European Commission

State of Health in the EU

Finland

Country Health Profile 2017

OECD
BETTER POLICIES FOR BETTER LIVES

European Observatory on Health Systems and Policies
a partnership hosted by WHO

The Country Health Profile series

The *State of Health in the EU* profiles provide a concise and policy-relevant overview of health and health systems in the EU Member States, emphasising the particular characteristics and challenges in each country. They are designed to support the efforts of Member States in their evidence-based policy making.

The Country Health Profiles are the joint work of the OECD and the European Observatory on Health Systems and Policies, in cooperation with the European Commission. The team is grateful for the valuable comments and suggestions provided by Member States and the Health Systems and Policy Monitor network.

Contents

Data and information sources

The data and information in these Country Health Profiles are based mainly on national official statistics provided to Eurostat and the OECD, which were validated in June 2017 to ensure the highest standards of data comparability. The sources and methods underlying these data are available in the Eurostat Database and the OECD health database. Some additional data also come from the Institute for Health Metrics and Evaluation (IHME), the European Centre for Disease Prevention and Control (ECDC), the Health Behaviour in School-Aged Children (HBSC) surveys and the World Health Organization (WHO), as well as other national sources.

The calculated EU averages are weighted averages of the 28 Member States unless otherwise noted.

To download the Excel spreadsheet matching all the tables and graphs in this profile, just type the following StatLinks into your Internet browser:
http://dx.doi.org/10.1787/888933593513

Demographic and socioeconomic context in Finland, 2015

		Finland	EU
Demographic factors	Population size (thousands)	5 480	509 394
	Share of population over age 65 (%)	19.9	18.9
	Fertility rate[1]	1.6	1.6
Socioeconomic factors	GDP per capita (EUR PPP[2])	31 600	28 900
	Relative poverty rate[3] (%)	5.3	10.8
	Unemployment rate (%)	9.4	9.4

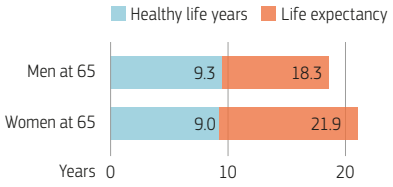
1. Number of children born per woman aged 15–49.
2. Purchasing power parity (PPP) is defined as the rate of currency conversion that equalises the purchasing power of different currencies by eliminating the differences in price levels between countries.
3. Percentage of persons living with less than 50 % of median equivalised disposable income.

Source: Eurostat Database.

1 Highlights

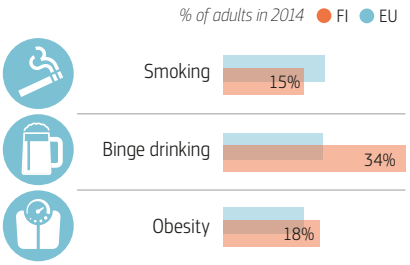
The life expectancy of people in Finland increased steadily over the past decades, but not all additional years of life are spent in good health, raising demands on health and social care. The health system is complex and decentralised, prompting major reforms to try to improve access and effectiveness of health care while achieving efficiency and controlling costs.

Health status



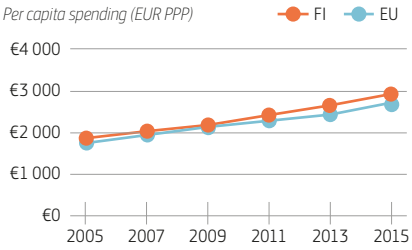
Life expectancy at birth in Finland reached 81.6 years in 2015, up from 77.8 years in 2000. It is now one year above the EU average. These gains in life expectancy were driven by steady reductions in deaths from cardiovascular diseases. However, at age 65, only about half of the remaining years of life for men are lived free of disability and only about 40 % for women. Alzheimer's disease and other dementias are now among the leading causes of morbidity and mortality in Finland in this age group.

Risk factors



In 2014, 15% of adults in Finland smoked tobacco daily, down from 23% in 2000, and well below the current EU average. On a more negative note, over one-third of adults (34%) reported in 2014 heavy alcohol consumption on a regular basis, a proportion well above the EU average. The obesity rate among adults went up: at 18% in 2014, it is higher than the EU average.

Health system

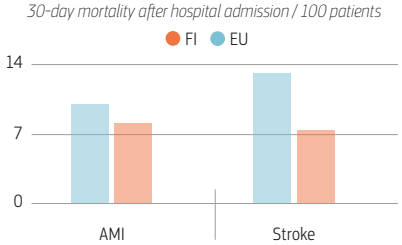


Health spending per capita in Finland has gone up over the past 10 years and is slightly above the EU average, reaching EUR 2 981 in 2015. This accounts for 9.4% of Finland's GDP, slightly below the EU average of 9.9%. Public funding accounts for 74% of all health spending in Finland, a lower share than the EU average (79%), with most of the remaining spending paid out of pocket by households.

Health system performance

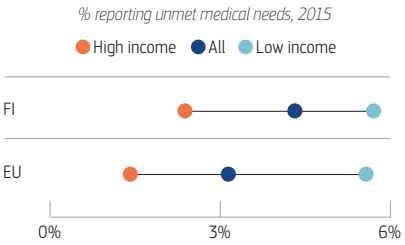
Effectiveness

Mortality amenable to health care is lower in Finland than the EU average. The low levels of deaths after hospitalisation for heart attack (AMI) or stroke are one indication that acute care is of good quality.



Access

Unmet needs for medical care are higher in Finland than the EU average. Most of these unmet needs are related to waiting times, particularly among low-income people and people without employment who have no access to occupational health care.



Resilience

Health and long-term care spending are expected to continue to grow as a share of GDP in the years to come. Although there has been a shift of activities from hospital to the ambulatory sector over the past decade, one of the main challenges is to improve access to primary care for all the population and achieve greater care coordination.

2 Health in Finland

Life expectancy is increasing and above the EU average

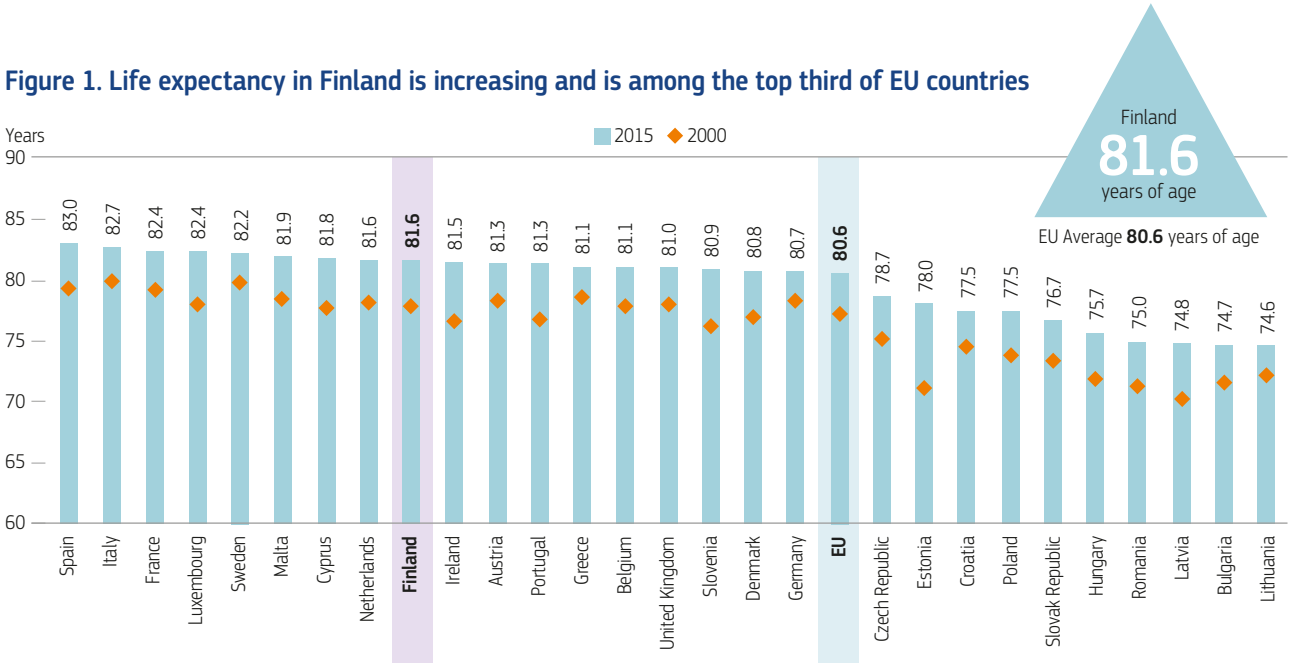
Life expectancy at birth in Finland increased by nearly four years between 2000 and 2015, to 81.6 years (Figure 1). It is one year above the EU average, which brings it one year short of closing the gap with the best performers.

However, the gender gap in life expectancy in Finland is slightly greater than the EU average, with Finnish men living almost six years less than women. Furthermore, the gap in life expectancy between socioeconomic groups is greater than in other Nordic countries, particularly among men. Life expectancy at birth among Finnish men with a tertiary education is more than six years higher than those with no more than a lower secondary education; this gap is slightly smaller between the most educated and least educated women (almost four years). This is mainly due to a greater prevalence of risk factors among people with lower levels of education (see Section 3).

Most of the gains in life expectancy since 2000 were driven by reductions in mortality rates after the age of 65. The life expectancy of Finnish women at age 65 reached 21.9 years in 2015 (up from 19.5 years in 2000) and that of men reached 18.3 years (up from 15.5 years in 2000). At age 65, Finnish women and men can expect to live approximately nine of their remaining years free of disability.[1]

1. These are based on the indicator of 'healthy life years', which measures the number of years that people can expect to live free of disability at different ages.

