

Health Care Systems in Transition

Finland



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Contents

CONTENTS	2
FOREWORD	III
ACKNOWLEDGEMENTS	IV
INTRODUCTION AND HISTORICAL BACKGROUND	1
INTRODUCTORY OVERVIEW	1
HISTORICAL BACKGROUND.....	3
ORGANISATIONAL STRUCTURE AND MANAGEMENT	6
ORGANISATIONAL STRUCTURE OF THE HEALTH CARE SYSTEM	6
PLANNING, REGULATION AND MANAGEMENT	8
<i>Decentralisation of the health care system</i>	11
HEALTH CARE FINANCE AND EXPENDITURE	12
MAIN SYSTEM OF FINANCE AND COVERAGE	12
HEALTH CARE BENEFITS AND RATIONING	14
COMPLEMENTARY SOURCES OF FINANCE.....	15
<i>Out-of-pocket payments</i>	15
<i>Voluntary health insurance</i>	17
HEALTH CARE EXPENDITURE	18
HEALTH CARE DELIVERY SYSTEM	23
PRIMARY HEALTH CARE AND PUBLIC HEALTH SERVICES	23
<i>Public health services</i>	27
SECONDARY AND TERTIARY CARE	31
SOCIAL CARE.....	36
HUMAN RESOURCES AND TRAINING.....	38
PHARMACEUTICALS AND HEALTH CARE TECHNOLOGY ASSESSMENT	42
FINANCIAL RESOURCE ALLOCATION	44
THIRD PARTY BUDGET SETTING AND RESOURCE ALLOCATION.....	44
PAYMENT OF HOSPITALS	46
PAYMENT OF PHYSICIANS	47
HEALTH CARE REFORMS	48
DETERMINANTS AND OBJECTIVES	48
CONTENT OF REFORMS AND REFORM IMPLEMENTATION	49
<i>Health for all policy</i>	50
CONCLUSIONS	52
REFERENCES	53

Foreword

The Health Care Systems in Transition (HiT) profiles are country based documents that provide an analytical description of the health care system and of any reform programmes under development. HiTs form the basis of the information system on health systems and reforms at the World Health Organization Regional Office for Europe (WHO/EURO).

The aim of the HiT initiative is to provide relevant comparative information to support the development of health care systems and reforms in countries in the European Region of WHO. This initiative has four main objectives:

- to learn about different approaches to financing, organization and delivery of health care services in the European Region of WHO;
- to describe the process and content of health care reform programmes and to monitor their implementation;
- to highlight common challenges and areas that require more in-depth analysis and which could benefit in particular from cooperation and exchange of experiences between countries;
- to provide a tool for dissemination and exchange of information on health systems and reform strategies between different countries in the WHO European Region.

The HiT profiles are produced by country experts in collaboration with staff in WHO/EURO's Health Systems Analysis Programme. In order to maximize comparability between countries, a template and a questionnaire have been developed. These provide detailed guidelines and specific questions, definitions and examples to assist in the process of developing the HiT profile. Quantitative data on health services are based on the *WHO Health for All Database*, *OECD Health Data* and *World Bank Data*.

The realization of the HiT profiles faces a number of methodological problems. In many countries, there is relatively little information available on their health systems and on the impact of health reforms. Most information contained in the HiTs is based on information gathered from individual experts in the respective countries. As a result, some statements and judgements may be coloured by personal interpretation. In addition, the wide diversity of systems in the WHO European Region means that there are inevitably large differences in understanding and terminology. As far as possible, these have been addressed by the development of a set of definitions but some differences may remain. These caveats, however, are not limited to the HiT profiles, but apply to most attempts to study health systems.

In addition, HiTs are a source of descriptive, up-to-date and comparative information on health systems, which should enable policy-makers to identify key experiences relevant to their own national situation. They constitute a comprehensive source of information which can form the basis for more in-depth comparative analysis of reforms. The current series of HiT profiles includes over half of the countries in the Region. This is an on-going initiative with plans to extend coverage to all countries in the Region and to up-date the material at regular intervals and to monitor reforms over the longer term.

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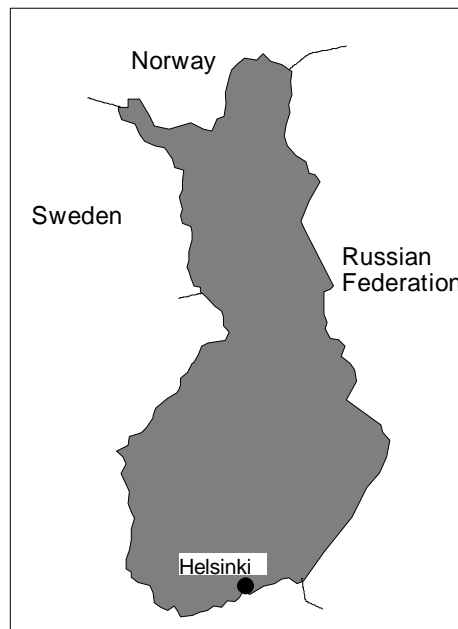
The HiT on Finland has been written by Jutta Niemelä, Ministry of Social Affairs and Health, Helsinki, and edited by Tom Marshall.

Introduction and historical background

Introductory overview

Finland is an independent republic located on the North East of the Baltic Sea. It is bordered by Norway in the North, the Gulf of Finland in the South, Sweden and the Baltic Sea in the West and Russia along the entire Eastern border. The land area is about 337 000 sq. km and the population is about 5.0 million. The bulk of the population is concentrated in the South of the country and much of Finland is forested and sparsely populated. About 62% of the population live in urban areas. There are two official languages in Finland, Finnish and Swedish - about 6% of the population are Swedish speaking. In addition there are small numbers of Same speakers in Lapland, the North of the country.

Map of Finland



Finland has a high level of economic and human development: four fifths of 25 to 29 year olds complete secondary schooling and in 1994 women accounted for 49% of the workforce. The economy is based on services and industry. Following the global economic recession, the collapse of the Soviet Union and some other reasons, Finland experienced a marked economic recession. Between 1990 and 1993 the economy shrank by 15% and unemployment rose from 3.5% to 19%. Since 1994 there have been signs that the economy is recovering with the level of unemployment slightly falling. Real GDP per capita (purchasing power adjusted) was \$16 300 in 1992, compared with an average of \$17 800 for the European Union.

Having been for centuries under Swedish and then Russian rule, Finland became an independent republic with its own constitution in 1917. The head of state is the President, who is directly elected for a six year term. Parliament has a single chamber of 200 representatives, elected for a four year term. Finland is divided into 11 administrative Provinces and the Åland Islands which have an autonomous status. Many responsibilities, including health services, education, social assistance and planning, are devolved to the level of the Municipalities. There are 455 of these throughout the country. Municipal councils are elected for a four year term and may raise revenue through a proportional income tax. In addition they receive a subsidy from central government. Municipalities account for 40% of public spending. The tradition of devolving responsibility to Municipalities has a long history in Finland, evolving over several centuries from a time when the country was under Swedish rule.

Some of Finland's health status indicators are better than average for Europe: the infant mortality rate at 4.4 per 1000 live births is the lowest in Europe. Nevertheless, cardiovascular diseases remain well above the E.U. average and deaths from suicides are among the highest in Europe. These contribute to a life expectancy, particularly male life expectancy, which is below the E.U. average.

Historical background

In Finland, the organisation and financing of health care has long been considered a public responsibility, a tax-financed health care system has developed gradually.

The Finnish Municipalities have long been the basic units to arrange health care for their citizens. In the time before the Second World War Municipalities concentrated mainly on the treatment of tuberculosis, other communicable diseases and mental diseases. Municipalities began to organise health services by employing General Practitioners and public health nurses. Municipalities usually provided these General Practitioners with facilities and personnel but a considerable part of General Practitioners' income came from direct payments by patients. As the overall number of doctors and nurses was small, they had to handle a wide variety of health problems.

In the 1940s maternity and child care centres began to be built throughout the country. The right to maternal and child health care was fixed by law to every mother and child irrespective of residence and financial situation.

The provision of hospital care was fairly modest in the first half of this century. Treatment for tuberculosis was provided at specific tuberculosis hospitals. In the 1940s Municipalities formed federations, so called Tuberculosis Districts, which were responsible for the treatment and prevention of tuberculosis.

The development of the hospital system was given a push in the 1950s. A new law stated that secondary care was to be provided by about 20 central hospitals which were built in larger towns with separate psychiatric hospitals. The bulk of state owned hospitals were passed into the possession of Municipalities. Later in the 1960s, regional hospitals were built in smaller towns. As tuberculosis became a minor concern, the treatment of tuberculosis was shifted into central hospitals and the tuberculosis hospitals were gradually changed for the treatment of other diseases.

In spite of all the progress in organising health services medical care and drugs were expensive and the income to live on were insecure during illness. A State Sickness Insurance scheme was therefore introduced in the 1960s. Part of the costs for medical care, drugs and some other services were reimbursed through this scheme.

In the beginning of the 1970s, there were still striking differences in the availability of health services. Most of the services were concentrated in urban areas. There was also an imbalance between primary and secondary health care. A network of specialised hospitals with high standard existed, but the supply of outpatient services and primary health care was insufficient. Also almost 90% of total health care expenditure was spent on hospital care and only 10% on primary care. Different primary care services, for example, general medical care by General Practitioners and mother and child care by nurses, were poorly co-ordinated with each other.

These issues were the reasons for the introduction of the Primary Health Care Act in 1972. A national plan for primary health care was also introduced then. The 1972 Primary Health Care Act obliged Municipalities to provide primary and public health care to their inhabitants. This care was to be provided in health centres. All primary and public health care which had until then been provided in a fragmented way, were brought together under the administration of health centres. This meant that the health centres began to provide primary medical care, various kinds of preventive services, home nursing, occupational health care and many other services. As health centres did not exist before the introduction of the law, the 1970s saw a comprehensive build-up of health centres in the country.

Other cornerstones in the history of Finnish health care are the inclusion of hospital care in the national planning in 1974 and the introduction of the Occupational Health Act in 1979. The latter obliges employers to provide occupational health services to their employees. In 1984, new legislation brought social services, (for example, children's day care and homes for the elderly) into the same planning and financing system as health care. Since then, the collaboration of social and health care has been stressed both on local and national level. A marked feature of the 1980s was the continuous decrease in the regulation by the state.

Organisational structure and management

Organisational structure of the health care system

In Finland, Municipalities have by law the main responsibility for arranging basic services like schooling, social and health services, to their populations. At the moment there are 455 Municipalities. The range of population varies from less than 1 000 inhabitants to about 500 000, the average size being about 11 000 inhabitants. Municipalities have the right to levy taxes. They also receive a subsidy from the state to enable them to arrange the services they are obliged to provide. In addition to the state subsidy for health care, Municipalities receive subsidies for social services and schooling.

The main decision-making power lies within the Municipal Council, which is elected every four years by the inhabitants of the Municipality. The council appoints a Municipal Government which is accountable to the council. The council also appoints members to the various Municipal Boards. These comprise the Health Board, the Board of Education, Board of Social Services, the Board of Traffic Affairs and a number of others. The Boards are appointed for four years. The Boards may consist both of members of the Municipal Councils and of other persons. However, an official or a person permanently working in a position subordinated to a Board is not eligible for the Board. The Municipal Council, the Municipal Government and the Boards are politically accountable to the inhabitants of the Municipality. In addition, a varying number of officials such as the director of the Municipality, Director of Finance, Technical Director and others work in the administration of Municipalities.

There are variations in details and emphasis in the decision-making process in Municipalities. Recently, the general trend has been towards delegating power from Municipal Councils to the various Boards and leading officials. Decisions concerning planning and organisation of health care are made by the Health Board, the Municipal council and Municipal Government. Again here are variations. The leading personnel of the Municipal health centres are often also included in the planning and organisation of health services. To improve the co-ordination of social and health services, the Boards of Health and Social Services have often been merged. At present, about 40% of the population of Finland live in Municipalities where these two boards have been merged.

The country is divided into 21 Hospital Districts, the Helsinki University Hospital being a separate entity. A Hospital District is responsible for providing hospital services and co-ordinating the public hospital care within its area. Each Municipality located in the district area must be member of the Hospital District. Typically, the administrative organisation of a Hospital District is a Council whose members are appointed by each Municipality, a Board appointed by the Council and an Executive Management. The Executive management consists of 2 to 6 permanent working, appointed managers (typically the Hospital District Director, a Medical Director and a Nursing Director). The Council meets a couple of times per year. Normally the administrative structure of a Hospital District is slim and does not contain many people.

The Ministry of Social Affairs and Health directs and manages social and health services at national level. It defines general social and health policy lines, prepares major reforms and directs

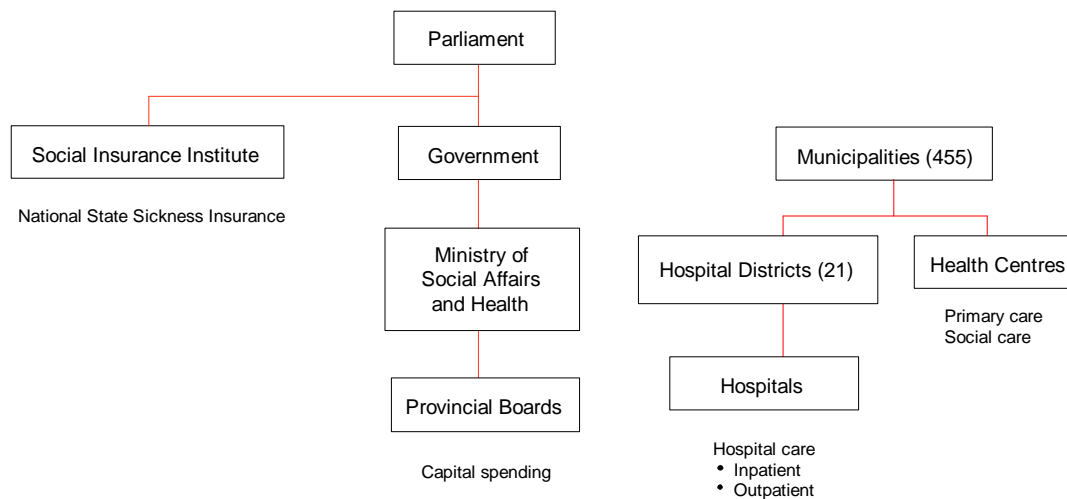
and monitors their implementation and assists the Government in decision-making. Attached to the Ministry of Social Affairs and Health is the Basic Security Council. On the initiative of the Ministry, the Council may investigate any deficiencies observed in the provision of Municipal health services. The Council may then make recommendations on how and when the deficiencies should be eliminated. There are several authorities and institutes subordinated to the Ministry of Social Affairs and Health which are responsible for various issues related to social and health care (some of them will be dealt with later).

