbursement by NHI under the basic category. After a mandatory two-year delay,* the Pharmaceutical Pricing Board, working in conjunction with the Social Insurance Institution, may also consider whether drugs are eligible for higher reimbursement status under one or other of the two special reimbursement categories, mentioned above.

The National Agency for Medicines tightly controls the number and location of Finland's 600 retail pharmacies (which have 200 additional branch outlets) with the aim, partly, of ensuring the availability of prescribed drugs throughout Finland. The retail pharmacies are mostly private companies owned by pharmacists. They are granted a monopoly of the sale of over-the-counter medicines as well as of prescribed medicines in Finland. The wholesale margin is uncontrolled and is determined by competition but the retail margin is a graduated mark-up which is smaller the higher is the wholesale price. Pharmacists are also paid a fee of EUR 0.42 for any drug dispensed. There is VAT at 7.4%. Pharmacies pay a "pharmacy fee" to the government which on average represents about 7% of net medicines sales. However, because the rate is graduated according to turnover, it acts as a cross subsidy to small pharmacies and services in sparsely populated areas.

* A representative of the pharmaceutical industry complained to the OECD mission team that this delay was unfair to the industry.

1.3.5. Private medical and dental practice

Doctors (and dentists) employed in both health centres and in hospitals may work in the private sector in their spare time, after completing their contracted hours for the municipality. About one third of all physicians work in both sectors. A relatively small number of physicians work exclusively in the private sector. Patients can approach a specialist directly in the private sector, without a referral from a general practitioner, and private specialists can refer patients to public hospitals. Only about 7% of all private consultations are with GPs as opposed to specialists.

1.3.6. Long-term care

Long-term care for elderly and disabled people is provided under the auspices of both the health and social service departments of the municipalities in Finland. There is also some private provision. Institutional care is provided in health-centre inpatient facilities, in municipal residential homes and in private residential homes. Home-based care is provided in sheltered housing/service flats and in ordinary housing by municipal community nurses, home helps and social workers. Informal carers play an important role in looking after elderly and disabled people and are supported in various ways by the municipalities.

1.3.7. Public health services

The Ministry of Social Affairs and Health takes the lead in health promotion and prevention at a national level, especially in relation to legislation, regulation, health education and taxation of alcohol and tobacco. However, it is the municipal health centres which deliver most preventive services at a local level including maternal and child health services, school health services, immunisation and cancer screening.

1.4. Payment of providers

In municipal health centres, most employees are salaried but where doctors have joined the “personal doctor scheme” they are paid approximately 60% by salary, 20% by capitation, 15% by fee-for-service and 5% by local allowances.

Most municipalities “buy” the bulk of hospital services from their district. Hospitals are paid by a changing mixture of methods in Finland. There are no national guidelines and a wide variety of pricing methods. Many quote case-based prices, such as DRGs, but there is no uniformity. Districts generally negotiate annually with individual municipalities over prices, volumes and budgets. In effect, they invoice their member municipalities for a share of the cost of providing services.

Because many municipalities are too small to bear the risk of treating high-cost patients, there are risk-equalisation mechanisms for spreading expenditure on very high cost patients among all the municipalities in each hospital district. The thresholds for identifying very high cost patients vary across the districts, as do the precise arrangements for sharing the excess costs.

There is centralised bargaining over wages for all municipal workers. Municipal hospital doctors are salaried but, as has been mentioned above, many have dual, private, outpatient practices.

Private practitioners are paid by the patient who can claim back 60% of an approved fee (as explained in Box 1.1). There is no need for a practitioner to have a contract with NHI to set up a private practice. Reimbursement by NHI accounts on average for about 35% of the total cost of private doctors and dentists services, the patient being left to pay the remainder of the cost.

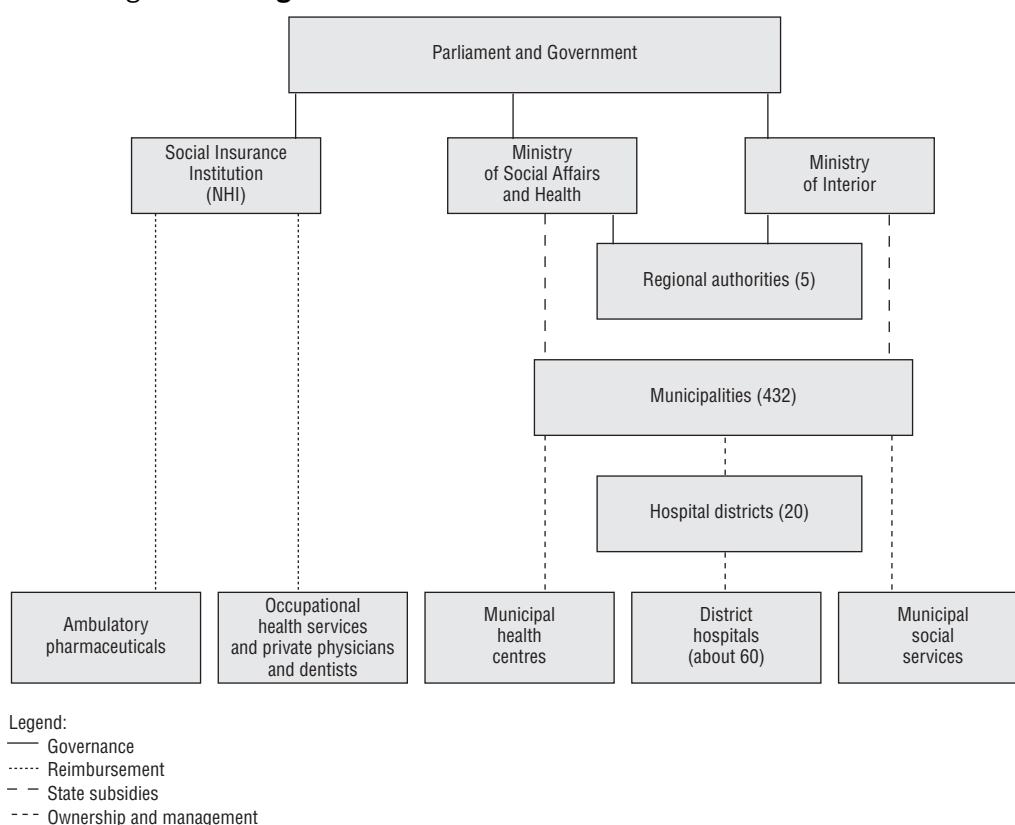
1.5. Investment in human resources

The Ministry of Education plays the leading role in determining policy on the training of health personnel in Finland. Doctors are trained at five medical schools which are dispersed around the country. Nurses and other health care professionals are trained at polytechnics. In both cases, the numbers to be trained are determined in effect by the Ministry of Education in consultation with the Ministry of Social Affairs and Health.

1.6. Governance

The governance of the health system in Finland is very decentralised and has parallel arrangements for NHI-funded and municipal services (Figure 1.3).

The Ministry of Social Affairs and Health has the overall responsibility for legislation and policy making in the system. It also sets certain input standards for services, such as the number of public health nurses per child and has recently set waiting-time guarantees for health services. It practices “steering by information” with the help of five regional authorities, which licence providers, handle patients’ complaints and monitor the delivery of services. In addition, the National Research and Development Centre for Welfare and Health (STAKES) plays an important semi-independent, role in collecting data on the health care system, conducting research, publishing statistics and benchmarking the performance of public providers, especially hospitals and long-term care services. In effect, there is promotion of “benchmark” or “yardstick” competition for municipal services throughout Finland.

Figure 1.3. **Organisation of health and social services in Finland**

It is the 432 municipalities, and the 20 hospital districts which represent them, which have been given the main lead in the financing, provision and management of health (and social) care, including decisions about capital investments. There is a long tradition of strong local government in Finland and the system became more decentralised in 1993 when central government relinquished to the municipalities many of its regulatory and management powers in relation to the delivery of health and social services, and changed to a non-earmarked, block-grant system for providing state financial support to local government. The average municipal population is around 12 000 but the median size is under 5 000. The smallest municipality has a population of less than 250 people. The largest municipality (Helsinki) has a population of about 560 000 people.

The municipalities are free to produce health and social services themselves, to contract with other municipalities or to contract with the private sector for their provision. In the case of outsourcing, a tendering process should be initiated for the provision of the service, under the EC Procurement Directive. In principle, this freedom to outsource could lead to much diversity in methods of delivering services but, in practice, direct provision of services remains the dominant model.

The system is fragmented further by the parallel arrangements for partial NHI funding of prescribed medicines in ambulatory care, occupational health services and private health services. The municipal and NHI arrangements are somewhat complementary and somewhat overlapping. They mean, among other things, that whereas there is general practitioner (GP) gatekeeping in the case of patients who rely solely on municipal health

services, there is no GP gatekeeping in relation to private hospital and specialist services funded with the help of NHI. The relative responsibilities of occupational and municipal GP services are not always very clear. For example, employed people can generally choose either an occupational health physician or a municipal GP for primary medical care.

1.7. Patient insurance

All patients are insured for expenses, loss of income and pain and suffering arising from significant bodily injuries sustained in connection with health care or medical treatment, without having to prove negligence. All health care professionals, public providers and private businesses engaged in health care have to take out insurance cover under the scheme. Private health insurance companies insure the risks. A Patient Insurance Centre handles and pays the claims. Difficult or disputed decisions can be submitted to a Patient Injuries Board or to the courts.

Chapter 2

The Performance of the Finnish Health System and its Determinants

2.1. Introduction

This chapter contains an evaluation of the performance of the Finnish health system and its likely determinants, using an assessment framework agreed among OECD member countries. Performance is judged against three principal objectives: macroeconomic efficiency (or financial sustainability); microeconomic efficiency (or “value for money”, where “value” means improvements to health and responsiveness to patients); and equity in the financing and use of health services. These criteria will be spelled out further below.

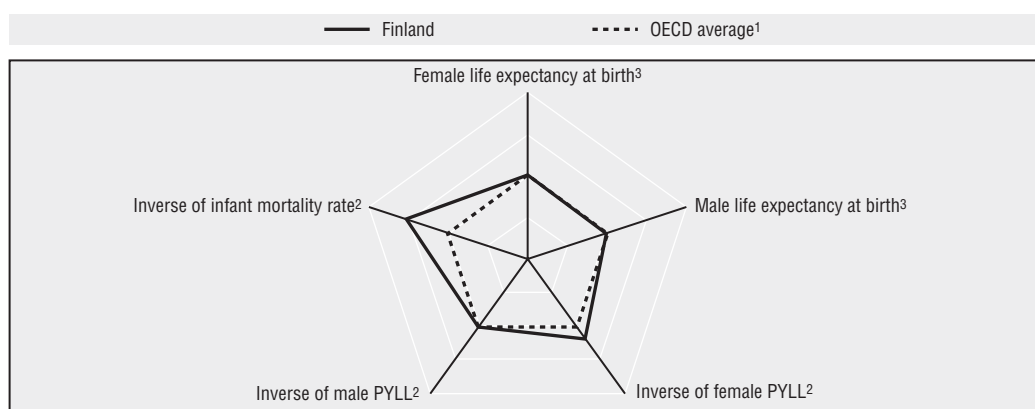
In what follows, there are many comparisons between the average level of key health system indicators in Finland and the average levels of these variables in a group of OECD comparator countries. Where time series are presented, the same group of OECD comparator countries are used through time for each indicator. Where comparisons at a point in time are made, the group of comparator countries usually changes from indicator to indicator, because of differences in data availability. The OECD averages should not be taken as indicating optimal levels of the variables in question. Where efficiency is concerned, the optimum levels lie, almost certainly, above the average levels, but it was not possible to estimate optimum levels within the scope of this review.

2.2. Health status

Before turning to the performance of the health system, it is useful to begin by reviewing the health status of the population in Finland. That is not because health status itself is a satisfactory measure of the performance of the health system. The level of health is affected by many factors other than health care, such as standards of living and levels of education. Rather, ill-health is one of the factors determining the demands facing the health system. Also, changes in health status may sometimes provide clues about the impact of the health system on health.

Figure 2.1 presents a “cobweb” diagram which compares five key measures of health status in Finland with the average levels for the corresponding variables in over 20 other OECD countries. An outer point in the cobweb represents a better performance. Some indicators have been inverted in this chart – and in subsequent figures – to ensure that an outer point always represents a better performance. The diagram suggests that in 2003, health status in Finland was similar to the OECD average for male and female life expectancy at birth and for male potential years of life lost (PYLL) and was superior to the OECD average for infant mortality and for female potential years of life lost. PYLL, or “premature mortality”, measures years of life lost by people who died below 70 years of age, per 100 000 population and is believed to be more sensitive to health care than is life expectancy in general.

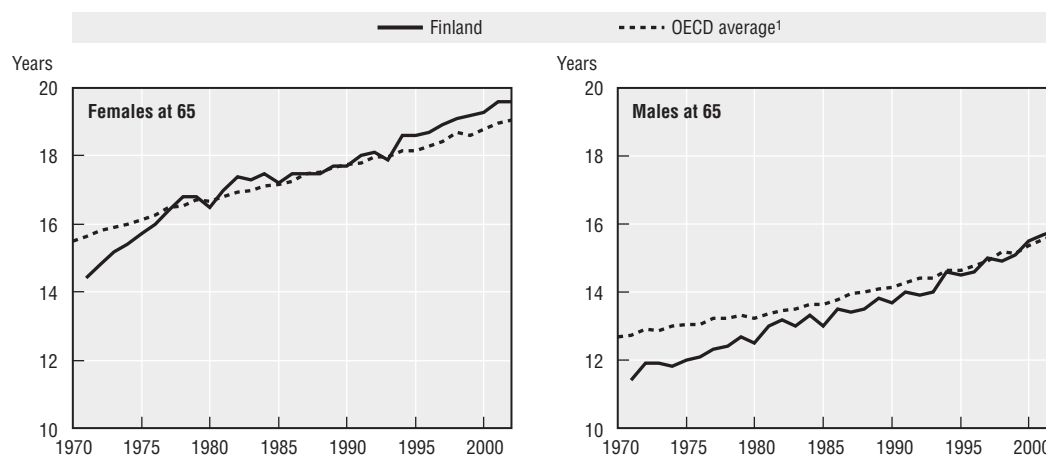
Data on trends in these key health status variables suggest that there have been dramatic improvements in the health of Finns in the past three or four decades. For example, Figure 2.2 shows that female and male life expectancy at age 65 rose faster than the corresponding OECD averages between 1970 and 2002. Figure 2.3 shows that female

Figure 2.1. **Health status in Finland and OECD average, 2003**

1. Unweighted average for 24 countries. It excludes Finland and the following other countries: Belgium, Denmark, Mexico, New Zealand and Turkey.
2. To avoid visual confusion, the inverse (1/x) of the infant mortality rate and of PYLL have been plotted so that an outer point represents a better performance, as for the other indicators in the diagram. PYLL stands for potential years of life lost. It measures years of life lost by people who died before 70 years of age. It includes all causes of mortality and is expressed per 100 000 population: male and female. In the case of PYLL data for Australia, Canada, France, Germany, Ireland, Italy, Sweden, Switzerland and The United States refer to 2001; data for Greece, Iceland, Japan, Korea, Norway, Poland, Portugal, The Slovak Republic, Spain and The United Kingdom refer to 2002.
3. Data for life expectancy at birth, both for female and male, refer to 2003 except for Canada, Ireland, Korea, Luxembourg, the Slovak Republic, Switzerland and the United States which refer to 2002.

Source: OECD (2005b), *OECD Health Data*, June, Paris.

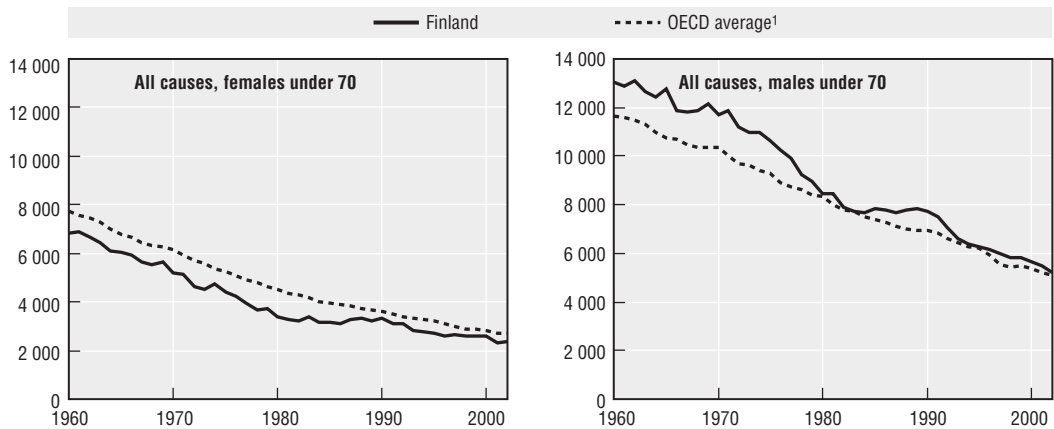
PYLL fell at about the same rate as the OECD average, whereas male PYLL fell faster than the OECD average, between 1960 and 2002. Prevention of cardiovascular disease is likely to have played a role in bringing about these improvements (see Figure 2.14 below).

Figure 2.2. **Life expectancy at 65, females and males, Finland and OECD average, 1970-2002**

1. OECD average excludes Finland and the following countries: Canada, Greece, Ireland, Iceland, Italy, Korea, Luxembourg, Portugal, Spain, Switzerland and the United Kingdom.

Source: OECD (2005b), *OECD Health Data*, June, Paris.

Figure 2.3. **Potential years of life lost per 100 000 population, females and males, Finland and OECD average, 1960-2002**

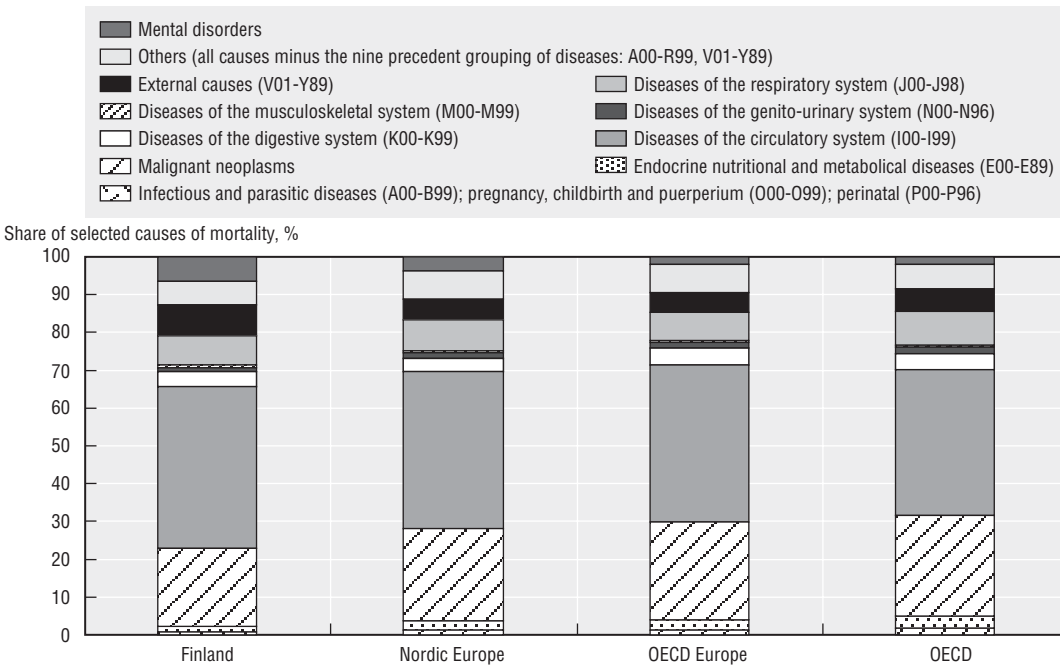


1. OECD average excludes Finland and the following countries: the Czech Republic, Korea, Luxembourg, Mexico, the Slovak Republic and Turkey.

Source: OECD (2005b), *OECD Health Data*, June, Paris.

Examination of the causes of mortality suggests that Finland has a higher proportion of deaths attributable to diseases of the circulatory system, and – possibly in consequence – a slightly lower proportion attributable to cancer, than other Nordic, European or OECD countries (Figure 2.4).

Figure 2.4. **Causes of mortality: Finland and selected country groupings, circa 2000**



Notes: Nordic Europe includes: Denmark, Iceland, Norway and Sweden. OECD Europe includes: Austria, Czech Republic, France, Germany, Greece, Hungary, Ireland, Italy, Luxembourg, the Netherlands, Poland, Portugal, the Slovak Republic, Spain, Switzerland and the United Kingdom. The OECD average excludes Belgium, Finland, Mexico and Turkey.

Source: OECD (2005b), *OECD Health Data*, June, Paris.

2.3. Macroeconomic efficiency (financial sustainability)

Macroeconomic efficiency requires finding the right path for total health expenditure and its main components, through time. That entails ensuring the fiscal sustainability of public expenditure on health when taxation is the main source of funding. Given that there will be limits on how much taxes can be raised, especially in a country like Finland where taxes are already high and the working population is expected to decline, the growth of public expenditure on health must be controlled, despite increasing demand from new technologies and ageing of the population, if central and local governments are to continue to balance their budgets in the long term.

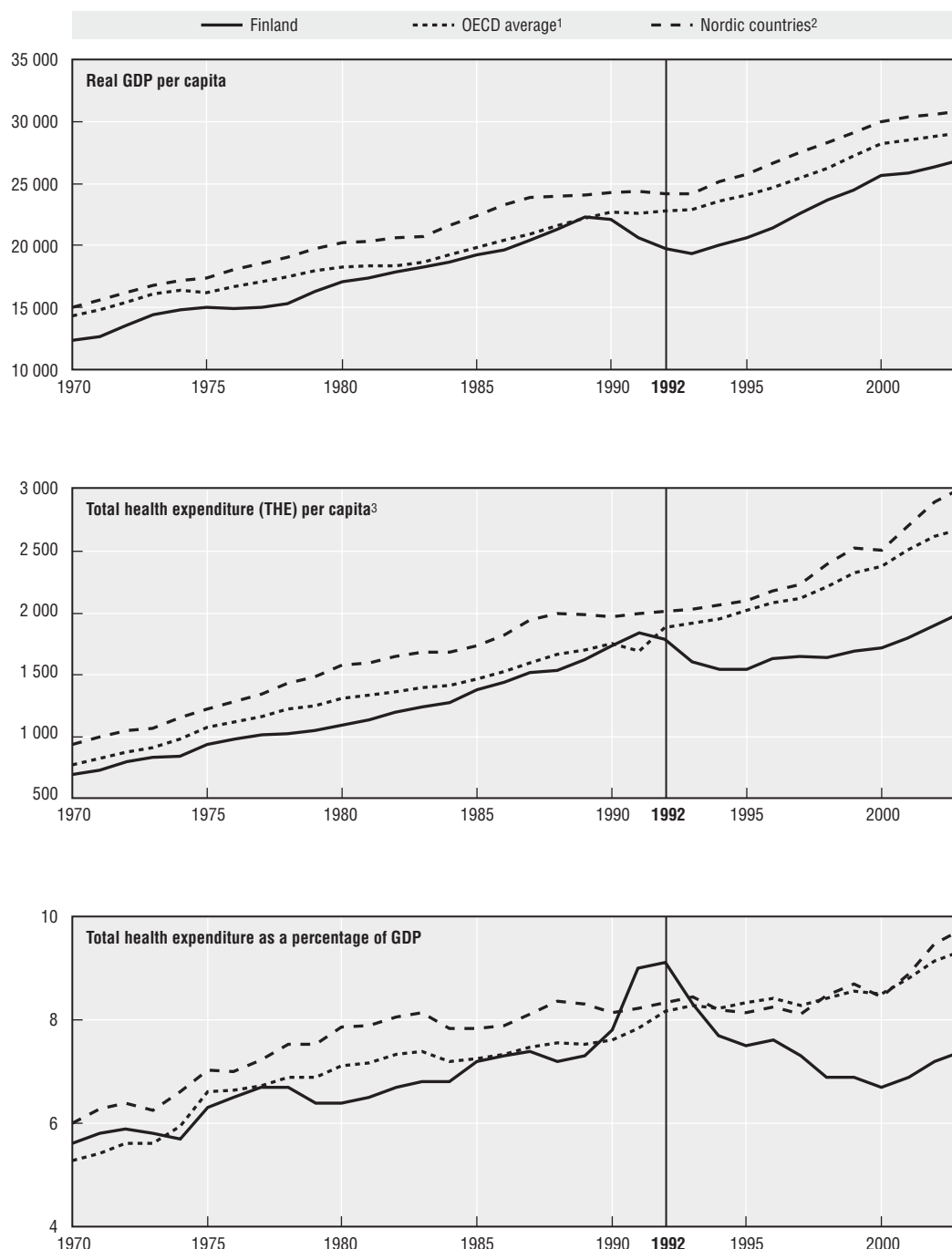
2.3.1. The growth of total health expenditure in Finland

The upper panel of Figure 2.5 shows that Finland experienced a sharp recession in the early 1990s. Real GDP per capita fell each year for four years from 1990, falling by 1994 to 87% of its 1990 value. The middle panel of Figure 2.5 shows that total health expenditure per capita continued to rise until 1991 and fell only slightly in 1992. As a share of GDP, health expenditure peaked at over 9% in 1992, 2% above the Nordic and OECD averages (lower panel of Figure 2.5). Subsequently, total health expenditure per capita did not resume rising until 1996, despite the fact that Finland's GDP increased faster than the rest of the OECD from 1994. As a result, health expenditure as a proportion of GDP fell almost continuously from its peak in 1992 until 2000. In 2003, it was still about 20% below the OECD and Nordic averages.

