Social and Healthcare Services in Finland 2018

Expert evaluation

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Introduction

The Ministry of Social Affairs and Health (STM) and the Finnish Institute for Health and Welfare (THL) have rehearsed the evaluation and guidance activities for the organisation of regional social and healthcare services between 2017 and 2019. Each evaluation and guidance round has improved the understanding of the current state of social welfare and health care services in the regions and provided an opportunity to practise the use of a jointly compiled knowledge base to support planning, guidance and decision-making.

The social welfare and health care reform will strengthen the dialogue between the ministry and service organisers, which the Finnish Institute for Health and Welfare will support by preparing an annual expert evaluation on the equal access and cost-effective implementation of services at both national and regional level. The evaluation examines the current state of social welfare and health care in Finland as a whole. The evaluation is based on nationally comparable indicator data, area-specific evaluations, materials on regional discussions and recent publications on social welfare and health care in Finland. The national evaluation at hand applies to 2018.

All the information required for the evaluation is not yet available. For example, there is no comparable information on several aspects of social welfare. The data sources in use also present challenges, which are described in more detail in the section on Methods and quality description of the publication. The indicator data used in the assessment is available to all interested parties in the Finnish Institute for Health and Welfare’s evaluation data online service, the Data Window (available in English).

When interpreting the results of the evaluation, it should be remembered that the provision of services in the regions can only be truly assessed once the responsibility for providing services has been transferred to the regions. Information on the activities of municipalities and joint municipal authorities is now mainly used in the evaluation. Occupational healthcare and other privately funded services are therefore mainly excluded. As the national steering of the service system will increasingly be based on information and interaction, knowledge base open to all and regular cooperation are essential prerequisites for success.

The purpose of this evaluation is to increase understanding of the current state of the social and health care system, and it is hoped that the results will benefit decision-makers at a national and regional level as well as officials and experts preparing decisions.

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Peak ageing is yet to arrive in growth centres

In Finland, regions develop in different directions, and many factors affecting service needs follow the segregation of regions. The birth rate has decreased, and since 2016 mortality has been higher than the birth rate. According to the forecast, one in four Finns will be over 65 years old and only one in seven will be under 16 years old in 2030. According to the forecast, the population in three regions will increase, while in others it will decrease. In areas with a declining population, the numbers of the aged will continue to increase moderately, but in areas with a large population, the numbers of the aged will increase significantly in the coming years.

In the future, the change in population structure will be reflected in all social and health care services, the services for elderly people being most clearly affected. In some areas, problems in the availability of basic services are manifested in the high costs of specialised services.

Our service system’s ability to identify hidden service needs at a sufficiently early stage is also inadequate. For example, the need for mental health services has not necessarily been adequately met, as the costs of mental health disability pensions and sickness benefit are high in some places.

Regional disparities in morbidity have remained

There are still clear regional differences in morbidity. However, the number of years of life lost due to premature mortality has decreased in all regions. In Finland, life expectancy is higher than the EU average, but gender differences in life expectancy have not been eliminated. The significance of risk factors affecting morbidity varies among different population groups, which also maintains the differences in life expectancy.

Some of the risk factors for diseases have clearly decreased, but obesity and excess weight are increasingly emphasised. According to the OECD, 20% of Finns are overweight, whereas the EU average is 15%. Good practices concerning the promotion of the good health of the population and the prevention of illnesses have been disseminated and established in Finland in many ways, for example in the Government’s key project, Promoting health and well-being and reducing inequalities, between 2017 and 2018.

Shortage of personnel can be seen as problems in the availability of services

Although more and more social and health care professionals’ permits have been granted, public social welfare and health care in particular are affected by a chronic shortage of staff, which is reflected as problems in the availability of primary services. In specialised medical care, there is a shortage of personnel in some fields. Special expertise is also needed at the basic level as the population’s service needs increase. In Finland, the number of nurses in particular is high in international terms, but it is difficult to find skilled personnel for home care, for instance. There is also a shortage of specialists in social welfare. According to the Ministry of Finance, by the mid-2030s, some 200,000 new social and health care employees will be needed.

Increasing numbers of people use electronic services

The number of different patient and client information systems used in the areas varies. The greater the number of information systems that are used in the region, the more complex, laborious and expensive it is to maintain and develop system compatibility. Different information systems are also often used at different levels of treatment. The development of technology has supported the availability and implementation of services, but very few actual electronic visits are still made. In services for elderly people, however, technology has already brought many additional benefits.