The main levels in the administrative organisation of health care are the central government and the Municipalities. The level between these two (the Provincial Boards) is not very strong in the administrative hierarchy. Finland is divided into 11 provinces. In addition, there are the Åland Islands which have an autonomous status. Each of them has its own Provincial Board. The Provincial Boards are state agencies and their members are appointed civil servants. The boards are responsible for directing and monitoring social and health services in their own provinces, in practice their main health care responsibility is the approval of capital investments plans.

The Government decides on general priorities and prepares bills to be discussed by Parliament. The Ministry of Education is responsible for planning and partly for financing the education of health personnel.

Within the health care system there is a statutory State Sickness Insurance scheme, the National State Sickness Insurance. The scheme is run by the Social Insurance Institute with about 400 local offices all over the country. The Social Insurance Institute falls under the authority of Parliament. The Institute is not attached to the Ministry of Social Affairs and Health. The amount of benefits and services offered by the National State Sickness Insurance have extended markedly since its establishment in the 1960s. At present, it is used to provide part reimbursement for prescribed medication, transportation costs (Municipalities are responsible for the transportation of a patient, but in specified cases the Sickness Insurance reimburses partly the costs for transportation), private medical care (i.e. private doctors' and dentists' fees as well as examinations and treatment ordered by them), occupational health care, student health care and rehabilitation in some cases specified by law. The National State Sickness Insurance scheme pays for income loss during illness, pregnancy and childbirth and compensates for the income loss occurred to parents of a sick child during treatment and rehabilitation of the child.

Chart 1. Organisational chart of health care system



Planning, regulation and management

Everyone in Finland has the right to health services regardless of ability to pay or place of residence.

The 1972 Primary Health Care Act obliges Municipalities to provide health counselling, medical care, rehabilitation (when it is not provided by the National State Sickness Insurance) and dental care for children and young adults. It also obliges Municipalities to provide school, student and occupational health care, screening (cervical and breast screening), mental health care appropriate to a health centre and patient transportation. The statutory services are to be provided in health centres: either the Municipality's own, or together with other Municipalities. They can also buy these obligatory services from the private sector.

Municipalities are also obliged by law to arrange specialised medical care for their citizens. The 1991 Hospital Health Care Act and the 1991 Mental Health Act regulate the organisation of these services. There is also separate legislation concerning some vulnerable groups of the population, for example, the disabled and chronically alcoholic. The law on social and health care planning and state subsidies also regulates the services provided by Municipalities. In general, the legislation does not regulate in great detail the range and method of providing services. When the legislation does not give any details on the right to certain services or on the range and method of service provision, it is at the Municipality's discretion to decide about the range and method of providing services.

In practice, there are differences in the organisation of services due to local circumstances and population's needs. For example, the age structure, the local policy targets, the social environment or the geographical location of a Municipality may influence the way services are organised and provided.

Until 1993, the state regulation of health service provision was rather strict and detailed. There was legislation and a national five-year plan for social and health care. The Ministry of Social Affairs and Health prepared this plan each year and it was approved by the Government along with the proposed state budget.

The implementation of the state subsidy reform in 1993 reduced regulation by the state. The main objective of the reform was to reduce central administration and to increase decision-making power and responsibility at the local level. The reform did not change the fundamental principle of the Finnish health care system: that the Municipalities are responsible for providing health services. Municipalities were given an even more active role in arranging services and to decide more freely on administration, personnel and user charges. They also got the right to purchase services from any provider they want to and contract out for services from the private sector.

At the same time with the implementation of the state subsidy reform the national plan was changed from a five-year plan to a four-year plan. Its role became also less significant. The main contents of the four year plan are general guidelines on activities in social and health care and information on the amount of state financing for running costs and capital investments.

The 21 Hospital Districts were formed in 1991. Before 1991, the number of Hospital Districts was much larger and the administration of the districts was different from the present one. The main problem in the organisation of secondary care was the fragmented administration of secondary care and the poor co-ordination between the different units and districts. The present 21 Hospital Districts are responsible for providing hospital services and co-ordinating public hospital care within a defined area. Each Municipality must be member of a Hospital District. One Hospital District usually comprises 1-3 acute (non-psychiatric) hospitals and 1-2 psychiatric hospitals. Both in-patient and out-patient care is provided in these hospitals.

Municipalities usually purchase services from hospitals within the Hospital District they belong to, although they may purchase services from outside their own district or from a private provider. The reasons for Municipalities not purchasing from outside their own district may be geographical (distance) or it may be that the service prices are higher for members of another Hospital District. As prices and services are defined in very different ways it is impossible to compare different producers and choose the most cost-effective one. The Hospital Districts can also bill Municipalities retrospectively on those occasions when the hospitals' revenues are not sufficient to cover all expenditure (some districts have abandoned retrospective billing and some are planning to do so, although not all districts).

Municipalities do not negotiate a formal contract with hospitals, rather they make an agreement with some hospitals on the provision of certain specialised services. Hospital Districts must have an equalisation mechanism to spread the risks of very high costs. If an individual patient's treatment costs exceed a specified threshold (agreed within the Hospital District) all Municipalities that are members of the same district will pay all or part of the excess. This threshold varies from FM 100 000 to FM 300 000. Most Hospital Districts have set the threshold at FM 200 000. There are some variations on how the right for equalisation is defined. Most Hospital Districts allow for equalisation for one illness period; one specifies that costs should be incurred in one hospital; while other districts have set the equalisation threshold for all hospital care costs in any one year.

The equalisation mechanism is very important due to the small size of Municipalities: without it, the risk of catastrophic costs to Municipalities would be too high. As can be imagined, the budget of a Municipality which has a population of 2 000 or 10 000 inhabitants cannot cover expensive treatments such as organ transplantation or certain cancer treatments.

In general, it is thought that the equalisation mechanism works reasonably well and that it is important for compensating Municipalities costly hospital treatment. The administration costs related to the equalisation mechanism are minimal.

Despite clear legislation defining the role of Hospital Districts (to arrange specialised medical care within their areas) their role is in practice unclear. Some districts seem to act as representatives of the hospitals in their area, i.e. as providers. Others seem to be representatives of the Municipalities which form the district (purchasers). Hospital Districts are a kind of local monopoly, but they can not be described as the parties in the "classical" model of a purchaser-provider split. It is thought that the role of Hospital Districts needs clarification, but no concrete plans have yet been made.

Hospital Districts seem to have a strong position in organising and providing specialised medical care. This is because Municipalities appear to be fairly powerless and cannot influence the provision and costs of hospital care. There is clearly an imbalance if one imagines a Municipality of 2 000 or even 10 000 inhabitants whose officials and political leaders try to negotiate with a large professionalised hospital. Municipalities, in most cases, also lack the medical, economic and other kinds of skills which are necessary for arranging services in the most efficient way. However, the purchasing of hospital services by Municipalities is not contract-based. (The method of paying for hospital care is explained later).

At present there are discussions on Municipalities' position in relation to specialised care, how it might be strengthened and what should be the role of Hospital Districts. The obligation that a Municipality be a member of a Hospital District has also been under discussion. However, if this were abolished the equalisation mechanism would have to be modified. As mentioned above, because of the size of Municipalities, an equalisation mechanism is essential. At present, as the whole of public administration in Finland is being discussed, there may be changes in public sector administration which also influence Hospital Districts and other health sector bodies. In addition to the health care services provided by Municipalities (which is the main system), private and occupational health care services are provided. Private health care in Finland comprises mainly ambulatory care, provided in large cities in the Southern parts of the country. The majority of physicians working in the private health sector are specialists, whose full-time job is

in a public hospital or health centre. The number of private hospitals is very small. The law on private health care regulates the provision of private health services.

The 1979 Occupational Health Act obliges employers to provide occupational health care to their employees. This Act defines obligatory occupational health care as those health services which are necessary to prevent health risks caused by work. Employers have to provide sufficient information on health risks related to work and to advise their employees on how to avoid the risks. They are obliged to arrange physical examinations and first aid for their employees at workplaces. Employers have also to investigate an employee's health condition when a job might endanger his health. It has to be noted that besides the Occupational Health Care Act employers must take into account legislation concerning safety at work as well. In addition to obligatory occupational health care employers can voluntarily provide other health care and medical treatment for their employees.

Employers can arrange occupational health care in different ways. They may, for example, set up their own health centres. Large firms tend to have a health centre of their own with one or more doctors and nurses working there. Employers may also form a health centre together with other employers or they may arrange occupational services at a health centre owned by a Municipality. A common way of providing occupational services is to buy the services of a private provider - usually a private group practice.

The National State Sickness Insurance reimburses, in most cases, employers with 50% of the (necessary and appropriate) costs of providing occupational health. Users of occupational health care are not charged anything. About 1.6 million people (90% of all employees) are offered occupational health care by their employers. It is emphasised that occupational health care should be preventive, but it is more often treating various medical problems than providing preventive health care.

The private and the public sector services are neither co-ordinated with each other nor are they real competitors with each other. The same is also true of occupational health services. The parallel systems, private and occupational health care systems, alongside the public health care system, offer more choice for patients than what just one sector would do, but at the same time, the parallel systems also create problems. More detail on the problems relating to these parallel systems is included in Health care finance and expenditure.

There are additional problems with the organisational structure of health care in Finland. These include poor co-ordination and planning of operational costs, capital investments and manpower planning. The Ministry of Education partly plans and finances the education of health personnel, but neither Municipalities, which are responsible for employing health personnel, nor the Ministry of Social Affairs and Health participate in manpower planning.

The negotiations for health personnel's wages, salaries, or fees occur between the Association of Municipalities and the labour unions. The relevant Ministries, do not participate in these negotiations.

Finland's Slot Machine Association has become an important financier of capital investments. (The Slot Machine Association operates slot machines, amusement machines and casino games. Its revenues are distributed to support the work of voluntary health and welfare organisations, for example, service housing for the aged and disabled, assistance for individuals and families in difficulties, youth work and care for substance abusers). In 1994, the Slot Machine Association financed around one third of all capital investments made in health care. This has resulted in greater need to co-ordinate investment activities. However, the association does not finance any public health services, for example, Municipal health services.

Citizens participate in the health care system through voting rights every four years in both Municipal and Parliamentary elections. There are also various patient associations which may influence decision-makers on issues concerning planning and management of public health care.

In 1987, a law to compensate patients for injuries came into force. According to this law a patient has the right to compensation for unforeseeable injury which occurred as a result of treatment or diagnosis. Notable in this law is the fact that health care personnel need not to be necessarily shown to be legally responsible for the injury. To receive compensation it is sufficient that unforeseeable injury occurred.

In 1993, a new law on patient's rights came into force. This mainly concerns the patient's right to information, the right to see any medical documents concerning him and the right to autonomy. A medical ombudsman was also introduced by the law.

Decentralisation of the health care system

The Finnish health care system is very decentralised, following a devolved model. As described above 455 elected Municipalities are responsible for arranging health care and have great freedom in doing this. The 1993 state subsidy reform gave even greater responsibility and decision-making power to the Municipalities. There has not been very much opposition to decentralisation. In Finland, the population of the country is dispersed and local decision-making has always been regarded important.

Decentralisation has highlighted significant variations both in clinical practice and in the delivery of health services. For example, the number of in-patient cases and surgical procedures varies markedly from region to region and the differences cannot be explained by different morbidity or age and sex structure. These variations already existed before the 1993 state subsidy reform. There are also wide differences in per capita expenditure on health care between Municipalities.

Municipalities have often a very small population: 75% of Municipalities have a population less than 10 000 inhabitants and 20% of Municipalities have a population less than 2 000 inhabitants. This creates problems with risk: one costly treatment can be unbearable to the economy of a small or medium-size Municipality. However, the equalisation mechanism within Hospital Districts described above helps with the problem by risk pooling.

Another problem arising from decentralisation to such small units is that Municipalities may lack skills and negotiating power. This is discussed above.

Health care finance and expenditure

Main system of finance and coverage

The Finnish health care system provides universal coverage based on residence. Everyone permanently residing in Finland has the right to health services.

The health care system in Finland is mainly tax-financed. Both the state and the Municipalities have the right to levy taxes. In 1994 about 33% of total health care costs were financed by the Municipal income tax, about 29% by the state, 13% by the compulsory National State Sickness Insurance (N.S.S.I.) and about 25% by private sources. About two-thirds of total health care expenditure is spent on health services provided by Municipalities. Most of the remaining one third is spent on medicines and other pharmaceutical products, private health care, medical aids and prosthesis and occupational health care. This third is largely financed from the N.S.S.I., out-of-pocket payments and employers.

The state's revenues consist mainly of a progressive income tax and indirect state taxes. After the economic crisis started in 1990, the state had to finance public sector activities by taking up a growing amount of loan. Combined spending on health, welfare and social security, accounts for about 30% of annual state expenditure. Of this health care is about 9 percentage units, social services about 7 percentage units and social security transfers about 14 percentage units. State finance on health care occurs to a large extent in the form of state subsidies, which are allocated by the Ministry of Social Affairs and Health to every Municipality. (The state also allocates subsidies for education and social services.) The allocation of state subsidies is explained in more detail in Section 4.1.

Municipal income tax is a fixed proportion of income, which varies from Municipality to Municipality. On the average it is 17% of income. Municipal tax revenues are not only used for health care but also for other services such as education and social services. On average, about 35% of Municipalities' budgets are spent on social and health services, about 19% is spent on health care alone.

National State Sickness Insurance revenues come from insurees and employers, returns on assets held and a state contribution. The contribution paid by wage and salary earners and pensioners is a specified percentage of their income and that paid by employers', a specified percentage of their employees' earnings. The state pays a share of the total costs of sickness, parenthood and special care allowances (about 13%, which was around 733 million FM in the year 1994). In 1995 and 1996, according to a provisional regulation, this state contribution was not paid to the National State Sickness Insurance. The revenues of the National State Sickness Insurance in a given year must be approximately equal to expenditure in that year. The state guarantees the solvency of the National State Sickness Insurance.

The existence of several public funding sources creates some problems. As explained above, the Municipal health care is financed by state and Municipal taxes (and a small proportion from user charges). The other public funding source is the National State Sickness Insurance which is used to finance private health care, occupational health care and many other services. State Sickness Insurance reimbursements do not affect the amount of the Municipalities' state subsidy even though a considerable proportion of a Municipality's population might use private and occupational health services. The National State Sickness Insurance is financed by all citizens, everywhere in

Finland but the majority of private health and occupational health care is provided in the largest cities in the South of the country. The utilisation of private and occupational services is therefore supported by citizens who themselves do not use these services. This is, of course, not equitable.