Finland's history over the past decade shows there need not be an automatic relation between health expenditure and GDP growth. Responsibility for financing health care was devolved to the municipalities in 1993, just at the time that their (and the central government's) taxable capacity had been reduced by the recession. It was fiscal discipline exercised by the municipalities and the state which brought about the reductions that were observed in total health expenditure from 1993 and the subsequent, somewhat muted, resumption of growth, at least until 2000. In contrast, public expenditure under the "parallel" NHI grew almost without interruption throughout, with a small exception in 1992 (KELA, 2003), reflecting the relatively uncontrolled character of NHI expenditure. Accordingly, whereas the municipal/state share of total health expenditure fell from about 70% in 1990 to about 60% in 2003, the NHI share rose from about 11% to about 17% over the same period. This seems to be one of the main disadvantages of parallel funding, the advantages and disadvantages of which are summarised in Box 2.1.

From the point of view of finding the "right" level for health expenditure, the relatively low health expenditure share of GDP in Finland, currently, does raise the issue of whether this is at the cost of lower health care capacity and activity. The evidence presented in the section on microeconomic efficiency, below, suggests that the picture was mixed. In 2003, the combined number of staff (in five categories) per thousand population in Finland, was above the corresponding OECD average but the combined number of acute and long-term care beds per thousand population in Finland was below the corresponding OECD average. Relative utilisation rates in Finland were also somewhat mixed compared with OECD averages. The superiority in Finnish staff numbers may be due partly to the fact that wages in the Finnish health system seem to have been below those in other countries. More specifically, new OECD data on remuneration of salaried specialists in 11 OECD countries – excluding private income – suggests that the ratio of specialists' pay to average

Figure 2.5. **Real GDP per capita, total health expenditure (THE) per capita and THE as a percentage of GDP, Finland, Nordic countries and OECD average, 1970-2003**



Notes: Due to statistical changes in 1993, THE series since 1993 are not totally comparable to previous years, for Finland. THE per capita and GDP per capita are measured in USD PPPs at 2000 GDP prices.

1. Unweighted average for 19 countries. Excludes Finland and the following countries: the Czech Republic, France, Greece, Hungary, Italy, Korea, Mexico, Poland, the Slovak Republic and Turkey.

2. The Nordic countries include Denmark, Iceland, Norway and Sweden.

3. In the case of THE, data for 1970 refer to 1971 for Australia and Denmark; 1972 for the Netherlands. Data for 2003 refer to 2002 for Australia, Austria, Ireland, Japan, Luxembourg, Poland, Sweden and the United Kingdom.

Source: OECD (2005b), *OECD Health Data*, June, Paris.

Box 2.1. The advantages and disadvantages of “parallel funding”

“Parallel funding” refers to the fact that there are two different channels for public expenditure in the Finnish health system: 1) municipal and state taxation which funds about 90% and 95% of the cost of municipal health centres and hospitals, respectively; and 2) national health insurance (NHI) which funds about 65% of the cost of prescribed medicines, about 45% of the cost of occupational health services, and about one third of the cost of consultations with private physicians, consultations with private dentists, and private diagnostic tests and treatments. In addition, NHI funds about 87% of the cost of patient transport needed for medical care, 60% of the cost of student health services and 100% of the cost of some rehabilitation programmes.

Advantages of parallel funding

1. It introduces an element of pluralism into the Finnish health system by encouraging choice of a private provider. NHI helps to lubricate a “safety valve” for those patients dissatisfied with municipal services who can afford the additional cost sharing involved in taking up private services.
2. It allows part of health expenditure to be “demand-led”, subject to the restraints of higher cost sharing.
3. NHI saves public expenditure and public capacity when patients take up private services which would otherwise be provided by the municipal sector (substitution).
4. It adds to private health care capacity in Finland.
5. It provides variety of work and additional income for many doctors and dentists employed in the municipal sector.
6. It has discouraged the development of private health insurance, which might have had worse equity and efficiency implications than those of NHI.

Disadvantages of parallel funding

1. By discouraging the development of private health insurance, it has arguably raised the level of taxation (that is, NHI contributions and state transfers) in Finland, other things being equal.
2. It is likely to lead to some loss of control over public spending on health care. NHI adds to public expenditure when patients take up services which would not be provided by the municipal sector (complementarity). There is no requirement for patients consulting a private specialist to see a GP gate-keeper first. Additionally, there is a risk of supplier-induced demand for some NHI spending.
3. It discourages consciousness of the cost of drugs among prescribing physicians, whether public or private. Arguably, that takes away the option for policy-makers to lower levels of patient cost-sharing for drugs. In the interests of cost-containment, patients must be required to be cost-conscious, because doctors are not.
4. It encourages cost-shifting from municipal institutional to non-municipal, ambulatory care which is reimbursed by NHI. There have been a number of disputes between municipalities and KELA on this issue.
5. It promotes duplicate provision of some ambulatory care in Finland which is associated with inequity among Finns in access to physicians and dentists, with likely knock-on effects for use of drugs, diagnostic tests and admissions to hospitals. It could be said that broadly speaking there are four different levels of access to ambulatory health care in

Box 2.1. The advantages and disadvantages of “parallel funding” (cont.)

Finland depending on whether a patient is employed or not (which determines whether he or she has access to occupational health services or not) and whether a patient receives above or below average income (which helps to determine whether he or she can afford to take up other NHI-funded services). There is a geographical dimension to the resulting inequity since private providers are mainly found in the large urban centres in the South of the country. Meanwhile, all adult Finns, including pensioners, are required to contribute to NHI. Also, NHI-funded expenditure is not taken into account in the state subsidies to the municipalities.

6. By encouraging many employees and those with high incomes to turn their backs on health centres, it may remove from the scene some of the most vocal and influential advocates for improving the services provided by health centres.
7. To the extent that the NHI sector grows, it may divert human or other resources from the municipal sector, at least in the short/medium term – until the supply of resources can adjust.

remuneration per employee in Finland, at 2.12 in 2003, was about 85% of the corresponding average ratio in the remaining ten countries in about the same year (OECD, 2005b). Data on remuneration for salaried nurses in ten OECD countries, suggest that the ratio of nurses' pay to average remuneration per employee in Finland, at 0.80 in 2003, was about 82% of the corresponding average ratio in the remaining nine countries in or about the same year. It is possible that in both cases, the Finnish ratios reflect compression in relative pay rates throughout the Finnish economy.

It should be noted that the sharp cuts that were made in health expenditure during the recession in the early 1990s did not seem to harm measured efficiency at the time. They were associated with apparent rises in productivity – that is, in activities per unit of real expenditure. For example, measured health centre productivity improved markedly in the early 1990s before deteriorating again after 1997, about the time that health expenditure resumed rising (Luoma et al., 2004).

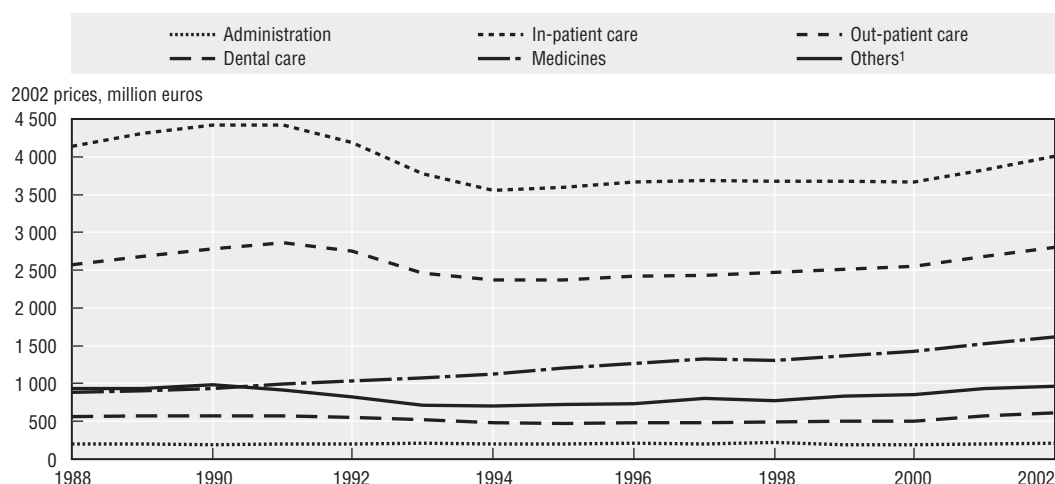
Judging by its current health expenditure share of GDP, Finland is now in a stronger position than most other OECD countries to meet the challenge of rising demand driven by expected changes in health technologies, an ageing population and rising expectations. However, municipal spending has been accelerating again since about 2000, especially on hospitals. Many municipalities report that they have little control over spending on hospital services by the health districts and that expenditure on some other services has had to be squeezed as a result. There have been signs recently that municipalities are facing growing financial difficulties and are increasingly supplementing tax-funding with borrowing (Ministry of Interior, 2005a). Also, as mentioned above, the NHI deficit has grown to about 5% of health expenditure.

2.3.2. Changes in health expenditure by function and rising expenditure on drugs

Figure 2.6 shows changes in health expenditure by function between 1988 and 2002. It confirms that the reductions in spending in the early 1990s related to in-patient and out-patient care funded by the municipalities. In contrast, spending on medicines rose almost

Figure 2.6. **Real health expenditure by function, Finland, 1988-2002**

Constant prices, million euros



Note: Due to statistical changes in 1993, data since 1993 are not totally comparable to previous years.

1. Others include: medical devices, environmental health, public expenses and travel expenses.

Source: STAKES (2004), *Trends in Health Care 2004*, National Research and Development Centre for Welfare and Health, Helsinki.

continuously throughout the period 1988-2002 at an average rate of about 10% per annum in nominal terms, falling below 5% in only a couple of years. The rise of public expenditure on drugs is perceived by many Finnish observers to threaten the overall control of public spending on health (Leppo, 2002). Reimbursements for prescribed drugs represent more than 50% of the expenditure on health services under NHI.

A closer examination of the growth of pharmaceutical spending by Pekurinen and Häkkinen (2005), suggested that most of it was attributable to rises in the volume (cost at constant prices) per user during these years. There were relatively small fluctuations in the total number of users around a virtually zero trend but there were rising proportions of users in the higher reimbursement categories and of users who had exceeded the cost sharing limits.

The rise in the cost per user, at an average rate of about 10% per annum during the past decade, is likely to have been due to a combination of at least two factors: the introduction of new, more effective and more expensive drugs; and the transfer of many sick patients from hospitals to the community because of reducing length of stay in acute hospitals and de-institutionalisation of long-stay patients. However, the former is likely to have been by far the dominant factor. An estimate of the elasticity of pharmaceutical expenditure to de-institutionalisation among the elderly in Finland suggests that only about 6% of the increase in drugs expenditure was due to de-institutionalisation between 1990 and 2002 (Häkkinen, personal communication).

It is possible to look in more detail at this phenomenon by examining which individual pharmaceutical products were the main drivers of rising expenditure over the recent past. Table 2.1 shows the ten drugs which accounted for the largest additions to the drugs bill between 2000 and 2004, ranked in order of the size of the addition to the bill. The growth of spending on these ten drugs alone accounted for about 40% of the growth of the total drugs bill between 2000 and 2004. It is striking that five of the ten drugs were newly introduced

Table 2.1. **The top ten drugs which contributed most to additions to pharmaceutical expenditure, Finland, 2000-2004**

ATC-category	Substance	Brand name	2000		2004		Difference in cost 2000-2004 (in thousand euros)
			Cost	Reimbursement	Cost	Reimbursement	
			(in thousand euros)		(in thousand euros)		
C10AA05 (Serum lipid reducing)	Atorvastatin	Lipitor	18 031	9 272	51 562	28 192	33 531
A02BC05 (Antacid)	Esomeprazol	Nexium	0	0	23 238	11 586	23 238
R03AK06 (Drug for COPD)	Salmeterol + Fluticasone	Seretide	10 288	7 382	33 289	23 954	23 001
N05AH03 (Antipsychotic)	Olanzapine	Zyprexa	11 622	9 078	29 724	28 006	18 102
R03AK07 (Drug for COPD)	Budesonide + Formoterol	Symbicort	0	0	15 235	10 526	15 235
N05AH04 (Antipsychotic)	Ketiapine	Seroquel	0	0	13 479	11 887	13 479
C09AA05 (ACE Inhibitor)	Ramipril	Cardace et al	2 692	1 738	15 547	9 175	12 855
C08CA01 (Calcium channel blocker)	Amlodipine	Norvasc	13 596	9 268	25 854	17 289	12 258
L04AA019 (Immunosuppressor)	Etanersept	Enbrel	0	0	12 159	10 845	12 159
C10AA07 (Serum lipid reducing)	Rosuvastatin	Crestor	0	0	11 775	5 516	11 775

ATC = Anatomical therapeutic chemical (medical classification of medicines).

Source: KELA.

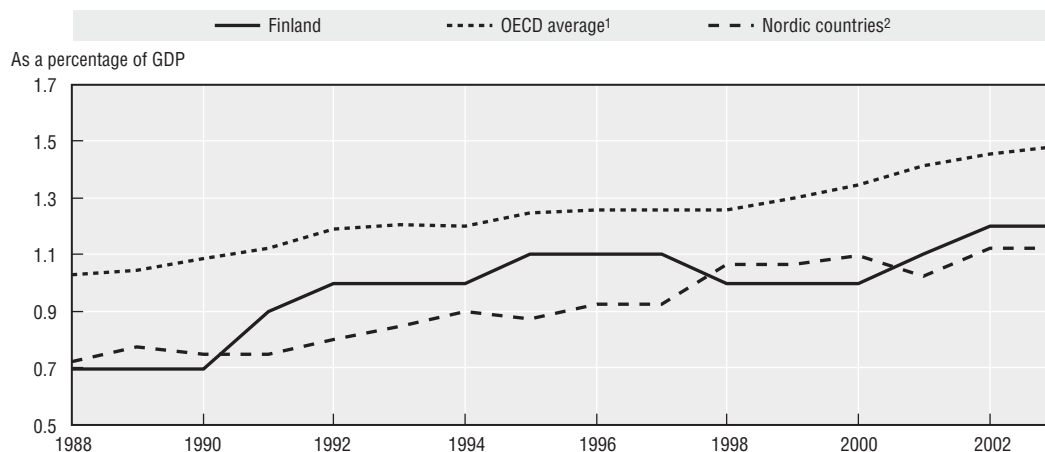
between the two dates. Four of the drugs are therapies for cardiovascular conditions while two are antipsychotic drugs.

Judging by international comparisons of the *pharmaceutical expenditure share of GDP*, Finland looks to be a relatively low spending country with a typical growth path for such spending. The pharmaceutical spending share of GDP in Finland rose from 0.7% in 1988 to 1.2% in 2003. It tracked the corresponding shares both in other Nordic countries and in remaining OECD countries, on average, but both it and the average Nordic shares remained below the average share in non-Nordic countries at the beginning and at the end of the period (Figure 2.7).

However, judging by the *pharmaceutical expenditure share of total health expenditure*, Finnish spending on drugs has been following a rising trend. This share rose from 9.5% in 1988 to 16.0% in 2003. The level of the share was similar to that in other Nordic countries in 1988 and well below that in non-Nordic countries. However, the subsequent rate of increase of the share was faster than that either in Nordic or in other OECD countries between 1988 and 2002. Consequently, the Finnish share converged, almost, with the average share in non-Nordic countries at the end of the period (Figure 2.8).

These contrasting pictures highlight the relative lack of control of expenditure on drugs in Finland under the NHI (compared with municipal expenditure) and raise questions about the desirability of continuing with such a trend in the long term. "Assessing the rationality of growing spending on drugs" is addressed in Box 2.2.

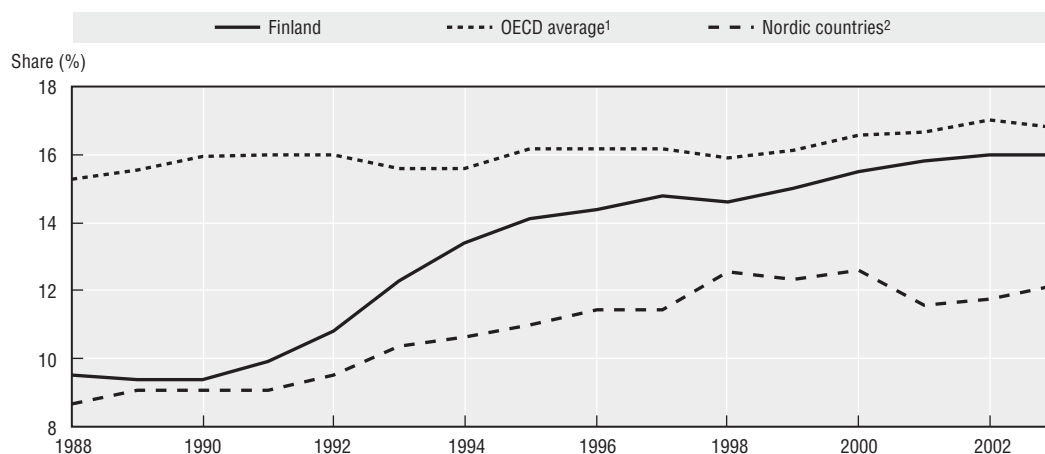
Figure 2.7. Pharmaceutical expenditure as a share of GDP, Finland, Nordic countries and OECD average, 1988-2003



1. Unweighted average for 16 countries. Excludes Finland, the Nordic countries (Denmark, Iceland, Norway and Sweden) and the following countries with a limited availability of data: Austria, Belgium, Hungary, Mexico, New Zealand, Poland, Portugal, the Slovak Republic and Turkey. (Data for 2003 refer to 2002 for Australia, Ireland, Japan, Luxembourg and the United Kingdom.)
2. Nordic countries include: Denmark, Iceland, Norway and Sweden.

Source: OECD (2005b), *OECD Health Data*, June, Paris.

Figure 2.8. Pharmaceutical expenditure as a share of total health expenditure, Finland, Nordic countries and OECD average, 1988-2003



1. Unweighted average for 16 countries excludes: Finland, the Nordic countries (Denmark, Iceland, Norway and Sweden) as well as the following countries with a limited availability of data: Austria, Belgium, Hungary, Mexico, New Zealand, Poland, Portugal, the Slovak Republic and Turkey. (Data for 2003, refer to 2002 for the following countries: Ireland, Japan and Luxembourg and to 2001 for Australia.)
2. Nordic countries include: Denmark, Iceland, Norway and Sweden.

Source: OECD (2005b), *OECD Health Data*, June, Paris.

Box 2.2. Assessing the rationality of growing spending on drugs

There is some literature from countries other than Finland, which assesses the rationality of growing spending on drugs. Some of the literature from the United States suggests that growing spending on prescription drugs has been rational and cost-effective in recent decades. For example, a US study, based on national survey data, suggested that hospital bed days fell most rapidly between 1980 and 1991 for those diagnoses which had seen the largest increase in the total number of drugs prescribed. A USD 1 increase in pharmaceutical expenditure was associated with a USD 3.65 reduction in hospital care expenditure but a USD 1.54 increase in spending on ambulatory care (Lichtenberg, 1996).

There is also some evidence that suggests that some newer and more expensive drugs not only yield health benefits but can pay for themselves. Another study of national survey data in the United States (data collected in 1996) suggested that people consuming newer prescribed medicines, were less likely to die by the end of the survey, were significantly less likely to experience work-loss days, and had lower non-drug spending than were people consuming older drugs. The reduction in non-drug spending from using newer drugs was nearly four times the additional prescribing costs: a reduction of USD 71 compared with prescribing costs of USD 18 (Lichtenberg, 2001).

The adoption of “disease management” and the “chronic care model” in the United States and other OECD countries, suggests that there is much scope for improving the health of patients with chronic diseases, and for avoiding premature hospitalisation, by improving patient self-management, and by adherence to optimal prescribing regimes (Casalino, 2005). In the case of Finland, there is some supporting evidence of regional differences in the treatment of patients with acute myocardial infarction (AMI) which suggested that the use of beta blockers and statins were important determinants of differences in AMI mortality across Finland between 1998 and 2001 (Häkkinen *et al.*, 2004). However, some other US studies have reached less optimistic conclusions, at least about cost savings from new drugs. A study of the 61% increase in spending on antipsychotic drugs under Medicaid in California, between 1993 and 2001, suggested that it had not reduced spending on other forms of medical care. Moreover, although psychotic symptoms had been reduced, there were adverse side-effects in the form of an increase in diabetes (Duggan, 2005).

However, some prescribing is, on balance, harmful and wasteful and there is some evidence to suggest that this is an important issue in Finland. The representative of the Finnish Pharma industry told the OECD mission team that the industry was concerned about over-prescribing associated with the prevalence of automatic renewal of prescriptions for health centre patients – which accounted for half of all prescribing outside hospitals in Finland. Meanwhile, a study of potentially inappropriate medication use among elderly patients (Fialová *et al.*, 2005), suggests that Finland had the third highest use of potentially inappropriate medication among eight European countries – above the levels in Denmark, Iceland and Norway. Inappropriate prescribing for the elderly can increase the risk of adverse drug events.

* It has been estimated that adverse drug events are the fifth most common cause of death and the cause of many hospital admissions in the United States (Fialová *et al.*, 2005).

2.3.3. The extension of public coverage on dentistry

The fiscal sustainability of health expenditure growth depends partly on the size of the package of services covered by the public sector. In that context, an additional strain was placed on municipal budgets and NHI by the extension to the whole population, in 2002, of public coverage for dentistry. Formerly, only patients born in or after 1956 were

eligible for public coverage for dentistry. Cost-sharing is now about one-third of the cost for municipal dentistry and about two-thirds of the cost for private dentistry. Expenditure in real terms on dentistry grew by about 8% between 2002 and 2003 (STAKES, 2005). Despite that, many health centres are now finding that they have excess demand for appointments with dentists, with long waiting times for non-emergency appointments. As a consequence, they sometimes purchase dental services from the private sector.

2.4. Microeconomic efficiency (value for money)

Microeconomic efficiency is concerned with maximising “value for money” in health care where “value” includes some weighted combination of: i) improvements in health due to the health system; and ii) responsiveness to consumers. It should be a major objective of health policy to achieve gains in microeconomic efficiency through time, because they will allow either reductions in cost for given benefits, or increases in benefits without adding to costs – thereby assisting with the achievement of *macroeconomic* efficiency. This section attempts to compare the microeconomic efficiency of the health system in Finland with that of other countries by comparing inputs, utilisation of services, “productivity” (utilisation/input ratios), improvements to health, responsiveness to consumers and satisfaction. It looks also at the issues of particular concern raised in this review: pharmaceutical spending; de-centralisation; human resources and waiting times for elective surgery. Prior to that, an international comparison is made of health expenditure by broad function – simply to check whether the mix of health services in Finland is very different from the mix of services that is found, on average, in other OECD countries.