Half of Finnish adults used My Kanta in 2018, and over six million e-prescription renewal requests were sent through the service in the same year. Publicly funded services, such as Omaolo and Medical Helpline 116 117, are used in many areas to support local services.

As a rule, the prerequisites for information-based management are good in Finland, but national information on social work, for example, is not yet available.
The tight economic situation of municipalities forces to find new ways of improving productivity

In 2018, the municipal finances deteriorated significantly, which impairs the municipalities’ ability to fund social and health care services for the population. Only approximately one third of the municipalities’ finances were in balance when assessing the economic situation on the basis of annual margins and depreciations. The weak economic situation of municipalities and the growing service needs of the population are an equation in which small municipalities in particular have very little room for manoeuvring.

The tightening economy of municipalities has forced to improve service productivity and lighten the service structure by increasing primary, remote and mobile services.

According to forecast calculations, the annual costs of social and health care services increase the most in the areas in which the population is concentrated. The costs of social and health care services in the entire country are expected to increase by approximately 17 per cent by 2030.

The health care expenditure per inhabitant proportional to the purchasing power of the population in Finland is close to the average in the OECD countries, but smaller than in the other Nordic countries.

Municipalities and joint municipal authorities have mainly made large investments in hospitals, which must be taken into account in the overall review of municipal finances. Investments may have cross-sectoral impacts. Although these are mainly investments in specialised medical care, modern construction projects can also support integration of primary and specialized services as well as integration of social and health care services. The roles of the hospital network and different areas are still alive and well with the Emergency Services Decree. The hospital is an important factor to the vitality of many regions.

The role of joint municipal authorities in the organisation has increased

The social welfare and healthcare service system is very fragmented, even though the number of basic service providers has decreased in recent years. A significant proportion of the population lives in large cities, which organise and provide a large proportion of the services themselves. Many municipalities have transferred the responsibility for organising the services to the joint municipal authority.

Although the service system is fragmented, it is positive that several regions have integrated basic and specialised services. Administrative integration is a good start, but only functional integration ensures smooth service chains and entities.

In the production of services, particularly services for elderly people and persons with disabilities, private production is emphasised. Outsourcing has been carried out in primary health care and oral health care, but their share of service provision is relatively small. Occupational health care plays an important role in providing primary health care services for working-age people.

There are problem areas in the availability of services

One of the key problems in the service system is access to primary health care physicians. Although the child and maternity clinic services work well, there are problems with the availability of services for families in need of special support. In specialised medical care, the care guarantee is mainly implemented well, and referrals are handled efficiently. Older people are able to have their service needs assessed quickly in urgent situations, but many municipalities and joint municipal authorities have tightened the criteria for providing actual services. Based on the surveys, there are unmet needs for services among older people.

Finland has a shared view that services should increasingly be offered at the customer’s home. Regional differences remain in the availability and content of services. However, there are good examples of developing new types of services.

People with a foreign background settle in population centres and the Helsinki Metropolitan Area in particular, which affects the organisation of services in these areas. Less than half of those with a foreign background reported that they had always been able to contact health care services and that they had access to laboratory tests.
There is still little information on the quality of services

Based on the information available, the quality of social welfare and health care services is generally good, and customers who have gained access to health care services are satisfied with the services they have received.

In 2018, the supervisory authorities paid particular attention to social welfare services, the organisation, production and steering of which was obviously problematic. In particular, the number of notifications and contacts on irregularities concerning services for elderly people increased, and as a result, complaints and contacts concerning disability services also increased.

Operating environments vary

When examining the service system, it must be taken into account that the operating environments of the regions differ and the service structures reflect the decisions made earlier. The service system is subjected to significant pressures for change, some of which can be solved regionally.

The Future Health and Social Services Centres programme supports the regional development of services.

National decisions mean that, for instance, pressures on personnel and other organisational pressures will not decrease in the near future.
Population and operating environment

Population growth in Finland is concentrated in only a few regions, and in 2030, one in four Finns will be over 65 years old. Although the health of the population has improved, interregional differences and differences between socio-economic groups have not developed in a positive direction. Services are still provided in Finland by a large group of municipalities and joint municipal authorities which differ from each other in terms of population numbers and population structure. In one way or another, a shortage of labour affects practically all regions.