Another problem with the existence of several public funding sources is that financing often determines how services are provided. For example, Municipalities are responsible for the financing institutional care and ambulatory care but the National State Sickness Insurance reimburses some ambulatory care costs (medication, transport, rehabilitation etc.). When it is not clear whether a treatment is ambulatory or institutional, both parties try to shift responsibility and costs to the other. This often leads to perverse incentives and inefficient utilisation of services. In addition, the parallel systems are said to have created overlapping capacity (in terms of facilities and equipment).

It is believed that health care in Finland will remain tax-financed in the future. Nevertheless, there seems to be a need to clarify and simplify the public financing system. At present, there are no plans to change the funding basis even though the marked economic recession has created - and still is creating - difficulties in the public sector economy.

Health care benefits and rationing

Some services are excluded from the statutory health system, these include some dental care, eye glasses and sight tests.

Dental care for adults born before 1956 is not publicly funded¹. However, those adults with certain specified illnesses and veterans of the Second World War are reimbursed by the State Sickness Insurance for dental care. It was planned to extend the reimbursement of dental care to cover the whole population but these plans have been shelved due to the economic recession and pressures on public expenditure.

Sight tests and eye glasses are generally not financed by the public system, nor are alternative therapy or complementary medicine. Cosmetic surgery is publicly financed when it is necessary due to a disease, for example, burns or tumours, but not for solely cosmetic reasons. In vitro fertilisation and surgery for varicose veins are not excluded from the public system.

Employers are obliged to provide occupational health services for their employees, but because many employers arrange additional health care services, there are differences in the services available to employees. All employees, however, have access to public sector services.

There are no plans for an explicitly stated basic package of benefits. However, there have been discussions about setting priorities. A priorities task force published its report in autumn 1994. The report did not contain any specific recommendations, only very general principles and guidelines. It did however, emphasise transparency in decision-making, stating that the main principles for these decisions should be human rights, self-determination, equality and justice. In setting priorities a distinction should be made between the priority setting at the political or administrative level and at the clinical level. For the time being, the benefits coverage is expected to remain about the same.

¹. The year 1956 is arbitrary. The provision of dental care started with children and was then extended to young adults. The extension of dental care provision stopped at the age group of those born before 1956 when the economic recession started.

Complementary sources of finance

As can be seen from Table 1 the share of private financing has been increasing. This is due to increased out-of-pocket payments by patients. The charges for Municipal services have been increased during the last 3-4 years (see next chapter). In addition to this, there have been reductions in the reimbursement of pharmaceuticals by the National State Sickness Insurance. Finally, tax-deductibles for drug and other medical treatment costs were abolished in 1992 (until then drug and other medical treatment costs were tax-deductible).

Table 1: Main sources of finance (percentages)

Source of Finance	1980	1990	1994
Public	79.6	80.9	75.2
Taxes	67.1	70.3	62.2
Statutory Insurance	12.4	10.6	13.0
Private	20.4	19.2	24.8
Out-of-pocket	17.8	15.6	20.8
Private Insurance	0.8	1.7	2.0
Employers	1.2	1.4	1.6
Relief funds	0.6	0.5	0.4

Source: Health Care Expenditure and Financing in Finland 1960-1993, Publication by the National Pension Institute T9:51, 1995.

Out-of-pocket payments

Those services which are free of charge are defined by law. A maximum out-of-pocket payment is defined by statute for those services where a fee is allowed.

Ambulatory care

Services which are free of charge are the following ones: preventive health care (for example, maternity and child care), psychiatric ambulatory care; immunisation (in most cases), the examination and treatment of some communicable diseases specified in law (sexually transmitted diseases, tuberculosis, hepatitis and some others), treatment of respiratory arrest patients, medical aids and prosthesis, transportation from a health care unit to another when ordered by a medical doctor and treatment of under 18-year old in hospital if it lasts for more than 7 days in any calendar year.

Municipalities are free to decide if they want to charge patients but they are not allowed to exceed the maximum limits set by statute.

Municipalities may choose from two alternative ways of charging for a visit to a health centre doctor: FM 100 which covers all visits during the following 12 months (if the patient does not want to pay the annual FM 100, he is charged FM 50 per each visit) or a FM 50 payment per visit which is paid for the first three visits with all further visits being free during one calendar year. Children under 15 years are not charged anything. Laboratory and x-ray examinations are included in the fees. Dental care is charged depending on the type of care, for example, dental preventive care is charged FM 0-100 and dental treatment FM 25-200 (under 19-year old are free of charges for all dental care).

Fees for private sector doctors and dentists are reimbursed by State Sickness Insurance up to 60% of the established basic tariff. However, the actual fees charged by private doctors are normally higher than the basic tariff. Treatment and examination by a private doctor is reimbursed 75% in excess of FM 70 of the established basic tariff. In 1993, State Sickness Insurance covered 36% of actual patient fees to private doctors, on average.

Dentists' fees are reimbursed by State Sickness Insurance for patients born in or after 1956. Also patients suffering from some chronic diseases and Veterans of the Second World War are partly reimbursed for dental treatment. The reimbursement rate for examination, preventive care and dental treatment is 60% of the basic tariff.

Hospital care

The maximum fee for an outpatient visit to a specialist at a hospital is FM 100 per visit and for inpatient care FM 125 per day. Hospitals are allowed to set lower prices. Charges for long-term care which is provided, for example, in the in-patient departments of health centres are determined according to a person's income.

Drugs

Patients receive 50% reimbursement for all pharmaceutical costs in excess of a fixed limit per single purchase (in 1996 this is FM 50) by State Sickness Insurance. Patients with certain chronic conditions are reimbursed 75% or 100% in excess of FM 25. There is a maximum limit for drugs to be paid by patients per year. In 1996 this limit is FM 3 158. All drug costs exceeding this limit are paid by State Sickness Insurance.

Medical aids and prosthesis

Medical aids and prostheses are generally free of charge by law. The main responsibility for providing and financing medical aids and prostheses is within the Municipal health services, i.e. they are supplied either by health centres or hospitals. Also other authorities such as the social services authorities, the Social Insurance Institute, private insurance companies and others provide or finance medical aids to their clients if the legislation concerned obliges them to do so.

Others

State Sickness Insurance also reimburses transportation costs if these exceed FM 45 per one transportation. If transportation costs paid by patients exceed FM 900 per year, State Sickness Insurance reimburses all transportation costs in excess of this limit.

Changes in out of pocket payments

The share of out-of-pocket-payments in total health care financing has been increasing. The deep economic recession which started in 1990 and created a growing public debt has forced a reduction in public spending. The relative share of out-of-pocket payments has therefore increased.

Out-of-pocket payments have also increased in absolute terms. User charges for health centres were introduced in 1993. Before 1993, visits to health centre doctors were free of charge. In addition to this, State Sickness Insurance has reduced its compensation for numerous services, for example, for drugs. Charges for hospital care have also increased in recent years.

Compared to other countries out-of-pocket payments are already rather high in Finland. It is thought that out-pocket-payments cannot be increased any more. If health care requires further funding, other financing sources will have to be found.

In a similar way to the annual limit for prescribed pharmaceuticals, an annual maximum limit for costs arising from other medical care than drugs has been planned. This would mean that patients would not have to pay anything for medical care when costs exceeded the set limit. However, the introduction of this cost limit remains uncertain.

Voluntary health insurance

Voluntary or private insurance is not significant in Finland. It accounts for about 2% of total health care financing. Private insurance mainly includes health care costs paid out of life and accident insurance schemes. No major changes are expected in this area.

Health care expenditure

Figure 1. Total and public health care expenditure as a share of GDP (%) in Western Europe, year 1993

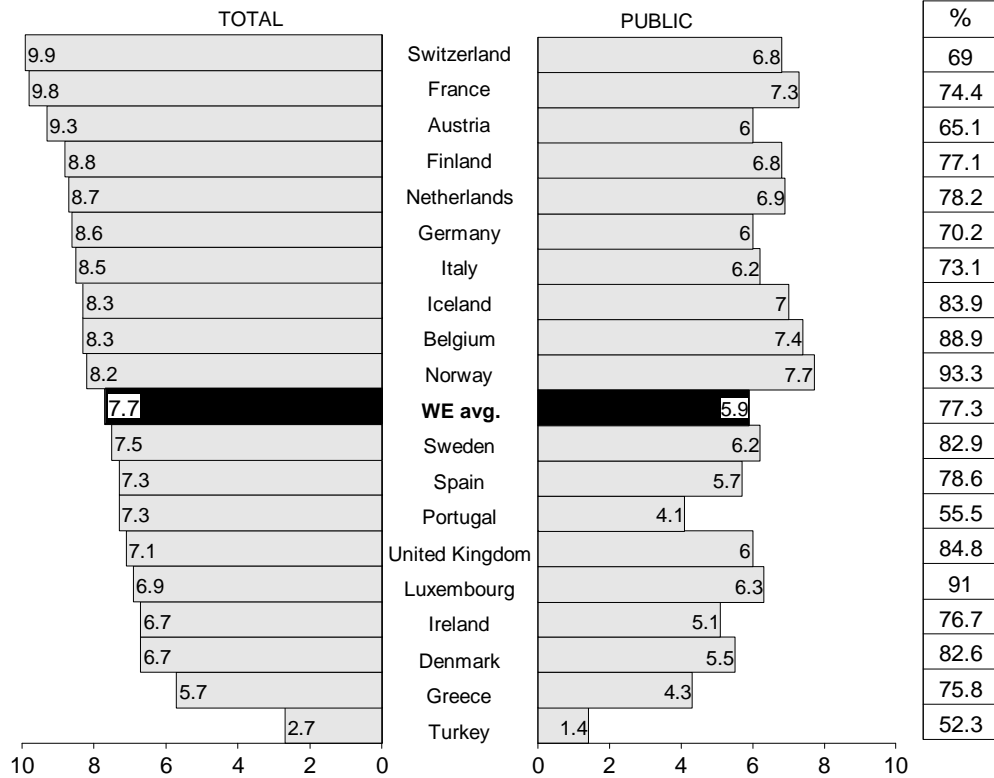


Figure 1. Health care expenditure as measured as a share of GDP in Finland is above Western European average. The public share is about the same level as the average in Western Europe. The public share consists of the contribution paid by the Municipalities and the state as well as the National State Sickness Insurance. The remainder is mainly financed by households.

Figure 2. Total expenditure on health as a percentage of GDP in western Europe, the CEE countries (1994) and the CIS countries (latest available year)

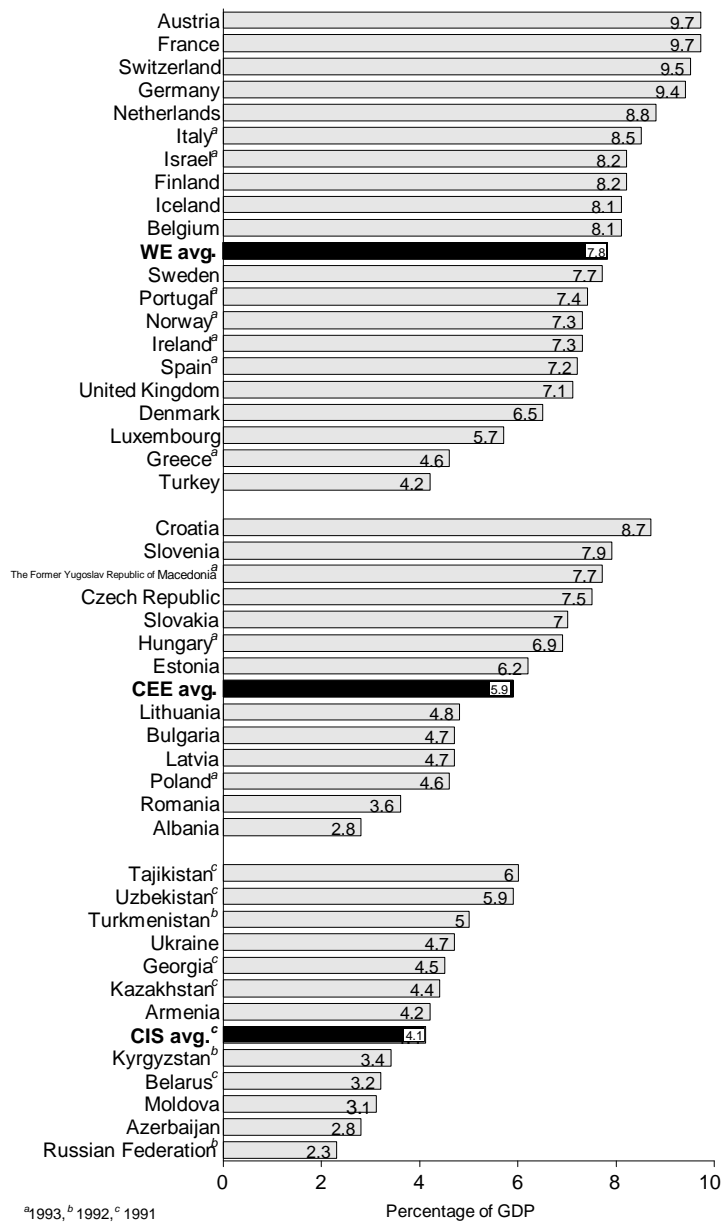


Figure 3: Trends in health care expenditure as a share of GDP (%) in Finland and selected Western European countries, years 1970 - 1993.

Error! Not a valid link. **Figure 3: Health care expenditure in \$PPP per capita is almost the same level as the average in Western Europe although the share of GDP accounted for by total health expenditure is above average. Health care expenditure in \$PPP per capita is at the same level with the other tax-financed countries such as Sweden, Denmark and the United Kingdom.**

Table 2: Trends in health care expenditure in Finland, years 1970 - 1995.

Total Expenditure on Health Care	1970	1975	1980	1985	1990	91	92	93	94	95
Value in Current Prices, 10 Millions of FMK	26	66	124	242	411	448	446	420		
Value in Constant Prices, 10 Millions of FMK90	171	244	290	338	411	418	404	372		
Value in Current Prices, per Capita (PPP\$)	164	312	521	852	1291	1416	1406	1363		
share of GDP (%)	5.7	6.4	6.5	7.3	8	9.1	9.4	8.8		
Public as share of Total Expenditure on Health care (%)	73.8	78.6	79	78.6	80.9	80.9	79.3	79.3		

Source: OECD Health Data File, version # 3.6 (1995)

Table 2: Total expenditure on health rose constantly from the 1970s until the beginning of the 1990s. The value of health care expenditure in constant prices grew by 3.5% annually until 1990, but in only three years (from 1991 to 1993) it declined by 9.5%. The declining trend was due to cuts in public expenditure on health care which followed the marked economic recession of the 1990s. Health expenditure as a share of GDP has risen constantly during the past decades. In 1991 and 1992 it was exceptionally high due to the dramatic decline in total GDP. Health care expenditure has declined in real terms since 1991. The health expenditure share of GDP has declined since 1992 as GDP has been growing again and expenditure on health care has been cut.