2.4.1. International comparisons of shares of health expenditure by function

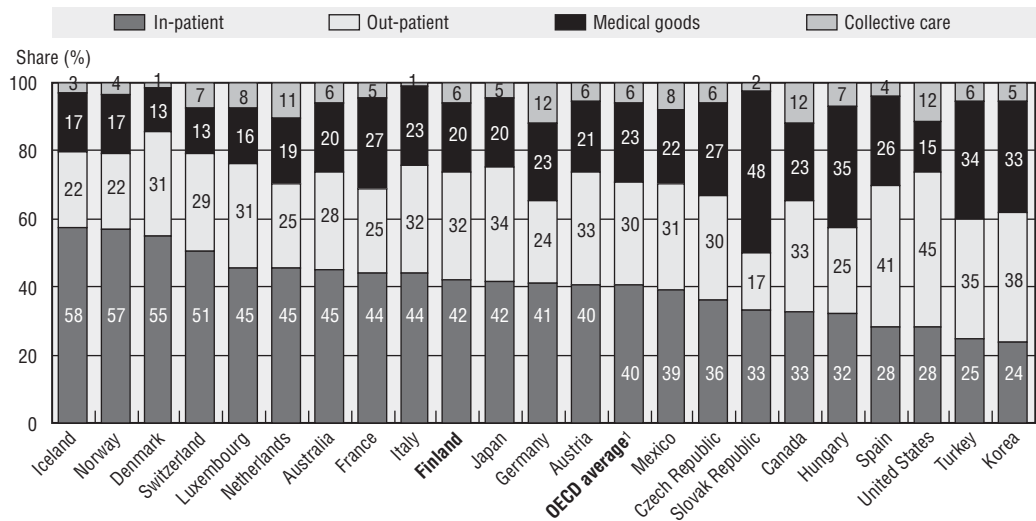
Figure 2.9 shows percentage shares of health expenditure by function in Finland and in 22 other OECD countries in 2003. An OECD average is also shown in the chart. Since we do not know what the optimum mix of health services is, this is not in itself a measure of efficiency. However, it is of interest to note that Finland has shares of health expenditure by function, which are close to the OECD average shares. It is also interesting to note that the share of spending on hospitals (at 42%) is slightly above the OECD average (at 40%) despite the role that health centres play in providing inpatient care in Finland.

2.4.2. Real inputs

Figure 2.10 compares levels of real inputs for five categories of health care professional (general practitioners, specialists, nurses, dentists, and pharmacists) and for acute and long-stay beds in Finland with the corresponding OECD averages in 2003. The cobweb diagram suggests that Finland reports more nurses, pharmacists and dentists and lower numbers of general practitioners and specialists per thousand population, compared with the corresponding OECD averages.¹ Total staff density for these five categories of professionals combined was 13.7 in Finland compared with an OECD average of 12.8. Finland reports considerably fewer acute-care beds and slightly more long-term care beds per 1 000 population than the corresponding OECD averages, but the former figures are probably understated and the latter are probably overstated compared with other countries.² Total reported (acute and long-term care) bed numbers were 9.4 per 1 000 population in Finland compared with an OECD average of 11.1 per 1 000 population.

In terms of institutional places for long term care, including places in service flats, old-age homes and nursing homes, Finland, at 7.3 beds per 100 people over 65, was reported as

Figure 2.9. **Health care expenditure by function, Finland and selected OECD countries, 2003**

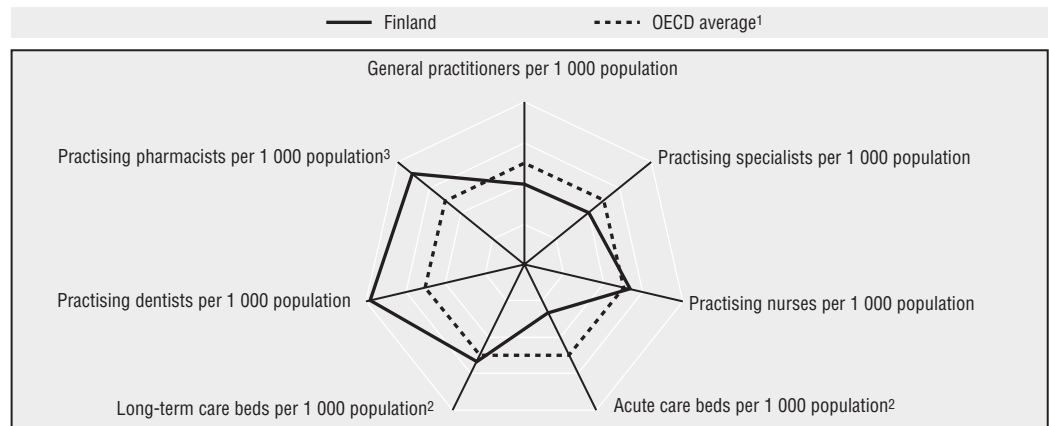


Note: Data refer to 2003 except for Austria, Hungary, Japan, Luxembourg and Sweden which refer to 2002; Australia which refer to 2001; and Turkey to 2000.

1. OECD average for 22 countries excludes Finland and the following countries: Belgium, Greece, Ireland, New Zealand, Poland, Portugal, Sweden and the United Kingdom.

Source: OECD (2005b), *OECD Health Data*, June, Paris.

Figure 2.10. **Real inputs to health care, Finland and OECD average, 2003**



1. Unweighted average for 18 countries excludes Finland and the following other countries: Greece, Ireland, Iceland, Italy, Japan, Korea, Mexico, New Zealand, Portugal, Spain and Sweden.

2. The following countries have been excluded from the OECD average due to differences in methodology for counting long term-care beds: Austria, Belgium, the Czech Republic, France, Hungary, Italy, Korea, the Slovak Republic and Spain. The OECD average excludes a number of countries for which long-term care beds are believed to be understated – marked with a “d” against the relevant data in OECD (2005b).

3. In the case of Finland, practising pharmacists include staff in community pharmacies with pharmaceutical education (M.Sc. Pharm. or B.Sc. Pharm). In the OECD average, data refer to 2003 except for Australia, Belgium, Denmark, Sweden, Switzerland and the United States, which refer to 2002.

Source: OECD (2005b), *OECD Health Data*, June, Paris; *The Annual Review of the Association of Finnish Pharmacies*.

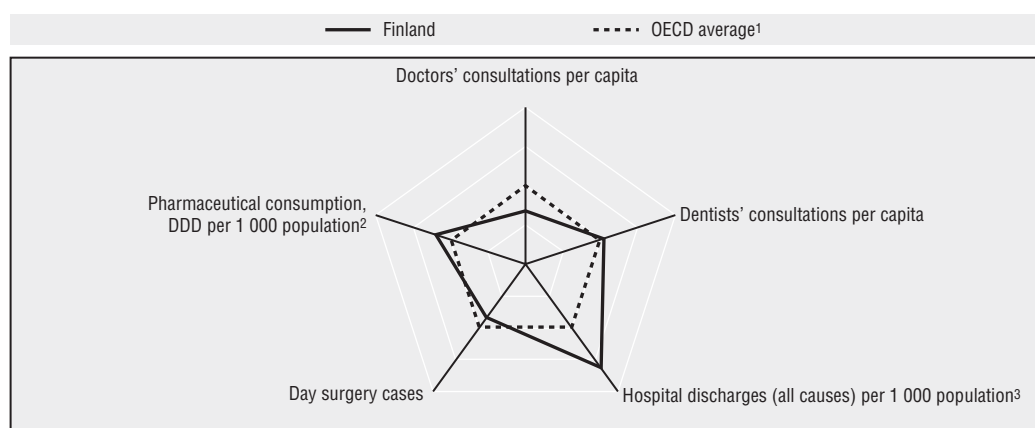
ranking 9th out of 16 European countries in the early to mid-1990s (Pacolet *et al.*, 2000). In terms of domiciliary services, including district nurses, home helps and social workers, Finland, at 4.1 personnel per 100 people over 65, was reported as ranking 4th out of 11 European countries in the early to mid-1990s (Pacolet *et al.*, 2000). However, in the past decade Finland has reduced places in residential homes and substantially increased places in service housing (STAKES, 2004).

2.4.3. Utilisation rates

Figure 2.11 compares reported national utilisation rates for five main health services in Finland with the corresponding OECD averages in 2003. The cobweb diagram suggests that utilisation rates in Finland were above those in the OECD comparator groups for three services (consultations with dentists, hospital discharges and pharmaceutical consumption) and below for two services (consultations with physicians and day surgery cases). The comparatively low consultation rates with doctors in Finland is likely to be due partly to the below-average number of generalists and specialists per thousand population in Finland (Figure 2.10). Consultations with “other professionals” including nurses (which represent about 60% of all health centre consultations in Finland) may take the place of consultations with doctors to a greater extent in Finland than in other countries – but international data on nurse consultations are lacking.

The comparison of the volume of pharmaceutical consumption relates only to Nordic countries (because of lack of comparable data for other countries). Part of the explanation for the 19% excess in the volume of drug consumption (in defined daily doses per 1 000 population) in some major therapeutic categories in Finland, compared with the average for other Nordic countries, may be a lack of cost-consciousness among prescribing doctors in Finland – discussed further below.

Figure 2.11. **Utilisation rates for five main health service areas, Finland and OECD average, 2003**



DDD = Defined daily doses.

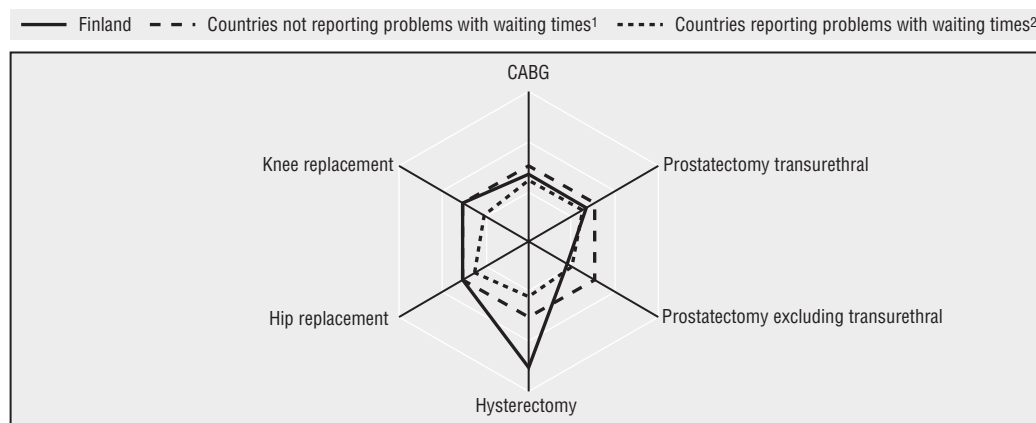
1. Unweighted average for 16 countries excludes Finland and the following countries: Austria, the Czech Republic, France, Greece, Iceland, Japan, Korea, Norway, Poland, the Slovak Republic, Sweden, Turkey and the United States.
2. Total pharmaceutical consumption in primary care and hospitals, expressed in defined daily doses (DDD) per 1 000 population. Finland versus the group of Nordic countries (only), which include: Denmark, Iceland, Norway and Sweden.
3. Hospital discharges in Finland are based on “episodes of care”, thus including transfers from one hospital unit to another. Discharges in other OECD countries do not include these intra-hospital transfers.

Source: OECD (2005b), *OECD Health Data*, June, Paris.

The excess in the Finnish hospital discharge rate over the OECD average is about 65%. Most of the explanation for this is likely to lie in the fact that the average acute length of stay in Finland was only 63% of the OECD average in 2002 (4.3 days *versus* 6.8 days).³ That, in turn, is likely to be linked at least partly to the availability of beds for convalescent patients in health centres. It should also be noted that day surgery cases are underestimated in Finland (for example, they exclude most private day surgery). However, there may be missing data in other countries.

Figure 2.12 compares reported rates of surgery for six inpatient surgical procedures [coronary artery bypass grafting (CABG), prostatectomy transurethral, prostatectomy excluding transurethral, hysterectomy, hip replacement and knee replacement] in Finland in 2003 with the corresponding averages for two OECD comparator groups – one a group of countries which *do not* report problems with waiting times, the other a group of countries which *do* report problems with waiting times (OECD, 2004, Chapter 5). The cobweb diagram suggests that, on average, surgery rates for these procedures were higher in countries which *do not* report problems with waiting times than in countries which *do* report problems. However, Finland (which *does* report problems with waiting times) had surgery rates which were well above those in the countries which *do* report problems with waiting times, with the exception of prostatectomy excluding transurethral, and were about equal to or above the average rates in the countries which *do not* report problems with waiting times, with the exception of both kinds of prostatectomy. The rate of hysterectomy in Finland was about twice the average rate in the first group of countries and over three times the average rate in the second group of countries. These comparisons and the links, if any, to waiting times themselves, are discussed further in the section on “Tackling waiting lists for elective surgery”, below.

Figure 2.12. **Elective surgery rates for six inpatient procedures, Finland and averages for selected OECD countries which do and do not report problems with waiting times, 2003**



Note: Data refer to 2003 except for Austria, Belgium, Australia, Canada, Norway, Spain and Sweden which refer to 2002 and France and the United States which refer to 2001.

1. Countries not reporting problems with waiting times include: Austria, Belgium, France, Germany, Japan, Luxembourg, Switzerland and the United States.

2. Countries which do report problems with waiting times include: Australia, Canada, Denmark, Finland (although not included in the average), Ireland, Italy, the Netherlands, New Zealand, Norway, Spain, Sweden and the United Kingdom.

Source: OECD (2005b), *OECD Health Data*, June, Paris; data for Denmark, Finland, Norway and Sweden for the following indicators: CABG, prostatectomy, hysterectomy and hip replacement are from NOMESCO (2002).

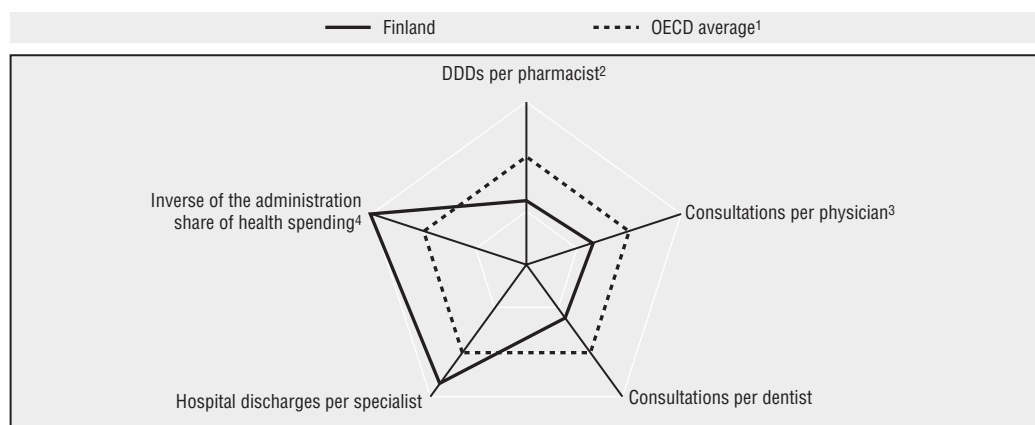
2.4.4. Productivity and cost

Some of the data on inputs and utilisation rates, discussed above, can be combined to provide rough estimates of productivity differences between Finland and other OECD or Nordic countries. Figure 2.13 makes such comparisons for four proxy measures of “productivity”: defined daily doses of pharmaceuticals per pharmacist; consultations per physician; consultations per dentist; and discharges per specialist. It should be noted that such indicators do not capture any international variations in the quality of health care. The same figure compares the inverse of the administrative share of total health expenditure in Finland with the corresponding OECD average. The cobweb diagram suggests that “productivity” was below average in Finland in 2003, except for hospital discharges per specialist (which is likely to reflect, mainly, the low, average, acute hospital length of stay in Finland).³ It suggests, also, that the administrative cost of health care is relatively low in Finland (because the inverse is relatively high). The message conveyed by this figure is that in terms of productivity and costs, the performance of the Finnish health system – so far as it can be measured – is mixed.

2.4.5. Indicators of the quality of primary prevention and public health activities

Finland has seen dramatic improvements in death rates from diseases of the circulatory system since the mid-1960s, which are directly attributable to a series of major health promotion campaigns, such as the North Karelia Project, which were aimed at improving the diet and lifestyle of the population. Death rates from circulatory diseases, which were among the highest in the OECD in the 1960s, have now converged with average OECD levels (Figure 2.14).

Figure 2.13. “Productivity” and cost measures in health care, Finland and OECD average, 2003

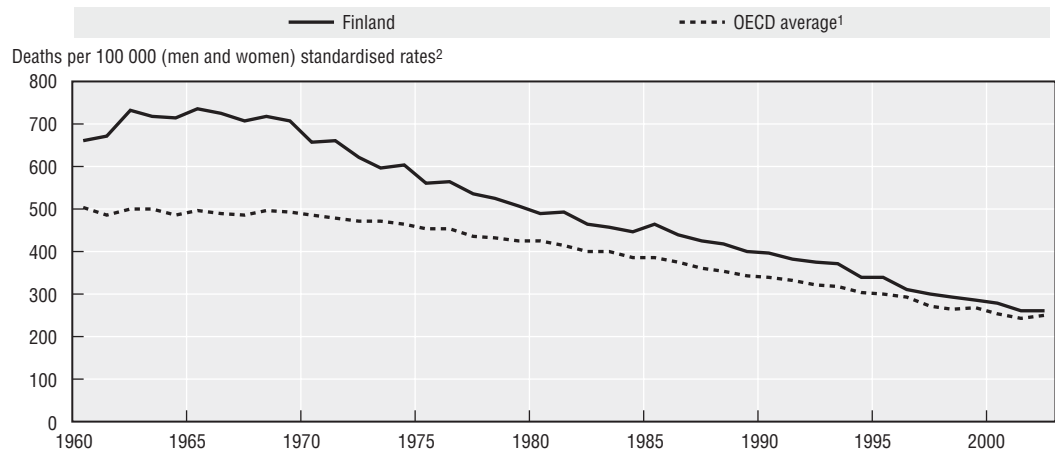


DDD = Defined daily doses.

1. Unweighted average for 17 countries excludes Finland and the following other countries: Belgium, Greece, Iceland, Ireland, Italy, Japan, Korea, New Zealand, Poland, Portugal, Spain, Turkey and the United Kingdom.
2. Total pharmaceutical consumption in primary care and hospitals is expressed in defined daily doses (DDD). Finland versus the group of Nordic countries (excluding Iceland), only. Finland's number of pharmacists comes from The Annual Review of the Association of Finnish Pharmacies. It includes staff in community pharmacies with a pharmaceutical education (M.Sc. Pharm or B.Sc. Pharm).
3. Practising physicians and practising specialists for Denmark, Finland, Iceland, Norway and Sweden are drawn from NOMESCO (2002).
4. In order to avoid visual confusion, the inverse of the administrative share of health expenditure (1/x) has been plotted, so that an outer point represents a better performance, as for the other indicators in the diagram.

Source: OECD (2005b), OECD Health Data, June, Paris; Association of Finnish Pharmacies (2004); NOMESCO (2002).

Figure 2.14. **Death rates from diseases of the circulatory system, Finland and OECD average, 1960-2002**

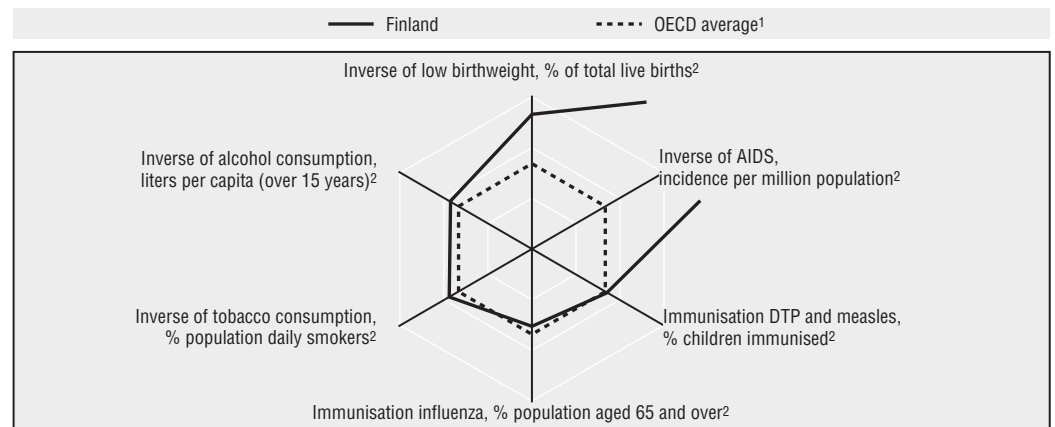


1. Age-standardised death rates per 100 000 population, are calculated by the OECD secretariat using the total OECD population for 1980 as the reference population.
2. The average (for 22 countries) excludes Finland and the following other countries: Belgium, the Czech Republic, Korea, Luxembourg, Mexico, the Slovak Republic and Turkey. Data refer to 2002, except for Australia, Canada, France, Germany, Ireland, Italy, Sweden, Switzerland and the United States which refer to 2001 and, Denmark and New Zealand, which refer to 2000.

Source: OECD (2005b), OECD Health Data, June, Paris.

Additional insights into the effectiveness and quality of preventive and curative health care can be gained by looking at indicators of avoidable health risks, health outcomes and effective processes delivered by health care. Figure 2.15 reports on some indicators of avoidance of public health risks, comparing Finland with the averages for some groups of OECD countries in 2003. The cobweb diagram includes: the inverse of the incidence of low birth-weight infants (which may reflect, in part, the effectiveness of ante-natal care); the

Figure 2.15. **Indicators of avoidance of public health risks, Finland and OECD average, 2003**



Note: In the case of AIDS incidence per million population, the diagram has been truncated. Finland's value is only about a fifth of the OECD average (4.9 versus 22.5).

1. Unweighted average for 13 countries includes Australia, The Czech Republic, Denmark, France, Germany, Hungary, Japan, New Zealand, the Slovak Republic, Spain, Switzerland, the United Kingdom and the United States.
2. The inverse of these variables have been plotted to ensure that an outer point represents a better performance, as with the other cobweb diagrams in this report.

Source: OECD (2005b), OECD Health Data, June, Paris.

inverse of the incidence of AIDS (which may reflect, in part, the effectiveness of health education measures); the percentage of children immunised against DTP (diphtheria, tetanus and pertussis) and measles; the percentage of people over 65 immunised against influenza; the inverse of the smoking rate (which may reflect a range of public health measures); and the inverse of alcohol consumption in litres per capita (which, again, may reflect, in part, a range of public health measures). Once again, the cobweb diagram suggests that Finland records relatively good performance on this set of public health risk indicators – it performed better than the OECD averages on four of these indicators, was equal to the OECD average on one and recorded worse performance only in relation to immunisation of the elderly against influenza.⁴ It is worth noting, in addition, that Finland reported some of the lowest rates of perinatal and infant mortality in the OECD area (OECD, 2005b). Finland also reported the second lowest rate of tobacco consumption (in grams per capita, for people over 15 in 1985) and the second lowest, age-standardised rate of death from lung cancer, in 2000, among 14 OECD countries (Chart 4.4, OECD, 2003a). The rate of tobacco consumption has declined further, by 40% since 1985, and remains one of the lowest in the OECD area.