Population only increases in a few regions

Approximately 5.5 million people lived in Finland at the end of 2018. In ten years, the population has grown by approximately 166,000 people. In recent years, however, population growth has slowed down. Birth rate has decreased and mortality has increased, and since 2016, mortality has exceeded the birth rate.

The population has grown in six hospital districts and declined in fourteen regions since 2009. Internal migration mainly targets large cities and the municipalities surrounding them. The percentage of people with a foreign background is increasing in the population. The largest number of people with a foreign background live in Helsinki and Uusimaa, the smallest in Southern Ostrobothnia. People with a foreign background mainly live in densely populated urban areas. According to Statistics Finland’s population forecast, the population will only increase in Helsinki and Uusimaa, Pirkanmaa and Southwest Finland by 2030. In relative terms, the population is declining most in the region of East Savo, Kainuu, Kymenlaakso and Western Ostrobothnia.

Figure 1: Population development by municipality

The population is declining in the majority of Finnish municipalities. In 2018, 38% of Finns lived in municipalities with a declining population. 14% lived in municipalities with a rapid decline in population. The classification of municipalities is based on a population change in the last five years.
In 2030, more than one in four Finns will be over 65 years old

According to Eurostat, Finland is one of the fastest ageing countries in the EU. In 2018, the share of those aged 65 or over was almost five percentage points higher than ten years ago. Uusimaa region had the fewest people aged 65 and over (17%) and eastern Savo region had the most (32%). According to the population forecast, the proportion of older people will continue to increase; in 2030, more than one in four Finns will be over 65 years old. The size of the age group will grow the most in the Helsinki and Uusimaa regions, where the forecast indicates that the number of people aged 65 or over will increase by more than 90,000.

Finland is among the ten countries with the lowest birth rates in the EU (Eurostat). The total fertility rate is also historically low. In 2018, only 47,577 babies were born, almost 13,000 fewer than ten years earlier. The number of live births is at its lowest since the famine in the late 1860s. The proportion of children and young people has decreased in all regions compared to 2009 and will continue to decrease. According to the forecast, approximately one in seven Finns will be aged 0-15 in 2030.

The demographic dependency ratio of working-age and non-working age people is weakening. The reduction in the share of working-age people reduces the proportion of people within the scope of occupational health care and shifts the pressure on demand to publicly funded social and health care services. The ageing of the population challenges not only the capacity of public finances but also the availability of social welfare and health care personnel.

Figure 2: Potential Years of Life Lost due to deaths before the age of 80 between 2009 and 2017

The number of potential years of life lost has decreased steadily in almost all regions. Development of the whole country is represented by a line, and regions are indicated with circles. Lost years of life are one of the most important indicators of the development of population health. The choice of the upper age limit is based on the life expectancy of Finns, which is approximately 80 years. The number of potential years of life lost is proportional to the population of the region and reported as a figure per one hundred thousand inhabitants.

The health of the population has improved, but regional differences persist

Population health has improved in terms of the number of potential years of life lost (PYLL) due to premature mortality (Figure 2). Death is considered premature when it occurs before the age of 80. In the whole country,
6,321 years of life per 100,000 people were lost, almost one fifth less than in 2009. There are considerable differences between the regions, which are not directly explained by the differences in the age structure of the population or by the size of the population. The largest number of years of life were lost in South Savo (7,720) and the lowest in the Vaasa Hospital District (5,149). However, the number of years of life lost has decreased steadily in almost all regions. The morbidity rate is particularly concentrated in those areas of Eastern and Northern Finland where the proportion of older people is also high.

The Finnish Institute for Health and Welfare’s non-age-standardised morbidity index (2016) describes the actual disease burden encountered by the service system in the regions. The lowest morbidity rates are found in Helsinki and Uusimaa, and the highest in North Savo. There are also variations within the regions; the population is mainly the healthiest in the central cities of the regions and the municipalities surrounding them. The computational need for social welfare and health care services was the greatest in the regions of Eastern Finland in 2017 (THL. Tarvevaihdon menot).

**Municipalities losing their population form joint municipal authorities**

In Finland, municipalities, joint municipal authorities and cooperation areas operating under the model of liable municipalities are responsible for organising social welfare and health care at the basic level. Less than half of Finns live in municipalities that organise social and health care services independently (48.4%). Less than one third of Finns (29.9%) live in the area of joint municipal authorities, and more than one fifth (21.8%) of Finns live in cooperation areas under the model of liable municipalities (Parhiala, 2019).