Table 3: Health care expenditure by categories, (%) of total expenditure on health care, years 1970 - 1995

Total expenditure on: as share of TEHC	1970	1975	1980	1985	1990	91	92	93	94	95
In-Patient Care (%)	50.4	48.5	49.2	46	44.7	44.3	43.6			
Pharmaceuticals (%)	12.6	11.9	10.7	9.7	9.4	9.9	10.7			
Public Investment (%)	1.3	1	0.7	0.7	0.7	0.6	0.5			

Table 3: The table shows general trends of recent years in the health service delivery system. In-patient care accounts for almost half of health care expenditure. The share of total expenditure which goes on pharmaceuticals has grown to 10%. This is due both to the decline in total health

expenditure and due an increase in costs of pharmaceuticals which in turn has been caused by the increase in user numbers and the use of new expensive drugs. In the 1970s, a large number of new facilities for health care were built. Since then, there has not been as much need for building new hospitals and health centres. This has resulted in the reduction of public investments. At present, there is considerable excess capacity, especially in hospitals.

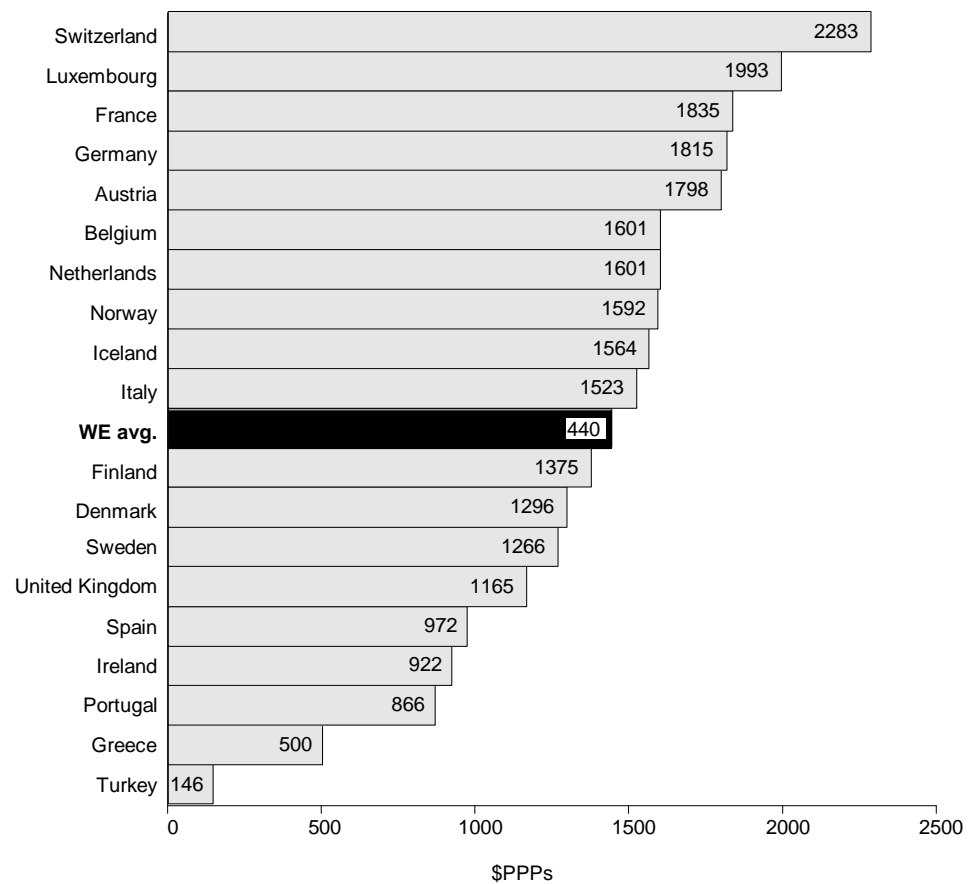
Figure 4. Health care expenditure in \$PPPs in Western Europe, 1993

Figure 4: In the 1970s and the 1980s Finland's health care expenditure compared to other countries was about or below average. However, in the beginning of the 1990s the share of GDP was one of the highest in Western European countries. As explained in the text above, this was not due to growth in health care expenditure but rather due to the dramatic decline in GDP. As can be seen from the figure, the share has reduced since 1992.

Health care delivery system

Primary health care and public health services

Primary health care is provided mainly in health centres. A health centre can be defined as a functional unit or an organisation which provides primary and public health care to its population. It is not necessarily a single building or a single location where care is provided. Health centre activities are often organised at several locations, for example, child and maternity care might be provided at a separate location from the General Practitioners' practice. Large cities usually have health centre activities organised at several places. Health centres are owned by one or more Municipalities and as they do not have independent status are non-profit making organisations and cannot borrow money on their own behalf. Municipalities, on the other hand, are allowed to borrow money and may do so on behalf of their health facilities.

In 1995 there were about 250 health centres in the country. In sparsely populated areas like Lapland, the distance to the nearest health centre is much greater than in the more densely populated South. The size of a health centres varies depending on the number of people it serves. When health centres were first set up, it was advised that they should serve a population of at least 10 000 inhabitants. However, there is no obligatory rule on this number at present.

The number and type of personnel in each health centre depends on its size and location and on local circumstances. The personnel inlaid General Practitioners, sometimes medical specialists, nurses, public health nurses, social workers, dentists, physiotherapists, psychologists, administrative personnel and so on. All are employed by the Municipalities. The number of patients per health centre doctor varies, on average it is about 2 000.

Health centres offer a wide variety of services: outpatient medical care, inpatient care, preventive care, dental care, maternity care, child care, school care, care for the elderly, family planning, physiotherapy and occupational health care. The minimum range of services to be provided by health centres is stated in legislation, but this does not generally define in great detail the range of services. In most cases it is left to the discretion of the Municipality to decide what should be provided.

Usually health centres are well equipped. In addition to the doctors' and nurses' consulting rooms, there are usually x-ray facilities, a small clinical laboratory, facilities for minor surgery, an electrocardiogram and sometimes ultrasound equipment and facilities for endoscopy.

The doctors working in health centres are mainly General Practitioners. About one fourth of all GPs working in health centres have specialised in general medicine. However, it is not obligatory to be a specialist in general medicine to work as a General Practitioner in a health centre.

The main work of health centre doctors is to provide office-based general medical care to patients of all ages. They are often involved in other kind of activities, as well. These include maternity and child care, occupational care, family planning, in-patient department of the health centre, home nursing (home visits by General Practitioners are not very common, these are more often done by nurses), consultation at a Municipal home for the elderly etc. The tasks are often divided between the health centre doctors according to the circumstances in the health centre and the experience or interests of the doctors.

There are also an increasing number of specialists working in health centres. For example, an internist might have been given responsibility for the elderly and the in-patient department, a radiologist the work of the radiological examinations. Some health centres also have arranged for specialists to come once a week for consultations, for example, a radiologist from the nearby hospital to interpret x-rays.

The in-patient department of a health centre works much the same way as a hospital department. A typical health centre has 30 to 60 beds. The number of in-patient departments within a health centre varies. Larger health centres tend to have at least 2-3 departments. The majority of their patients are elderly and chronically ill.

Nurses have an essential role in Finnish health centres. There are nurses with a general nursing education who, in addition to assisting General Practitioners, have their own consulting hours for giving injections, removing sutures, measuring blood pressure and so on. Maternity and child care are important parts of nurses' work. These are largely carried out by public health nurses who are nurses specialised in preventive work. Their work also involves, in addition to maternity and child care, family planning, school care, occupational health services, home nursing and sometimes other kinds of consulting related to health.

The occupational health care offered at health centres is offered to those employees whose employers have elected to arrange occupational health care in this way. Occupational health care is provided by one of the health centre General Practitioners² along with one or several nurses.

Physiotherapy and rehabilitation is offered mainly by physiotherapists. They not only give treatment to individual patients but also arrange guidance and physical exercise to groups of patients suffering from the same disorder. The health centre physiotherapy department is also usually the place which provides medical aids and prosthesis to patients.

Dental care provided at health centres covers all children and young people under 19, Veterans of the Second World War and usually also the disabled and some other vulnerable groups. However, there are variations in the provision of dental care by health centres. Some Municipalities have managed to offer dental care to the whole population while some others offer only the obligatory services.

Health centres often employ social workers, to deal with various problems related to illness such as helping patients to apply for benefits or arranging home help and other services needed by patients discharged from in-patient care.

Sometimes health centres employ psychologists. Their work varies from consultations done by other health centre workers to work with children and schools. However, ambulatory psychiatric care is normally organised at the out-patient departments of psychiatric hospitals and at separate clinics, so called mental health centres (explained in more detail in Section 3.3).

Pharmacists work in some large health centres. However, health centres do not have a pharmacy for the sale of prescription drugs to patients. Health centres have a storage of pharmaceuticals of their own for emergency cases, for minor surgery, for acute cases in the night when pharmacies are closed, for in-patient departments and some other purposes. Patients are given drugs as part of their in-patient care included in the charge for in-patient care.

Health centres are of different sizes and the Municipalities are free to decide on the organisation of health services. Usually, the head of a health centre is the chief physician. However, in large and middle-sized health centres the management often includes several leading persons. Often there are several chief physicians (who might be accountable to one medical director), one or several chief nurses and directors of finance and/or administration.

² The practitioner may be specialist in occupational health care which is a medical speciality in Finland.

The quality of services and facilities are of a high standard. As with the range of services, the quality of services has generally not been defined in detail. Various kinds of projects concerning quality assurance have raised growing enthusiasm, both in primary and specialised care. Also National guidelines for quality assurance in social and health care were drawn up at the end of 1995.

If a patient wishes to see a health centre doctor, they usually are assigned to the doctor who is responsible for their population area (division into responsibility areas is explained later). This means there is not much choice of General Practitioner for patients. However, if a patient wishes to change his/her doctor within the health centre, they are usually allowed to do so. According to patient surveys a vast majority of patients is satisfied with their assigned doctor.

In the public sector, patients need a referral from their General Practitioner in order to get access to a specialist, i.e. to the outpatient and inpatient care in a hospital. In practice, many patients go directly to hospital emergency units in order to bypass the referral process. In the private sector, there is direct access to private specialists and either private General Practitioners or specialists can refer to public hospital specialists.

In general, patients cannot choose the hospital where they will be treated. Health centres have instructions where to send patients with certain symptoms and diagnoses. Hospitals, however, as far as possible, do try to allow patients to choose their hospital doctor.

Under discussion is the suggestion that patients should have more freedom to choose their doctor and hospital. It is also being discussed whether patients should be allowed to see a health centre doctor outside their own Municipality while leaving financing responsibility to their own residential Municipality. As yet, however, no decisions have been made on these issues.

Both primary health care physicians and hospital specialists may work in the private sector in addition to their work in the public sector. Almost one third of all doctors (both General Practitioners and specialists) have some kind of private practice. In 1995, only 7% of all doctors worked full-time in private practice. There are no restrictions on the entry of doctors into the National State Sickness Insurance, this means that any patients who are treated by any licensed medical doctor are partly reimbursed by the National State Sickness Insurance.

After the 1972 Primary Health Care Act came into force, government financing was first given to building of health centres in the remote and rural areas. These areas were poorer than the urban areas and also had less private health services as a result, the development of Municipal health centres was more rapid in rural areas than in the larger cities.

By the 1980s, although an increasing amount of resources had been allocated to primary care, there were problems with access to health centre doctors and with continuity of care. These problems particularly concerned the larger cities. Waiting times to see a health centre doctor were often 2-6 weeks for non-urgent cases, although there was always the possibility of seeing the doctor on-call. But on-call work was often busy and only the most acute problems could be dealt with, in such a way that patients could come again during usual appointment times or for another on-call visit. Health centre doctors did not feel real personal responsibility for patients' care and the continuity of care was poor since the patient would usually see another doctor on their next consultation.

To overcome these problems a number of projects were launched in the 1980s. One was the introduction of the personal doctor system in some parts of Finland. In this system a person or a family is always assigned to the same health centre doctor. In 1988-93 a project was carried out in which some private doctors in large cities acted as personal doctors.

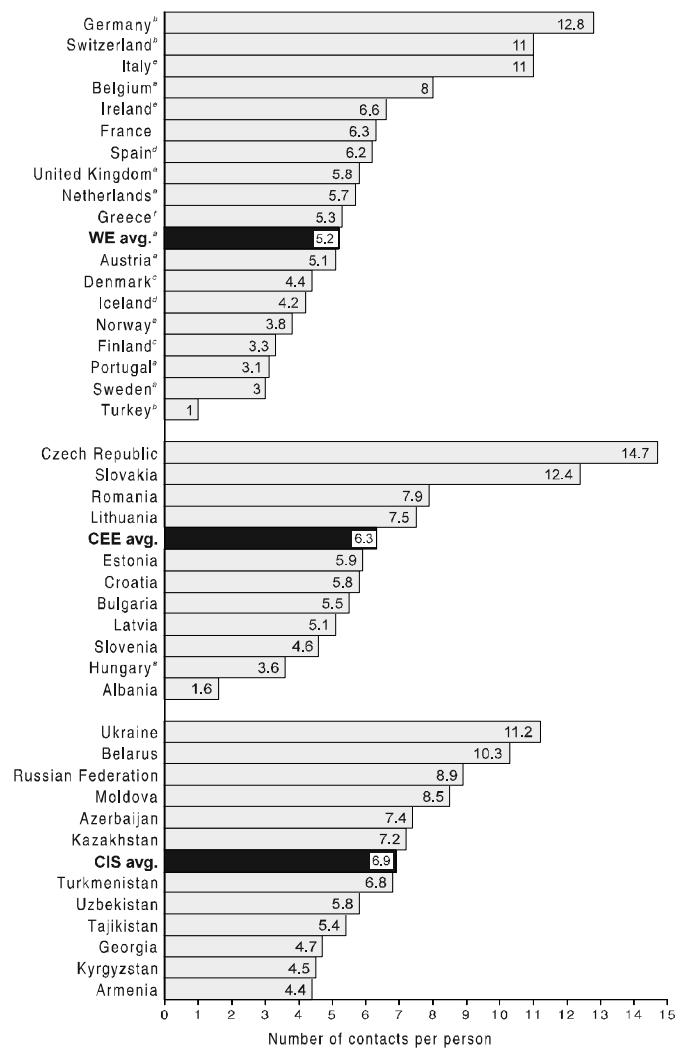
In the personal doctor system doctors are more or less free to organise their practice as they wish but on condition that patients can see their doctor within three days. The method of payment of doctors has also been altered, to relate better (than a fixed monthly salary) to the expertise and

experience of the doctor and the population structure he or she is responsible for (payment of personal doctors is explained later).