Figure 1. Life expectancy in Finland is increasing and is among the top third of EU countries



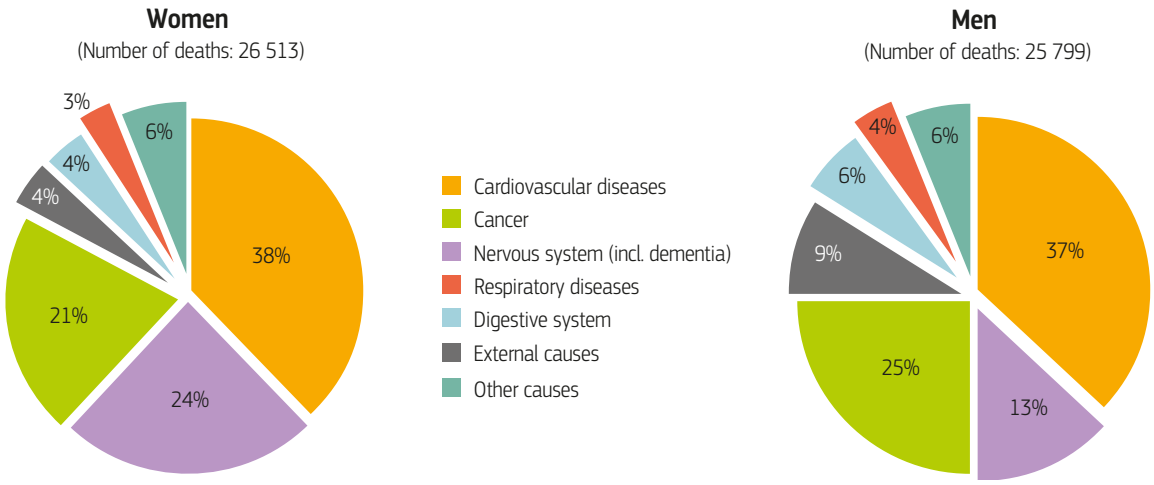
Source: Eurostat Database.

Cardiovascular diseases are the leading causes of death, followed by cancer and nervous system disorders

Cardiovascular diseases, cancer and nervous system disorders (including dementia) are the leading causes of death among women and men in Finland (Figure 2). In 2014, nearly 20 000 people died from cardiovascular diseases (accounting for 38% of all deaths among women and 37% of all deaths among men) and almost 12 000 died from cancer. Nervous system disorders (including dementia) are now the cause of a higher number of deaths among women than cancer. External causes of death (including suicides, accidents and other violent deaths) remain particularly high among Finnish men.

Looking at trends in more specific causes of death, the top three causes of death in Finland have stayed the same since 2000, but their positions changed (Figure 3). The number of people dying from Alzheimer's and other dementias has more than doubled since 2000, making it the second most common cause of death behind ischaemic heart diseases. This reflects population ageing, better diagnosis and lack of effective treatments, as well as more precise coding of Alzheimer's and other dementias as the main cause of death.

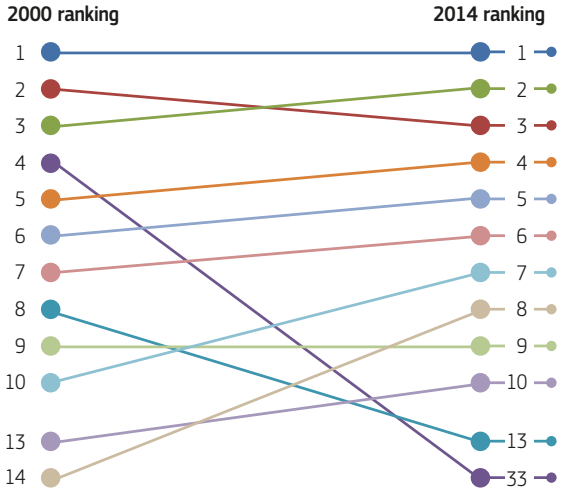
Figure 2. Cardiovascular diseases, cancer and nervous system disorders are leading causes of death in Finland



Note: The data are presented by broad ICD chapter. Dementia was added to the nervous system diseases' chapter to include it with Alzheimer's disease (the main form of dementia).

Source: Eurostat Database (data refer to 2014).

Figure 3. Heart diseases are the leading cause of death, followed by Alzheimer's and other dementias and stroke



1	Ischaemic heart diseases	20%
2	Alzheimer and other dementia	15%
3	Stroke	8%
4	Lung cancer	4%
5	Other heart diseases	4%
6	Lower respiratory diseases	2%
7	Colorectal cancer	2%
8	Liver diseases	2%
9	Falls	2%
10	Pancreatic cancer	2%
13	Suicide	2%
33	Pneumonia	0%

Note: A large part of the decline in deaths from pneumonia is due to a change in the WHO coding rule, which also influenced deaths from other causes. Many deaths formerly assigned to pneumonia are now classified as deaths due to Alzheimer's disease and other dementias and to cardiovascular diseases.

Source: Eurostat Database.

Lung cancer is the main cause of cancer deaths, but the number of deaths from other types of cancer such as colorectal and pancreatic cancers increased, although the age-standardised death rates from these types of cancer remain substantially lower than the EU average. Mortality from liver diseases (including cirrhosis) also increased substantially, partly linked to excessive alcohol consumption (see Section 3).

On a more positive note, the number of suicides has declined substantially since 2000, although the age-standardised death rates remain higher than in most other EU countries.

Musculoskeletal problems, depression and other chronic conditions are among the leading causes of poor health

Apart from the leading causes of mortality, musculoskeletal problems (including low back and neck pain) are an increasing cause of disability-adjusted life years (DALYs)[2] lost in Finland. Major depressive disorders and suicides also continue to be major causes of DALYs, although their importance has diminished since 2000 (IHME, 2016).

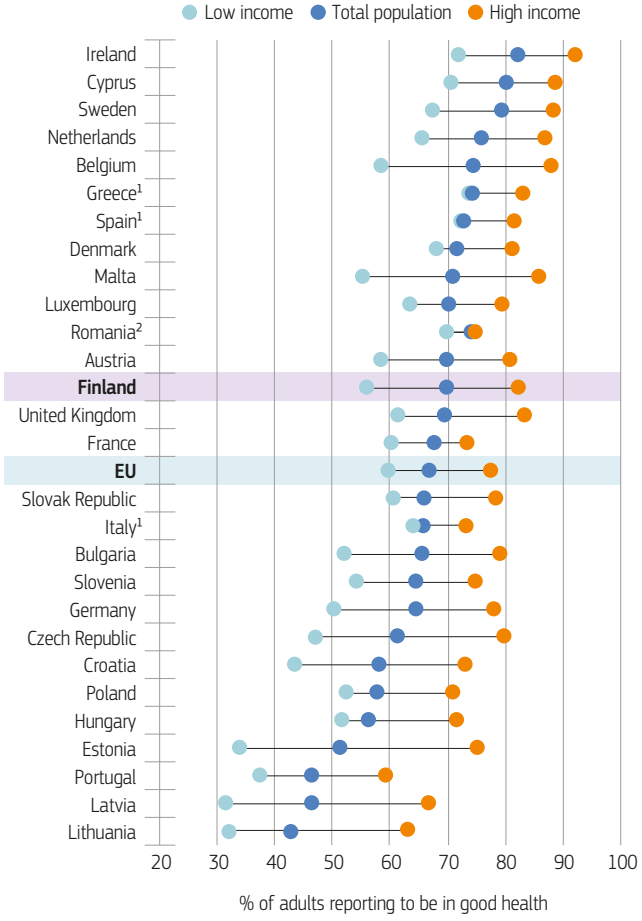
2. DALY is an indicator used to estimate the total number of years lost due to specific diseases and risk factors. One DALY equals one year of healthy life lost (IHME)

Based on self-reported data from the European Health Interview Survey (EHIS), one in nine people in Finland live with asthma, more than one in ten people live with chronic depression, and nearly one in twelve live with diabetes. Wide disparities exist in the prevalence of these chronic diseases by education level. People with the lowest level of education are nearly twice as likely to live with asthma and almost three times more likely to report having diabetes as those with the highest level of education.[3]

Most people report being in good health, but the gap between income groups is large

Overall, 70% of the population in Finland report being in good health, a slightly higher percentage than the EU average (67%). However, the proportion is much higher in the highest income quintile (82%) than in the lowest (56%). This gap is greater than in Sweden, Denmark and the EU as a whole (Figure 4).

Figure 4. Most people in Finland report to be in good health, but large disparities exist by income group



1. The shares for the total population and the low-income population are roughly the same.
2. The shares for the total population and the high-income population are roughly the same.

Source: Eurostat Database, based on EU-SILC (data refer to 2015).

3. Inequalities by education may partially be attributed to the higher proportion of older people with lower educational levels; however, this alone does not account for all socioeconomic disparities.

3 Risk factors

Unhealthy lifestyles are major public health issues in Finland

Based on estimations from the Institute for Health Metrics and Evaluation (IHME), more than a quarter (28%) of the overall burden of disease in Finland in 2015 (measured in terms of DALYs) could be attributed to behavioural risk factors – including smoking, alcohol use, dietary risks and physical inactivity, with dietary risks and smoking contributing the most (IHME, 2016).