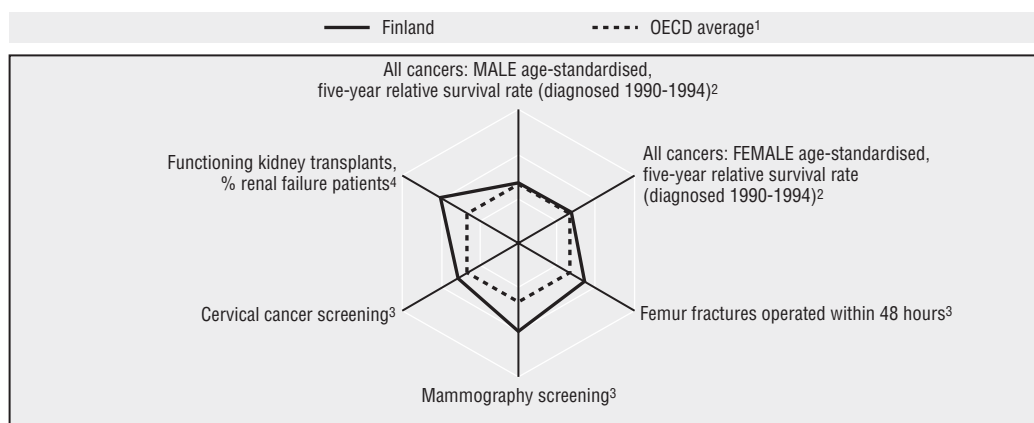
Nevertheless, there is cause for concern about other risk factors. Less than one third of Finns had cholesterol levels less than the recommended 5.0 $\mu\text{mol/l}$ in 1999. There is concern about excessive salt consumption. Both the mean body mass index and the prevalence of obesity have increased among adults during the past 30 years. 55% of men and 39% of women are now overweight ($30 \text{ kg/m}^2 < \text{BMI} < 25 \text{ kg/m}^2$) and 14% of both sexes obese. Physical activity, however, has been increasing recently among Finns. 53% of men and 65% now exercise more than 30 minutes twice weekly and 29% of men and 47% of women spend more than 15 minutes biking or walking daily to their workplace (information provided by Ministry of Social Affairs and Health).

2.4.6. Indicators of the quality of secondary prevention and treatment activities

Figure 2.16 reports on a small selection of potential indicators of success with secondary prevention and treatment activities, again comparing Finland with averages for some groups of OECD comparator countries. The cobweb diagram includes: the rate of five-year relative survival after a diagnosis of cancer (for all malignant neoplasms) shown separately for males and females; the rate of mammography screening; the rate of cervical cancer screening; the percentage of patients operated on within two days after hip fracture; and the percentage of patients with kidney failure who received a kidney transplant. The diagram suggests that Finland performed at, above, or well-above average on all of these indicators of quality of care. These indicators cover only a fraction of the range of investigations and treatments offered by the Finnish health system, so no conclusive judgement can be drawn from them. Nevertheless, to the extent that they are representative, they add to the picture of a relatively well-performing system.

The determinants of these quality characteristics may include: the high standards of training of professional staff in Finland, the strong culture of professional self-improvement, and various quality improvement activities, such as the establishment of “quality registers” for various conditions and procedures.⁵ It appears that professionals employed by the hospital districts have significant clinical autonomy in the Finnish health system. This may well strengthen the motivation of professional staff to deliver services of high quality. The good overall performance suggests that this more than compensates for any lack of expertise in municipal management and for any adverse effects of the “hands-off” role adopted by central government in relation to hospital management since the early 1990s.

Figure 2.16. **Potential indicators of success with secondary prevention and treatment activities, Finland and OECD average, 2003 or latest years available**



1. Due to different data availability across sources, five OECD averages have been calculated, all exclude Finland. For "All cancers", both males and females, it is a 15 country average excluding: Australia, Belgium, Canada, Japan, Mexico, New Zealand, Portugal and the United States. For "Femur fractures" it is a seven country average including: Canada, Italy, Mexico, the Netherlands, Norway, Portugal and the United Kingdom. For "Mammography screening", it is a 14 country average, which includes: Australia, Canada, France, Iceland, Italy, Japan, the Netherlands, New Zealand, Norway, Sweden, Switzerland, the United Kingdom and the United States. For "Cervical screening", it is a 13 country average which includes: Australia, Canada, France, Germany, Iceland, Italy, Japan, Mexico, the Netherlands, New Zealand, Norway, the United Kingdom and the United States. Finally for "Functioning kidney transplants", it is a 13 country average including: Australia, Austria, Canada, Denmark, Germany, Iceland, New Zealand, Portugal, the Slovak Republic, Spain, the United Kingdom and the United States.
2. Data from EUROCARE refer to 1994-1995; the United Kingdom data refer to an unweighted average of separate figures for England, Scotland and Wales.
3. Data for "Femur fractures" refer to 2003 for all countries with the exception of Canada (2002), Italy (2001), the Netherlands (2001) and Portugal (2004). Data for "Mammography screening" also refer to 2003 except for Australia (2001), Iceland (2004), Italy (2000), the Netherlands (2002), New Zealand (2002), Sweden (2004) and Switzerland (2002). Finally, data for "Cervical screening" refer to 2003 with the exception of Australia (2001), Finland (2002), Germany (2002), Iceland (2004), Italy (2000), Mexico (2002), the Netherlands (2001), New Zealand (2002), Norway (2000) and the United Kingdom (2004). (Source: OECD Health Care Quality Indicators Project.)
4. Data refer to 2003 for all countries with the exception of Canada, the United Kingdom and the United States, which refer to 2002. (Source: OECD Health Data.)

Source: Sant, M. et al. (2003), "EUROCARE – 3: survival of cancer patients diagnosed 1990-1994 – results and commentary", *Annals of Oncology* 14 (Supplement), Oxford University Press, pp. 61-118; OECD (2005), Health Care Quality Indicators Project. These are indicators under development; OECD (2005b), *OECD Health Data*, June, Paris.

Against this, there have been reports that communications are sometimes poor between health centre physicians and specialists. Some referrals are unnecessary and feedback by specialists to health centre doctors is often lacking or delayed (OECD, 1999). More generally, the review team was also told that despite the outward appearance of integration across the municipal health and social services, there were often barriers between different professions and services which affected the accessibility and continuity of care for patients. Such barriers are typically characterised by attempts by each professional/service group to hoard resources and to shift work across the boundaries with another profession/service.

2.4.7. Indicators of responsiveness to consumers and satisfaction with health care

Responsiveness to consumers and their satisfaction with health care are also goals of a health system. A distinction should be made between:

1. indicators of "patients' experience", embodying objective evidence about the responsiveness of services (such as how long patients waited for treatment and whether they were given information and choices about alternative care plans); and

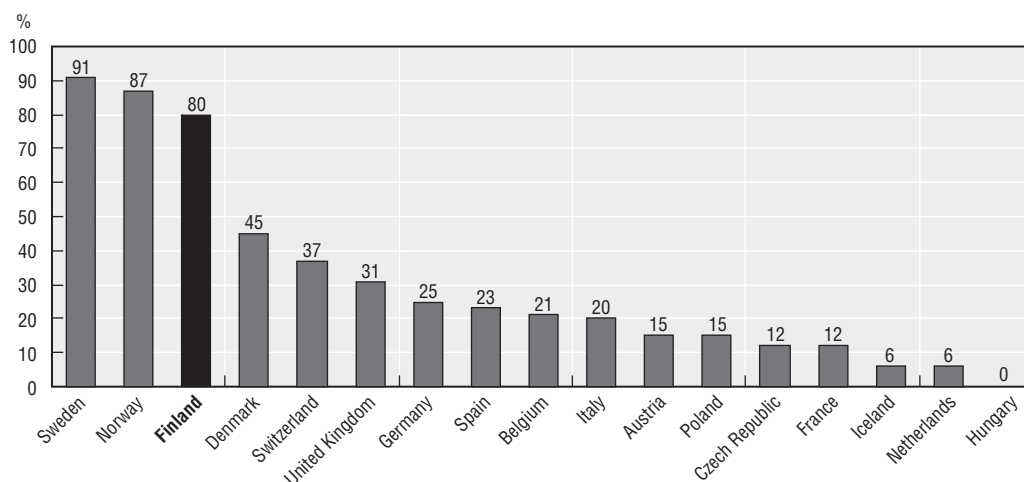
2. indicators of “patients’ (or citizens’) satisfaction” with health care, embodying subjective opinions about the acceptability of care received by patients (or perceptions by other citizens of the acceptability of care received by patients).

The latter are more difficult to interpret, particularly in international comparisons, because they may be affected by variations in patients’/citizens’ expectations about standards of service across countries.

In relation to patients’ experience of the lack of timeliness of care, Figure 2.17 compares the percentage of general practitioners with waiting times for consultations of two or more days in Finland and 16 other (European) OECD countries in the mid-1990s (Boerma and Fleming, 1998). The figure suggests that Finland, at 80%, had the third highest percentage of GPs with delays for appointments of two or more days in this group of countries, following Sweden and Norway. In other words, Finland’s performance seems to be relatively poor on this measure of timeliness of care.

Figure 2.17. **Waiting times for consultations with general practitioners, Finland and selected OECD countries, mid-1990s**

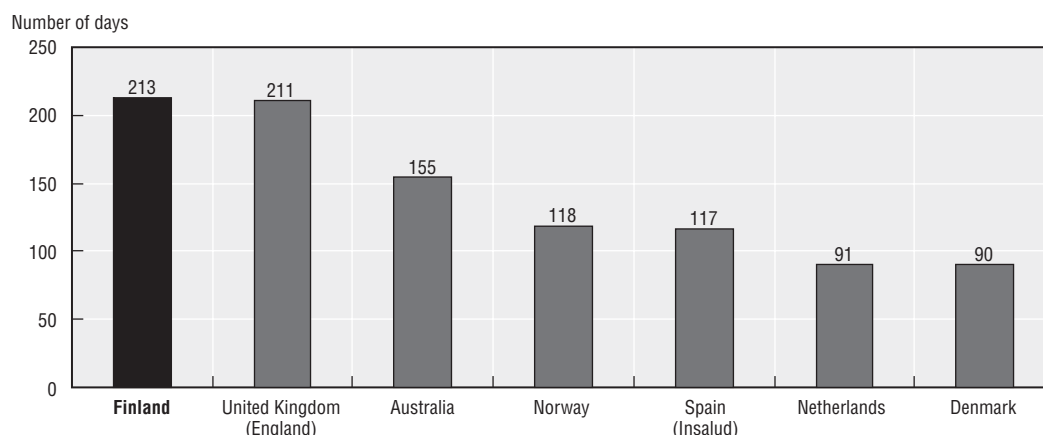
Percentage of GPs with average delays of two or more days



Source: Boerma, W.G.W. and Fleming, D.M. (1998), *The Role of General Practice in Primary Health Care*, WHO Regional Office for Europe.

Also in relation to experience of the timeliness of care, Figure 2.18 shows average waiting times for surgery in 2000 in seven countries for a combination of six procedures which, together, tend to dominate elective surgical waiting lists. The data were reported to the OECD’s project on waiting times (Hurst and Siciliani, 2004). Finland and the UK reported the longest waiting times for these conditions, on average, across this group of countries in 2000. Waiting in Finland was roughly twice as long as in Norway or in Denmark. This international comparison is not necessarily very reliable because methods of measuring waiting times probably varied between the countries and, in the case of Finland, there were missing data for many hospitals. However, waiting list data appear to confirm that there was still a problem in Finland in 2003. In that year, Finland had 165 000 patients who had waited over six months for surgery (Socius, Finland, 2003). By comparison, England, which has a population nearly ten times greater than that of Finland, had 189 000 patients who had waited over six months for surgery in March of the same year (Department of Health, 2004).

Figure 2.18. **Average waiting times for surgery for six elective procedures,¹ selected OECD countries, 2000**



1. Hip replacement, knee replacement, cataract surgery, stripping of varicose veins, cholecystectomy and inguinal, and femoral hernia.

Source: OECD (2004b), *Towards High Performing health Systems: Policy Studies*, Paris.

The reasons for the long waiting times for health centre medical care are probably mixed. First, physician capacity is constrained and partly committed to inpatient care. As shown above, Finland seems to have slightly fewer GPs per thousand population than the OECD average. Meanwhile, many GPs in municipal health centres in Finland have responsibilities for inpatients (there are, on average, an estimated seven health centre beds per health centre physician in Finland) whereas GPs in most other OECD countries are free of such responsibilities. That is likely to reduce the time that Finnish GPs have to offer consultations, other things being equal. However, health centre GPs are very well supported by nurses who outnumber them by about 2:1 and handle many preventive and routine chronic care consultations and almost all the home visits in Finland. Both of these factors may contribute to the low consultation rate with (combined GP and specialist) physicians in Finland (4.2 per capita compared with an OECD average of 6.2 per capita).

Secondly, an additional factor which may contribute to low consultation rates and the long waiting times for appointments, is that physicians in health centres have few financial incentives to be responsive to patients and to alter their pace of work in response to demand. For most of them, their patients are virtually a captive clientele – many patients are assigned to their “personal doctor” according to the zone in which the patient lives. Moreover, the GPs are paid mainly by salary, with some partial capitation payment, and their hours of work in their health centre appointments are generally of a nine to five variety. That gives them few financial incentives to raise their activity rates compared with GPs paid wholly or partly by fee-for-service. That may help to explain why the average patient contacts per day with GPs in Finland were estimated in one study to be only 19 compared with an average of 29 contacts per day in a group of 29 other European countries – in Germany, the average was 50 patient contacts per day. Also booking intervals for appointments with patients, at 18 minutes in Finland, were relatively high (Boerma and Fleming, 1998).

The probable reasons for long waiting times for elective surgery are dealt with in a separate section, below.

Turning to expressions of satisfaction by users of services, Finnish survey data published in 2001, suggested that roughly three out of four Finns were satisfied with the services they received from municipal health centres.⁶ The main causes for dissatisfaction were long waiting times and the difficulty of obtaining appointments. About one third of clients were dissatisfied with the waiting times and about one fifth with getting appointments. High levels of satisfaction (in excess of 80%) were reported by users of day-care services, maternity and child welfare clinics and elderly care. Over 90% of relatives of elderly family members receiving care in old people's homes in the City of Helsinki, were either satisfied or very satisfied with the quality of care received by their relatives (Ministry of Social Affairs and Health, 2002).

In relation to the general public, successive "Eurobarometer" surveys have reported that a high proportion of Finnish citizens are "very" or "fairly" satisfied with the way health care "runs" in their country.⁷ In 2002, Eurobarometer data suggested that over 70% of Finns thought either that their health system ran "quite well" or that "only minor changes were needed to make it work better". This was the highest satisfaction figure recorded among the EU-15 countries (Ministry of Social Affairs and Health, 2003). The high levels of reported satisfaction in Finland are especially striking when allowance is made for the fact that Finnish health expenditure per capita is below the European average – since there are signs that, across European countries, "satisfaction" rises with health expenditure per capita.⁸

2.4.8. Microeconomic efficiency in the market for prescribed drugs outside hospitals

It is possible to raise questions about the incentives and regulations governing the market for prescribed drugs outside hospitals. There are wide variations in patterns of prescribing across the Nordic countries which suggests that there is probably scope for rationalising consumption in all of them (NOMESCO, 2004). By comparison with most other OECD countries, patients in Finland pay a high share of the cost of prescribed pharmaceuticals outside hospitals. For many prescribed drugs, patients pay over half the cost. However, the co-payment rate is reduced to 25% or 0%, after the first EUR 5 has been paid, for patients with particular conditions, and cost sharing is capped at about EUR 607 for all patients. As a result of these rules, the public sector pays for about two thirds of the total bill for drugs prescribed outside hospitals. At 51.8%, Finland appears to have had the second highest share of private spending on all medicines (including over-the-counter medicines) after Denmark among 13 European countries reporting data in 2001 (OECD, 2003a).

The public share of the prescribed drugs bill is borne by NHI, not the municipalities (or patients in the case of occupational health services or private consultations). As a consequence, outside hospitals, prescribed drugs may look like a "free good" so far as the prescribing physician is concerned (see Box 2.1). Meanwhile, NHI is in no position to influence the decision to prescribe. In other words, there is separation between the decision to prescribe drugs and the responsibility to meet the public share of the cost. Such a combination of incentives will do little to discourage waste.

In addition, this separation provides incentives for cost-shifting from municipal budgets to NHI. The municipality pays the drugs costs for patients in institutions. Patients may be moved prematurely into non-institutional settings because it reduces prescribing costs which would otherwise fall on the municipal budget.

Regulation of the retail pharmacy market may be failing to set capacity economically. According to IMS comparisons, Finland ranked 5th lowest out of 14 countries in terms of wholesale prices for the top 100 best-selling pharmaceuticals in Finland but 5th highest in terms of retail prices among the same countries for the same pharmaceuticals (Pharma Industry, Finland, 2005). Somewhat similar findings have been reported for a smaller group of drugs across seven European countries (Martikainen *et al.*, forthcoming). However some of the explanation for that seems to lie in Finland's relatively high taxation of retail drugs – at about 14% of the retail price (7% in VAT and 7% in the “pharmacy fee”). That appears to be the third highest tax rate among the EU-15 countries judging by Table 11.1 in Mossialos *et al.*, 2004 (after correcting the data in that table for Finland). VAT on medicines is 24.5% in Iceland and 24% in Norway (NOMESCO, 2004). The *pharmacy* share of the retail price itself, at about 24% in Finland (excluding tax), seems to have been about typical for an EU-15 country (Association of Finnish Pharmacies, 2004; and Mossialos *et al.*, 2004).

Nevertheless, there appears to be a relatively high number of pharmacists in the country (see Figure 2.10). Each community pharmacy in Finland serves about 6 500 people (Association of Finnish Pharmacies, 2004). That is fairly typical for a European country but it is below the levels reported for Denmark, Norway and Sweden (Mossialos *et al.*, 2004). Each community pharmacy in Norway and Sweden serves more than 10 000 people, although the population density in both these countries is similar to that in Finland. The additional pharmacies in Finland may be the result of the regulation/licensing arrangements which give pharmacists geographical monopolies and exclusive rights over the dispensing of over-the-counter medicines. The Ministry of Trade and Industry told the OECD mission team that it favoured de-regulation of retail pharmacy arrangements in Finland and the adoption of a competitive retail market for dispensing. However, the regulation system serves access and equity purposes which would have to be considered carefully in any review.

2.4.9. The impact of decentralisation on efficiency

The Finnish health system is one of the most decentralised of its kind. For example, comparing it to the other three Nordic countries with populations of a similar size to that of Finland – Denmark, Norway and Sweden – only Finland delegates the financing and governance of all three main health and social services – primary care, hospital care and social services – to more than 400 municipalities.⁹ Whereas all three of the other countries also delegate social services to municipal level, only Norway joins Finland in delegating primary care to this level. Primary and hospital care are governed at county level in Denmark and Sweden, currently, and from 2007 Denmark will concentrate the governance of these services under five regions. Sweden is currently reviewing the structure of local government – with a focus on rationalising health care administration. Norway both nationalised and regionalised the administration of its hospital services in 2001 – like Denmark under five regions.

Decentralisation of the governance of health care on the scale found in Finland is likely to have both positive and negative impacts on efficiency. The potential *pros* and *cons* of such decentralisation are considered in Box 2.3. It is concluded there, that the potential *pros* include the gains from allowing communities to exercise local preferences and use local knowledge; and the potential *cons* include problems with variations in taxable capacity, losses from reduction in purchasing power, diseconomies of scale, lack of expertise, conflicts of interest and lack of national transparency (if information gathering and use is exclusively decentralised).

In practice, however, steps have been taken in Finland to avoid or to mitigate the potential adverse effects of decentralisation for efficiency.

- As has been mentioned above, the municipalities are obliged to cooperate in 20 districts over the management of hospital services and they sometimes co-operate in the provision of health centre services.
- National guidelines are set for the delivery of some services – such as those introduced in 2005 setting various national waiting time targets for services.
- There is national wage bargaining for staff employed by the municipalities.
- Professional education, training and regulation are centralised or regionalised. It is possible that professionalism has been encouraged by the relative weakness of municipal management in Finland.
- There is a national policy of “steering by information” and considerable centralisation of the gathering and the use of information. STAKES monitors the performance of hospitals and social services, enabling there to be “benchmark (or yardstick) competition”.

Turning to the evidence on efficiency of health care in Finland, it is difficult to disentangle the effect of decentralisation of governance on efficiency from the effect of other factors such as the horizontal integration of services (especially in health centres) and the degree of professionalism in health care. Results from a comparison of hospital efficiency between Finland and Norway, using identical DRG codes, suggest that Finland's hospitals were more efficient than those of Norway in 1999, when the administration of hospital in Norway was still at county level (Linna, Häkkinen and Magnussen, 2005). Part of the explanation for the differences lay in the fact that relative wage levels for hospital staff were higher in Norway than in Finland.

There is plentiful “evidence” from analysis of national data in Finland that inefficiencies exist in the provision of all types of municipal health services (see Luoma *et al.*, 1996 and 2004 for health centres; Linna and Häkkinen, 1996 for hospitals; Björkgren *et al.*, 2001 for long-term care units; and Linna *et al.*, 2003 for dental care). Measured productivity in health centres fell, on average, from 2000 to 2003 after a sharp increase during the recession in the early 1990s, followed by a period of stability (Luoma *et al.*, 1996; and Aaltonen *et al.*, 2005). Measured productivity in health centres in 2003 was about the same as measured productivity in 1988 (Aaltonen *et al.*, 2005). In hospitals, measured productivity¹⁰ fell over the four years from 1999 to 2003 as episodes of care failed to increase in line with rising expenditure (STAKES, 2004). These results suggest that there may well be scope for eliminating waste in the Finnish health system. Several of the studies found evidence that measured efficiency across providers was inversely related to higher state subsidies. In addition, the studies both of health centres and of hospitals suggested that measured efficiency was inversely associated with the ratio of physicians in the workforce and the study of dentistry suggested that efficiency was inversely associated with unemployment in the municipality. The authors speculated that the last finding may have been due to the pursuit of local employment objectives by municipal authorities: municipal providers were pressured into employing more unskilled staff than was necessary.

Little, if any, direct evidence has emerged from these studies that measured inefficiency is related to the size of the municipality. When that hypothesis was tested in the dental care study, there was no significant association found in three of the models tested out of four.

However, it should be noted that none of these studies was able to allow fully for variations in complexity or in the quality of care across providers. There have certainly

been increases in complexity of demand over time, mainly because of technological change and the ageing of the population. Likewise, there have probably been major improvements in the effectiveness of municipal health services, not least because of the rising quality of drugs prescribed to ambulatory patients and better diagnostic techniques.

Turning to the quality dimension of care, an international study of clinical quality management (QM) in health care (Sluijs *et al.*, 2001) based on questionnaire responses, has contrasted arrangements in the Netherlands with those in Finland. In the Netherlands, clinical QM is required by law and is organised at a national level. In Finland, QM is not required by law and the management of health care is organised mainly at municipal level. In the Netherlands, QM is highly regulated. In Finland, QM policy in the 1990s has been professionally-led and has been based on “steering by information” – it has taken the form of recommendations drawn up by bodies representing the decentralised actors in the system. Interestingly, although there was more overt evidence of QM activities in the Netherlands than in Finland, there were also many reports of negative bureaucratic side-effects in the Netherlands. Moreover, more positive effects of QM were reported from Finland than from the Netherlands. Also, there was negligible regional variation in QM in Finland, despite decentralisation.

However, a review of the outcomes of hip and knee arthroplasty surgery in Finland in 1998, using the country’s Arthroplasty Register, suggested that there were problems from de-centralisation. Arthroplasty operations were being carried out in about 70 hospitals, many with volumes below three procedures per week. There was evidence that outcomes were improved in hospitals where volumes were higher. Revision operations for hip arthroplasty – a possible measure of poor quality – were “... almost double as compared with (a) good international level” (Nevalainen *et al.*, 1998).

2.4.10. Human resources: shortages, incentives and skill-mix

Shortages of human resources

Finland has experienced a shortage of doctors and dentists recently and is facing potentially much larger shortages of all categories of health and social services staff during the next decade or two because of rising demand, together with ageing of the workforce.