The results of the personal doctor system projects have been encouraging. Access to General Practitioners has improved and waiting times have clearly reduced. Both doctors and patients seem to appreciate the system. In the 1990s, about one third of the population has been assigned to a personal doctor.

Recently, the personal doctor system has been further developed into a model which is called "vaestovastuu" in Finnish. This means "population responsibility". Collaboration between different health care personnel has been encouraged in this model: doctors and nurses form a team which is responsible for a geographically defined area covering 1 500 - 5 000 persons. Most health centres are now moving towards the principle of population responsibility. Where it has not been introduced yet the size of the population covered is so small that the principle of population responsibility already exists in practice.

Figure 5. Physicians contacts per person, year 1994



^a1993, ^b1992, ^c1991, ^d1989, ^e1988, ^f1982

As Figure 5 shows, the number of physician contacts per person in Finland is among the lowest in Western Europe. This may be due to the fact that Finnish doctors do not ask patients to come for

a control visit as often as doctors in other countries do. In part this may be due to different medical traditions but it is likely that the fee-for-service payment system existing in insurance-financed systems plays an important role. The important role played by nurses, and by public health nurses, is probably also a reason for the low number of physician contacts in Finland. Nurses in Finland may carry out tasks which their colleagues in other countries may not do.

Public health services

At national level, the Ministry of Social Affairs and Health is concerned with the protection and promotion of public's health. The department for promotion and prevention within the Ministry of Social Affairs and Health directs and develops preventive social and health care. It is responsible for health protection, environmental health and chemical affairs and products (tobacco and alcohol) control. Several offices and institutes which are subordinated to the Ministry of Social Affairs and Health carry out some of these tasks. One of them is the National Public Health Institute. It carries out research to find out the causes of common national diseases and how to prevent them. It also collects data on communicable diseases, on health behaviour and on the effects of health promotion. As well as this, it must ensure the availability of vaccines in the country.

The Finnish health centres have an important role in providing public health services at local level. Maternal and child care and school care provided by health centres are central to preventive health services. Maternal and child care have a strong tradition in Finland. It is largely due to the comprehensive network of maternal and child care services and the great emphasis placed on these services that infant mortality in Finland is one of the lowest in the world.

The general immunisation programme in Finland covers the whole population. It starts with child care in health centres and is continued in schools. High immunisation coverage rates have been achieved for tuberculosis, polio, tetanus, diphtheria, measles, mumps, German measles and Haemophilus.

Municipalities are obliged by law to provide mammography screening for all women between the ages of 50-59 and cervical screening for 30-60 year old women. Municipalities often buy these services from a private provider. The vast majority of Finnish women participate in the screening programmes. Other screening programmes are not routinely carried out at national level.

Health education is carried out by the health care system, by schools and by various voluntary organisations which represent different patient groups. Central issues in health education are smoking, nutrition, physical exercise and reproductive health. The Ministry of Social Affairs and Health also carries out health education and allocates a specific grant for this purpose.

Efforts have been made to reduce the consumption of harmful products. This has partly been achieved by taxation which has kept the prices on alcohol and tobacco at high level. As in most other Scandinavian countries alcohol has been a state monopoly. This has made it possible to regulate pricing and sales of alcohol. Total consumption of alcohol is about the same as 20 years ago, which represents an average level in Western European countries. Consumption is not evenly distributed throughout the population: a small proportion of the population consumes most of the total. There is a general trend towards less strong drinks such as medium strength beer. This has been achieved partly due to pricing policy. However, as Finland is now a member of the European Union, pricing and licences to sell alcohol cannot no longer be used as a means to regulate alcohol consumption.

The prevalence of smoking in the adult population has declined, especially among men, although men still smoke more than women. Campaigns, pricing and legislation have been used to reduce smoking. In 1995, a strict law on smoking came into force, which aims at preventing passive smoking by prohibiting smoking in almost all public places. It also is intended to reducing smoking among children and young adults. Selling tobacco to children under 18 has therefore

been prohibited. Drugs are not a large problem in Finland, although data indicates that use is increasing.

The dietary habits of Finns have improved considerably during the last few decades. This has been partly due to health education and partly due to other measures. The food industry has taken recommendations on healthy nutrition into account in its product development. For example, the supply of milk products with a low percentage of animal fat has widened and the use of vegetable oil has increased. Healthy nutrition has also been supported by legislation. In 1993, a statute came into force defining the salt content of the most important foodstuffs. Those exceeding the defined salt content must be marked "strongly salted" and those containing less than the defined content can be marked "slightly salted".

The control and follow-up of communicable diseases is defined by legislation and other regulations of the Ministry of Social Affairs and Health. The National Public Health Institute has given recommendations concerning the follow-up and prevention of communicable diseases. The Institute also reports on communicable diseases to health authorities, health care providers and the mass media.

The National Public Health Institute and the Hospital Districts maintain communicable disease registers. Doctors are obliged to report those communicable diseases defined by law. Those diseases which have been chosen to be followed up are either quarantine diseases or diseases where prevention of epidemics is a concern (for example, STDs and salmonellosis).

The prevention of STDs is based on the detection of all those infected and easy access to treatment: treatment is therefore free of charge. All those possibly infected must be traced and directed to a health centre or another place to receive treatment. The largest cities have separate STD clinics, but otherwise the treatment of STDs is provided as part of the other health care services.

At a national level the Ministry of Social Affairs and Health is responsible for matters related to environmental health. At local level the Municipalities are responsible for tasks concerning proper water supply, waste management and other environmental matters.

Finnish public health policy has been particularly successful in some areas. A lot of efforts have been made to reduce mortality and risk factors related to cardiovascular diseases which is a major national disease. More efficient treatment and early diagnosis of coronary heart disease and other cardiovascular diseases have also reduced mortality. Active campaigns and education on nutrition and life-style factors have been carried out by health professionals, health authorities and voluntary organisations.

The prevalence of cardiovascular diseases among men in the Eastern parts of Finland has been higher than in other parts of the country and is one of the highest in the world. In 1972 the North Karelia project was launched in the Eastern province of North Karelia in response to a local petition to reduce the high levels of heart disease. The planning was done by Finnish experts, but also involved representatives from North Karelia and experts from the World Health Organisation. The project was integrated as far as possible into the local service system and social organisation. Various methods were used in the project: provision of general information and health education (through materials, mass media, meetings, campaigns etc.), development of referral and screening procedures in health services, encouraging environmental changes (such as smoking restrictions, promoting vegetable growing, collaborating with food manufacturers), preventive work directed at children and young people, training and education of health personnel and monitoring the results. Most of the practical work was carried out by various bodies in the community itself.

The original project period lasted from 1972 to 1977, but it continued operating beyond this period and activities were expanded elsewhere in the country. Since the very beginning the project has undergone careful and scientific evaluation. The monitoring systems originally developed for the North Karelia project were adopted over the years as a national monitoring system.

The project has been successful in changing life-style and reducing other risk factors. The changes over 20 years have been considerable: Both in male and female population average serum cholesterol and average blood pressure have declined. Especially in men, smoking has markedly reduced. The reduction in risk factors also resulted in a fall in death rates from cardiovascular diseases: At the beginning of the 1990s, male mortality from coronary heart disease was almost 60% lower than at the beginning of the project. Mortality from other cardiovascular diseases also declined.

It must be noted that the project was not restricted to North Karelia only. Similar efforts to reduce prevalence of and mortality in cardiovascular diseases have been made also elsewhere in the country. The development in risk factors and mortality elsewhere in the country has been along that of North Karelia.

Family planning and dental care for children in the Finnish public health care system deserve a particular mention. The abortion rates in Finland have fallen constantly from a peak in 1973. This is despite a liberal abortion law. The reason rather is the comprehensive family planning services provided by health centres and health education directed at young people. Another success story in public health care is systematic dental care for children which has provided very good outcomes.

Figure 6. Levels of immunization against measles in WHO European region, 1994

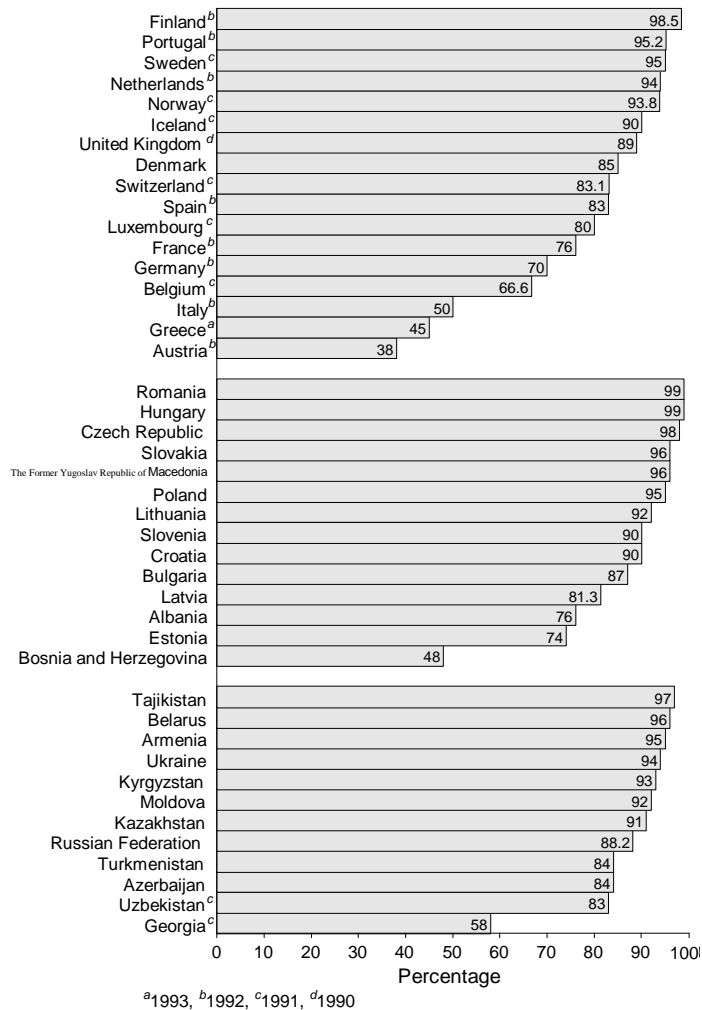


Figure 6: As can be seen from Figure 6 Finland has the highest level of immunisation against measles in Western Europe with almost 100% of children immunised. This is also true of childhood immunisation against most other viral infections. This is clearly thanks to the well advanced child care and the comprehensive network of child care centres within health centres.

Secondary and tertiary care

Secondary and tertiary care are provided in hospitals, through outpatient and inpatient departments. The range of specialised care varies according to the type of hospital. There are 5 university hospitals, 17 central hospitals and over 30 other less specialised hospitals. There is only a small number of private hospitals.

Hospital personnel are salaried employees. The management structure of hospitals is similarly organised to that of Hospital Districts. The management board usually consists of a chief physician, a chief nurse and a director of finance (and/or administration), but there are variations, with larger hospitals having a more complex management structure. Hospital managers are accountable to the Council of the Hospital District.

Hospital assets are owned by Hospital Districts, which are in turn formed by Municipalities. Hospitals are non-profit making organisations. There are variations in how much the Hospital Districts influence the functioning of a single hospital. Hospital Districts are allowed to borrow money.

The number of patients and the number of episodes treated in the in-patient departments of hospitals have increased in recent years, alongside a decline in the mean length of stay. For acute non-psychiatric care, this has dropped from 7.0 days in 1988 to 5.1 days in 1993. Similar reductions have occurred in all medical specialities. The number of patients treated at acute non-psychiatric hospitals has increased by 4.2% in the same years. Bed occupancy rate has been fairly constant in the last few years varying from about 80% to 85%.

About 80% of all treatment episodes take place at acute non-psychiatric hospitals, but only 36% of total bed days in all institutions are spent in acute non-psychiatric hospitals.

The reduction in the length of stay has partly occurred due to more efficient medical treatment, for example the use of day care surgery. It has also resulted in reduced waiting times for surgical procedures. However, there are still considerable local variations in waiting times for specific surgical procedures.

Psychiatric care has usually been fairly institutionalised in Finland. Therefore, efforts have been made to reduce the number of beds in psychiatric hospitals. The number of beds in psychiatric hospitals was 4.1 per 1 000 inhabitants in 1982 and 1.9 per 1 000 inhabitants ten years later in 1992. At the same time, resources have been shifted from in-patient care to ambulatory care although not to the same extent as beds have been reduced. Some Municipalities have reported deficiencies in the supply of mental health services. Attention has been paid now to this issue.

Primary and secondary care are not always very well co-ordinated. General Practitioners often complain that they do not get sufficient information about the further treatment of patients they have referred to a hospital. It has been suggested that one person, for example the personal doctor, should have an overall view of the patient's when they are treated in different levels of the health system.

There is much excess capacity in the hospital sector. Departments or even whole hospitals have been closed. Some have been put up for sale. At present, there are no plans to build hospitals.

Table 1 : In-patient utilization and performance, Finland, years, 1970 - 1995

In-Patient	1970	1975	1980	1985	1990	91	92	93	94	95
Admissions per 100 population	18.2	18.9	21	22.6	22.4	22.7	23.5	24.4		
Average Length of Stay in Days	24.4	23.2	21.6	19.9	18.2	18.8	16.6	14.8		
Occupancy Rate (%)	91	88.9	86	85.3	82	80.3	79.7	84.9		

Source: OECD Health Data File, version # 3.6 (1995)

Table 4: The number of patients treated in in-patient departments has risen constantly. At the same time, the average length of stay has almost halved from what it was in 1970. In other words, more patients are treated in a much shorter time. The reasons for this are the growth in healthcare resources and in the number of health care personnel. The development of more efficient medical treatment, new medical technology and the introduction of day surgery play an important role as well.