Population shares and organisational models can also be examined by utilising, for example, the municipal classification used in reporting on the status of basic services by the Ministry of Finance. In the classifier, municipalities are divided into large cities, urban municipalities, densely populated municipalities and rural municipalities. The classification also examines the population change in municipalities, in which case municipalities are classified as rapidly growing, growing, rapidly degenerating, declining and rapidly declining municipalities. When different models of organising municipalities are included in the examination, it is observed that almost one third (30.8%) of Finns live in a growing municipality which organises services independently. Another large group consists of municipalities which are losing their population and have transferred the responsibility for organising the services to the joint municipal authority. About a fifth (19.4%) of Finns live in the area of such a municipality.

In terms of the number of municipalities, rural municipalities which have transferred the responsibility for organising the services to the joint municipal authority are a clear group, 36 per cent of all Finnish municipalities. However, the combined population of these municipalities is only 5.7% of the Finnish population. From the perspective of national steering, there is a risk that a group of increasingly polarised municipal and urban centres as well as a group of large joint municipal authorities will be formed of small municipalities which are drastically losing their population. The mentioned municipal groups also differ in their population structure and dependency ratio, which places different pressures on service providers.

**My Kanta in frequent use**

The number of electronic client and patient information systems used in the regions varies (Figure 3). In 2017, in nine of the hospital districts of Finland, all municipalities and joint municipal authorities used the same client and patient information system in primary health care. Seven regions had 2–3 different systems and five regions had 4–5 systems (Jormanainen, Parhiala & Reponen, 2019). In the area of five hospital districts, the same client information system was used by all municipalities in social services. In thirteen hospital districts, municipalities had two different client information systems in place, and in three hospital districts, 3–4 different systems were used (Jormanainen, Rötsä & Parhiala, 2019). Integration solutions and maintenance of electronic information systems are expensive. The maintenance of several different systems in a region also means a greater amount of resources allocated to education.

Almost half of Finnish adults used the My Kanta online service for citizens in 2018. Over six million e-prescription renewal requests were sent through My Kanta. (Jormanainen et al., 2019.) Publicly supported services, such as Omaolo and Medical Helpline 116 117, have also been introduced to support service provision in many areas.

As a rule, the preconditions for information management in the regions are good in Finland, but there are still sectors, such as social services, from which national or regional information practically cannot be obtained at all. Differences in recording practices make it more difficult to use comparable information between regions.
The maintenance and use of several different client and patient information systems in the areas impairs the functional prerequisites for integration. The more systems used in the region, the more difficult the situation is.

**The number of personnel has increased**

The number of social welfare and health care professionals increased between 2010 and 2018. In 2018, 457,000 people of working age had been granted the right to engage in social welfare and health care activities, compared to 335,700 in 2010. This does not fully reflect the change, as a significant part of the increase is linked to legislative changes. For example, social welfare professionals were only entered in the Valvira (National Supervisory Authority for Welfare and Health) professional register from 2016 onwards. Between 2017 and 2018, the increase was approximately 4%. The number of health and social welfare professionals relative to the population was partly evenly distributed by region. In some professional groups, however, the differences between the regions were double or triple in relation to the population. (THL, 2020a.)

The challenge for the future is to find skilled personnel, especially for services for elderly people. In 2018, the number of practical nurses in health care was 173,000, and the number has increased by some 10,000 each year between 2010 and 2018. In addition, there were 166,000 practical nurses working in social welfare in 2018. The concern is that the number is insufficient and not distributed according to need, and regional inequalities in services will continue to increase.

In 2018, there were more than 26,000 new individuals with an authorisation to practise a profession, while more than 6,000 retired (THL, 2020a.). While the retirement of employees has not been a problem yet, according to forecasts, the need for additional labour force in social welfare and health care tasks will increase sharply by 2035 as the retirement of employees and care needs increase (VM, 2020).

Finland has 302 inhabitants per doctor, while EU countries have 311 inhabitants per doctor. In contrast, there are 69 inhabitants per nurse in Finland, compared with 135 in EU countries. (WHO, 2019.)
Employees move to the private sector

At the end of 2014, a total of 385,482 people worked in social welfare and health care services, which is 17 per cent of those working in Finland. 47% of them worked in health services and 53% in social welfare services. In the 2000s, the number of personnel in the private sector and organisations has increased faster than the number of personnel in the public sector. One third of social services personnel already worked in the private sector in 2014, whereas in 2000 their share was about one fifth. The proportion of health care personnel working in the private sector increased from 17% to 22% between 2000 and 2014. (THL, 2018.)