In 2003, about 11% of posts for physicians in health centres, about 8% of posts for physicians in hospitals and about 7% of public posts for dentists were unfilled. The shortages were more severe in remote and rural areas than in the main urban centres in Finland. The main reason for these unfilled vacancies is that, during the recession in the early 1990s when there was significant unemployment among doctors, the intake to medical schools was cut from about 500 per annum in 1990 to about 350 per annum in 1995. When the demand for doctors resumed rising, and retirements also began to increase, in the late 1990s, there were not enough graduates to fill the new vacancies. Such cyclical imbalances between demand and supply are quite common in skilled labour markets because of the adjustment lags associated with long professional training programmes, which can give rise to alternating periods of surpluses and shortages.

Finland is facing the potential for much larger imbalances between the demand for, and the supply of, health workers of all kinds during the next decade as a result of technological change and client ageing (which will increase the demand for health services), a surge of retirement from the existing workforce (which will reduce the supply of staff unless recruitment increases to compensate) and dwindling cohorts in the younger age groups from which most recruitment takes place. The Committee on Estimation of Labour Demand in

Box 2.3. The advantages and disadvantages of decentralisation in health care

In theory, there will be both advantages and disadvantages of decentralisation of the governance of publicly-funded health and social services (Levaggi and Smith, 2005). Clearly, the balance of *pros* and *cons* will depend on the size of the country concerned and the degree of decentralisation. In what follows, the potential effects of decentralisation to small local authorities of the size found in Finland are considered (implicitly) against centralisation in a country the size of Finland, without taking into account the arrangements which have been made, in practice, to mitigate the adverse effects of decentralisation in Finland. The advantages and disadvantages of such decentralisation are considered from the point of view of efficiency (under four headings: raising funds; spending funds; providing services; and gathering and using information) as well as from the point of view of equity.

It should be borne in mind that efficiency may be affected by other organisational factors, such as the degree of horizontal and vertical integration of finances and services and the strength of professional training and regulation.

Impacts of decentralisation on efficiency

Raising funds: *pros* – local communities can exercise preferences over tax rates and decentralisation may encourage fiscal discipline; *cons* – problems with variations in taxable capacity between municipalities and over time: and some extra administrative costs in raising taxes.

Spending funds: *pros* – local communities can exercise preferences over priorities and there can be local innovation in methods of purchasing services; *cons* – reduction of purchasing power, reduction of purchasing expertise, possibility of conflict of interest between: i) serving patients; and ii) providing local employment and activity, especially in relation to public sector providers.

Providing services: *pros* – local communities can exercise some preference over production methods, production can be tailored to demand using local knowledge, and there can be local innovation in methods of provision; *cons* – likely reduction in management expertise; likely loss of economies of scale and of specialisation (at least for hospital care).

Gathering and using information: *pros* – less information may be required if use is only local; *cons* – lack of common definitions and standards, lack of national data base, lack of national transparency and comparability, barriers to diffusion of some innovations (“not invented here”).

Impacts of decentralisation on equity

Pros – local communities can exercise some preference (at least in terms of local fine-tuning) over the degree of equity in payment for and/or access to publicly funded health services.

Cons – local choice over funding levels and service mix is fundamentally incompatible with national standards of equity in payment for and receipt of health care. In addition, there are major problems posed by organising public financing of health services on the basis of small, local populations. Ability to pay (or taxable capacity) and the need for services tend to vary both systematically and inversely by locality. That may become exacerbated over time if – as in Finland – there is internal migration involving, disproportionately, those of working age moving from remote areas to a few growing population centres. Also, there is random local incidence of very high-cost patients (despite predictable national incidence).

Box 2.3. The advantages and disadvantages of decentralisation in health care (cont.)

Health systems which establish one national, public health-insurance pool, funded by national taxation, together with a mechanism for allocating national funds to local areas on the basis of their need for services, and a mechanism for ensuring that the expenses of very high-cost patients are shared nationally, can ensure that payment is matched to ability to pay (by making taxes, say, proportional to income) and treatment is matched to need (and not to income) for all citizens.

In contrast, putting aside the exercise of local choice, if income and need vary geographically and inversely and there is random incidence of very high cost cases, decentralisation of funding will lead either to payment for health care which is pro-rich or to treatment for need which is pro-rich, or to some combination of these two types of inequity. It is difficult to organise cross-subsidisation to compensate for that with decentralisation of the degree found in Finland.

Conclusion

From the point of view of *efficiency*, decentralisation, on the scale found in Finland, will strengthen local democracy and ownership of publicly funded health services at the cost of likely problems with taxable capacity, reduction in purchasing power, diseconomies of scale, lack of expertise, conflicts of interest and loss of national transparency. Much may depend on the extent to which the professionalism of providers can make up for weaknesses, here. From the point of view of *equity*, there is likely to be a fundamental trade-off between choice and national equity. Apart from that, highly decentralised funding will make it difficult to achieve national equity in payment according to ability to pay and national equity in treatment according to need, despite the possibility of cross-subsidisation.

Social Welfare and Health Care has estimated, using as a baseline all staff employed in health and social care in 2000, that by 2015 new demand will add about 30% of new posts to the (all staff) baseline for health and social care. Retirements will lead to about 43% of existing posts becoming vacant, giving a total of 73% of posts needing to be filled compared with the baseline. For physicians and nurses, 78% of baseline posts will need to be filled.

So far as physicians are concerned, if the current rate of intake to medical school of over 600 is continued for the next ten years, the cumulative number of graduates will be sufficient to replace those doctors expected to retire in the next ten years (allowing for some wastage in the education and training system). However, it will not be sufficient to fill the new posts which STAKES has estimated will be required because of the anticipated rise in demand. Hence, the threat of shortages seems set to persist during the next decade, unless further measures are taken to close the gap.

Incentives

Incentives for staff may be financial or non-financial. In the case of financial incentives, Finland relies mainly on salary payments to staff, with some capitation payment of doctors in health centres. These methods are good for controlling costs but they do not in themselves provide encouragement for staff to provide higher rather than lower levels of activity.

So far as non-financial incentives are concerned, the OECD review team was told (anecdotally) that registered nurses are accorded high professional status in Finland. Finnish nurses who had worked in England during the period of high unemployment in Finland in the mid-1990s, had reported that they were accorded lower status in the British

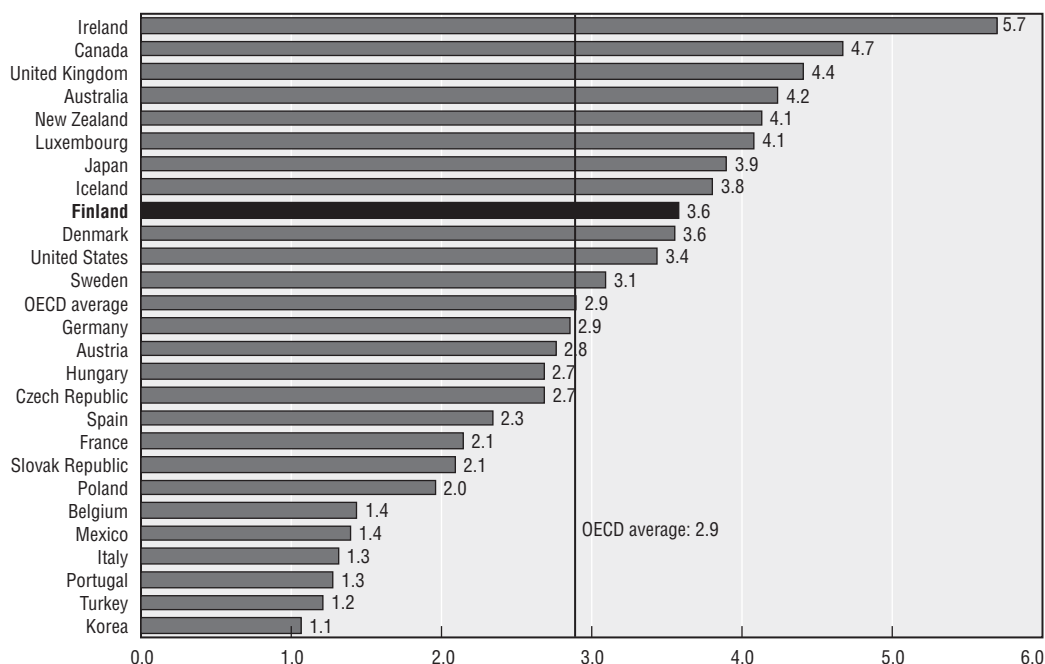
NHS than in Finland. The important role of nurses in the health centres is another sign of this professional recognition, although they are not allowed to prescribe. However, Super, the union which represents practical nurses in Finland, has reported declining entrant volumes and high attrition rates recently. It drew attention to the results of a Gallup survey of public opinion that suggests that a majority of Finns think that the care sector is underpaid and undervalued (Super, 2005).

Skill-mix

The provision of modern health and social services is a complex activity which relies on multi-professional and multi-service teamwork. The roles of different professional members of these teams can depend as much on traditional job demarcations, dating from an earlier era, as on a division of labour which maximises efficiency. If so, there may be opportunities to reap efficiencies by modernising the roles and mix of staff in the workforce (changing the “skill mix”), provided that such changes are brought about through consultation and are supported by appropriate training. In practice, debates about changing skill-mix have mostly involved searching for opportunities (as qualification levels rise generally) to transfer certain tasks from more highly qualified and more highly paid staff (such as doctors) to less highly qualified and less highly paid staff (such as nurses) where these tasks can now be performed safely and appropriately at the relatively less qualified level.

Judging by the reported aggregate data, Finland has a professional skill mix which is lean in physicians, somewhat rich in nurses (including registered practical nurses) and very rich in dentists and pharmacists compared with the averages for other OECD countries (Figures 2.10 and 2.19). Nurses seem to play a particularly important role in

Figure 2.19. **Ratio of practicing nurses to practicing physicians, Finland and selected OECD countries, 2003**



Note: Data refer to 2003 except for Australia, Belgium, Denmark, Japan, Luxembourg, Sweden, and the United States, which refer to 2002.

Source: OECD (2005b), *OECD Health Data*, June, Paris.

health centres: in the provision of preventive services; in nurse triage and care of patients with minor acute complaints; and in the ongoing treatment of many chronically ill people.

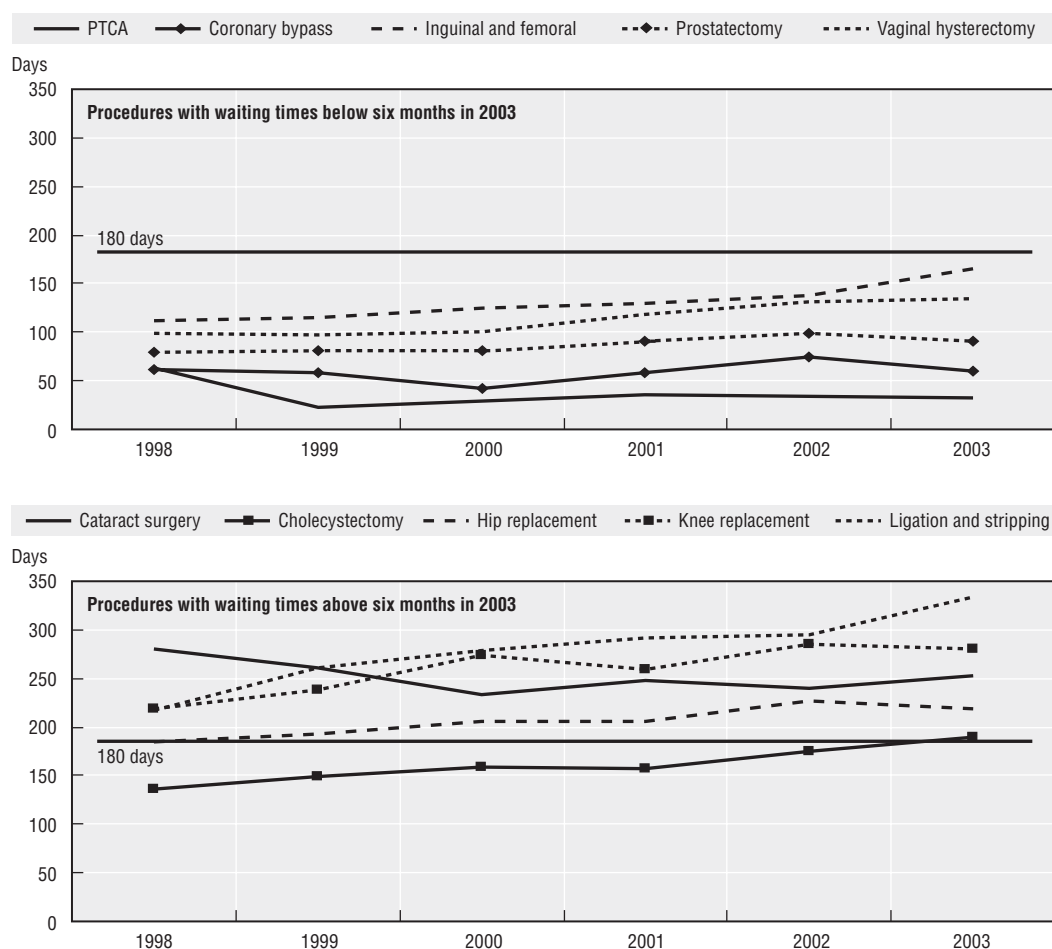
The high numbers of pharmacists reported by Finland could be regarded as a problem from the point of view of making savings on dispensing costs. However, if the role of pharmacists in the primary care team were to be expanded, these numbers could prove to be an advantage.

2.4.11. Waiting times for elective surgery

It has been shown already that, from an international perspective Finland had relatively long waiting times for publicly-funded elective surgery in 2000 (Figure 2.18). There is no international agreement on what length of waiting time is “too long”, but many countries are now setting targets for maximum waits of around 3-6 months (including Finland – see below).

Mean waiting times seem to have become longer for most procedures in Finland in the past five years. Figure 2.20 suggests that waiting times rose for seven out of ten procedures between 1998 and 2003. The six month (180 days) benchmark was exceeded for five major procedures in 2003.

Figure 2.20. **Waiting times for elective surgery in Finland, 1998-2003**



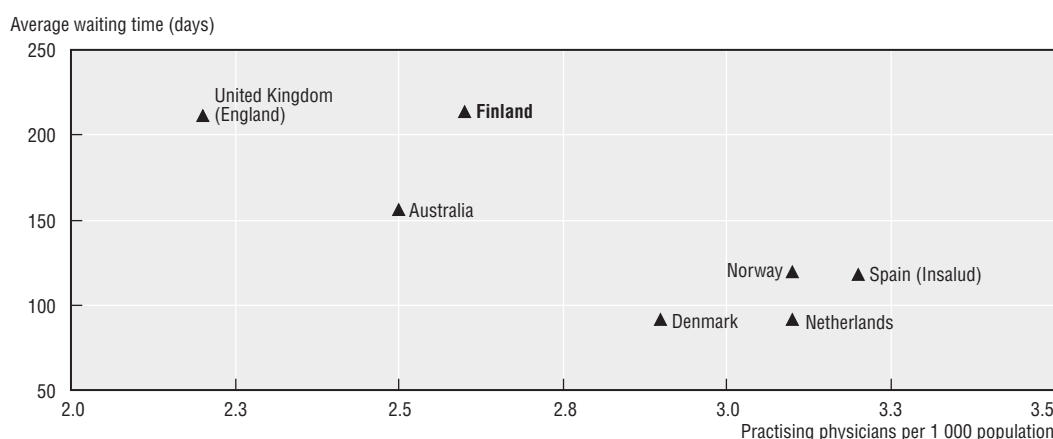
Source: STAKES.

The OECD Waiting Time Project suggested that the causes of variations in waiting times for elective surgery across countries included differences in the constraints on the supply of publicly funded surgery and differences in the incentives for managing the demand for surgery. In relation to constraints, Figure 2.21, which plots average waiting times for a combination of six procedures against practising physicians per thousand population across seven countries, suggests that Finland's relatively few physicians per capita might be part of the explanation for her long waiting times. An inverse relationship between waiting times and physicians per thousand across countries was confirmed by econometric analysis which controlled for a number of confounding variables in the OECD project. However, waiting times in Finland seem to be higher than might be expected from the inverse relationship suggested by Figure 2.21. Unfortunately, the data are not available to compare surgeons per thousand population or other indicators of surgical capacity across these countries.

Could long waiting times in Finland be due to an inadequate supply of surgery? That seems unlikely judging by current procedure rates. Figure 2.12 showed that, with the exception of prostatectomy, Finland's rates of surgery for certain major elective procedures are comparable to, or above (and, in the case of hysterectomy, well above) the average rates in a number of countries which do not report any problems with waiting times. Finland seems to achieve high levels of surgical activity despite limited physicians, acute beds and expenditure per capita.

If surgical activity is relatively high in Finland, why are waiting times not lower? One explanation might be that the real demand for surgery is higher in Finland than in other countries. The elderly have higher rates of surgery for many procedures than the young – but the proportion of the elderly (65+) in Finland was about the same as the OECD average in 2001. Nevertheless, it is possible that a backlog of people with chronic diseases requiring surgery had built up during the years of reduced health expenditure in the 1990s. Although productivity rose, the modest rise in activity during the decade may not have been

Figure 2.21. **Physician density and average waiting times for elective surgery, Finland and selected OECD countries, 2000**



Note: Data for average waiting time refer to 2000, whereas data for practising physicians refer to 2003, except for Australia and Denmark whose data refer to 2002.

Source: OECD (2004b), *Towards High Performing health Systems: Policy Studies*, Paris; OECD (2005b), *OECD Health Data*, June, Paris.

sufficient to keep pace with the rising demand, driven both by the ageing of the population and by technological changes.

Alternatively, the expressed demand for surgery may be higher in Finland than in other countries because the thresholds for referring patients for elective procedures and for putting them on waiting lists are set lower in Finland than abroad. Large international variations in surgery rates, which cannot be explained by differences in morbidity, have been demonstrated repeatedly both across small and large geographical areas for many OECD countries. These are likely to be reflected in corresponding variations in the thresholds for admitting patients to waiting lists, where waiting lists have formed. The explanation usually offered is “clinical uncertainty” or “clinical signature” – in other words, there is much subjectivity among surgeons about the decision to offer surgery. Perhaps Finland is a country whose surgeons are particularly enthusiastic about operating – leading not only to a high surgery rate but also to a high propensity to add new patients to waiting lists and, therefore, to long queues.

The OECD Waiting Times Project identified a number of incentives which might underpin any such enthusiasm. All of the incentives which were identified can be found in Finland. First, GPs in Finland’s Health Centres, who notionally act as gatekeepers, have few if any incentives not to refer to surgeons any patients who might benefit (however slightly) from surgery. Secondly, hospital districts have every incentive to encourage the maintenance of long queues for surgery to strengthen their hand in annual negotiations with the municipalities about hospital budgets. Finland has a method of financing hospitals where it seems likely that “public money follows the queue”. Although there is widespread use of activity-based funding in many Finnish hospital districts, it seems to play the role of helping to determine the share of the total budget falling on each municipality rather than the role of determining the size of the total budget itself. Thirdly, surgeons in Finland also have incentives to maintain queues because they frequently have dual practices – “private fees follow the queue”.

2.4.12. Long-term care

In 2003 about one quarter of people over 75 were receiving some sort of regular, subsidised long term care from the municipal health and social services. The services included home help, home nursing, residential homes, service housing and long-term care in health centres. In the case of regular home help and home nursing services, there was a decline between 1995 and 2003 from 13.8% to 11.4% of those over 75 receiving services (STAKES, 2003 and 2004). This excludes private care funded by the households themselves. It is difficult to say whether this recorded reduction in regular care at home represents a cut in support for this age group, an increase in the use of private care funded by households, or a sign that elderly Finns are becoming less disabled through time. Over the same period, there was a fall in the use of residential homes by those over 75 from 6.7% to 4.7%, a fall in the use of health centre beds from 3.7% to 2.6% and a rise in the use of serviced housing from 2.7% to 5.5% (STAKES, 2004). 45% of the places in service housing are now provided by municipalities, 44% by private voluntary organisations and 11% by commercial enterprises (STAKES, 2003).

The shift from residential home places and health centre beds to serviced housing was desirable, given the aim of caring for people in their own homes, wherever possible. However, the shift may also have been influenced by the different rules for cost-sharing and for means-testing between institutional care and domiciliary care. In institutional care

in Finland, all pharmaceuticals are provided as part of the treatment. However, if patients are accommodated in serviced housing, they pay rent and receive a housing allowance from NHI, while any pharmaceuticals have to be purchased through pharmacies and are reimbursed subject to KELA rules. This means that the net cost to the municipalities of caring for people in such housing is much less than the cost of caring for them in residential homes, even in those cases where the intensity of the care needed is the same.

The administrators questioned by the OECD mission team denied that they allocated care in response to such cost considerations. Also, detailed STAKES data on care setting by care needs, suggests that those with severe needs are in appropriate care.

2.5. Equity in the financing and use of health care

2.5.1. Equity in the financing of health care

One of the main aims of public funding of health services is to achieve a fairer share of the burden of paying for health care across the population than would be the case if, say, all payments were made out-of-pocket. Fairness, or equity, in financing health care may be examined by comparing the distribution of all forms of payment for health care (via taxes, social insurance contributions, private health insurance premiums and out-of-pocket payments) by households with different levels of income with the distribution of income across households. The distribution of payments may be alternatively: proportional to income; regressive/pro-rich (lower income groups pay a higher proportion of their income for health care than higher income groups); or progressive/pro-poor (lower income groups pay a lower proportion of their income for health care than higher income groups).

An international study of equity in the financing of health care across 12 OECD countries (Wagstaff *et al.*, 1999) suggested that Finland had progressive/pro-poor funding of health care in 1990. Finland was one of five countries with progressive funding around 1990 and ranked 3rd among these countries. However, by 1994 Finland had slipped somewhat in terms of progressivity. Payment for health care had become almost proportional to income. The reason for this change was a shift in the sources of funding of health care towards regressive indirect taxes and out-of-pocket payments, which was part of the government's response to the economic recession of the early 1990s (Klavus and Häkkinen, 1998). The relative stability of the main sources of finance for health care in Finland since the mid-1990s suggests that equity of financing may have changed little subsequently (Häkkinen, personal communication).

2.5.2. Equity in the use of health care in relation to income and need

Another major aim of public funding of health services is to achieve greater equity in use of health care than would otherwise be the case. Equity in use of health care can be examined by comparing the observed distribution of utilisation with the expected distribution across income groups. The latter is estimated from regressing variations in utilisation of care on variations in determinants of need, such as self-reported health status, across individuals, using health or household survey data. Use of services in relation to need may be proportional to need across the different households, pro-rich or pro-poor.

A recent international study of equity in use of health services in 21 OECD countries (Van Doorslaer and Masseria, 2004; and OECD 2004b, Chapter 3) suggested that in 2000 Finland had slightly progressive use of hospital services (although use was not significantly

different from being proportional to need) and significantly regressive use of dental services. In these two respects, Finland was quite typical of the other OECD countries in the study. However, Finland stood out among the 21 countries as having the most regressive distribution of visits to GPs and the second most regressive distribution of visits to specialists. There are also inequities in access to some types of surgery (Keskimäki, 2003). The explanation for this comparative inequity in Finland lies probably in the fact that around one third of visits to doctors in Finland are to occupational health providers or to private physicians, part funded by NHI, and access to both these types of physician – and probably subsequent referrals – are quite inequitable by income. That outweighs the fact that medical consultations in health centres are progressive and in out-patient departments are roughly proportional to income (Häkkinen, 2005). As a consequence of “parallel funding”, Finland could be said to have “four-tier” medicine, depending on whether a patient is employed or not and whether he or she receives high or low income (see Box 2.1).

Although Finland stands out as having *relative* inequity in visits to physicians, compared with other OECD countries, the *absolute* differences in need-adjusted utilisation were not very large across the population. It would require only about 3-4% of total visits to physicians to be redistributed from the richest half of the population to the poorest half, to achieve equity in utilisation in Finland (Häkkinen, 2003).

2.5.3. The impact of decentralisation on equity

The potential impact on equity of decentralisation of the financing and governance of health services is reviewed in Box 2.3, which concludes that decentralisation tends to increase inequity: there is a trade-off between local choice and equity. In addition, if the national objective is to achieve payment for health care in accordance with ability to pay and treatment in accordance with need, then full decentralisation of the financing of health care to small municipalities will tend to frustrate the achievement of one or other of these objectives (or some combination of both of them) because geographical variations in taxable capacity are generally inversely associated with geographical variations in need. In addition, achievement of equity can be threatened by the random local incidence of very high-cost patients.