Smoking rates continue to decline, but binge drinking remains an important public health issue

The proportion of adults who smoke every day in Finland has decreased sharply since 2000 (from 23% to 15% in 2014) and is now the third lowest among all EU countries after Sweden and Luxembourg (Figure 5). Regular smoking among 15-year-old adolescents decreased even more rapidly (from 30% in 2001–02 to 13% in 2013–14), but remains higher than in several EU countries.[4] This reflects the positive results of a fairly comprehensive tobacco control policy (see Section 5.1).

Alcohol consumption in Finland rose rapidly after 2004 when the government lowered alcohol taxes after Estonia joined the EU, but it has decreased since reaching a peak of over 10 litres per person aged 15 and over in 2007–08 to 8.5 litres per person in 2015.

Excessive alcohol consumption among adolescents and adults also decreased in recent years, but remains higher than in most other EU countries. In 2013–14, about 30% of 15-year-old adolescents in Finland (27% of girls and 32% of boys) reported having been drunk at least twice in their life, above the EU average of about 25% (24% of girls and 27% of boys). More than one-third of adults in Finland (34%) reported in 2014 to engage in regular binge drinking,[5] the fourth highest rate among EU countries. The rate among men (48%) is more than two times greater than among women (21%).

The proposed reform of the Alcohol Act to liberalise alcohol sales might reverse the recent progress in reducing harmful alcohol consumption (see Section 5.1).

4. Results from the 2017 Adolescent Health and Lifestyle Survey in Finland show further reductions in smoking among adolescents, with only one in ten 16- to 18-year-old girls and boys (10%) smoking cigarettes daily.

5. Binge drinking behaviour is defined as consuming six or more alcoholic drinks on a single occasion, at least once a month over the past year.

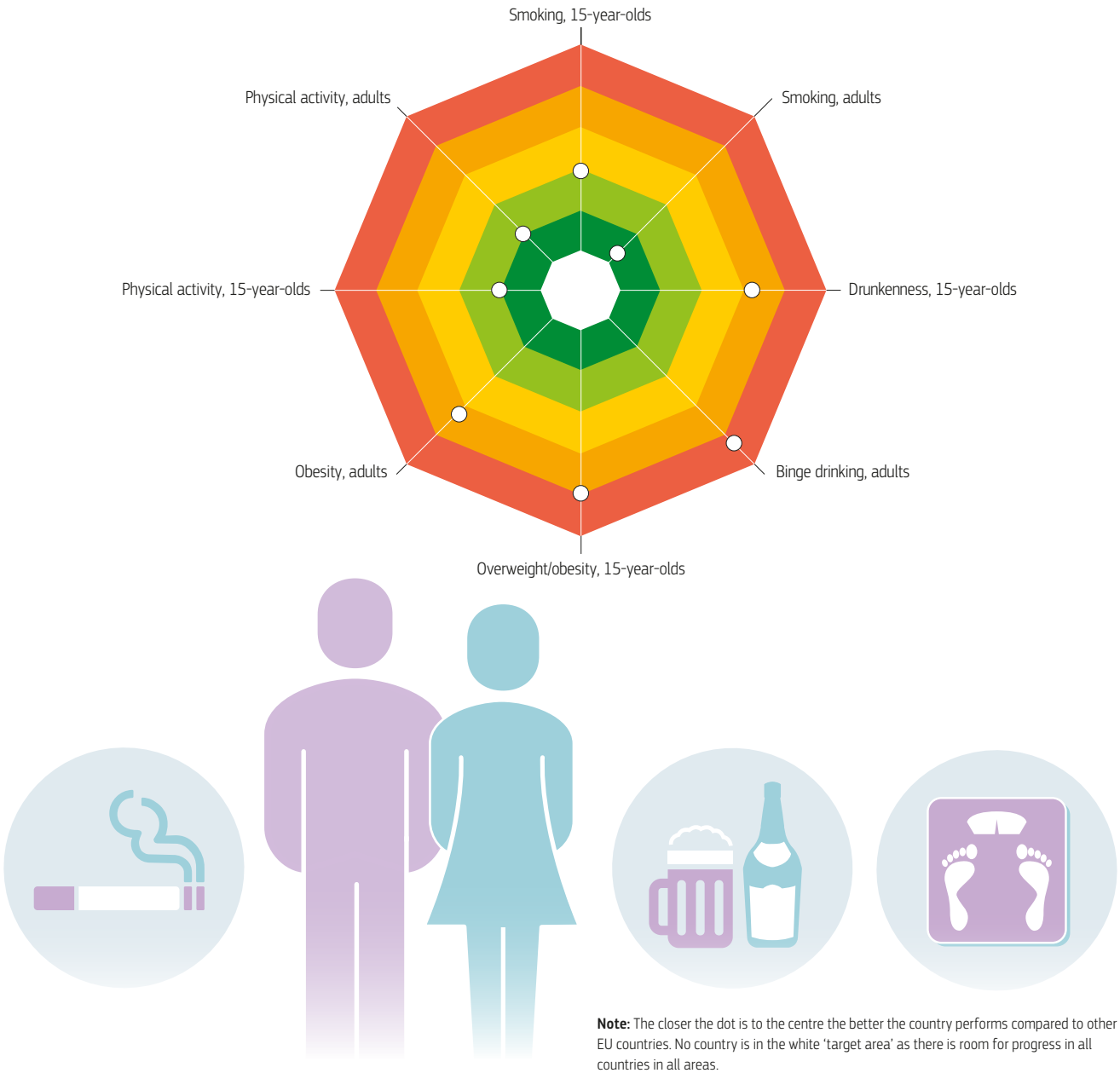
Rising rates of overweight and obesity among adults and adolescents pose a growing challenge

Based on self-reported data (which underestimate the true prevalence of obesity), almost one in five (18%) adults in Finland were obese in 2014, putting it above most EU countries.[6] Also based on self-reported data, one in five (20%) 15-year-olds were overweight or obese in 2013–14, up from 13% in 2001–02, and now in the highest quintile of EU countries.

Many behavioural risk factors are more common among disadvantaged populations

As in other EU countries, many behavioural risk factors are much more prevalent among populations with lower income or education, with the exception of binge drinking among adults, which is slightly more frequent among more highly educated people. The prevalence of smoking is almost twice as high among the population with the lowest level of education. The obesity rate is over 50% higher among the population with the lowest level of education than among those with the highest level. This higher prevalence of risk factors among disadvantaged groups contributes greatly to disparities in health status.

Figure 5. Excessive alcohol consumption and overweight and obesity are important public health issues in Finland



Note: The closer the dot is to the centre the better the country performs compared to other EU countries. No country is in the white 'target area' as there is room for progress in all countries in all areas.

Source: OECD calculations based on Eurostat Database (EHIS in or around 2014), OECD Health Statistics and HBSC survey in 2013–14. (Chart design: Laboratorio MeS).

6. Based on measured rates of obesity, almost one in four adults (24.8%) were obese in Finland in 2011.

4 The health system

Health care is mainly organised at the local level

Finland's health system is complex and decentralised, and care is delivered in municipal, occupational or private facilities. Over 300 municipalities (local authorities) are responsible for the provision of basic services, such as education, health and social care, to their residents. Municipalities fund and organise (often jointly) the provision of primary care, and form 20 hospital districts to fund and provide hospital care. At the national level, the Ministry of Social Affairs and Health is responsible for developing and implementing health reforms and policies, and it extensively relies on a network of expert and advisory bodies in its work.

Funding for health care comes through municipalities with taxation right and the statutory National Health Insurance (NHI) scheme, run by the Social Insurance Institution and accountable to Parliament. The NHI is responsible for funding outpatient medications, health care-related travel costs, and sickness and maternity allowances. In addition, it effectively subsidises occupational health care, as in Finland employers are obliged to organise and provide health services for their employees, and the NHI covers about half of employers' health care costs.

Furthermore, the NHI reimburses part of services provided in the private sector, mainly ambulatory care. This somewhat unique structure of the health system has been both recognised for being able to adjust to the needs of a dispersed population and criticised for contributing to inequalities and inefficiencies (Couffinhal et al., 2016) (see Section 5.2).

A major reform is under discussion, aiming to establish a more centralised county-based health and social care system with single-payer financing (see Box 1).

The health system has multi-channel financing and extensive user fees

In 2015, Finland spent 9.4% of its GDP on health (an increase from 8.0% in 2005), slightly below the EU average of 9.9%. On a per capita basis, health spending in Finland reached EUR 2 981 per person in 2015 (adjusted for differences in purchasing power), a level that is slightly higher than the EU average (Figure 6), but lower than in Denmark and Sweden.

BOX 1. WIDE-RANGING REFORMS ARE BEING PROPOSED IN FINLAND

The stated aims of the proposed reforms (as of July 2017) are to improve equity, access and effectiveness of health and social care services while ensuring efficiency gains and containing costs. An overarching goal is to curb expenditure growth through cost savings (Couffinhal et al., 2016).