The percentage of foreigners in social welfare and health care personnel was still relatively small in 2014 and 4.6% (17,755 people) were ethnically non-Finnish people (THL, 2020a).

Shortage of employees in some hospital districts

In 2018, the number of social welfare and health care personnel increased in some hospital districts, but in the majority of districts, it decreased. Due to the objective of the organisers and producers to reduce person-years in the area of several hospital districts in 2019, it is anticipated that the declining trend in the number of health care and social services personnel will continue.

At the same time, there were problems in the availability of personnel. In 2019, specialists in social work, hearing researchers and speech therapists as well as general practitioners were, on the list of an occupational barometer compiled in the autumn, among the five occupational groups with the greatest labour shortage. Hospital districts also report on shortages in several other professional groups, including specialists, chief physicians, nurses, practical nurses, dentists, oral hygienists, radiologists, bioanalysts and psychologists. The shortage of workers in different occupational groups varied by region. The shortage of general practitioners was almost 20 per cent in one hospital district. Although the total number of doctors has increased in recent years, the shortage of general practitioners remained at approximately 4–6 per cent between 2013 and 2018 (VM, 2020). The shortage is explained by the fact that an increasing number of doctors have been placed in specialised medical care, the private sector and occupational health care in recent years (VM, 2020).
Social and healthcare services funding and costs

The costs of social welfare and health care services organised by the municipalities in 2018 (EUR 18.3 billion) increased by 2.9% from the previous year. The share of social welfare and health care services in municipalities’ net operating economy costs are nearly 60 per cent. In proportion to the population’s service needs, the social welfare and health care costs per inhabitant were, in 2017, the lowest in North Karelia and the largest in Lapland. The costs of social welfare and health care services are predicted to increase by 17% throughout the country by 2030. The largest cost increase forecast is in the Helsinki and Uusimaa region. The financing of the costs arising from the use of social welfare and health care services by the ageing population has been hampered by the severe weakening of the municipal finances, which continued in 2019. In addition, planned and ongoing hospital and other construction projects in the social welfare and health care sector will significantly increase the financial responsibilities of municipalities.

The increase in the costs of social welfare and health care services has accelerated from 2017 onwards

In 2018, the net operating costs of municipal social welfare and health care services totalled EUR 18.3 billion, an average of EUR 3,319 per inhabitant. The costs varied between EUR 2,888 in Helsinki and Uusimaa and EUR 4,510 in East Savo.

The net operating costs of social welfare and health care services per inhabitant remained almost unchanged after 2015, but in 2018 they increased by 2.9 per cent compared to the previous year (Statistics Finland, 2019a). Specialised medical care accounted for the largest share of the total costs of social welfare and health care services, about 38 per cent, and basic health care for the second-largest share. Municipalities spent EUR 6.9 billion on specialised medical care and EUR 3.3 billion on basic health care.

Need-adjusted expenditure was lowest in North Karelia and highest in Lapland

Social welfare and health care expenditure varies by hospital district according to service needs (age, gender structure, morbidity, socio-economic status). Service needs are greatest in the regions of Eastern Finland. The smallest service needs are in the Helsinki and Uusimaa regions, 12 per cent lower than average. (THL. Tarvevakioidut menot.)

In 2017, the need-adjusted social welfare and health care expenditure was the lowest in North Karelia, 7% lower than the national average. Taking the population’s service needs into account, the expenditure was highest in Lapland, where it was 11% higher than average. (THL. Tarvevakioidut menot.)

The forecast for the costs of social welfare and health care services are largest in Helsinki and in the Uusimaa region

According to the Finnish Institute for Health and Welfare’s forecast calculations, the annual costs of social welfare and health care services increase the most in areas where population growth is more higher compared to other areas. During the current decade, population growth will concentrate in the areas of Helsinki and Uusimaa, Pirkanmaa and Southwest Finland. In other regions, the population trend forecast for 2030 is decreasing. On the other hand, the number of elderly people will increase during the same period in all regions. The number of older people (aged 65 or over) is predicted to increase most significantly in Uusimaa, by approximately 35 per cent.

The costs of social welfare and health care services in the entire country are projected to increase by approximately 17 per cent by 2030 (hospital districts 0.9–27 per cent). In all regions, the costs of services for elderly people are predicted to increase the most (50% in the entire country). The greatest cost increase is forecast in the Helsinki and Uusimaa regions.