In practice, steps have been taken in Finland to avoid or to mitigate the potential adverse effects of decentralisation on equity.

- The Ministry of Interior provides grants which help to bring about partial convergence in the taxable capacity of municipalities.
- The Ministry of Social Affairs and Health provides grants which go some way towards compensating for differences in the need for services and in costs between municipalities.
- The hospital districts are required by law to arrange equalization mechanisms for sharing the burden of very high-cost patients among the participating municipalities. If an individual patient's treatment costs exceed a specified threshold, all municipalities that are members of the district will share all or part of the excess.

The problem remains that these mechanisms do not seem to make complete adjustments for differences in ability to pay and in need. First, the grants of the Ministry of Interior are designed to achieve only partial convergence in taxable capacity between municipalities. Secondly, the need-adjustment formula used by the Ministry of Social

Affairs and Health has been deliberately simplified. It contains only one need indicator, apart from age weighting. STAKES has estimated a more complex formula (Häkkinen and Järvelin, 2004) which would adjust more completely for differences in need across municipalities – at the cost of losing simplicity – but this is not used. Meanwhile, there is no attempt to adjust municipal revenues for the geographically unequal flows of public reimbursement for drugs, occupational health services and private services, which are funded by NHI. Thirdly, in the absence of a national risk pool, there seem to remain problems about sharing the burden of some very high-cost patients in Finland.

Some impression of the effect that decentralisation has on equity of payment for health care can be obtained by noting that the rate of municipal income tax varied from 16% to 21% across municipalities in 2005. Some impression of the effect that decentralisation has on equity in access to treatment can be obtained by examining the variation across municipalities in an index of their need-standardised¹¹ expenditure on health and long-term care services, net of out-of-pocket payments. In 2003, the range of variation in this index (Finland = 100) was from 60 to 138, a more than two-fold variation.

It is not clear from the data available to the OECD how much of this variation was due to causes outside the control of the municipalities, such as incomplete adjustments in the state grant formulas for differences in need across municipalities, and how much was due to the effect of factors within the control of the municipalities, such as the exercise of municipal choice over the level of spending and remediable variations in efficiency.

An important question is whether the additional decentralisation introduced in 1993 increased inequity in the Finnish health system. The evidence suggests the contrary. For example, the coefficient of variation of population-weighted, per capita, municipal expenditure on health and institutional care of the elderly (without need adjustment) declined from 15.1% in 1993 to 13.1% in 2003 (Source: STAKES).

2.6. The bottom line

2.6.1. Macroeconomic efficiency (sustainability)

Municipal expenditure on health services was well controlled in Finland in the mid and late 1990s. However, there are now reports that many municipalities are under financial stress, feel that they have little influence over hospital expenditure and have been forced, in relative terms, to squeeze spending on health centres. Many have resorted to additional borrowing recently. Also, spending has been rising rapidly on prescribed drugs – funded by NHI. The rate of growth of drugs spending as a share of GDP seems to have been fairly typical for an OECD country but, as a share of total health expenditure, it has been growing faster than in other Nordic or in other OECD countries. That draws attention to the relative lack of control of spending funded by NHI. So long as the levels of these shares of spending on drugs remain, as they now do, below OECD averages, the picture is not very alarming. Nevertheless, there is some evidence of inappropriate prescribing (see below).

2.6.2. Microeconomic efficiency (value for money)

International comparisons, using highly aggregated data, suggest that despite its relatively low level of health spending, Finland manages to purchase an above-average level of some key inputs to her health system (with the exception of doctors and acute-care beds) – partly because wages relative to the national average are below the corresponding ratios in other countries. Levels of inputs do not always translate commensurately into

utilisation rates because “productivity” (measured crudely) appears to be below average for some services. That may be a result, partly, of the relatively low financial incentivisation of staff, built into current remuneration methods. Nonetheless, the volume of drug utilisation and hospital discharges are above average.

The technical quality of services seems to be relatively good compared with the OECD average, judging by some indicators of avoidance of public health risk and a few indicators of health outcomes and appropriate procedures. The first may be due to policies which favour prevention and the second to the strong professional skills and motivation which seem to pervade Finnish health care. In contrast, responsiveness to consumers seems to be somewhat lacking judging by the long waiting times for appointments with health centre physicians and the long queues for elective surgery. A combination of lack of patient choice and the incentives facing providers may account for these characteristics. Finns, in general, report high satisfaction with their health system but that might depend partly on low expectations.

Among the topics of special concern to the Ministry of Social Affairs and Health, there are some reports of waste in prescribing and question marks can be raised over methods of regulating retail dispensing. There are reasons to suspect that decentralisation is a hindrance to efficiency but it is difficult to find evidence to that effect – perhaps because measures are in place to encourage cooperation among municipalities and professionalism among the providers may compensate for some weaknesses in municipal management. The evidence suggests that Finland does well in international comparisons of hospital efficiency but good average performance co-exists with high variability across hospitals – offering opportunities for even better performance.

As for the health care workforce, there are shortages of personnel in some staff groups. Skill mix is rich in nurses, dentists and pharmacists and poor in doctors. Shortages of health centre physicians may help to explain some of the long waiting for appointments but the lack of financial incentives for responsiveness may also play a part. The long waiting times for elective surgery are likely to be due more to a set of incentives for providers which discourage appropriate management of demand than to a lack of surgical procedures – judging by the comparatively high surgical procedure rates in Finland.

2.6.3. Equity in the financing and use of health care

Payment for health care, taking all sources of funding for health care together, seems to be broadly proportional to income in Finland. International comparisons suggest that Finland offers less equitable access to GPs and specialists than many other countries. Inequitable access to GPs is likely to be due to the availability of relatively abundant occupational health care, free of charge to employees, combined with relatively tight rationing of, and charging for, access to health centre physicians for non-employees. However, consultations with nurses may compensate somewhat for the latter.

It seems that three main conclusions can be drawn about the impact of decentralisation on equity. First, the adjustments to the taxable capacity of municipalities and to the needs formula for state grants are incomplete. Secondly, local autonomy is a leading goal in the system and there is a trade-off between that goal and geographical equity. Thirdly, the decentralisation reforms of the early 1990s do not seem to have been followed by an increase in inequity.

2.6.4. Conclusion

In summary, Finland is doing rather well on most aspects of macroeconomic and microeconomic performance and on equity compared with OECD averages. Among the apparent strengths are: relatively low costs as a share of GDP; rates of utilisation for some services that are at or above OECD averages; evidence of success in health promotion; good-quality technical outcomes; broad equity in payment for health care across income groups; and high public satisfaction with the system as a whole. Among the apparent weaknesses are: a rate of increase in spending on prescribed drugs which causes policy makers discomfort (although the level of spending on prescribed drugs, as a share of GDP, is below the OECD average and the rate of growth of this share is in line with the OECD average); relative inequity in access to general practitioners across income groups; evidence of considerable variations in use and productivity of some services across Finland; signs of some inefficiency in prescribing and dispensing outside hospitals; shortages of staff in some areas; and long waiting times for many patients to obtain appointments at health centres and access to elective surgery in public hospitals.

Notes

1. These figures have not been adjusted for any differences in part-time working between countries. In the case of dentists, Finland has a higher proportion of female dentists – and, hence, presumably of part-time dentists – than many other countries.
2. Acute-care beds are probably understated because, from 1996, beds in Finland have been estimated by dividing annual, occupied, bed days in acute and long-term care hospitals by 365 (which assumes a 100% occupancy rate). Occupancy is usually well below 100% in acute units. Long-term care beds may be overstated because of the inclusion of beds in health centres and “old age homes” in the Finnish numbers. All beds in health centres are counted as long-term care beds.
3. It should be noted also that hospital discharges are measured in a way that inflates them in Finland compared with other OECD countries. This is likely to lower length of stay in Finland compared with other OECD countries. See footnote 3 to Figure 2.11.
4. The level of this indicator may be under-reported in Finland, because of variation in local registration methods for adult immunisation.
5. Recent American research suggests that factors such as developing the right culture, attracting and retaining the right people, devising and maintaining the right in-house processes and giving the staff the right tools (including IT tools) to do the job, are critical in achieving high quality care in hospitals (Meyer *et al.*, 2004).
6. However, representatives of the Finnish Patients’ Association told the OECD mission team that reports of Finnish contentment with services were in part a result of a delusion (Finnish Patients’ Association, 2005). Citizens who rarely used municipal services had faith in the system. In contrast, users of municipal services, who were more often poor or disabled, were in a weak position. If they received poor quality and delayed services, they were reluctant to complain directly. The style of services in the municipal sector was paternalistic and although there is a complaints system, it often seemed to operate in the interests of the providers.
7. See for example, Eurobarometer 52.1 (1999). The Eurobarometer question reads, “In general would you say you are very satisfied, fairly satisfied, neither satisfied nor dissatisfied, fairly dissatisfied or very dissatisfied with the way health care runs in (our country)”?
8. However, there is room for different interpretations of these results. It is not clear whether the Eurobarometer question, above, is intended to refer to satisfaction with the quality of care delivered, or to satisfaction with the general arrangements for the way that services are financed and organised in a country.
9. It should be noted, however, that municipalities in Finland are required to cooperate over the provision of hospital services – in 20 districts.

10. Using in the numerator in the productivity ratio, activities linked into episodes of care for the same patient. Such “episodes” of care are likely to adjust partially for any differences in quality or effectiveness of care over time, such as changes in readmission rates.
11. Using the more complex need formula estimated by STAKES rather than the official, somewhat simplified, formula.

Chapter 3

Recent Reforms to the Finnish Health System

3.1. The “Health 2015” public health programme

In 2001, the government published a new strategy for improving public health in Finland under the title, “Government Resolution on the Health 2015 public health programme” (Ministry of Social Affairs and Health, 2001). The Resolution included a set of eight new health targets concerning: increasing child health; decreasing smoking by young people; cutting accidental and violent deaths among young men; improving working and functional capacity among people of working age (supporting the postponement of retirement); improving functional capacity among the elderly; increasing life expectancy; maintaining high public satisfaction with health services; and reducing inequalities in health status across the population. Implementation of the targets was mapped out under 36 action points aimed both at the government itself and at more decentralised actors in the system such as the municipalities, business and industry and non-governmental organisations. Plans were outlined to monitor progress with implementation of the programme up to 2015.

3.2. The SOMERA Commission

Against a background of concern about the future sustainability of the social protection system in Finland (which embraces health and social services, pensions and social security benefits) the Ministry of Social Affairs and Health set up the SOMERA Commission in April 2000 (Ministry of Social Affairs and Health, 2002a). The Commission’s brief was three-fold: i) to assess the challenges that the social protection system would face in the medium and long term; ii) to assess the ability of the system to meet the challenges; and iii) to cost the desired development of social expenditure.

The Commission reached the conclusion that despite the challenges that the social protection system faced, such as rapid ageing of the population and technological change, it should be possible to provide adequate social support in Finland in the foreseeable future. However, extensive actions would be needed to meet the many challenges. The Commission produced several projections of social expenditure including a baseline projection which assumed that the health and social welfare expenditure share of GDP would rise by about two percentage points between 2000 and 2030. It also produced several projections of the staff required in municipal health and social services, including a baseline projection that assumed that staff requirements would rise by about 15% between 2000 and 2030.

After re-stating the basic premise that the Nordic model of social protection would be maintained in Finland, the Commission recommended that various measures should be taken to reform the system. These measures included: promotion of work and functional capacity in the workforce, including postponing the average age of retirement by at least three years; more flexibility and efficiency in the provision of health and social services, including giving clients more choice; new investment in the numbers of staff trained and in the content of training for these services; an improved division of labour between central government, local government and providers; greater transparency in the financing arrangements for the services; and more evaluation of the efficiency of operating methods.

3.3. The National Project on Safeguarding the Future of Health Care Services

Before the SOMERA Commission had completed writing its report, the government set up a “National Project on Safeguarding the Future of Health Care Services”. This project was charged with preparing “...a plan and implementation programme to ensure health care functions and the availability and quality of health care services”.

As a result of the work undertaken under this project, an important package of recommendations for reforms to the health system was announced in April 2002 (Ministry of Social Affairs and Health, 2002b).

The recommendations from the project fell into seven areas:

1. A renewed stress should be put on health promotion by the local authorities, in line with the previously published “Health 2015” proposals (Ministry of Social Affairs and Health, 2001).
2. New steps should be taken to improve access to and quality of services including: meeting targets that patients should wait no more than three days for assessment by a primary care professional, no more than three weeks for assessment by a specialist and no more than three to six months for recommended treatments or care; the introduction of national guidelines on what preventive and curative treatments should be offered for the principal classes of illness; the introduction of a minimum of three to ten days in-service training per year for health care staff; and improved health technology assessment for major new treatments which might be offered in Finland.
3. Certain structural reforms should be pursued including: more regional co-operation among municipalities to coordinate the provision of local health services across areas serving at least 20-30 000 inhabitants; more co-operation among hospital districts and municipalities to rationalise specialist services; steps to economise on the provision of laboratory and imaging services; and steps to develop national compatibility of IT systems and electronic patient records across Finland.
4. Measures should be taken to stimulate the availability, skills and motivation of staff, including: improving management training; reviewing the division of labour between physicians and nurses; increasing enrolment in medical schools from 550 to 600 per year; increasing enrolment in the training of other key professions; requiring new doctors to spend more time working in health centres and diverting doctors who would otherwise be involved in research to clinical work; setting up national and regional advisory boards for training in social welfare and health care; and revising the payment arrangements for hospital physicians to promote efficiency objectives.
5. The different ceilings for patient cost-sharing for public services should be unified.
6. The sickness insurance reimbursement rates for laboratory and imaging tests should be reduced to a level corresponding to the cost of providing such services in efficient operating units.
7. Sufficient financial resources should be made available to the municipalities by the State to enable services to be developed, conditional upon implementation of the proposed reforms.

A newly elected government approved these recommendations in April 2003 and by March 2005 many of them had been implemented or were in the process of being implemented (Ministry of Social Affairs and Health, 2005a).

Some of these reforms and a number of separate reforms are discussed in further detail below.

3.4. Reforms to the regulation of medicines

The government has adopted a number of measures to try to encourage rational and cost-effective prescribing. Doctors in health centres, as in other countries, habitually prescribe drugs by brand name. In 2003, the government introduced a requirement for pharmacists to employ generic substitution (substitution of branded prescription medicines, no longer under patent, by the cheapest generic equivalent) unless the patient or the physician indicated otherwise. The idea was not only to substitute cheaper generic products for branded (patent-expired) drugs but also to encourage price competition among pharmaceutical companies. Either doctor or patient can forbid the substitution and in that case the patient gets the original prescribed product without extra cost. In other words, substitution is an option in Finland – although pharmacists are obliged to suggest it. For substitution to take place, the products have to be pharmacologically and clinically substitutable – containing the same active substance in the same amount and form – and bioequivalent. About one in eight prescriptions were substituted during the first year of the scheme, generating about EUR 88 million in savings – about EUR 49 million in public expenditure and about EUR 39 million in private expenditure. About one third of the savings were generated by substitution itself and about two thirds were generated by price reductions (National Agency for Medicines and KELA, 2004). The total savings by March 2005 represented about 7% of total expenditure on reimbursed medicines. In addition, proposed reductions of the wholesale prices of drugs in 2006 are expected to generate further savings of another 4%.

The government has also encouraged the development of advice for doctors on rational prescribing which is independent of, and a counterweight to, marketing by the pharmaceutical industry. A start was made in 1998 under the experimental “Rohto” programme which was funded by the government but led by the Finnish Medical Society, Duodecim. Essentially, this programme involved the development of continuing medical education on drug-related topics, using small local groups of doctors and facilitators to develop a problem-based approach to rational and cost-effective prescribing (Helin-Salmivaara et al., 2003).

The process utilised prescribing feedback – since 1997 all doctors who have written more than 200 prescriptions in a year, have received from the KELA a summary of their annual prescriptions and their costs, benchmarked against the average doctor in the relevant specialty. Prescribing doctors have been able to access evidence-based guidelines for the treatment of common diseases and health problems, developed by Duodecim.

In the wake of the perceived success of the Rohto programme, a new Pharmacotherapy Development Centre (PDC) was set up in 2003 with a remit to provide doctors with “balanced information on new medicines and treatments”. The PDC is linked to the National Agency for Medicines and will have access to its know-how and its files on medicine assessments (Hermanson, 2002).

3.5. Human resources

According to the Committee on Estimation of Labour Demand in Social Welfare and Health Care, approximately 12 000 more employees were needed to meet the increasing demand for social and health services by the year 2010. In addition, about 49 000-55 000 employees in social welfare and health care would retire by 2010. The Committee estimated that to meet this demand and fill the gaps created by retirements,

8 500-9 000 openings were needed per year in initial vocational training in social and health care from 2002 to 2010.

To tackle the shortage of doctors, the annual medical school enrolment was increased from a low of around 350 in the mid-1990s to 600 in 2002 and by 2004 had reached 630. From 2003, more physicians were graduating than were retiring. The Finnish Medical Association has stated that shortage of doctors had begun to decrease by 2005. However, the Association has also stated that the situation will require continuing monitoring (Finnish Medical Association, 2005). Nurse training has also increased, although there are unfilled places for practical nurses.

Postponing retirement of health and social services staff should be made easier by the adoption of new national policies on retirement generally. In the late 1990s, Finland as a whole had one of the lowest average male retirement ages among a selection of OECD countries – 59 years compared with a (then) statutory retirement age in Finland of 65 (OECD, 2003b). Steps have now been taken across the whole workforce, to encourage older workers to defer their retirement by altering the statutory, earnings-related pension scheme. From 2005, the statutory retirement age of 65 will be replaced by a flexible retirement age ranging from 62-68. If the pension is drawn at 62, it will be substantially reduced but if it is delayed, the accrual rate will be increased from its standard rate of 1.5% per year, to 1.9% per year between the ages of 53 and 62 and to 4.5% per year between the ages of 63 and 68 (OECD, 2004).

There was a doctors' strike, mainly over pay rates, which lasted for over five months in 2001. As a result, the salaries of doctors were increased by about 16.6% comparing 2002 to 2000.

The municipal pay system has been reformed recently. Although it is still based on collective agreements between the Commission for Local Authority Employers and the staff unions, there is now scope for more local flexibility over the pay of individual workers, including doctors and nurses. Pay is based on three components: a job-related component (depending on the demands of the job, the skills required and local circumstances); a person-based component (depending on personal competence and performance) and a goal-sharing plan (paid for achievements to job goals for individuals, set in advance). The collective agreements set minimum job-based and person-based pay. Higher remuneration can be paid by negotiation and as a result of performance.

3.6. Waiting times

The government began to implement two reforms in March 2005, under the Project to Safeguard the Future of Healthcare, aimed at tackling the problems of variations in treatment rates across the country and excessive waiting times for appointments and treatments. The first was the introduction of clinical guidelines for a wide range of treatments, based on previous work by Duodecim, aimed partly at bringing about some convergence across Finland in rates of elective surgical procedures and in the setting of thresholds for admission to waiting lists for procedures. The second was the introduction of a set of maximum waiting-time targets for non-urgent examinations and treatments at health centres and hospitals. For example, patients contacting health centres should be offered an assessment by a doctor or other health professional within three days. Patients deemed to require assessment by a specialist, should be offered an appointment within three weeks. Recommended hospital treatments, including elective surgery, should be

offered within 3-6 months. If the patient's own health centre or hospital is not able to provide the necessary assessment or treatment within the set timeframe, it must arrange the option of treatment in another municipality or in private health care, without extra cost to the patient (Ministry of Social Affairs and Health, 2005b).

These measures seemed to be taking effect by mid-2005. The Ministry of Social Affairs and Health reported that 80-90% of Finnish health centres were working to the new appointment waiting-time targets. With the help of overtime working in public hospitals and some contracting out to private clinics, the number of patients waiting longer than six months for elective surgery had fallen to 34 000 by August 2005, down from 60 000 in October 2002. However, it remains to be seen whether these improvements will be maintained in the longer term. The guidelines and targets have been introduced without any important changes to the incentives which underpin the system.

3.7. Electronic patient records

Considerable progress had been made by 2005 on the objective set under the National Project to introduce a national, electronic patient record. As a result of previous local initiatives, encouraged by national legislation in 2000 on "seamless service chains in social welfare and health care services", most health centres and about two thirds of hospitals had electronic patient records in daily use by 2003 and there were a number of local systems which integrated primary and secondary care records. However, these local systems were often incompatible with one another and work is continuing to develop a common national framework and set of standards to allow national interoperability across Finland of all electronic patient records. That is an important objective in view of the evidence, cited above, of gaps and delays in communication of patient information, particularly between health centres and hospitals.

3.8. Concentration of public laboratory and imaging services

Concentration of public laboratory and imaging services had boosted activity and reduced costs. In one University Hospital District, the average cost of a laboratory test decreased by 23% following concentration.

3.9. Long-term care vouchers and proposals to reform the system of support for informal carers

Legislation was introduced in 2004 to promote the use of "service vouchers" for the purchase of private home-care services by the elderly as an alternative to direct provision of municipal home-help services. The municipalities could award elderly people vouchers of varying value, depending on their needs and means. The value is supposed to be the cost to the municipality of providing the services (after the client pays the required co-payment). Clients who accept such vouchers (rather than opting for direct care) then choose their supplier from a list approved by the municipality, and pay as a fee the difference between the price of the service and the value of the voucher. In the health sector, the fee paid by the client cannot be greater than the charge if the service were directly provided by the municipality. This constraint does not apply to social services.

In addition, proposals have been made to reform the system of support for informal carers in Finland (Ministry of Social Affairs and Health, 2004). The aim is that support for informal care should cover 8% of persons over 75 years and include: services for the person

cared for; and monetary compensation and (respite) support for the carer. Monetary compensation for carers should be offered at three levels and applied uniformly across Finland. A number of related amendments should be made to tax and employment regulations to help finance informal care and to help carers to combine employment and care responsibilities.

3.10. Local reforms

There is significant scope for local experimentation and reform in the Finnish health system which arises from its decentralised nature, the opportunities that municipalities have for cooperation with one another and the freedoms they enjoy to provide services themselves, to contract with other municipalities, or to contract with the private sector for the provision of services. There have been a number of local experiments involving one or more of three types of organisational development within the past decade: regional cooperation among municipalities; integration of primary and secondary care and outsourcing of services to public or private providers. The first type of development has sometimes been combined with the second or third.

For example, nine municipalities in the Kainuu region of North East Finland (covering about 85 000 inhabitants) cooperated in 2005 to create a new regional administrative body to provide education services, and health and social care. Primary and specialist care were integrated under this organisation. Five municipalities in the health care district of Forssa (covering about 35 000 inhabitants) merged their health centres with the regional hospital into one administrative organisation in 2001. Purchasing of more specialised care from outside the area was organised jointly. An underlying aim of this reform was to provide patient-centred care with improved pathways for patients between primary and secondary care. The municipalities of Mänttä and Vilppula (with a population of about 12 000) merged their health centres with the regional hospital of Mänttä in 2002 and put the integrated services under the hospital district of Pirkanmaa.

Some orthopaedic services in the Tampere area have been outsourced to a specialised orthopaedic hospital, Coxa, since 2002. Coxa is a limited company which is owned by a public/private partnership between four hospital districts, a Finnish foundation and a German private hospital company. The municipality of Karjaa contracted in 1998 with a private, non-profit organisation, the Samfundet Folkhälsan, to provide all primary health care and services for the elderly. The aim was to reduce health expenditure and a recent evaluation showed that the rise in expenditure per capita had been slower than in the rest of Finland and that expenditure per capita had converged with the national level. The city of Lahti has contracted out the services of one of its health centres to a Finnish private company, MedOne, mainly to overcome difficulties in recruiting physicians. Within the public sector, there has been experimentation with formal contracting between the municipalities that own the Pirkanmaa hospital district, and the district itself. The contract involved specifying in advance the services to be delivered and the financing to be provided, with a view to enhancing efficiency and cost control.