The main proposed changes include:

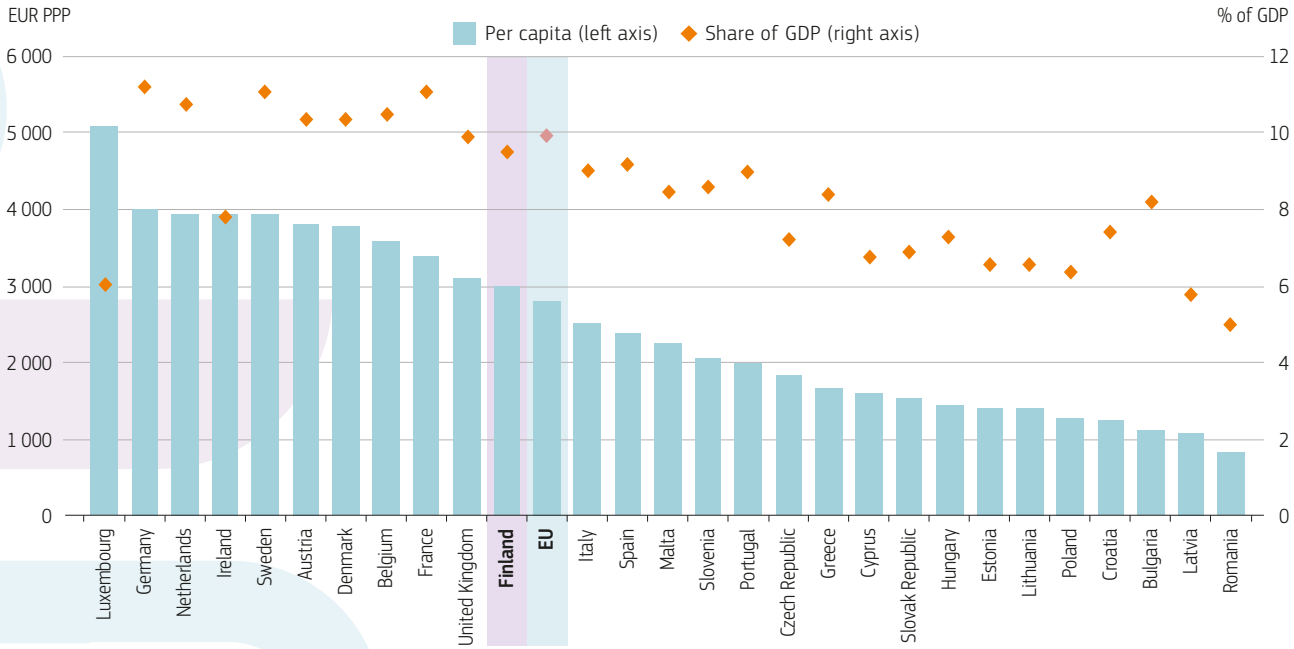
- **Administration**: Transferring responsibility for the organisation and provision of health and social care services from municipalities to 18 regional governments (counties), expected to be established in 2020.
- **Financing**: Moving from a multi-payer towards a single-payer financing system, financed through general taxation.
- **Provision of services**: Introducing a purchaser-provider split and provider competition, extending freedom of choice, strengthening service integration and continuity of care, and centralising emergency care and certain specialist services.

Private funding of health expenditure is higher than in other Nordic and Western European countries (26% of total expenditure) and consists largely of out-of-pocket payments, with private health insurance playing a much smaller role (see Figure 10 in Section 5.2). Approximately 74% of health expenditure is publicly funded: about three-fifths of this comes from taxes, with the NHI covering the rest. Municipalities have substantial powers to raise taxes, allocate funds and set user charges (up to a nationally specified maximum) and are subsidised by the state. The NHI's budget consists mainly of compulsory employment contributions, as well as about 30% of state transfers.

Population coverage is broad but co-payments for services are extensive

The NHI covers all permanent residents in the country, while municipal health care services are accessible to residents of the respective municipalities. Certain population groups (irregular migrants, tourists, temporary visitors from non-EU countries) are not covered, but are entitled to essential emergency care.

Figure 6. Health spending per capita in Finland is slightly above the EU average



Source: OECD Health Statistics, Eurostat Database, WHO Global Health Expenditure Database (data refer to 2015).

The occupational health care scheme covers the employed (approximately one-third of the total population) and provides further benefits in addition to the NHI. A growing share of the population (now 15%) also has duplicate, complementary and/or supplementary private health insurance, mainly to cover the cost of private services and outpatient pharmaceutical drugs not covered by the NHI.

User fees in the form of co-payments are quite extensive, as charges apply to most municipal health care services, including primary and emergency care. A cap of EUR 691 per person per year applies to user charges for health services. Patients pay the first EUR 50 spent on prescribed medicines in a given year. Above this deductible, most drugs are reimbursed at a 40% rate (others can obtain a special reimbursement level of 65% or 100%), but out-of-pocket spending is capped at EUR 605 per year. Some services are free of charge (e.g. outpatient primary and dental care for children, visits to maternal and child health clinic, occupational health care services), and people with certain diseases and disabilities are also exempted from payments.

The number of hospital beds has decreased while the availability of equipment has improved

In 2015, Finland had 305 acute care hospital beds per 100 000 population, one of the lowest level in the EU. The overall number of hospital beds has been reduced by nearly 40% since 2000 in efforts to control cost and improve efficiency (see Section 5.3). On the other hand, hospitals and other health care facilities are better equipped than in most other EU countries, with a higher number of diagnostic and treatment equipment per capita (such as magnetic resonance imaging units, PET scanners, angiography and radiotherapy equipment).

The number of doctors and nurses has increased since 2000

The number of doctors, nurses and other health workers has increased since 2000, both in absolute number and on a per capita basis. The ratio of nurses to population is the second highest in the EU after Denmark, and substantially higher than the EU average (14.6 nurses per 1 000 population in 2014, latest year for which the data is available, compared to an EU average of 8.4), while the ratio of doctors is below the EU average (3.2 versus 3.6 per 1 000 population in 2014). The roles of some nurses have expanded greatly with new functions such as patient case managing, consultations and prescribing, although the actual number of nurses practising in these expanded roles still remains relatively low.

Non-employed people face long waiting times and there is a general lack of coordination between primary and secondary care

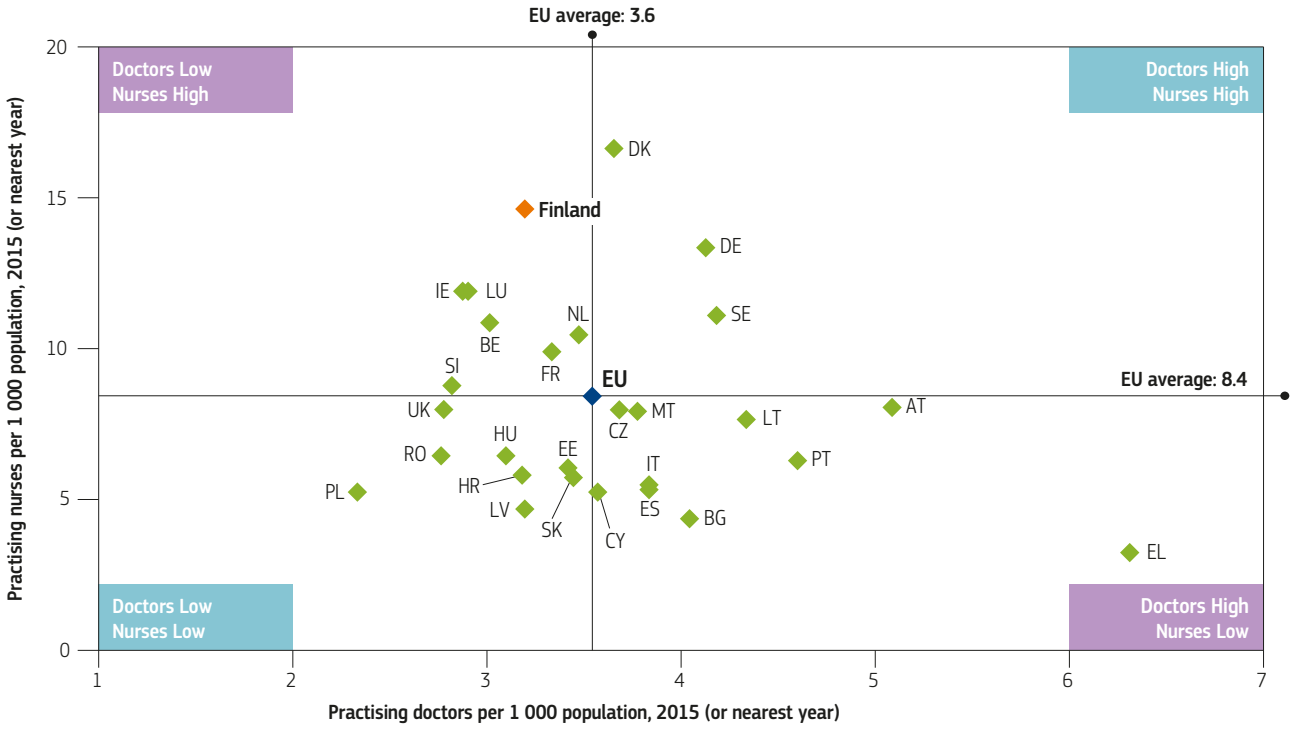
Primary care offers multiple services (including prevention and outpatient treatment, dental care, maternity and child health) in health centres and occupational health units. Health centres commonly have General Practitioner (GP)-run inpatient units, largely for chronic and long-term care patients.

Secondary care (including specialised outpatient care, inpatient care and day surgery) is mainly provided by hospitals organised in municipality-owned hospital districts. Tertiary care is delivered in five university hospitals. Patients need a referral to access specialist care, except for emergency cases. Finland has few private hospitals, but private providers of specialist outpatient care are much more common. Emergency care is provided 24 hours a day/7 days a week by health centres and hospitals, while changes are being implemented to concentrate a wide scope of emergency care in 12 major hospitals.

Recognised issues in health care delivery include long waiting times[7] in particular for the non-employed population who have no access to occupational health, a lack of coordination between primary and secondary care settings, and variation in standards and quality of services.