Table 5: In-patient utilization and performance in WHO European Region, 1994

Country	Hospital beds per 1000 population	Admissions per 100 population	Average length of stay in days	Occupancy rate (%)
Austria	9.4	26.5	10.3	80
Belgium	7.6	19.7 ^a	12 ^a	83.5 ^a
Denmark	5.0 ^a	20.5 ^a	7.6 ^a	84.8 ^a
Finland	10.1	25.1	13.1	90.3
France	9	23.4 ^a	11.7 ^a	80.5 ^a
Germany	10.1 ^b	21.3 ^b	15.8 ^b	86.6 ^b
Greece	5.0 ^a	13.1 ^b	9.8 ^b	70 ^c
Iceland	15.8 ^b	28.2 ^c	17.8 ^c	84 ^c
Ireland	5.0 ^a	15.5 ^a	7.7 ^b	n/a
Italy	6.6	15.5 ^b	11.2 ^b	69.6 ^b
Luxembourg	11.8 ^a	20.3 ^b	16.5 ^b	81.4 ^b
Netherlands	11.3	11.2	32.8	88.6
Portugal	4.3	11.5	9.5	68.7
Spain	4.2 ^c	10 ^a	11.5 ^a	77 ^a
Sweden	6.4	19.5 ^a	9.4 ^a	83 ^a
Switzerland	8.7	14.6 ^b	n/a	82.6 ^c
Turkey	2.4	5.8 ^a	6.7 ^a	57.8
United Kingdom	5 ^a	21.6	10.2 ^a	n/a
Albania	2.8	8.07	8.98	71.8
Bulgaria	10.2	17.71	13.6	64.4
Croatia	5.9	12.78	13.78	81.6
Czech Republic	9.8	20.61	13.5	77.7
Estonia	8.4	17.82	14.2	83
Hungary	9.9	22.76	11.3	n/a
Latvia	11.9	20.14	16.4	78.7
Lithuania	11.1	20.6	15.9	79.1
Poland	8.2 ^d	n/a	n/a	n/a
Romania	7.7	21.1	10.3	77.4
Slovakia	7.9 ^a	n/a	12.74 ^a	n/a
Slovenia	5.8	15.8	10.6	79.4
The Former Yugoslav Republic of Macedonia	5.3 ^c	n/a	n/a	n/a
Armenia	7.6	7.6	16.32	n/a
Azerbaijan	10.1	8.52	17.9	41.5
Belarus	12.4	24.65	15.3	83.2
Georgia	8.1	5.5	15.2	28.3
Kazakhstan	12.1	18.17	16.8	68.9
Kyrgyzstan	9.6	17.7	15.4	77.9
Moldova	12.2	22	17.3	n/a
Russian Federation	11.9	21.6	16.8	n/a
Tajikistan	9.1	16.44 ^b	14.5 ^b	58.3 ^b
Turkmenistan	11.5	17.01	15.1	66.6 ^a
Ukraine	12.7	n/a	16.91	n/a
Uzbekistan	8.8	19.3	14.3	n/a

^a 1993, ^b 1992, ^c 1991, ^d 1990.

Source: OECD Health Data File, 1996; WHO Regional Office for Europe, health for all database.

Table 5. Compared to other Western European countries, Finland has a relatively high number of hospital beds per 1000 population and a high utilisation rate, measured by admission and occupancy rates.

Figure 7. Hospital beds per 1000 population in the WHO European Region, 1980 and 1994

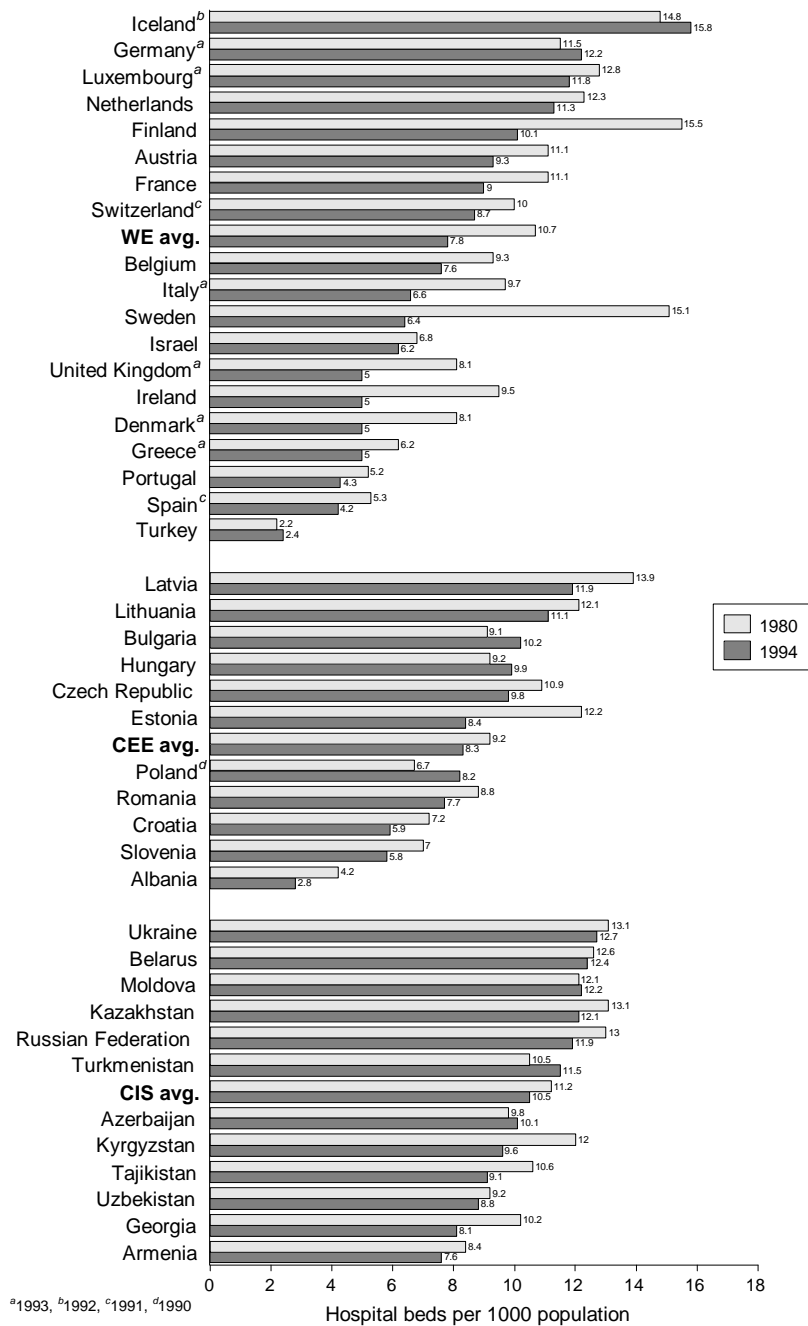


Figure 7: As can be seen from Figure 7, the number of hospital beds per 1 000 population in Finland is above the average number of hospital beds in Western Europe. Until the beginning of the 1990s, the health delivery system was one of the most institutionalised in Western European countries. Patients were not only treated too much in institutions but some of them were not at the most appropriate place.

Figure 8: Hospital beds per 1 000 population in Finland and selected Western European countries, years 1970 - 1993.

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Figure 8: Compared to some other Western European countries the number of hospital beds has always been rather high in Finland. The number of hospital beds has fallen due to an active campaign that has been carried out to reduce institutionalised care, particularly chronic institutionalised care and to improve the supply of various kinds of ambulatory care (explained in Part III). As the number of hospital beds in other countries has declined also, the number of hospital beds in Finland is still among the highest in Western Europe. The number of hospital beds is expected still to continue falling.

Social care

The provision of social services is the responsibility of Municipalities. Like health care, social services are financed from Municipal taxes, state subsidies and user charges. The state subsidies for social services are paid to Municipalities according to certain criteria. These criteria are: number of inhabitants, age structure and unemployment rate within the Municipality.

The majority of patients receiving long-term care are elderly (almost 90% are over 65 years old). Long-term care of the elderly is provided in the in-patient departments of health centres. There are also many homes for the elderly, the majority of which are owned by Municipalities but a number of which are private homes. Health centres often work closely with homes for the elderly by, for example, sending a health centre doctor for consultations once or twice a week.

Other long-term services for elderly include home help services, home nursing, day hospitals and other day care centres, part-day nursing and so called service housing. Service housing are houses where the elderly live in their own apartments but are offered different kinds of services such as nursing and other help needed for daily life. The national plans for social and health care have stressed support for the elderly living in their own homes, this is the preferred alternative of older people themselves. As a result, a lot of effort has been made to improve the supply of supportive services offered to the elderly in their homes.

The disabled are also offered special homes and other services by the Municipalities. Legislation requires that disability services must be provided according to the need in a Municipality.

Psychiatric institutionalised long-term care is usually provided in psychiatric hospitals, but there are considerable regional variations in how long-term care is organised. A variety of services exist to support ambulatory and semi-institutionalised care for long-term psychiatric patients. These comprise residential homes, rehabilitation homes, shared apartments, day hospitals and day care centres, sheltered housing and so on. Which organisation it is that provides these services varies from region to region, sometimes it is the Municipal social and health service system, sometimes the private sector and sometimes specialised psychiatric hospitals.

A common way of providing ambulatory psychiatric care are the so called mental health centres where both acute and long-term care patients can seek for help. These offices work under the management of psychiatric hospitals and are staffed by psychiatrists, psychologists, psychiatric nurses and social workers among others. At present, some of the smallest mental health centres are being transferred to the administration of health centres as personnel working in the smallest centres involve only couple of nurses and cannot therefore be regarded as specialised out-patient clinics.

As explained above, institutionalised psychiatric care has been reduced more than ambulatory services have been increased. The supply of supportive services and intermediate services has not been sufficient. This issue is regarded as needing more attention now.

Figure 9 : Chronic care beds and psychiatric beds (total hospital beds minus acute hospital beds) in Western European countries per 1 000 population, year 1991

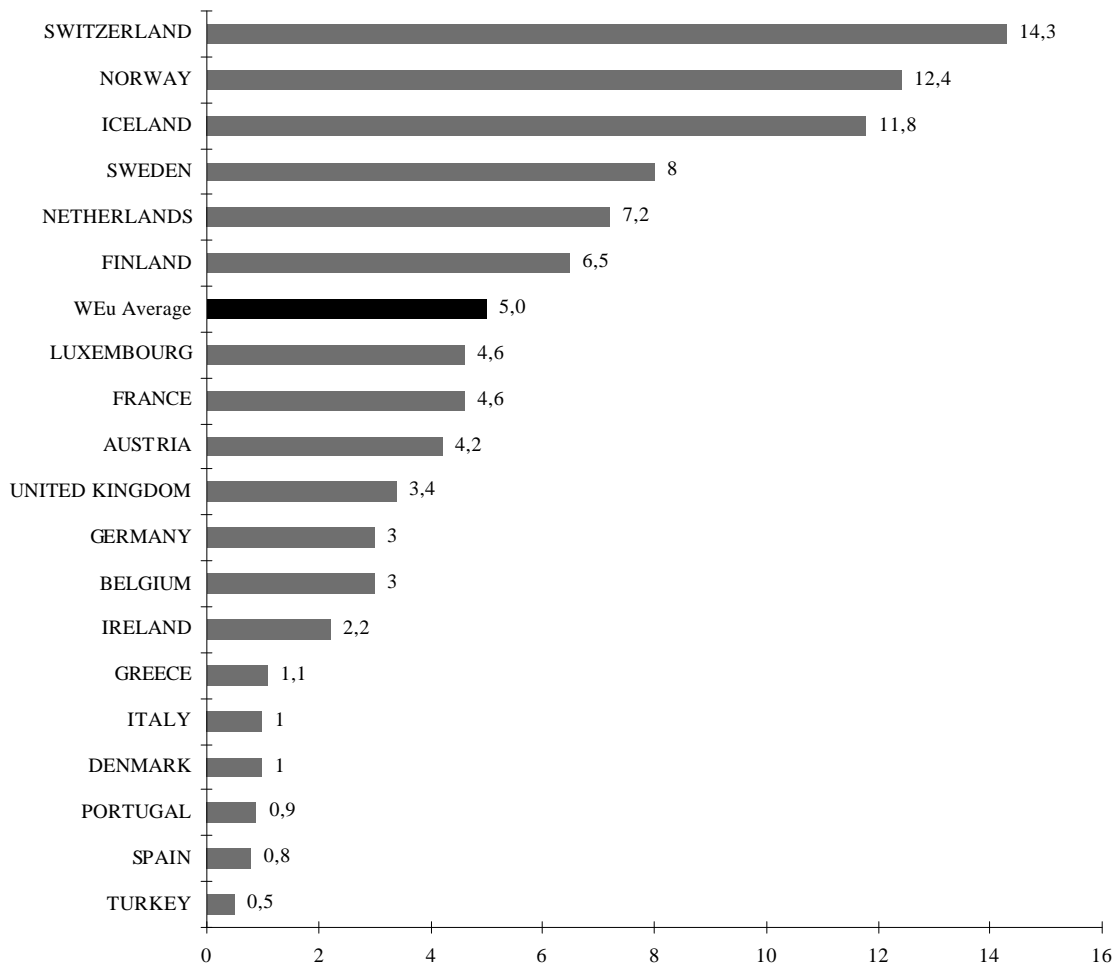


Figure 9: As can be seen from Figure 9 the number of chronic care and psychiatric beds is rather high in Finland compared to other countries. One reason is that in Finland families do not take care of the elderly as much as in many Southern and other European countries. Not enough resources have been allocated to semi-institutionalised and other supportive care either. However, a lot of efforts have been made now to reduce in-patient care and to encourage other kinds of care. In particular, the number of psychiatric beds has been reduced in recent years.

Human resources and training

The Ministry of Education is responsible for the education and training for health personnel in Finland. Medical doctors are trained at five universities and basic medical training lasts 6 years. To obtain a licence to practice independently 2 years of practical work both at hospitals and health centres is required. Part of this training may be completed in the private health care sector or by doing research. After licensing doctors can continue working at health centres, specialise in one of the numerous medical specialities or establish a private practice.

Specialisation of doctors starts with working at a central or regional hospital under supervision of an experienced doctor. After that at least two years working at a university hospital is required for the most medical specialities. Doctors must register with a faculty of medicine for the relevant specialist training programme. Specialisation lasts from 4 to 6 years varying from speciality to speciality. To obtain a specialist diploma a specified amount of theoretical training is required and a national examination has to be passed.

The theoretical training while specialising and other complementary training is organised by the medical faculties, hospitals, the various medical associations, pharmaceutical companies and other organisations.

Specialisation in general medicine takes four-years of training after licensing as a medical doctor. This includes two years working in a hospital, another two in a health centre, a specified number of theoretical courses and successful completion of a national examination.