Most of these experiments are undergoing some form of evaluation but it is usually too early to draw conclusions.

3.11. The project to restructure municipalities and services

In May 2005, the government set up a major project to develop proposals for restructuring municipalities and services (Ministry of Interior, 2005b). The project was

tasked, among other things, with: reviewing the responsibilities of municipalities, evaluating amalgamation of, and cooperation between, municipalities, identifying best practice in the delivery of services, evaluating the national steering process, and reviewing the division of duties and allocation of costs across Central government and the municipalities. The project was charged with concluding its work by the end of May, 2006.

3.12. Commentary

The baseline projection of the SOMERA Commission is quite optimistic about the future fiscal sustainability of the Finnish health and social service system. The Commission projected an increase of about 2% in the ratio of municipal and NHI expenditure on health and social services to GDP in the next 40 years, anticipating rapid ageing of the population. Yet in the last 40 years the corresponding share of GDP increased by about 4% in Finland, during a period of slow ageing of the population. It is believed widely that the main driver of past growth in health expenditure has been changing medical technology. There is no sign that the flow of medical innovations is about to dwindle.

The reforms set out by the National Project on Safeguarding the Future of Health Care Services, and the other reform measures described above, seem to be well aimed to tackle some of the weaknesses of the Finnish health system and to address future challenges. In particular, the new targets for maximum waiting times for appointments and recommended treatments and care already seem to be reducing the queues for surgery, although it remains to be seen whether the reductions can be maintained. The new guidelines for clinicians on what treatments should be offered should help to reduce the geographical variations in levels of many services which are seen across Finland and any excessive rates of surgical procedures – such as hysterectomy rates. The measures to encourage more regional co-operation among municipalities, both in relation to local services and specialist services, and to develop national interoperability of IT systems, should enhance efficiency. The steps taken to stimulate the availability, skills and motivation of staff are already reducing current shortages and should contribute to preventing future shortages of staff. The reforms to long term care arrangements seem to be appropriate adjustments in the face of an ageing population and the growing demand for elderly people to make their own choices, often to remain in their own homes cared for by those close to them, wherever possible.

Experience with change led from the bottom-up – that is with local reforms – seems to be a valuable feature of the Finnish health system. However, it is not clear how quickly such reforms will be generated, nor how strong are the mechanisms for evaluating them and for replicating those that are successful.

Although these national and local reforms seem to be in the right direction, it is not clear how much they do to change the incentives and structures underlying the Finnish health system. The project to restructure municipalities and services may recommend more radical reforms when it reports in 2006. Meanwhile, it remains to be seen whether the more modest reforms, described above, will continue to deliver improvements in the longer term.

Chapter 4

Assessment and Recommendations

The Finnish health system performs well but faces growing challenges.

This chapter looks towards the future. What challenges does the Finnish health system face and what further reforms might be considered to help it to meet these challenges? It has been shown above that, in many respects, the Finnish health system performs well in international comparisons. However, like other OECD health systems, it faces continuing or growing pressure from demand and cost-increasing technological change, and rising expectations among consumers. It faces greater pressures than most other countries in the near future from population and workforce ageing. It also appears to have some weaknesses in its underlying structures and incentives which may prove to be more costly in the future unless they are tackled soon.

This chapter considers additional reforms to the system.

Consideration is given here both to additional fine tuning of some aspects of the health system and to selected reforms of some structural features, such as: parallel funding, the degree of decentralization and the reliance, principally, on the Nordic (or “public-integrated”) model for the funding and delivery of services. This Chapter is organized under the three broad objectives of health policy which were highlighted earlier in this report: macroeconomic efficiency (including fiscal sustainability), microeconomic efficiency (value for money) and equity (in payment for and access to health services). There will often be tradeoffs between these broad goals.

4.1. Macroeconomic efficiency (sustainability)

Municipalities are finding it increasingly difficult to control hospital expenditure and spending on drugs is rising rapidly.

The aim of macroeconomic efficiency is to find a future path for total health and social service spending that balances benefits with costs and is fiscally sustainable through time. Given the small role that the private sector plays in the Finnish health system, finding such a path is currently the responsibility, mainly, of Finland’s central and local governments. These governments demonstrated that they were able and willing to exert strong discipline over public spending on health care during the 1990s. That put Finland in a stronger position than most other OECD countries to meet the pressures for higher spending at the beginning of the current decade. However, as has been indicated above, there are now signs that municipalities are finding it difficult – or judging it undesirable – to maintain this thrifty position. Hospital spending, which accounts for about 60% of municipal outlays on

health care, grew by over 12% in real terms between 2000 and 2003. Many municipalities have complained recently that hospital spending is out of their control. They have been resorting to borrowing and many have started to accumulate deficits in recent years, partly as a result of the pressure to fund higher health expenditure. Meanwhile some elements of the parallel stream of NHI expenditure have been growing even more rapidly than hospital expenditure. In particular, expenditure on drugs grew by over 16% in real terms between 2000 and 2003 (STAKES, 2005). Partly as a result, the deficit at the NHI has grown to about 5% of total health expenditure.

4.1.1. Challenges ahead

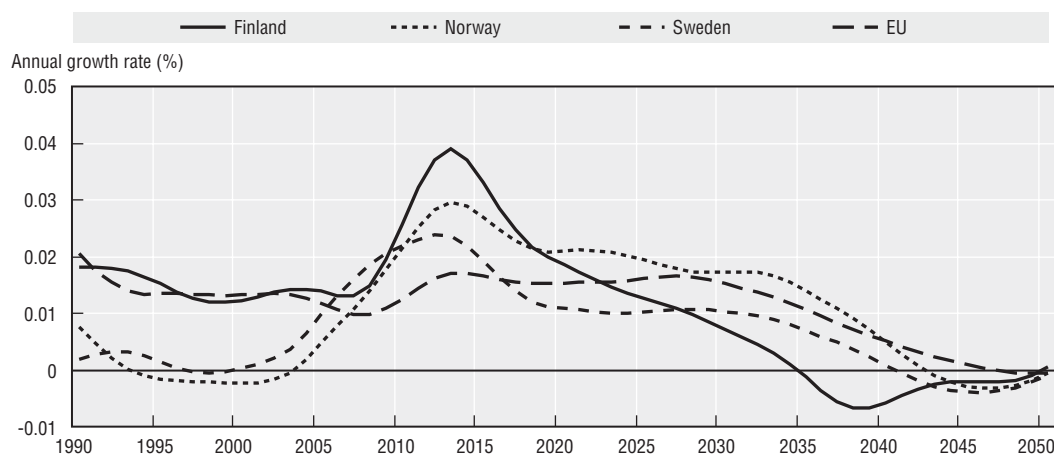
Ageing of the population will be more rapid in Finland than in most other countries from 2010 to 2020.

Looking ahead to the medium term, the fiscal sustainability of the Finnish health system must remain in question, despite the reassurances of the SOMERA Commission. On the demand side, although Finland faces similar pressures to other countries from changing health technologies and rising expectations, over the next decade or so it faces higher demand pressures from population ageing than other Nordic and EU countries. The proportion of the population aged 65 and over in Finland will rise more rapidly than in Norway, Sweden or the average EU country from about 2010 to about 2020 (Figure 4.1).

Current fiscal policy is not sustainable without higher taxes.

Taxation in Finland was already higher as a proportion of GDP in 2001 (at about 46%) than in all but two other OECD countries (OECD, 2004c). An economic assessment by the OECD of the implications for public expenditure of ageing in Finland has suggested that, “with ageing happening earlier and more rapidly than in most OECD countries, the current

Figure 4.1. Projections of the population aged 65 and over in Finland and in selected OECD countries, 1990-2050



Source: OECD (2003b), OECD Economic Surveys: Finland, Paris.

fiscal policy is not sustainable in the sense that the current generosity of pension and transfer incomes and spending on public services cannot be maintained at current levels without raising taxes in future” (Lundsgaard, 2005). Any further rise in taxes would be likely to fall mainly on a dwindling working population – which is expected to decline by about 11% by 2025.

Technical change is likely to be the main driver of growth in demand for health care.

Turning to the health and social services sector, the likely effects of population ageing on the demand for services in the medium term are relatively well understood. It is anticipated that for demographic reasons alone, expenditure on health centres will have to grow by 1.7% per annum, expenditure on hospitals will have to grow by 0.6% per annum and expenditure on long-term care will have to grow by about 2% per annum, simply to maintain current standards up to 2020 (Ministry of Interior, 2005a). The rate of technological change is uncertain but is likely to be the main driver of demand for health care in future, as it has been in the past. Technological changes are expected to reduce the range of conditions that cannot now be treated and to improve the treatments for conditions that can now be treated. In both cases, it is likely that costs will increase. There seem to be relatively few prospects for cost-reducing technological change. In addition, public expectations about the responsiveness of public services are likely to rise, especially if general economic conditions continue to improve.

The public authorities should maintain control over the rate of growth of health expenditure.

Against this general fiscal background and in the light of these anticipated trends, it is vital that the public authorities should strive to maintain control over the rate of growth of spending on health and social services. The options will include: stronger budget setting and adherence to budgets; limiting the scope of the package of health services funded by the public sector; increasing cost-sharing; managing demand; and improving efficiency.

4.1.2. Maintaining control over the rate of growth of spending on hospitals

It may be desirable to review the way hospitals are funded and the way their budgets are set.

In view of the fact that spending on hospitals represents 60% of municipal spending on health care and is now seen as out of control by many municipalities, it is urgent to review the method by which hospitals are funded and the way their budgets are set. Many municipalities seem to be too small to provide suitable countervailing power in the negotiations with hospitals over budgets. One solution would be to pursue regionalisation of the financing and delivery of hospital services, as has happened in Norway and is planned in Denmark. Another would be for the Ministry of Social Affairs and Health to assume more responsibility for the funding of services and to take the leading role in national negotiations over the rate of growth of hospital expenditure. In addition, it would be desirable to restore a favourable trend to hospital efficiency and productivity – a matter on which suggestions are made below.¹

There is a strong case for developing an “early information” system for health expenditure.

Although the review team was told by a number of representatives of municipal authorities that hospital spending was “out of control” in 2005, neither the Ministry of Social Affairs and Health nor STAKES were able to confirm or to deny such claims by supplying hospital expenditure data later than 2003. There appears to be a 1-2 year delay in compiling recent and concurrent, national estimates of health expenditure in nominal and in real terms. From the point of view of both “national steering” of the health system and public understanding of the evolution of health expenditure against plans, that seems to us to be a problem. There is a strong case for developing an early information system for health expenditure which would develop “now-casts” of health expenditure on the basis of a representative sample of municipalities. We recommend that work be undertaken to address this issue – drawing on good modern business models and techniques.

4.1.3. Gaining control over the rate of growth of spending on drugs

Controls over the rate of growth of spending on drugs outside hospitals are inadequate.

There are inadequate mechanisms for controlling the rate of growth of public spending on prescribed drugs outside hospitals in Finland – spending which represents over 50% of the total NHI outlays on health care. The public share of the cost of drugs is met by the open-ended reimbursement arrangements of NHI, not by the health centres or occupational health services where most of the prescribing decisions are taken.

Several options exist for making further savings by reducing the prices of drugs.

There are a number of options for making further savings in expenditure on drugs by reducing prices. Methods which have already been used successfully include negotiating lower wholesale prices for drugs and increasing generic substitution. Is there a case, also, for introducing reference pricing, as in countries like Germany, the Netherlands and New Zealand? Under reference pricing, medicines are classified into groups based on similar therapeutic effects. The pricing authority sets a reference price for each group based on a relatively low benchmark price – such as the minimum or median price observed in the group. This reference price becomes the basis for patient reimbursement for all the medicines in each group. A manufacturer can continue to charge more than the reference price for a particular medicine but in that case, the patient must pay the extra. However, reference pricing is based on regulating reimbursement, not on controlling prices and has been introduced, usually, to enhance price competition in what was previously – and from the point of view of pricing, remains – a free market. It is not clear how much relevance it would have in Finland, where drug prices are controlled directly and where some of the aims of reference pricing have already been achieved by international benchmarking of prices (see Box 1.2, above) and by the adoption of generic substitution. Furthermore, reference pricing would be controversial because, unlike generic substitution, which is based on the principle of the bioequivalence of different drugs which contain the same molecule, it is based on the weaker standard of the “therapeutic equivalence” of different

drugs which contain different molecules. “Therapeutically equivalent” drugs may differ in their effectiveness, and have different side-effects, for many patients.

A possible way to restrain the rate of growth of drugs expenditure would be to remove drugs expenditure from NHI and to introduce drugs budgets...

Meanwhile, greater economy in prescribing is not likely to be achieved if prescribed drugs outside hospitals look like a “free good” to the prescribing physicians. A possible way to encourage more cost-effective prescribing would be to transfer the responsibility for public spending on medicines in health centres from the KELA to the municipalities and in occupational health services from the KELA to the employers (partially or wholly). That would mean that public expenditure on drugs prescribed in health centres and hospital outpatient departments would come under the same budgetary discipline as public expenditure on drugs prescribed for inpatients. There could be an appropriate reduction in NHI contributions accompanied by an increase in, say, general taxation combined with higher state grants to municipalities. In the case of health centres, to incentivise more rational prescribing, it would be desirable to devolve drugs budgets to health centre physicians and to allow them to transfer at least part of any savings to other purposes – such as increasing staff capacity. In the case of consultations with private physicians, the full cost of drugs might be transferred to the patient.

... leaving the administration of reimbursement for drugs with the KELA.

If such budgets were introduced, it could well be administratively convenient for the KELA to continue to handle determination of patients’ eligibility for reimbursement, payment of additional reimbursements (in excess of the annual limits on cost-sharing), and analysis of prescribing data, at least in respect of health centres and occupational health services. In effect, the KELA would remain responsible (under contract to the government) for the administration of the medicines reimbursement scheme and for the collection of data, although the financial responsibility for the reimbursement cost of medicines would pass to the municipalities, to the employers and to private patients.

Drugs budgets could be based initially on information held by the KELA.

The KELA already informs physicians annually of their past year’s prescribing volume and cost, benchmarked against the average doctor. In the case of health centres, it would be possible to construct prospective budgets on this basis – perhaps by using a growth factor based initially on the average annual rate of growth of prescribing costs in the past five years. The aim should be to set budgets in future which would accommodate all necessary and cost-effective prescribing but squeeze out unnecessary prescribing.² Expenditure against such budgets could be monitored monthly or quarterly and in the case of health centres, any savings made, or a proportion of them, could be authorised for transfer to other purposes within the health centre, such as adding to the numbers of GPs.

Overspending would be strongly discouraged, as with municipal expenditure generally. Such a recommendation is based on the assumption that the municipalities would agree generally not to offset any savings by cutting their health centre budgets – to do otherwise would be likely to defeat their purpose.

Such budgets might save 6% of the drugs bill over the subsequent three years.

Judging by the experience in England of introducing drugs budgets to successive waves of GP “fundholders” in the early and mid-1990s, the introduction of such budgets in Finland could generate a saving of about 6% in the drugs bill over three years, followed by a resumption of the original growth rate in drugs spending (from the lower baseline) (Harris and Scrivener, 1996). It might be expected, again on the basis of English experience, that the savings would arise from a reduction in the average cost per prescription, rather than from a change in the number of prescriptions. However, experience in Finland might be different if the problem is with the volume of consumption rather than with the cost per prescription (for example, there is already generic substitution in Finland). A rough estimate suggests that a recurrent annual saving of 6% of the reimbursement costs for drugs prescribed in health centres could pay for an increase of about 15% in the number of physicians employed in health centres in Finland, allowing only for their salary costs. In practice, the affordable increase in physician numbers would be less than 15% because, to be effective, each additional doctor would require supporting expenditure in addition to his/her salary – including a drugs budget.

It might be desirable to introduce weighted capitation targets for drugs budgets...

An objection to such a scheme in health centres is that it would be too rewarding for the patients of significant over-prescribers and that it would lock-in rationing for the patients of significant under-prescribers. A more sophisticated scheme would establish weighted capitation targets for the drug needs of the population served by each health centre, based on analysis of KELA data, and would manage the process of making savings with a view to bringing prescribing in each centre gradually into line with weighted capitation targets. In moving towards weighted capitation targets, it would be necessary to strike a careful balance between the need to incentivise savings and the desirability of achieving some convergence in prescribing rates. Such a process could be facilitated by the new Pharmacotherapy Development Centre (PDC). Indeed, the process described above would provide an economic framework for, and be complementary with, the work of the PDC.

... and a risk-sharing mechanism for patients requiring very expensive medication.

Another objection to health centre drugs budgets is that they could not cope with the occasional patient requiring very expensive medication. To cope with this, it would be necessary to have risk-sharing mechanisms at, say, district level to fund catastrophic spending on drugs (spending exceeding some pre-determined limit) for such patients.

In addition, there may be scope for more post-marketing surveillance and evaluation of the leading new pharmaceuticals.

As a further complementary measure, it would be desirable to introduce more post-marketing surveillance and evaluation of the leading new pharmaceuticals in Finland. It has been noted already that as few as ten new drugs accounted for 40% of the rise in total spending on drugs in Finland between 2000 and 2004 (Table 2.1). It would therefore be quite feasible to track the use of the fastest growing, major new drugs in Finland with a view to monitoring not only their direct costs, post-marketing, as is already done (National Agency for Medicines and the KELA, 2003), but also their benefits, side-effects and indirect savings and costs – such as those arising from averted or precipitated hospital admissions – with a view to advising physicians on the rate of their adoption. A possible model for such investigations is the study of regional differences in the treatment of AMI patients in Finland, which suggested that the use of beta blockers and statins were important determinants of differences in AMI mortality across Finland between 1998 and 2001 (Häkkinen et al., 2004). Such studies would require cooperation between the National Agency for Medicines, the KELA, STAKES and the PDC. Gaining insights into the evolution of the benefits as well as the costs of the main products driving pharmaceutical expenditure upwards, would not only assist the work of the PDC, but would also provide more public accountability for the steeply rising drugs bill. Staff at KELA told the review team that additional analysis of prescribing data would be possible to identify irrational spending. Further analysis of these data is recommended.

4.1.4. Limiting the scope of the package of health and social services funded by the public sector

These reforms might need to be accompanied by measures to limit further growth in the package of health services covered by the public sector.

These reforms might need to be accompanied by further measures if the Finnish economy were to grow more slowly, and the pressures for additional health and social service expenditure were to be greater, than is now anticipated. One important way to economise would be to restrict further growth in the scope of the package of health and social services covered by the public sector.

A leading candidate for such a restriction would be cosmetic dentistry for adults in health centres.

For example, a candidate for such a restriction would be any plans to offer cosmetic dentistry to adults in health centres. Dental care has been available to a part of the population through health centres for many years. Recently, such coverage was extended to the whole population. It is not clear that the resource implications of this extension have been adequately addressed. Basic dental preventive services are appropriately provided through the health centre system, since they can prevent recourse to more extensive urgent interventions for untreated conditions. However, many dental care procedures

available today have a cosmetic nature. It would be sensible to clearly define the preventive and curative services which the health centres are expected to provide, and to leave cosmetic dental services for provision through the private sector.

4.1.5. Increasing cost-sharing

But increasing cost-sharing generally would be likely to deter necessary as well as unnecessary utilisation, especially by the poor.

Following these suggestions, it could be argued that raising the level of cost sharing generally in the Finnish health system would help to achieve the goal of fiscal sustainability because it would reduce the volume of services demanded, allowing savings to be made if capacity were cut in response, and would transfer some of the burden of financing health care from the public to the private purse. However, research evidence suggests that increasing cost sharing generally would almost certainly discourage necessary as well as unnecessary care and it would almost certainly deter utilisation of essential services by the poor more than by the rich (Canadian Health Services Research Foundation, 2001). Out-of-pocket, cost sharing is already quite high in Finland. Finland ranked 7th out of 23 OECD countries in terms of the out-of-pocket share of health spending in 2000 (OECD, 2003a). Indeed, the existing level of cost-sharing in Finland may help to explain some of the inequities in access to physician services recorded earlier in this report.

There are better ways to manage demand.

There are better ways to manage demand. For example, in the interests of both macroeconomic and microeconomic efficiency it will be important to continue to develop health promotion and primary and secondary preventive programmes. It will also be desirable to continue to increase support for carers of people needing long-term care and for the third (private, voluntary) sector.

4.2. Microeconomic efficiency (value for money)

The pursuit of value for money in the health system is an end in itself and will also complement the search for macroeconomic efficiency.

The pursuit of value for money in the health system is not only an end in itself but is also one of the means to achieve macroeconomic efficiency, because a more efficient system will make it easier to afford any given level of outcomes. Some parts of Finland's health system already seem to offer good value for money judged against a set of OECD average benchmarks: despite below-average costs, considerable emphasis is given to prevention, the volume of some therapeutic services is high, and the technical quality of care – so far as it can be measured – is good. However, there seem to be a number of ongoing challenges including adverse trends in the measured performance of some services and signs of some underlying structural and incentive weaknesses. Suggestions for putting value for money in the health system on a rising trend are offered sector by sector, below.

4.2.1. Health promotion and disease prevention

There are anticipated increases in many of the big public health risks in Finland.

The “Health 2015” public health programme has provided a good framework for action to improve the health of the Finnish population, but there are anticipated increases in many of the big risks to public health in Finland and it is not clear that sufficient resources are being devoted to tackling them.

New and emerging problems include allergies, chronic lung disease, asthma, type-2 diabetes, memory disorders and dementia.

The top four public health concerns in Finland today are cardiovascular diseases, cancers, osteoporosis and other musculoskeletal disorders and mental health problems. New and emerging problems include allergies, chronic lung disease, asthma, type-2 diabetes, memory disorders and dementia. The main causes for many of these conditions are unhealthy life habits and a sedentary lifestyle, together with ageing of the Finnish population. Poor nutrition, lack of physical activity and smoking play a major role in the aetiology of coronary heart disease, cerebrovascular disease, hypertension, cancer, metabolic syndrome, type-2 diabetes and osteoporosis. Increasing numbers of Finns are overweight or obese. There is an alarming increase in smoking prevalence and excess alcohol consumption among young people, particularly among girls and pregnant women.

Higher priority should be accorded to the development of health promotion and disease prevention.

Higher priority should be accorded to the development of health promotion and disease prevention activities at the national, regional and local levels. In particular, priority should be given to the primary prevention activities of health centres, whenever it seems likely to be cost-effective to do so. Furthermore, opportunities to pursue cost-effective primary prevention should become a key factor/argument in decision making throughout Finnish society. Secondary prevention should be adopted as a guiding principle for all treatments in hospitals and health centres.

4.2.2. Primary care

There are some failings in the responsiveness of physicians’ services in health centre and there are signs of tight constraints on capacity.

The evidence reviewed above suggests that there are some failings in the responsiveness of physicians’ services in health centres and there are signs of tight constraints on capacity. There are unfilled vacancies for health centre GPs in some parts of Finland, especially in remoter areas. The government has recently introduced targets to bring down the waiting times in health centres and these seem to be meeting with some

success. However, it is not yet clear whether the new targets will continue to be met in the long run in the absence of changes to incentives, structures and capacity.

One way of creating incentives in health centres would be to encourage more patient choice of GP and to pay staff “for performance”.

One way of creating incentives would be to encourage more patient choice of health centre physician and of other services and to align the incentives facing physicians and other staff with patients' demands. This could be done by increasing the capitation element in the GP's remuneration package and by pressing on with the adoption of electronic patient records. Patients might be expected to choose physicians with shorter waiting times, other things being equal. That would remain consistent with personal doctoring. An alternative approach would be to introduce a larger element of fee-for-service payment into GP's remuneration, such as a payment per consultation. The international evidence suggests that changing the pay structure in this manner would almost certainly stimulate a higher activity rate (Chapter 4 in OECD, 2004b). Since it would also put upward pressure on costs, it would be desirable to combine any such additional incentives with tight budgetary controls. The aim should be to continue to control costs while raising productivity – hence lowering the implied price of each activity. A third approach would be to reward responsiveness directly – for example, “team bonuses” for reaching waiting-time targets might be paid not only to physicians but also to other staff such as nurses and receptionists who had contributed to achieving shorter waiting times. Indeed, “paying for performance” might well have wide application in health centres. Part of staff remuneration might be linked to a whole series of preventive, curative and responsiveness targets such as achieving immunisation and screening rates above certain benchmarks, controlling hypertension and meeting patient responsiveness guarantees.