7. These concerns about waiting times led to the adoption of a Health Care Guarantee legislation in 2005 that provided guidelines on the maximum waiting times for a range of primary care and specialised care services. In 2011, this legislation was refined and transferred to the new Finnish Health Care Act (1326/2011), which merged the Primary Health Care Act (66/1972) and the Specialised Medical Care Act (1062/1989).

Figure 7. Finland has a lower number of doctors per capita than the EU average, but a greater number of nurses



Note: In Portugal and Greece, data refer to all doctors licensed to practice, resulting in a large overestimation of the number of practising doctors (e.g. by around 30% in Portugal). In Austria and Greece, the number of nurses is underestimated as it only includes those working in hospital.

Source: Eurostat Database.

5 Performance of the health system

5.1 EFFECTIVENESS

Mortality amenable to health care is below the EU average

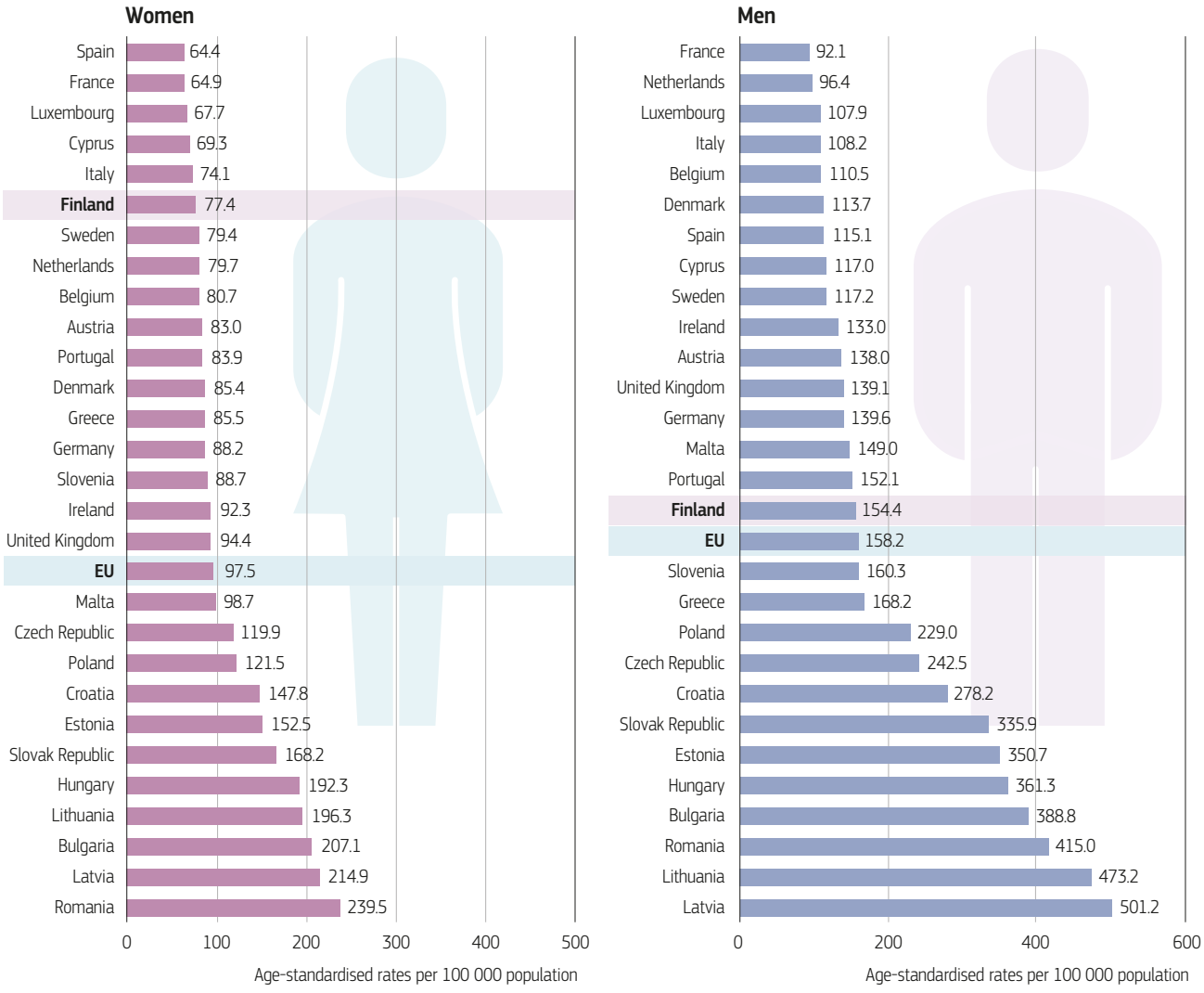
Amenable mortality in Finland has decreased since 2000 and is now lower among women than in most EU countries and just below the EU average for men (Figure 8).[8] The higher rate of amenable mortality among men is due mainly to high rates of mortality from ischaemic heart diseases, which are considered to be amenable to health care, although this may also be reduced through effective prevention policies.

8. Amenable mortality is defined as premature deaths that could have been avoided through timely and effective health care.

Mortality following hospitalisation for acute myocardial infarction and stroke is among the lowest in EU countries

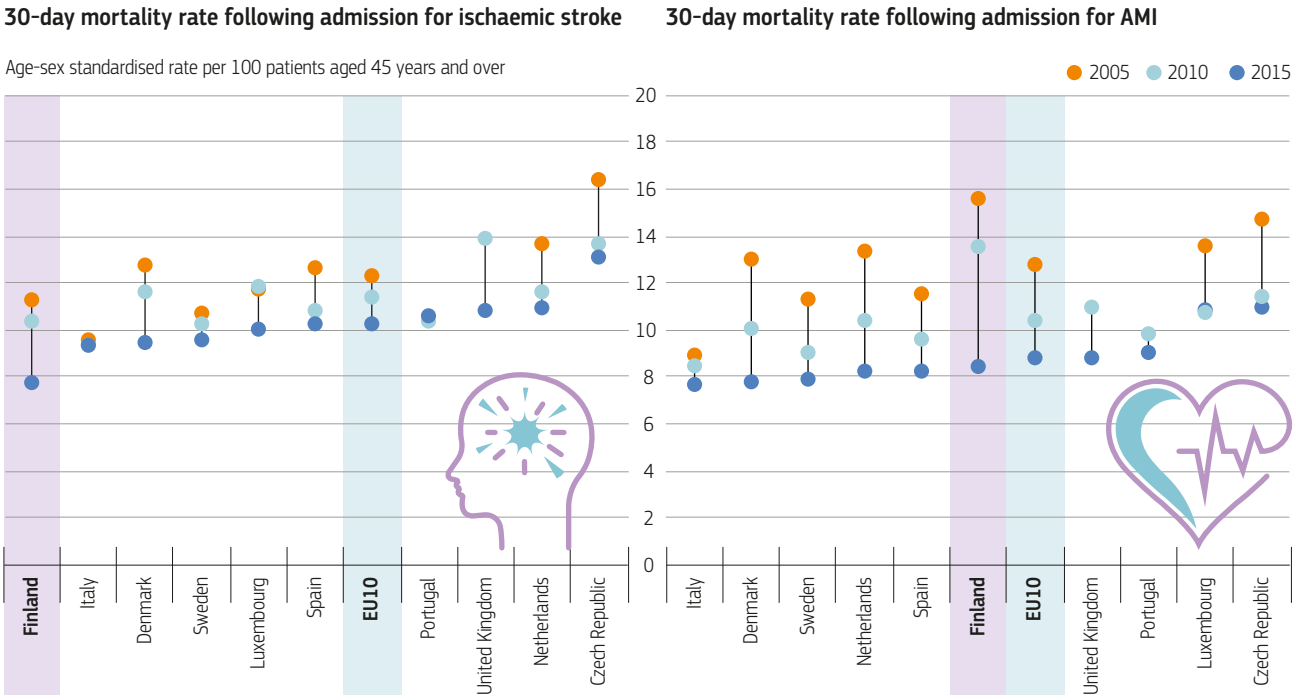
Hospitals in Finland deal very effectively with patients requiring acute care following acute myocardial infarction (AMI or heart attack) and, particularly, stroke. Substantial progress was achieved over the past decade in reducing mortality rates for people admitted to hospital for these life-threatening conditions, with the 30-day mortality rate now the lowest among EU countries with available data for ischaemic stroke (Figure 9). This reflects the streamlining of emergency care processes and the provision of better treatments, notably a greater use of thrombolysis for ischaemic strokes.

Figure 8. Amenable mortality among women in Finland is one of the lowest in the EU but closer to average for men



Source: Eurostat Database (data refer to 2014)..

Figure 9. Mortality rates following hospital admissions for stroke and heart attack (AMI) reduced sharply in Finland



Note: This indicator is based on patient-level data. Three-year average for Luxembourg. The EU average is unweighted.

Source: *OECD Health Statistics 2017.*

Cancer care is generally effective

Cancer care in Finland is generally good. Due to early diagnosis and effective treatments, people in Finland diagnosed with various types of cancer, such as breast, cervical, colon and rectal cancer, have higher survival rates than in most EU countries: (OECD, 2017), and overall mortality from cancer is among the lowest in the EU.

Finland established national cancer screening programmes earlier than most EU countries – in 1968 for cervical cancer and 1987 for breast cancer. Screening rates for the target group of women for these cancers have been relatively high for many years now. Finland also offers the human papillomavirus test for the early identification of cervical cancer.