The Ministry of Education estimates the need for general physicians and specialists. It makes proposals for the numbers of students to enter the medical faculties. Basically, universities are free to decide on the numbers of students to be taken in, but in practice, the authorities and the universities agree on the numbers of doctors to be trained.

The training of nurses and other health care personnel such as physiotherapists, laboratory personnel and others takes place at nursing colleges.

Until the end of 1980s, education of nurses followed a general education programme for nurses. The specialisation of nurses took place after the general programme. In the present education programme the general and specialisation programmes have been combined. When entering training students have an opportunity to choose from a number of specialities: (i) nursing for surgery and internal medicine, (ii) paediatric nursing, (iii) anaesthetic and operating theatre nursing, (iv) psychiatric nursing. Training for each of these specialities takes three and a half years. The training programme for public health nurses lasts three and a half years and that for midwives four and a half years. Assistant nurses used to be trained in a one year programme, but this programme has been abolished. Instead, a new two and a half year programme has been launched to give qualifications for various tasks in both the health and social sector services.

The Ministry of Education also estimates the need for nurses. The nursing colleges make suggestions for the number of students to be taken in for training. It is then agreed with the authorities on the number of students to be taken in for training.

The National Board of Medico-legal Affairs which is subordinated to the Ministry of Social Affairs and Health is responsible for licensing, registration and monitoring of health care personnel. It also undertakes disciplinary procedures concerning health care personnel.

Unemployment among health care personnel is a recent phenomenon. Until the 1990s unemployment among medical doctors and nurses was practically non-existent. The recent economic crisis has led to unemployment among doctors, nurses and other personnel: about 9%

of the total numbers of clinical personnel. The number of students entering training has therefore been reduced.

Figure 10. Finland : trends in numbers of physicians per 1000 population

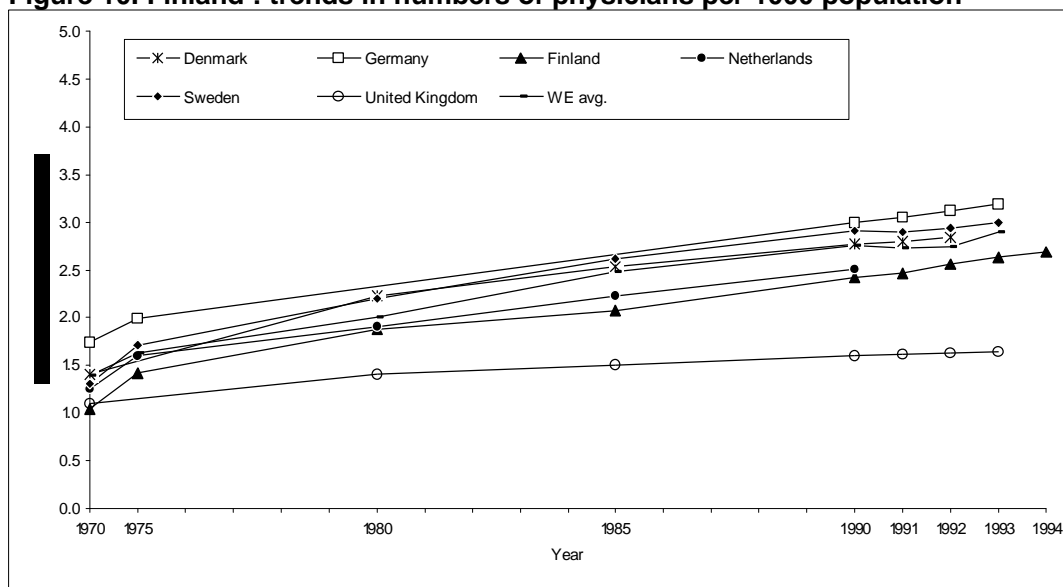


Figure 10: The number of physicians has constantly grown as in other European countries although the number per capita is still below the average for Western Europe.

Figure 10. Finland: Trends in numbers of nurses per 1000 population

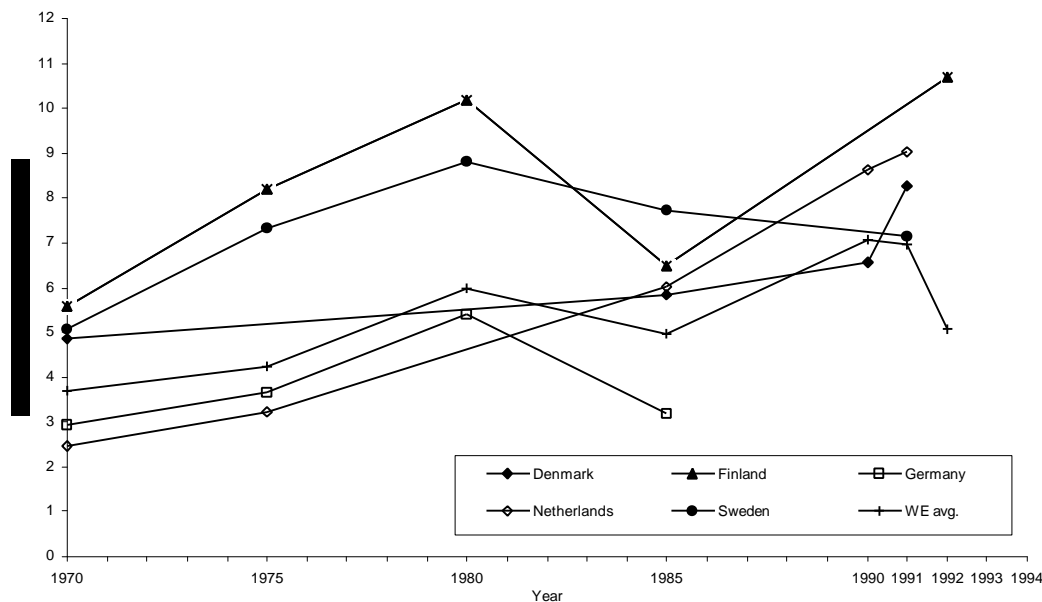


Figure 11: The number of nurses per capita in Finland is higher than in other Western European countries. This may be for one of a number of reasons. First, historical reasons - in the past the number of doctors was very low and therefore more nurses were needed for various tasks. Secondly a large number of public health nurses are needed for the various roles in public health care, especially maternal and child care.

Figure 12. Number of physicians and nurses per 1000 population in the WHO European Region, 1994

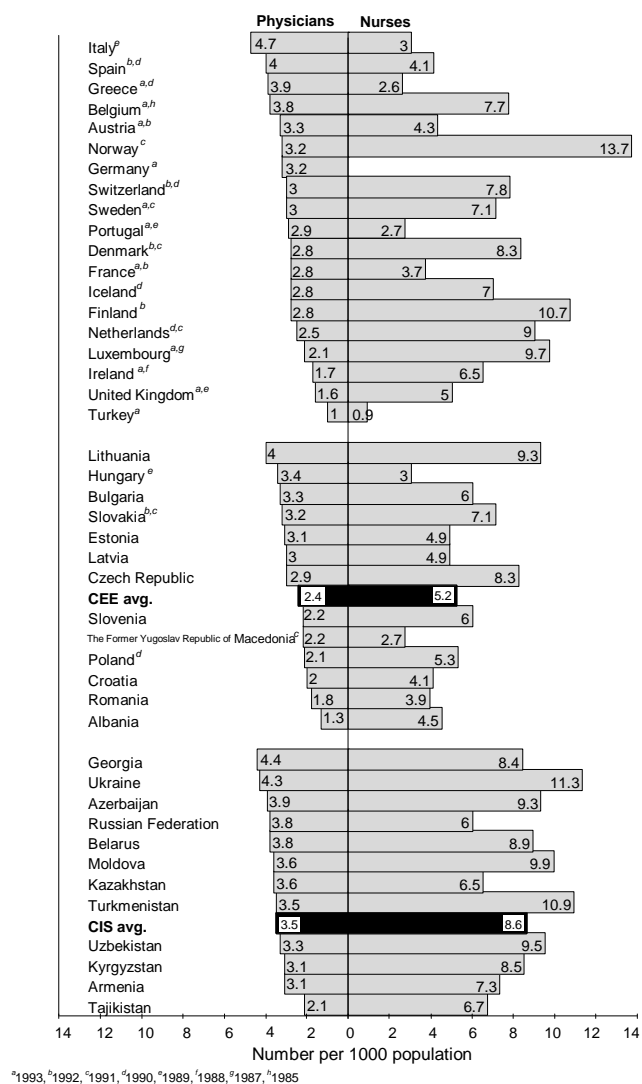


Table 6 : Health care personnel, Finland, years 1970 - 1995

	1970	1975	1980	1985	1990	91	92	93	94	95
Active Physicians /1 000 pop	1.04	1.42	1.88	2.08	2.42	2.46	2.56	2.6	2.69	
Active Dentists /1 000 pop	0.59	0.69	0.82	0.80	0.90	0.91	0.92			
Certified Nurses /1 000 pop	5.59	8.18	10.19	6.50		6.50				
Active Pharmacists /1 000 pop	1.00	1.04	1.05	1.50	.		1.38			

Source: OECD Health Data File, version # 3.6 (1995)

Source: WHO Regional Office for Europe, Health for all statistical database

Pharmaceuticals and health care technology assessment

Pharmaceutical products may be sold only by permission of the Medicines Control Agency. The Medicines Control Agency is subordinated to the Ministry of Social Affairs and Health. Until 1994, a reasonable price was one prerequisite for getting permission to market a drug. At the beginning of 1994, pricing matters were transferred from the Medicines Control Agency to the National Board for Drug Reimbursement which is also attached to the Ministry of Social Affairs and Health.

In order to be licensed as a reimbursable drug the wholesale price of a pharmaceutical - as determined by the National Board for Drug Reimbursement - must be reasonable. Several criteria are used to decide whether a price is reasonable or not. These include the total costs of treatment, the benefits of the pharmaceutical, the price when compared to similar preparations, the price in other countries and the development and manufacturing costs of the pharmaceutical. Other matters related to reimbursement of drugs are handled by the Social Insurance Institute. The retail price is determined on the basis of the wholesale price which was decided by the government.

The majority of drugs which have been granted a sales permission in Finland also are licensed as reimbursable. Only some mild analgesics which are sold in very small packages or pharmaceuticals whose manufacturer has not asked for a reimbursement licence are excluded. In these cases the manufacturer itself decides the price of the pharmaceutical. This is often done in the case of preparations used in hospitals (anaesthetics and radiological contrast mediums). The hospital and the producer negotiate a contract on the amount and price of such products.

Pharmaceuticals can be sold only by pharmacies. Prescription drugs are sold by an order of a medical doctor, a dentist or a veterinary surgeon. Pharmacies are privately owned but require a permit from the Medicines Control Agency. The number and location of pharmacies are therefore controlled.

Efforts have been made to reduce costs arising from prescribed pharmaceuticals and to encourage medical doctors to prescribe the cheapest preparations. In 1993, doctors were given the permission to write the letter "G" next to the brand name of the product on their prescription. By doing this they allow pharmacies to choose the cheapest generic preparation. However, this kind of prescribing has not been very popular among doctors and only a very small number of all prescriptions are marked with the letter "G".

A new law on generic prescribing was introduced in March 1996. According to the new law doctors can write the generic name of the pharmaceutical on the prescription instead of the brand name as is obligatory now. The pharmacies are obliged to deliver the cheapest preparation or a preparation whose price only slightly differs from the cheapest one. The new law also allows prescribing in electronic form. This means that drugs can be prescribed by fax or electronic mail if the sender and the recipient can be identified.

In 1995, a centre for health care technology assessment, called FINOHTA, was established in Finland. The main activities of the centre are encouraging and financing health care technology assessment and providing information on the results of health care technology assessment, i.e. to function as a "clearing-house" concept. Two full-time and two part-time workers are employed in the centre. The centre has started supporting some health care technology assessment projects and publishing its own leaflet. The activities of the centre are expected to be extended in the near future.

Financial resource allocation

Third party budget setting and resource allocation

The Government makes the state's annual budget proposal to the Parliament and Parliament makes the final decision on how much state resources will be allocated to the health care sector. The Health Board of each Municipality prepares the Municipality's budget for health care. The Municipal council approves the total Municipal budget and within this budget the resources allocated for health. The council of each Hospital District determines the budget for hospital care (within its district area).

Until 1993 state subsidies were allocated retrospectively according to actual costs. These were adjusted for the wealth of the Municipality, the richer a Municipality, the smaller the subsidy and vice versa. If Municipalities provided services which did not follow the national five-year plan, Municipalities did not get a state subsidy for these services. The state subsidy was also earmarked and could only be spent on health care. This system helped achieve equal access and good quality services everywhere in the country, but as the state paid part of the hospitals actual costs retrospectively, there were no incentives for efficiency.

In 1993, the state subsidy system was reformed. The reform was intended to achieve cost-containment and to improve efficiency within Municipal health services. It was also aimed at giving more power to the Municipalities and reducing state regulation. Under the new system, all state subsidies are calculated according to demographic criteria. In health care the criteria for state subsidies (for running costs) are the population's age structure, mortality, population density and land area. The subsidy is automatically paid in advance to the Municipality and it is not earmarked.

There was not much opposition to the state subsidy reform. The reform was designed during the time when the economic situation of the country was good and no clear signs of the crisis were in sight. Municipalities also appreciated the new freedom and decision-making power that they were being given. Agreements for a transitional period were made so that changes in the amount of state subsidies would not be too radical for Municipalities.