It is desirable to improve measurement of the quality of care delivered by health centres in order to identify outliers.

As has been noted above, there appear to be large variations in the efficiency of health centres in Finland, so far as that efficiency can be measured. Also, measured efficiency has been declining recently. That suggests that significant savings in staff and financial resources could be made if the efficiency of the least productive units were brought up to the efficiency of the best. However, there must be doubt about whether the current measures of efficiency capture outcomes adequately. It is desirable to develop indicators of the quality of care delivered by health centres – such as blood pressure control, immunisation rates and waiting times for appointments. These could be combined with detailed investigations of health centres which appear to be outliers, with a view to obtaining lessons about the causes of variations in efficiency, and, hence, remedies for inefficiency which could be put into practice generally. It may also be desirable to ascertain whether there is an optimal size for health centres with a view to encouraging or even requiring municipalities which have health centres below such a size to merge some of their health centres or pool their services with other municipalities.

Consideration should also be given to increasing GP capacity in health centres.

Consideration should be given to increasing GP capacity in health centres and to filling more of the vacancies in remote areas. The latter might be achieved partly by further increasing relative pay in remote areas and by compensating the municipalities concerned for the extra expenditure by adding to the state subsidy for remote areas. Most of these options – especially increasing capacity – would raise costs. However, it is possible that such costs could be funded by savings in pharmaceutical expenditure (see below) and by restraining the rate of growth of expenditure on municipal hospital services.

4.2.3. Dispensing of drugs outside hospitals

It is desirable that de-regulation of the retail pharmacy market should be examined.

Evidence reviewed above suggests that although wholesale prices for drugs are relatively low in Finland, retail prices are relatively high, judging by international comparisons – partly because of higher VAT rates than in some other countries. Retail dispensing is highly regulated in the interests of ensuring the availability of prescribed drugs throughout Finland (see Box 1.2, above) with the result that there is a lack of competition both for dispensing of prescribed drugs and for over-the-counter medicines. It is desirable that de-regulation of the retail pharmacy market should be examined, with a view to introducing competition and economies in dispensing. Clearly, any new arrangements must safeguard the professional competence and advisory functions of pharmacists and ensure continued access by the population to medicines in less populated areas. The cross-subsidisation built into the pharmacy fee should remain but consideration should be given to opening up the retail margin to competition – by freeing entry to the market – and to removing the restriction that only pharmacists can sell over-the-counter medicines. Both Iceland and Norway have de-regulated their pharmacy markets in the past decade. In both cases, competing pharmacy chains have tended to take over from individual pharmacist businesses. In Iceland, price competition has led to discounts for consumers, at least in Reykjavik. However, in both countries supplementary regulations have been needed to channel competitive forces in socially desirable directions (Anell and Hjelmgren, 2001). The growing opportunities for internet dispensing should also be kept under review (Mäkinen et al., 2005).

4.2.4. Hospital services

There remain some question marks over the efficiency of hospital services.

Despite the evidence from international comparisons about the relatively good performance of Finland's hospital and specialist services, there remain some question marks over the efficiency of these services. There is evidence of variations in measured efficiency across hospitals, deterioration in measured efficiency over time, evidence that some procedures are being carried out in units which are too small to achieve optimum quality of care, and long waiting times for elective surgery (see below) despite above average rates of some procedures.

There are weaknesses arising from the degree of decentralisation of finance and provision and the continuing reliance (mainly) on the public integrated model.

Although there are undoubtedly strengths in Finland's arrangements for financing and delivering hospital services, there are also some weaknesses arising from the degree of decentralisation of finance and provision and the continuing heavy reliance on the public integrated model (direct provision). On the finance side, the point has been made already that many municipalities (average population about 12 000) may be too small as funding bodies to exert adequate countervailing power in their bargaining with hospital providers over budgets. In particular, they may lack the necessary technical and management resources to articulate an appropriate demand for services on behalf of the communities which they serve. Also, they may suffer from conflicts of interest in choosing between local providers and more distant providers. Dispersion of hospitals is perceived to improve employment, income generation and prestige in small towns and rural areas, though other measures may be more cost-effective for achieving these aims.

As specialisation in medicine increases, the optimum provision of some specialist inpatient care requires facilities to be concentrated.

On the provider side, although management of municipal hospital services has been amalgamated into 20 hospital districts (average population about 250 000), these may still be too small to manage all hospital services effectively, given that there are growing economies of scale in many branches of specialised medicine. The optimum provision of some specialist care may require facilities to be concentrated on one site for populations of 1 million or more. The gains from greater concentration, in terms of quality of care and reductions in operating costs, have to be weighed against increased travel costs for many patients. To avoid adverse effects on equity of access, some of the efficiency gains may need to be spent on transport subsidies and accommodation for accompanying relatives.

There are a number of options for reforms on the provider side.

There are a number of options for reforms on the provider side – such as regionalising the management of hospital services, as in Denmark (soon), or centralising them, as in Norway. The consequence is likely to be an accelerated pace of amalgamation of some hospitals, or hospital departments, and closure of others. The “Project to restructure municipalities and services” will have to weigh the likely gains in quality and operational efficiency against the loss of local democracy and the likely rise in the cost of access by remote populations, if it considers such reforms.

The public integrated model for hospital services has both strengths and weaknesses.

In relation to reliance on the public integrated model for hospital services in Finland, it is important to weigh its strengths and weaknesses. Among the strengths, are: the potential for the integration of hospital services with both primary care and social services under the municipalities; the opportunities given for professionalism to flourish (at least in the Finnish case); and economy of administration. Among the weaknesses, are: the comparative absence of financial incentives for staff to be responsive to patients; the possibility of poor communication and barriers across services; the conflict of interest inherent in municipalities both funding and owning hospitals; and the risks to efficiency arising from placing reliance on providers which are public monopolies. Also, whereas, in principle, this model should give municipalities management control over hospitals, in practice, the technical nature of the provision of specialist services and the introduction of districts, puts municipalities – especially small municipalities – in a weak management position vis-à-vis hospitals. The hospitals are, therefore, public monopolies with weak local accountability.

One of the advantages of current regulations is that they grant municipalities freedom to experiment with different ways of delivering services.

One of the advantages of current regulations, in principle, is that they grant municipalities freedom to experiment with different ways of delivering services: to produce health and social services themselves, to contract with other municipalities or to contract with the private sector for their provision. As has been noted above, at least two modifications to the dominant public integrated model have begun to emerge in a few localities in Finland as a result of the exercise of these freedoms: integration of the management of health centres and hospitals in some localities; and the outsourcing of specialist services to public or private contractors in others.

More co-operative working between primary and secondary care services seems to be capable of achieving gains in efficiency.

More co-operative working between primary and secondary care services seems to be capable of achieving gains in efficiency judging by an international comparison between Kaiser Permanente, the private, profit-making, Californian health maintenance organisation, and the British NHS (which resembles the health system in Finland) (Feachem et al., 2002). This comparison suggested that Kaiser was the more efficient of the two and that the leading reason was closer co-operation between primary and specialist care in Kaiser than in the NHS. In particular, Kaiser was more successful than the NHS at averting unnecessary hospitalisation of chronically ill patients and average length of stay was much shorter in Kaiser than in the NHS, for similar patients. There is likely to be potential for such gains to be made in Finland, not least because in current circumstances referrals to hospitals may generally look like a “free good” to health centre physicians. It is

not suggested that Finland should consider the adoption of American profit-maximising health maintenance organisations. Nevertheless, there is scope for strengthening physician capacity and productivity in health centres and for applying the principles and practices of “disease management” programmes as in Germany, the United Kingdom and the United States (Nolte and Mckee, 2005; Schreyögg and Busse, 2005; and Casalino, 2005).

Finnish experiments with outsourcing take place against a background of growing international experience with such reforms.

In the case of purchaser/provider separation and outsourcing, Finnish experiments take place against a background of growing international experience with replacing integrated systems with contract systems, including introducing greater autonomy for public hospitals and full purchaser/provider separation. The results of such reforms have been rather mixed and it is not easy to derive conclusive lessons for health policy (Prekker and Harding, 2005; Harrison and Calltorp, 2000). However, there are signs that such reforms will succeed in delivering efficiency improvements when they are coherent – that is, when they meet a number of critical conditions simultaneously, such as: appropriate autonomy for provider units; suitable market incentives (such as “money following the patient”); ability for provider units to retain savings; the explicit funding of any social obligations (previously cross-subsidised); and the achievement of accountability through performance measurement (Prekker and Harding, 2005).

Much scope exists for further experimentation with, or adoption of, such reforms in Finland...

There seems to be much scope for further experimentation with, or adoption of, such reforms in Finland. For example, municipalities could retain control of funding and purchasing of these services but relinquish ownership of hospitals. They could continue to negotiate budgets for specialist services and to represent the interests of their local constituencies, particularly in matters concerning access to services and the responsiveness of services to patients. On the assumption that they would continue to run health centres, there could be an augmented role for health centre physicians in advising (or even acting as) municipal purchasers of hospital services. Meanwhile, the hospitals themselves might be encouraged to become more independent as public enterprises, and municipalities could be encouraged to exercise more choice among them, at least in large urban areas. If such reforms became widespread, such hospital enterprises might report to a National Board or to the Ministry of Social Affairs and Health which would be responsible for strategic regulation and planning but not for their day-to-day management.

... together with more evaluation of local reforms.

To the extent that local experimentation develops further, it will be important to strengthen the nation’s ability to learn from the results. What is needed is more systematic evaluation of local reforms to extract national lessons and more dissemination of the results, especially in respect of sustainable gains in efficiency. An important component of such an evaluation programme would be continued monitoring by STAKES of the performance of the

hospitals concerned and publication of the results. Again, since measures of performance based only on patient episodes and costs may be potentially misleading, it is desirable to move as quickly as possible to measuring the quality of care as well as the volume of care delivered by hospitals. That could be done by integrating data on clinical quality and responsiveness into the measures. This would involve speeding up the work on this topic that has been started by STAKES (which covers long-term care as well as hospitals). The further development of electronic patient records will be critical to the success of such a venture.

It would also be desirable to establish a process for encouraging more private involvement in the supply of hospital services, if justified on economic grounds...

Because of the inhibitions many municipalities face currently in contracting with the private sector for specialist services, it would also be desirable to establish a process for encouraging more outsourcing, if justified on economic grounds, and to require the hospital sector to comply with national competition policy. That would be complemented by requiring market-testing for some support services – such as cleaning and catering – within the hospitals. It would also be possible to introduce market-testing for provision of clinical services themselves in large urban areas – although whether this would deliver greater gains than “benchmark” competition is debateable. In the absence of good measurement of the quality of care, it might generate gaming and other adverse side-effects, given the likely asymmetry of knowledge between purchasers and providers.

... and to introduce a uniform national system for pricing hospital services.

An additional reform, which would help to inform both “benchmark competition” and market competition (if any), would be to introduce a uniform national system for attributing prices to hospital services, based on Nordic DRGs, across Finland, to allow comparisons to be made across different providers. At present there is little, if any, uniformity in methods of classifying services for purposes of pricing across different hospital districts.

4.2.5. Parallel funding for specialist services

The rate of NHI reimbursements for visits to private specialists could be made conditional on using a GP gatekeeper.

The arrangements for NHI reimbursement for consultations with private specialists lack any provision for GP gatekeeping, which means that some patients may approach specialists unnecessarily. Since NHI contributions are compulsory and state taxation funds about 40% of NHI expenditure, public policy considerations should be applied to their use. One possible reform would be to make the magnitude of public reimbursement for consultations with specialists conditional on the patient first having a referral from a GP. Although such a reform might add to consultations in health centres and in occupational health services, it would almost certainly pay for itself by reducing unnecessary specialist consultations and consequential treatment – some of it in municipal hospitals. More

generally, it has been shown that health systems which have strong primary care can both raise quality and reduce costs (Gérvás *et al.*, 1994; and Starfield, 1994). Making the magnitude of reimbursement conditional on consulting a GP gatekeeper has been introduced recently in France and Germany, and has long been the case in Australia and Canada. Those who wish to consult specialists directly would of course be free to do so, but should not be entitled to NHI subsidisation.

4.2.6. Waiting times for elective surgery

It may prove necessary to alter the underlying incentives in the provision of elective surgery to achieve a sustained reduction in waiting times.

The Ministry of Health and Social Affairs believes that recent measures to tackle variations in rates of treatment and excessive waiting for elective surgery are more broadly-based and better designed than in other countries. They may mark the beginning of the end of long queues for elective surgery in Finland. However, experience in other countries, including other Nordic countries, suggests that the introduction of *maximum waiting-time targets* may have only temporary effects on bringing down waiting times in the absence of changes to incentives (Hurst and Siciliani, 2004). Previous experience of using moral pressure to reduce surgical waiting times in selected districts in Finland during the mid-1990s was disappointing (Rissanen and Häkkinen, 1999). The new targets and guidelines in Finland will do little to change the financial and structural incentives underlying the formation of queues for surgery. It may prove necessary to alter the underlying incentives to achieve a sustained reduction in waiting times. For example, following the principle of paying for results, the municipalities could make part of hospital funding conditional on the meeting of waiting-time targets and guidelines for surgery. Similarly, surgeons and managers could be given pay bonuses for meeting the same targets and guidelines, as in Spain in the late 1990s (Hurst and Siciliani, 2004).

4.2.7. Investment in, and utilisation of, human resources

It is desirable to raise the supply and productivity of health care staff.

Because of the anticipated wave of retirements among health and social service staff and because of competition for staff from other sectors of the economy, it is desirable to try to raise the supply and productivity of staff in various ways – some suggestions are made below.

One possible route to retaining older health care workers in the sector longer is to allow them to “downshift”.

Apart from the national measures that have already been taken to encourage workers to defer their retirement, such deferment can also be encouraged by allowing older workers to “downshift”, by offering them, for example, part-time work, appropriate responsibilities and, if necessary, retraining. There are already clear signs that part-time working is now much more common among Finnish physicians in their late 50s and early 60s than it was 15 years

ago (Aailasmaa, 2005). There can be significant benefits from retaining older employees in the health and social care workforce at a time of high turnover. Tehy, the union which represents qualified health care personnel in Finland including licensed nurses, has stated that it is in favour of the creation of special “senior employment posts” in which older workers would be encouraged to act as mentors for younger workers (Tehy, 2005).

Another is to increase intake rates to the health and social care professions but this will necessitate higher pay and better working conditions.

It may also be necessary to increase further the training intake rates to the health and social care professions. However, that would have to be done against a background of an anticipated decline in the size of younger age cohorts in Finland (OECD, 2004a). It seems likely that, other things being equal, the health and social services will only be able to recruit a larger share of new entrants to the workforce by taking steps to improve their relative pay and conditions of service. However, “other things” might not be “equal”. For example, if the rest of the economy were to grow relatively slowly in the next decade or so, it would prove easier to recruit (and retain) additional health and social services staff than would otherwise be the case.

A third option of recruiting more staff abroad may not be desirable.

A further option would be for Finland to recruit skilled health and social service staff from abroad. However, given that there are shortages, or risks of shortages, of health and social service workers in many other OECD countries (and even more so in many developing countries), a policy of self-sufficiency in staffing the health and social services in Finland may remain preferable. In addition, foreign recruits would usually have to overcome a serious language barrier before they could work effectively with most Finnish patients.

A promising way to raise staff productivity would be to pay staff for “results”.

One of the most important options for matching the supply to the demand for staff is to raise staff productivity further in Finland. As has been discussed in the section on primary care above, a promising way forward may be to pay staff for “results” – that is, for the quality and outcome of the services they provide. Also, more could be done to address low morale and low professional status among registered practical nurses – perhaps by introducing a scheme to reward good performance (as reported by patients) linked to discretionary annual bonuses.

There may well be further opportunities to improve skill mix in Finland.

There may well be further opportunities to improve the skill mix in Finland. A particular aim would be to free up more of the time of physicians in health centres. The

Finnish Medical Association told the OECD mission team that according to the act regarding health care professionals, it is the responsibility of a doctor to make a diagnosis and decide about treatment. However, doctors were willing to discuss what tasks that are currently performed by them could be done by other groups. For example, follow-up of some chronic diseases could be done by skilled nurses and there were good experiences of that (Finnish Medical Association, 2005). There is, indeed, some international evidence that nurses can be just as effective as doctors in treating a variety of patients with chronic conditions in primary care settings and also patients with minor injuries in hospital emergency departments (Buchan and Calman, 2004). Finland may already be exploiting such opportunities but further opportunities to improve skill-mix may remain. For example, some categories of licensed nurses could be given limited prescribing rights. Successful schemes were introduced in the 1990s in the United Kingdom and in Sweden to allow specific categories of nurses, such as district nurses, health visitors and midwives, to prescribe limited lists of drugs (Bourgueil *et al.*, 2005). In addition, nurse-led telephone-help lines could be introduced in primary care.³

4.2.8. Investment in information technology

Completing an interoperable electronic patient record system throughout Finland is a key requirement.

The government's drive to complete an interoperable, electronic patient-record system throughout Finland by the end of 2007 is a key requirement for a more efficient health system delivering high-quality care. It is likely to be critical for the development of more integrated care for patients, particularly across health centres, pharmacies and hospitals. It is likely to offer opportunities to reduce duplication of diagnostic testing. And it is also likely to be crucial, as was noted above, for the development of improved measures of performance which capture the quality of care.

4.3. Equity in the financing and use of health care

The equity goal in terms of financing health care is being met in Finland...

Payment for health care in accordance with ability to pay and access to health care in accordance with need, are among the key goals of the Finnish health system. Payment for health care appears to be broadly proportional to income in Finland.

... but there are inequities in access to GPs and across municipalities.

However, as has been noted above, international comparisons suggest that access to physicians is comparatively inequitable across income groups, after adjusting for differences in need. It is likely that differences in access to physicians cascade onwards into other treatment programmes such as prescribing. Also, there appear to remain geographical inequities in access to municipal health services, despite the attempts to reduce them via the state grant system.

The measures set out above to increase the availability and responsiveness of physicians in health centres should help to tackle inequities in visits to GPs.

The likely main cause of the inequities in visits to GPs is that the employed population enjoys access to free occupational health care whereas the non-employed population has access only to health centre physicians, whose services are relatively rationed, weakly incentivised and carry charges. The measures set out above, to increase the availability and responsiveness of physicians in health centres, should also serve to tackle these inequities in visits to GPs. The extra costs might be funded (indirectly) by the potential savings in the drugs budget, as discussed above. There would seem to be no case for tackling the inequities by reducing access to occupational health services. It is surely rational to give the working population good access to primary care, especially when the workforce is ageing.

Equity in access to specialists would be likely to improve if NHI reimbursements for private consultations were withdrawn.

A likely contributor to the relatively large inequities in visits to specialists in Finland is the availability of NHI reimbursements for consultations with private specialists, which are taken up disproportionately by people with high incomes. Access to specialists through occupational health services may also play a part. Such inequities have a geographical aspect, because private services are used more intensively in urban areas and there is no attempt to compensate for this in the national funding formula for municipal health and social services. Equity in access to specialists would be likely to improve if the NHI reimbursements for private consultations were withdrawn. However, since inequities in access to specialists characterise almost all OECD countries, it is unlikely that they would disappear altogether. Also, any gains in equity would have to be weighed against increasing financial barriers to exercising patient choice – somewhat lacking in the Finnish health system – and a likely loss of private capacity.

The problem of achieving geographical equity in access to health services would be eased if municipalities were merged and if more of the financing of services were transferred from the municipalities to the state.

In relation to geographical inequities, the state grant formulas have not yet put municipalities on an equal footing in their ability to provide citizens with equal access to municipal services across Finland. The problem of achieving geographical equity in access to health services would be eased if municipalities were merged and if more of the financing of services were transferred from the municipalities to the state. These are no doubt matters which will be reviewed by the “Project to restructure municipalities and services”. Subject to any changes which will be recommended by this project, it would be desirable to investigate the reasons for continuing variations in need-adjusted health and

social service expenditure per capita, across municipalities. The state grant formulas could be re-examined in the light of research by STAKES which suggests that improvements to the formula could be introduced (albeit at the expense of simplicity).

4.4. Conclusions

Some of the recommendations drawn together in Box 4.1 would involve tradeoffs between the goals of health policy – tradeoffs which are best left to the judgement of the Finnish government and electorate.

This chapter has made a number of recommendations for incremental changes to certain structural features of the Finnish health system which cause difficulties and for other fine-tuning of the system. The recommendations have been drawn together in Box 4.1. The main structural features which have been considered are: parallel funding, decentralisation and reliance on the public integrated model for hospitals. Significant changes to these features will generally involve tradeoffs between the different goals of health policy – tradeoffs which are best left to the judgement of the Finnish government and the Finnish electorate.

Building on the strengths of the Finnish health system and tackling its weaknesses will be essential if its good performance is to be maintained.

While Finland's health system currently performs well by international standards, it is faced with challenges similar to those in other countries due to cost escalation and ageing in the population. Building on its inherent strengths and tackling its apparent weaknesses will be essential if its good performance is to be maintained into the future.

Box 4.1. Summary of assessment and recommendations

Improving the financial sustainability of the health system

- Maintain public control over the rate of growth of health expenditure.
- Review the way that hospitals are funded and the way that their budgets are set.
- Develop a national “early information” system for estimation of health expenditure.
- Transfer the responsibility for the reimbursement cost of medicines from the KELA to the municipalities and (at least in part) to the employers and introduce drugs budgets in health centres and occupational health services.
- Develop systematic post-marketing evaluation of the most important new drugs.
- Refrain from municipal spending on cosmetic adult dentistry.

Box 4.1. Summary of assessment and recommendations (cont.)**Improving value for money in the health system****Health centres**

- Accord higher priority to spending on health promotion and prevention.
- Encourage more patient choice of services offered by health centres and introduce payment for results.
- Increase the relative pay of health centre doctors in remote and rural areas.

Dispensing outside hospitals

- Review the regulation of retail pharmacies.

Specialist services

- Consider regionalisation or centralisation of the governance of hospitals.
- Consider separating the purchasing and provider roles for specialist services and allow hospitals to become self-governing, subject to good performance.
- Require compliance with national competition policy and market testing for some support services in hospitals and specialist services and perhaps for specialist services themselves, building on local experience.
- Consider developing a uniform national method for pricing inpatient services, based on Nordic DRGs.
- Require more evaluation of local reforms and develop as quickly as possible a quality dimension to the benchmarking of the performance of health centres and hospitals by STAKES.
- Consider whether NHI subsidies for consultations with private specialists should be made conditional on patients having a referral from a general practitioner.

Waiting for elective surgery

- Introduce financial incentives to support waiting-time targets and the implementation of clinical guidelines (in the light of experience).

Human resources

- Continue to invest in human resources along the lines set out in “Safeguarding the Future of Healthcare”.
- Do more to recognise good performance among licensed practical nurses and consider the introduction of nurse prescribing on a circumscribed basis and the development of nurse-led telephone help services in primary care.

Other

- Continue to invest in the development of a national electronic patient record.

Improving equity

- Consider using any savings in drugs budgets to employ more physicians in health centres.
- Consider whether NHI reimbursement for private consultations with specialists should be withdrawn altogether.
- Investigate the determinants of variations in needs-adjusted spending on health and social services across municipalities and consider revising the state grant formulas for health and social services.

Notes

1. These are presumably all matters which will be addressed by the “Project to restructure municipalities and services” (see previous chapter) which was still in progress when this report was completed.
2. It would be necessary to avoid making false economies in prescribing – see Box 2.2, above.
3. The United Kingdom now has a national nurse-led telephone help line: “NHS Direct”.

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In addition to the recent reforms to the health system now being implemented, further improvements are needed to secure its future. After reviewing the strengths and weaknesses of the system, this report makes recommendations for improvements in the areas of fiscal sustainability, efficiency and equity.

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