While the planning and delivery of cancer treatments for rare and some of the most serious cancers are centralised in Finland, the treatment of most other cancers is carried out close to the patient's home. Finland has also focused on promoting the specialisation of health professionals in cancer care through licensing and certification systems (OECD, 2013).

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

Prevention policies have been effective in reducing smoking

As noted in Section 3, smoking rates have been reduced greatly in Finland over the past 15 years and are now among the lowest in the EU. Finland continues to implement a range of tobacco control policies and programmes, including tobacco cessation programmes, health warnings on cigarette packages, public awareness campaigns through mass media, and high taxation of tobacco products (WHO, 2015).

Alcohol-related problems and deaths in Finland are much higher than in most other Nordic and EU countries. The 1994 Alcohol Act included a number of regulations to reduce alcohol consumption, such as advertising restrictions, the granting of a monopoly to a government-owned company (Alko) for the retail sales of alcohol products exceeding a certain threshold of alcohol level, and the restriction of opening hours for both retail sales and the sales of alcohol in bars and restaurants. These measures contributed to some reduction in overall alcohol consumption among adolescents and adults in recent years.

However, in 2016, the government proposed to reform the Alcohol Act with a view to deregulate the sales of alcohol by loosening up the advertising of alcoholic beverages, increasing retail sales of a greater range of alcoholic drinks to more stores and premises,

and extending the opening hours for both retail sales and sales of alcohol in bars and restaurants. This proposed deregulation of alcohol control policy raises serious concerns that this might reverse recent progress in reducing alcohol consumption in Finland.[9]

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

Programmes have been put in place to reduce suicides

The prevalence of depression and other mental illnesses in Finland continues to be fairly high, and suicide rates have historically been high. Since the 1980s, Finland has implemented national suicide prevention programmes, involving cross-sector collaboration and a range of stakeholders, that have proven to be effective in gradually reducing suicide rates. Targeted programmes were put in place for groups particularly at risk, such as young men aged 15 to 29, through a so-called 'Time Out! Back on Track' initiative that was implemented in over 100 municipalities and has shown positive results (Patana, 2014).

9. The National Institute for Health and Welfare estimated that the initial proposal if implemented would increase the use of alcohol by 5–6% and the annual number of alcohol-related deaths by 150.

5.2 ACCESSIBILITY

The Finnish health system covers nearly all the population, but copayments can be high

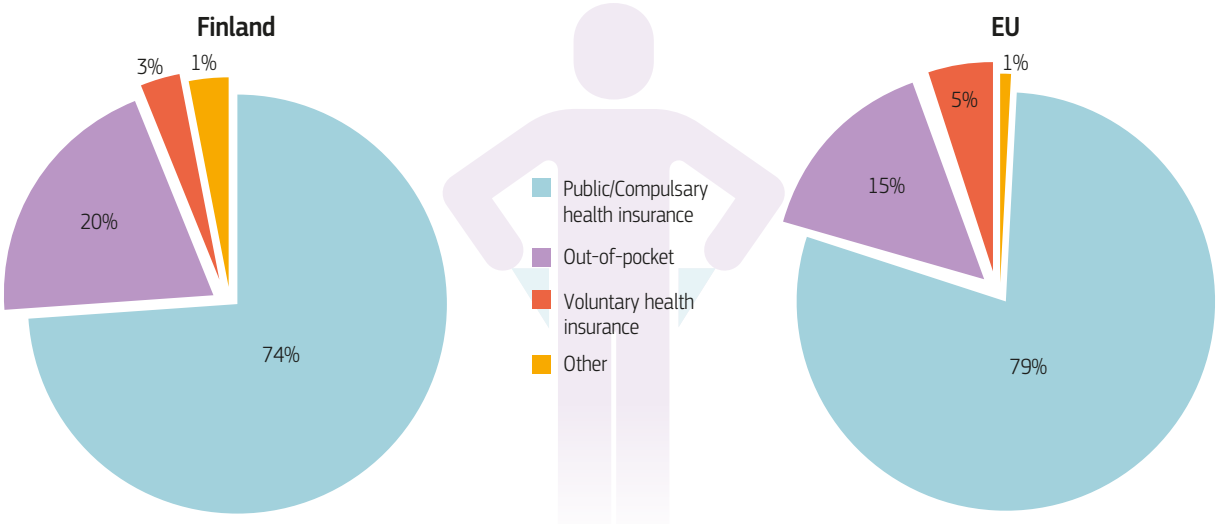
As described in Section 4, all permanent residents are entitled to health insurance coverage, although coverage is better for those with access to occupational health and private insurance.
A wide range of health services and goods is publicly covered, but with user fees applied to most services and goods, notably for outpatient pharmaceutical drugs and dental care.

In 2015, out-of-pocket payments accounted for 20% of current health expenditure in Finland, a higher share than in most EU countries (Figure 10). These out-of-pocket payments averaged EUR 718 per capita, up from EUR 417 in 2000. More than one-third of these out-of-pocket payments are used to purchase pharmaceuticals, while another fifth go to purchase dental care services.

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

The proportion of people in Finland reporting unmet needs for medical care is higher than the EU average. In 2015, over 4% of the Finnish population reported unmet medical care needs either for financial reasons, geographic barriers or waiting times, compared to just over 3% on average across the EU (Figure 11). By far the main reason for people reporting such unmet needs was waiting times. The proportion of low-income people reporting unmet needs for medical care was more than two times greater than that among high-income people.

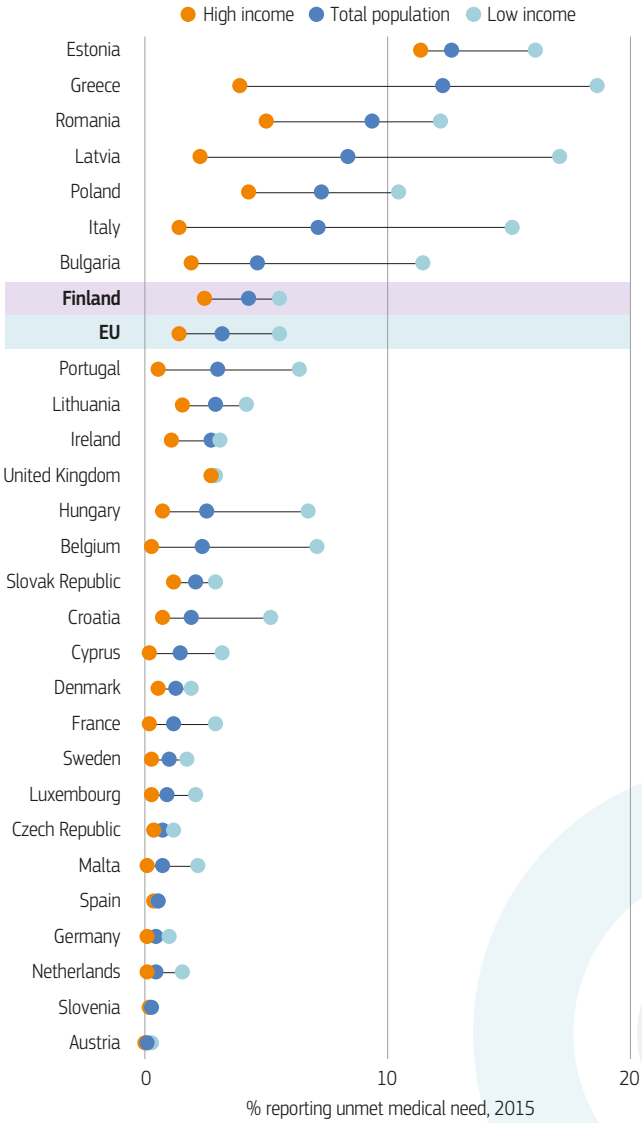
Figure 10. The share of out-of-pocket payments in current health expenditure is high in Finland



Source: OECD Health Statistics, Eurostat Database (data refer to 2015).

Unmet needs for dental care are even greater. According to EU-SILC, more than 5% of the Finnish population reported some unmet needs for a dental examination in 2015 (compared to 4.5% for the EU average), with most of these unmet needs also related to long waiting times.

Figure 11. Many low-income people in Finland report unmet medical care needs, mainly because of waiting times



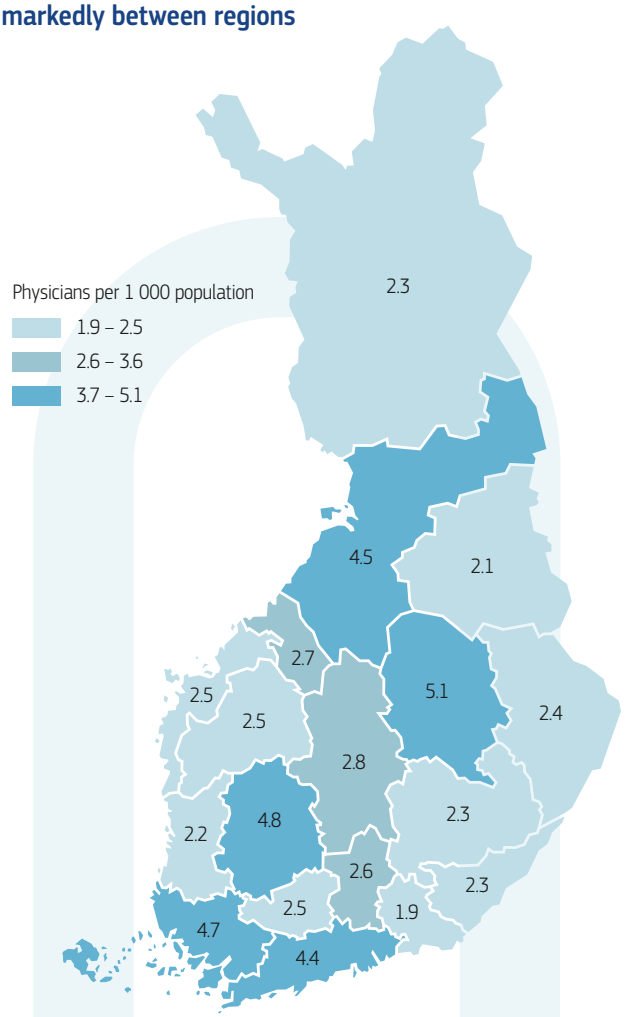
Note: The data refer to unmet needs for a medical examination due to costs, distance to travel or waiting times. Caution is required in comparing the data across countries as there are some variations in the survey instrument used.