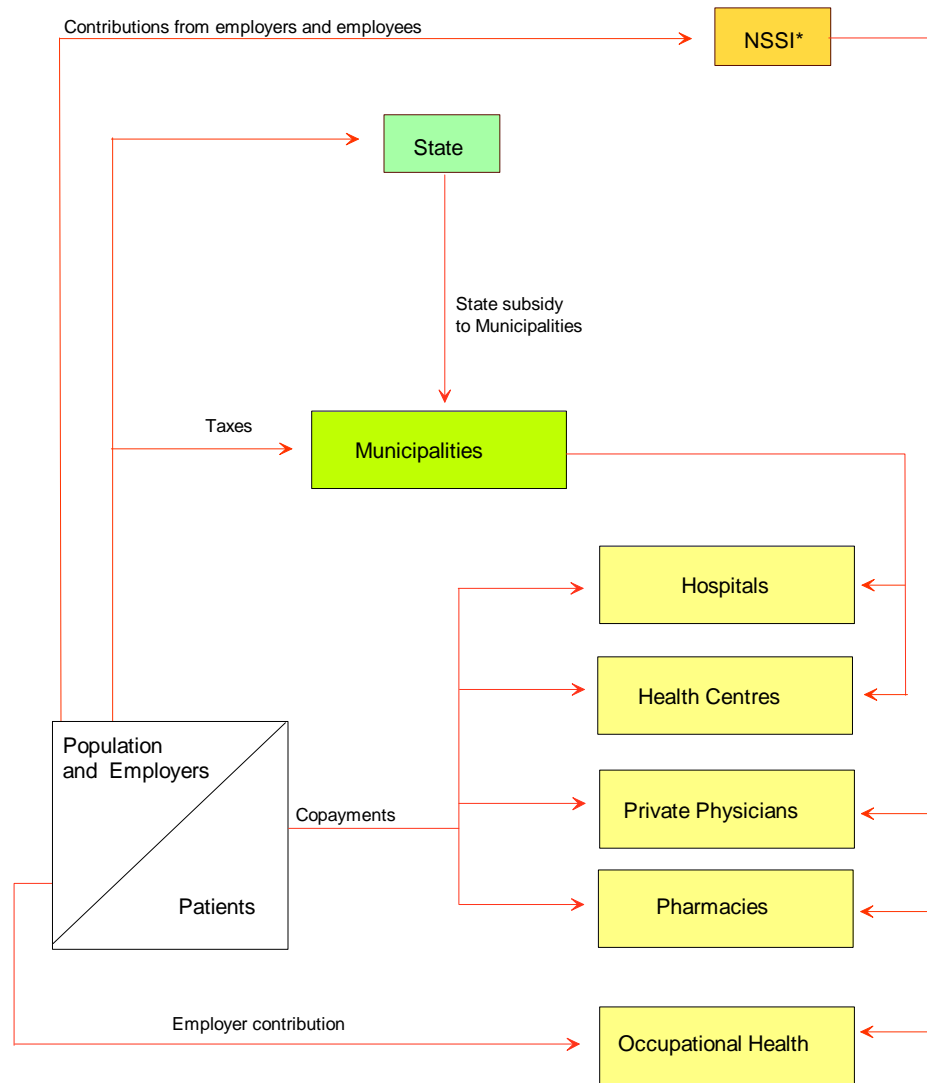
It was estimated that those Municipalities who had organised their health care reasonably and efficiently would have "gained" from the reform and those who had not been doing as well suffered. However, it is difficult to assess the impact of the state subsidy reform because it came into force at the same time as strong economic decline - which started in 1990.

The criteria for determining the amount of state subsidies are planned to be changed in 1997. It is not yet clear, in what way the system will change. At the moment, research is being done on which criteria would best describe the need for health care services. However, it is not felt that there is a great need to change the present subsidy system. It may be, that there will be some adjustments to the demographic criteria for calculating the subsidy for health care.

The state subsidy reform did not significantly change the financing of capital investments. Capital investments are financed in different ways depending on their size. Medium-sized (2-25 million FM) and major (over 25 million FM) capital investments are subsidised by the state. The state subsidy varies from 25% to 50% of the capital investment's costs depending on the per capita income of the Municipality. Municipalities submit their plans for capital investments to the

Provincial Boards which are state authorities. Medium-size investments may be approved by the Provincial Boards, but major capital investments require approval by the Government. The Ministry of Social Affairs and Health allocates state funding for medium-size capital investments to the Provincial Boards.

Chart 2. Financing flow chart



* National State Sickness Insurance

Capital investments can be financed without the state's financial contribution also, for example by Municipalities, contributions from private sources and patient associations. Municipalities are allowed to borrow money to finance capital investments (or for other purposes). The Finnish Slot Machine Association has markedly increased its share of all capital investments in health services, at present accounting for about 30% of all capital investments in health care. It should be noted that this association supports only private producers, i.e. it does not give money towards Municipal capital investments.

After the 1993 reform of the state subsidy system, which places more financial responsibility and risk on the municipalities, the problems related to the small size of Finnish Municipalities have become even more obvious.

Payment of hospitals

The financing of hospitals changed at the same time as the state subsidy reform in 1993. Before 1993, hospitals received about half of their revenue from the state via the Provincial Boards. The other half of hospital revenues came from Municipalities, but as the actual costs were reimbursed through state subsidies, risk of high costs was largely borne by the state rather than the Municipality. This former system did not encourage hospital productivity: hospital revenues, being largely allocated historically, were fairly automatic from year to year and Municipalities did not actively control costs. When the state subsidy system changed, the risks and incentives facing Municipalities also changed. With prospectively fixed budgets, the risks of overspending were borne by Municipalities - as are the advantages of making savings.

Since 1993 hospitals have been paid per item-of-service. Hospitals determine prices for their services without national guidelines. Much effort has been made within hospitals to define services and to calculate a price for each service. Services are defined and prices calculated in very different ways: there is not even uniformity within a single Hospital District. The most common method of pricing is based on a bed day. Bed-day prices are often divided into categories or groups according to the range and level of care needed by the patient. Service-package prices for in-patient care have also become fairly common. A service-package includes certain services (the diagnosis or type of treatment, for example, childbirth or cholecystectomy) for a specified length of stay. The prices for out-patient care also vary. Normally, the price is set per visit and often according to the range and level of treatment.

There are variations in how hospitals bill Municipalities, usually they send a monthly bill to the health centre which then passes it to the Municipality. The Municipality pays the bill directly to the hospital's account. Municipalities do not usually negotiate on prices, which means that they accept the prices announced by hospitals. However, very recently, Municipalities have become more reluctant to accept prices without question.

Billing and pricing by hospitals are in a continuous process of change. At present, it is extremely difficult to compare services and prices between different hospitals and Hospital Districts because, as has been said, they are defined in different ways and the prices can be changed during the course of the year.

Probably the biggest problem associated with the Finnish hospital payment system is that Municipalities who finance hospitals do not have very much power. As a result they are unable to influence prices or the level of services and they are not able to negotiate on them. Setting service priorities and prices is very much producer-centred. Some experiments have started, however, in which Municipalities and hospitals make a contract in advance on the basis of predicted levels and prices of services.

Even though the billing often occurs on a bed-day basis, there is little evidence that hospitals prolong lengths-of-stay. Hospitals want to appear efficient and are motivated to discharge patients as quickly as possible in order to increase productivity. On the other hand, hospitals are not reluctant to admit patients to hospital for new treatment episodes.

In addition to their revenues from Municipalities, the five university hospitals in Finland receive a special state subsidy to compensate additional costs arising from teaching and research. This special subsidy is granted according to the number of medical doctors and specialists graduating from the university (and university hospital) and the number of scientific publications which are done by researchers in the university hospital. Each doctor or specialist graduating and each publication count for a specified number of points. A point is worth a specified amount of money (determined annually by the Ministry of Social Affairs and Health). Studies which are published in prestigious medical journals receive more points (and therefore more money) than those published in less esteemed medical journals. In 1995, the total state subsidy paid to university hospitals was about 650 Million FM (around 12% of their running costs).

Payment of physicians

Physicians in hospitals are salaried employees, the basic monthly salary depending on the physician's post and length of career. Various bonuses can be paid, for example, for increased responsibility. There is additional remuneration for being on-call (it can also be paid as time off). Physicians can charge fees for certificates of health status or statements for other authorities. The payment of General Practitioners in public health care centres varies. Most are salaried employees with the same conditions as hospital physician's concerning additional extra remuneration. In those health centres where the personal doctor system has been introduced the doctors are paid a combination of a basic salary (approximately 60%), capitation payment (20%), fee-for-service payment (15%) and local allowances (5%). The personal doctor payment is thought to give better incentives for cost-efficiency than the monthly salary payment. In the private sector, physicians are paid fee-for-service, patients being partly reimbursed by the National State Sickness Insurance.

The physicians' labour union negotiates with the Association of the Municipalities over physicians' salaries. The government does not have any influence on this procedure. The average income of medical doctors is above the general average income in Finland. Specialists who work in private practice in addition to their work in public hospitals and personal doctors who see a lot of patients and do a lot of on-call work usually have a somewhat higher income than other doctors.

Health care reforms

Determinants and objectives

While there has been no major reform of the health care system in Finland, there have been a number of changes to deal with specific problems. When waiting times to see a primary care doctor increased to unacceptable levels and there were problems noted with continuity of care, in the 1980s a personal doctor system was introduced. Because the number of patients treated as in-patients (per capita) is much higher than in many other countries, an important aim of Finnish health policy has been to reduce hospital and other kinds of institutional care and to develop out-patient and home care services. The growing number of elderly and financial pressures have also influenced this emphasis on ambulatory care. In order to improve efficiency and to contain costs, in 1993 the state subsidy system to Municipalities was reformed.

Content of reforms and reform implementation

Several minor reforms have been undertaken in Finland in recent years.

An action programme was developed in 1991-92 to reduce institutional care. The main objective of the programme is to develop those forms of services which will enable elderly and other persons to live in their homes as long as possible. It is aimed that in the year 2000 no more than 10% to 12% of those over 75 years will be placed in institutional care.

There are striking variations in the health care expenditure per capita between Municipalities, up to 2.5 fold in some cases. The variation can only to a small extent be explained by need factors such as age structure, mortality and very low population density. Variables which can be decided by Municipal policy-makers (for example, the volume of inpatient facilities) are more strong determinants of the variation. This means that there is scope for reducing health care costs and increasing productivity and efficiency.

The Ministry of Social Affairs and Health has directed and co-ordinated the process of transferring resources from institutional care to ambulatory services. From the very beginning it was perceived that decisions should be made on the local level in the Municipalities. The Provincial Boards have also been involved in this process as well as the Association of the Finnish Municipalities.

In general, the process has advanced at a good pace. The objectives have been widely accepted by Municipalities and the change is going in the right direction. However, the change is occurring at different pace in different parts of the country. A number of Municipalities have already made successful changes in their service delivery system while others are not as advanced.

In general, institutionalised care has been reduced in the whole country in the past years, mainly due to the more efficient use of ambulatory services. The transfer of personnel from institutional care to other services has not occurred as was originally planned. During the process it has become obvious that if apartments and other housing services are not available it is impossible to reduce institutional care.

Enormous variations in treatment practices have also been revealed. These variations could not be explained by demographic or other exogenous factors. During 1995 the Ministry of Social Affairs and Health raised this question into discussion, so far mainly among national-level health care experts.

The state subsidy system which was implemented in 1993 has somewhat changed since the beginning of 1996. Until the end of 1995 Municipalities had been classified into different categories according to their financial capability (classification was determined by the Ministry of the Interior). In the years 1993-95, state subsidies for health care depended on the population's age structure, morbidity, population density, land area and financial capability of the Municipality. The classification for financial capability has now been abolished.

At present, a comprehensive project is carried out to investigate the functional and economic relationships between the state and the Municipalities. Therefore, the overall regional administration is being discussed. As stated above, research on new criteria for determining the state subsidy for health care is being done. Some adjustments to the present criteria for calculating the state subsidy may be made according to the results of research.

In addition to the reforms concerning the whole country some local projects are being carried out in Finland. Experiments with a waiting time guarantee (for elective procedures) are planned for three Hospital Districts (South Karelia, Vaasa and Middle-Ostrobothnia) in Spring 1996. The

waiting times will concern both primary and specialised care, the objective being that a patient should have access to a primary care doctor within three days and to a hospital specialist within 1 to 2 weeks. In the projects that have been planned the maximum waiting times for specific treatments have not yet been defined, but they will probably vary between districts. If the patient does not have access to care within the time limit (s)he will be offered treatment at another health centre or hospital.

Health for all policy

Finland published its own national Health for All-programme in 1986. The main guidelines of the programme were the promotion of healthy life-styles, the reduction of preventable health problems and the appropriate development of the health care delivery system. Since its publication the programme has been the basis for Finnish health care policy.

The Regional Office of the World Health Organisation made an evaluation of the Finnish Health for All programme and published a report about the evaluation in 1991. The evaluation showed the strong sides of the Finnish health care system but also the areas where Finland had not succeeded. It was criticised that Health for All had been restricted to health professionals and health experts even though the programme should have been extended to other sectors, too. There was also insufficient local input, weak management practices and poor public and private sector co-ordination.

The programme was reviewed along the statements and recommendations by WHO. The revised Health for All programme was approved as the basis for the development of the Finnish health policy by the Government in December 1992.

Conclusions

Any discussion of the health care system in Finland starts with the observation that it is in many ways a model of success. There is already a comprehensive primary care system covering the entire country. Health services are locally accountable through the Municipalities and the health care system has been changed and developed gradually over a long period of time.

It is difficult to assess the impact of recent changes to the funding of Municipal health services in view of their introduction at a time of economic crisis. From the point of view of equity in provision, the health care system in Finland provides care to the entire population. The financing of this care still contains a number of unusual features which undermine an otherwise equitable system of financing. The National State Sickness Insurance system in effect subsidises both private health care and occupational health care. Neither of these, but particularly the former, are accessible to the whole population. A second equity problem arises from the rising proportion of health spending coming from out-of-pocket payments: are a regressive source of funding. That these have risen is more likely to be a function of economic constraints imposed by the recession than a consequence of recent changes in the health care system.

Efficiency is difficult to judge in Finland. Services are defined in different ways in different places, data on prices are not readily comparable between hospitals. Lengths of stay for inpatient care have declined but it is not clear that there are incentives on hospitals to improve efficiency nor that Hospital Districts are in a position to force efficiency improvements. There are also marked variations in expenditure and activity rates between different Municipalities and in international comparisons, Finland's health care system still has a relatively high number of hospital beds.

Consumer choice is another area where there might be improvements. Patients have little choice of either primary care doctor or hospital. In practice, however, Finland's geography and the relatively high rural population impose some constraints on this.

It is likely that targeting waiting times will result in improvements in this aspect of quality of care. The advent of the personal doctor system may also help improve continuity of care. If moves towards increased social care in the community continue, this will help meet the needs aspirations of a growing elderly population.

Despite the fact that the Municipal system has served the country well, there are structural problems when responsibility is devolved to such a local level. The small size of Municipalities is problematic, with their small population, they do not have the same know-how and negotiating power as professional producers, especially large secondary care hospitals. This creates an imbalance between the Municipalities who pay for services and the producers of services. The role of Hospital Districts also needs to be clearly defined. Financing and provision are not generally sufficiently separated for Hospital Districts to act as third-party purchasers, nor are they sufficiently integrated with hospitals to exert strong managerial control.

Finland faces a number of challenges in the field of health and health care. The rates of heart disease and diseases of the circulation are still unacceptably high and the number of suicides is alarming. Perhaps the next big challenge will be to translate the successes of the health care system into improvements in health status.

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