Source: Eurostat Database, based on EU-SILC (data refer to 2015).

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

The uneven distribution of health care resources in Finland reinforces disparities in access to care. The density of doctors is much greater in Helsinki and other major cities due to the concentration of hospitals and specialised care units in urban areas, with relatively fewer numbers working in remote and sparsely populated regions (Figure 12). This uneven allocation of human resources contributes to long waiting times for people living in these remote regions.

Figure 12. The number of doctors per capita varies markedly between regions



Source: Eurostat Database.

Occupational health care and private health insurance, mainly covering people from higher socioeconomic groups, also reinforce inequalities in access to care as they facilitate faster access through wider provider choice, while people from lower socioeconomic groups and older people (those beyond working age) have less provider choice and have to wait longer to access services.

The proposed regionalisation of health and social care (see Section 4) may help achieve a more balanced resource allocation across regions and reduce waiting times.

An important challenge to address is the current lack of coordination between hospital districts and municipal primary care authorities, which has resulted in the slow development of primary care resources since the 1990s.

5.3 RESILIENCE[10]

Public spending on health has been constrained by slow GDP growth

Public spending on health slowed down and even declined in recent years in Finland as the economy came out of another recession (Figure 13).

The overall public debt as a share of GDP increased steadily in Finland over the past 10 years to reach about 75% of GDP in 2015, adding pressures to control spending on health and long-term care to reduce budgetary deficits.

Looking ahead, public expenditure on health and long-term care as a share of GDP is projected to increase due to population ageing and modest economic growth (European Commission and European Policy Committee, 2015).

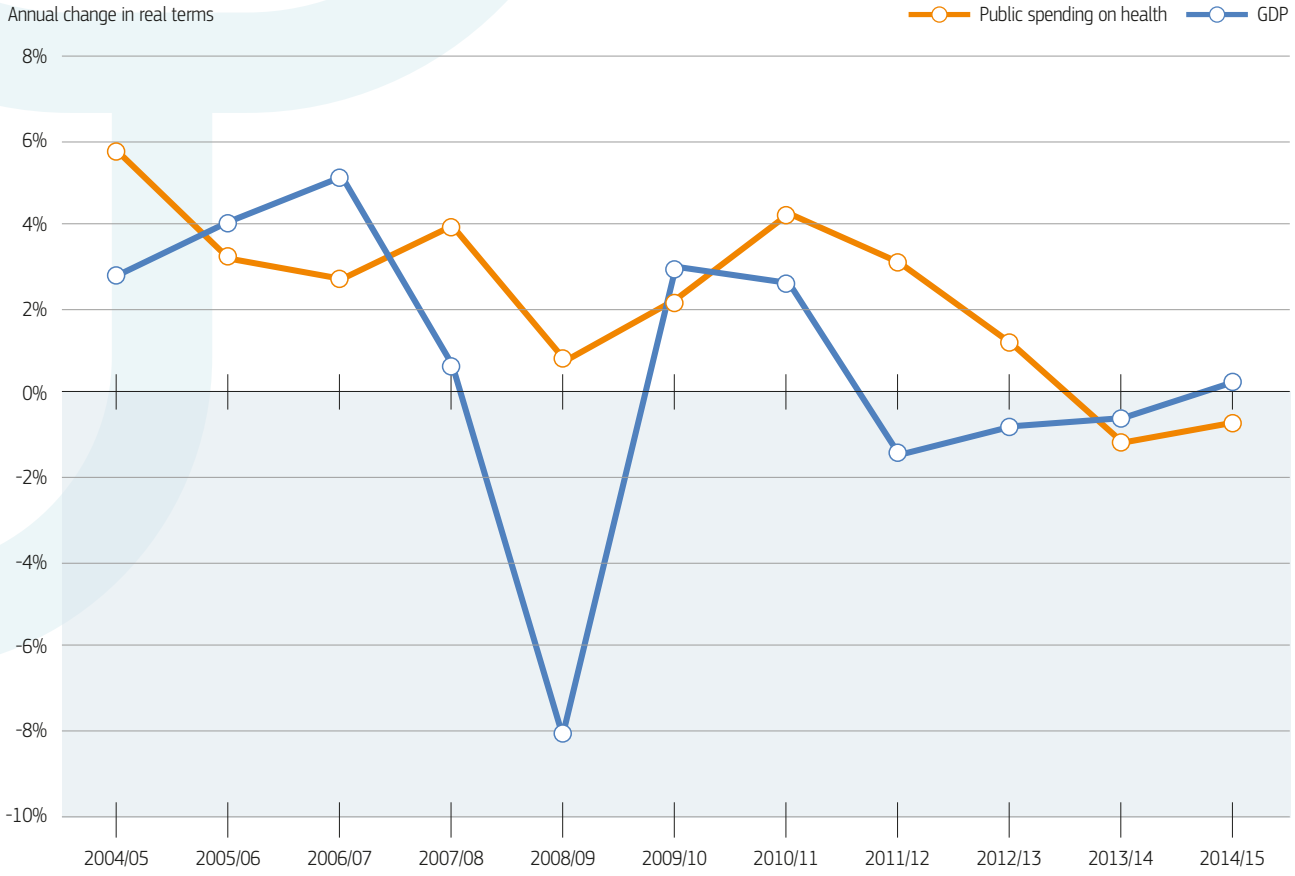
The efficiency of the hospital sector seems to have improved since 2000

The efficiency of the hospital sector seems to have improved in Finland over the past 15 years. The 40% reduction in the number of hospital beds per capita was accompanied by a reduction of over 25% in average length of stay (Figure 14). The number and share of day surgeries also increased for many procedures, although further progress might still be possible for some conditions.

Policies to control pharmaceutical spending have generally been successful

A number of policies were implemented in Finland to control the growth of pharmaceutical spending, including price controls and the promotion of generics (Box 2 and Figure 15). As a result, the share of pharmaceutical spending in overall health spending decreased considerably (from about 16% in 2000 to 12.5% in 2015). This is substantially lower than the current EU average of 17%. Spending on pharmaceuticals per capita in Finland was EUR 377 in 2015, a lower level than in most other EU countries.

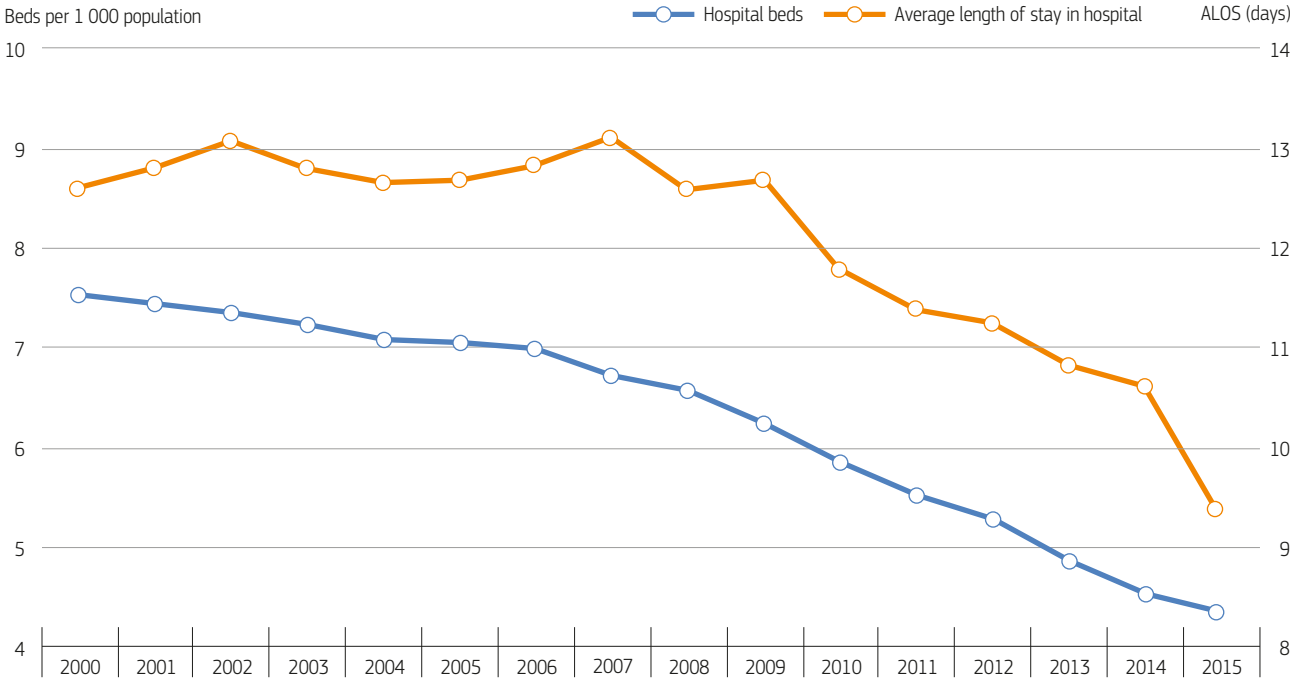
Figure 13. Public spending on health slowed down sharply in Finland in recent years in a context of sluggish economic growth



Source: OECD Health Statistics 2017.

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

Figure 14. The hospital sector capacity has been reduced in Finland, while the average length of stay declined



Source: Eurostat Database.

BOX 2. FINLAND HAS IMPLEMENTED NUMEROUS POLICIES TO CONTROL PHARMACEUTICAL SPENDING

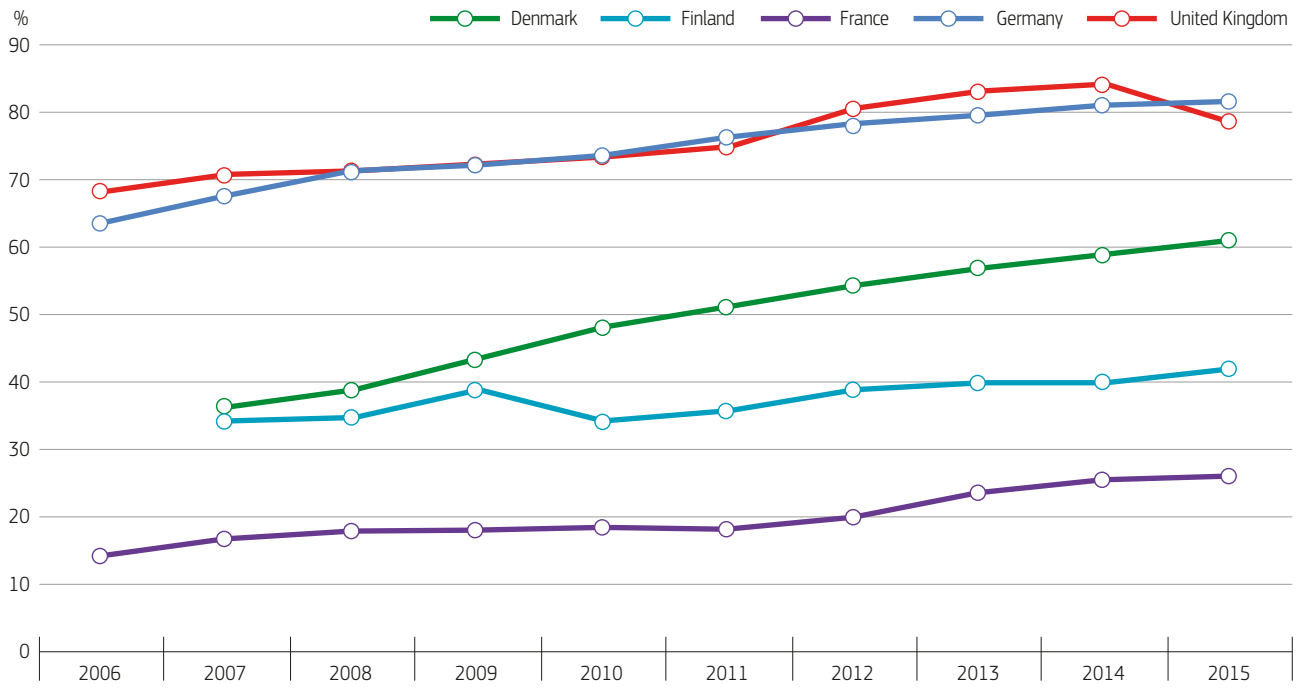
In Finland, the price of pharmaceuticals reimbursed by the National Health Insurance is based on clinical performance, economic evaluation, the cost of existing treatments and prices from many other European countries. To contain cost, Finland has also used price freezes and cuts. In 2009, reference pricing was introduced and reimbursement since then is based on the reference price, that is, the price of the cheapest substitutable product plus a small premium.

Finland defines a range of reimbursable drugs and reimbursement decisions are valid for five years. Coverage decisions are reviewed based on the reassessment. Although it is not common to withdraw a pharmaceutical from a positive list or to change a cost-sharing rule for the drug concerned, population coverage may be adjusted following changes in therapeutic value (Auraaen et al., 2016).

Finland also introduced several policies to reduce inappropriate prescribing. It promotes rational prescribing of doctors through treatment guidelines complemented with monitoring of their prescribing patterns, and education and information campaigns on the prescription and use of medicines. Pharmacists are obliged to dispense the cheaper product and replace the prescription by a generic medicine if available.

Some actions target patients and their purchasing behaviours. Following the introduction of reference pricing, if a patient chooses a product whose retail price exceeds the reference price, he/she needs to pay the share above the reference price.

Figure 15. The share of the generic market in Finland has increased, but remains lower than in many EU countries



Source: OECD Health Statistics 2017.

Strengthening primary care and care coordination remains a challenge

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

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

To promote greater care coordination, Finland invested substantially in eHealth. It introduced a nationwide harmonised electronic patient record, the national Patient Data Repository (referred to as KANTA). This information system includes all public and private health care providers. It also includes mandatory electronic prescription and a health portal allowing citizens to review their own information. These electronic patient records cover all the population since September 2016.

Proposed reforms will need careful steering to assure high-quality and timely health care to all

As already noted, major reforms are under discussion to reorganise the health and social care system in Finland, involving profound changes in the governance structure and providing greater choices for patients to choose between public or private providers (see Section 4). The regional governance reform is particularly ambitious, and tactful steering will be needed to realise the expected benefits in terms of reduction in inequalities and improved coordination and access. Many stakeholders have expressed doubts that the government can achieve its ambitious stated objectives of increasing access to care for the whole population, efficiency and cost control.

Another challenge is to strengthen quality assurance mechanisms, for instance through public monitoring and reporting of differences in quality of care across regions and providers, and generally through a more systematic use of these statistics to promote high-quality care.

6 Key findings

- Life expectancy in Finland increased strongly over the past few decades, reflecting the positive impacts of public health policies and health care system interventions in reducing both preventable and amenable mortality. However, important disparities in life expectancy by gender and socioeconomic status remain: in 2015, the life expectancy at birth of Finnish men with a tertiary education was more than six years higher than for those who had not completed their secondary education.

- Substantial progress has been achieved in reducing smoking rates in Finland, while obesity rates have increased. Most inequalities in health status are due to a greater prevalence of risk factors among people with the lowest level of education and income. An important challenge for public health policies is to find effective ways to reach these disadvantaged groups.

- Alcohol consumption remains an important public health issue in Finland, with more than one-third of adults reporting heavy alcohol consumption on a regular basis. The proposed liberalisation of alcohol sales raises serious concerns that this might exacerbate alcohol-related problems and deaths.

- Health spending in Finland is slightly higher than the EU average on a per capita basis, but slightly lower as a share of GDP. Public spending accounts for 74% of overall health spending, below the EU average (79%), with the remaining paid mainly out of pocket by households. Looking ahead, public expenditure on health and long-term care as a share of GDP is projected to increase in the coming decades, due to population ageing and slow economic growth. This increases the need to achieve efficiency gains in health and long-term care delivery, so that these services remain affordable.

- An important challenge in Finland is to strengthen access to primary care and promote greater coordination between primary care providers and hospitals. More timely and effective access to primary care for the whole population would help reduce unnecessary visits to specialists or hospital emergency departments for the growing number of people living with chronic conditions. The role of nurses has been expanded to improve access to primary care, but so far the actual implementation of these new roles remains fairly limited.

- A particular concern is that occupational health care, directly funded by employers and providing primary care through private providers, reinforces inequalities in access to care. It mainly facilitates faster access through wider provider choice for people from higher socioeconomic groups, while people from lower socioeconomic groups and older people (beyond working age) have to wait longer to access services. The overcapacity in occupational health care not only raises equity issues, but also issues about allocative efficiency in the system.

- The current government has proposed major reforms in the organisation of health and social care services, funding mechanisms and the regional governance structure. The regional governance reform and the freedom of choice reform are particularly ambitious, and tactful steering will be needed to assure health care delivery will not be negatively affected following this reform. The proposed timelines for implementing these reforms have been postponed, given the complexities of the changes involved.

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Country abbreviations

Austria	AT	Denmark	DK	Hungary	HU	Malta	MT	Slovenia	SI
Belgium	BE	Estonia	EE	Ireland	IE	Netherlands	NL	Spain	ES
Bulgaria	BG	Finland	FI	Italy	IT	Poland	PL	Sweden	SE
Croatia	HR	France	FR	Latvia	LV	Portugal	PT	United Kingdom	UK
Cyprus	CY	Germany	DE	Lithuania	LT	Romania	RO		
Czech Republic	CZ	Greece	EL	Luxembourg	LU	Slovak Republic	SK		

European Commission

State of Health in the EU

Country Health Profile 2017

The Country Health Profiles are an important step in the European Commission's two-year *State of Health in the EU* cycle and are the result of joint work between the Organisation for Economic Co-operation and Development (OECD) and the European Observatory on Health Systems and Policies. This series was co-ordinated by the Commission and produced with the financial assistance of the European Union.

The concise, policy relevant profiles are based on a transparent, consistent methodology, using both quantitative and qualitative data, yet flexibly adapted to the context of each EU Member State. The aim is to create a means for mutual learning and voluntary exchange that supports the efforts of Member States in their evidence-based policy making.

Each Country Health Profile provides a short synthesis of:

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

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