Strongly weakened municipal finances threaten the adequacy of funding

Municipal finances deteriorated significantly in 2018. This has also impaired the ability of municipalities to finance the social welfare and health care services of the population, which account for approximately 58 per cent of the total net costs of the municipalities’ operating economy.
In 2018, municipal tax revenue decreased by 0.5 per cent compared to the previous year. The annual margin deteriorated in all municipal group sizes, but in relative terms it decreased the least in municipalities with more than 100,000 inhabitants. There were 43 municipalities with a negative annual margin, compared with four municipalities a year earlier. In over 200 municipalities, the annual margin was not sufficient to cover the depreciations. On the basis of the 'annual margin minus depreciation' indicator, approximately one third of municipalities were in balance in terms of their finances, whereas over 80 per cent of municipalities had been in balance in the previous year. The result for the financial year was negative in ten hospital districts, and one year earlier in three hospital districts. (VM, 2019.) According to the 2019 financial statements of mainland Finnish municipalities and joint municipal authorities, the weakening of municipal finances continued in 2019 as operating expenses and the loan portfolio increased (Kuntarahoitus, 2019; Statistics Finland, 2019b).

**Record-breaking hospital investments**

A significant increase in investments in social welfare and health care is reflected in the increase of municipalities' loan portfolio. Under the Act on the Restriction of Building Investments, which entered into force in 2016, almost four billion euros' worth of permits for investments in health and well-being centres and hospitals have been granted in the social welfare and health care sector although a derogation has been required from the Ministry of Social Affairs and Health for investments exceeding five million euros. According to a report prepared by the Counties' Service Centre for Facilities and Real Estate Management, at the beginning of 2018 the hospital and special care districts had ongoing or planned construction projects worth approximately five billion euros. In addition, a number of social and health care investments are underway in municipalities. The largest individual hospital investments in progress are worth billions, such as the construction of a new university hospital in Oulu, which has a cost estimate of over EUR 900 million.

**Weakening municipal finances forces costs to be cut**

In the next few years, the increasingly stringent economic situation combined with the growing service needs of the ageing population will force municipalities to adapt their economies more actively, for instance by increasing their income and real estate tax rates, developing their service network and producing services in new ways with the aim of improving productivity (VM, 2020). Many municipalities and joint municipal authorities for social welfare and health care have started or are also about to launch extensive co-determination negotiations to balance the economy.
Promoting health and well-being

The structures for coordinating and managing the promotion of municipal well-being and health have developed favourably. Non-governmental organisations play a key role in promoting the well-being and health of municipal residents. The population’s experiences in well-being and health vary in different parts of the country and in different age groups. The majority of young people are satisfied with their lives, but regardless of this, an increasing percentage of upper comprehensive school pupils feel anxious and feel their health has deteriorated. The entire population and the social welfare and health care service system are challenged by the phenomenon of excess weight and obesity, which is becoming increasingly common in all age groups. On the population level, smoking has decreased, but the use of snuff among young men in particular has become more common.

The structures of coordinating and managing health promotion have developed positively

The structures for promoting health and well-being vary in different areas of the country, but overall, the structures for coordination and management of different administrative sectors have developed positively (THL, 2019a). According to a survey on the promotion of well-being and health directed at the management of municipalities, 83 per cent of the municipalities have appointed a person responsible for the coordination of well-being and health care matters (in hospital districts, 39–100 per cent). 94 per cent of municipalities have approved the extensive statutory welfare report. Slightly less than two thirds of municipalities (33–85% in hospital districts) have reported to the council on health differences between population groups. Since 2015, the opportunities for municipal residents to participate in and influence the development of services have been increased in an increasing number of municipalities. In 2019, more than two thirds of municipalities reported on their website on opportunities for participation.

Non-governmental organisations play a key role as partners in health promotion in the regions

Social welfare and health organisations are key municipal well-being and health care partners and play an important role in promoting the well-being and health of the population. The organisations have also been actively involved in the preparation of regional structures. According to the Finnish Federation for Social Affairs and Health (SOSTE), there are some 10,000 registered social welfare and health care associations in Finland. The number varies by region, from approximately 200 associations in Kainuu to 1,700 associations in Helsinki and Uusimaa. Of the social and health care associations, approximately four out of five operate on a voluntary basis only.

The Funding Centre for Social Welfare and Health Organisations (STEA) manages grants for social welfare and health care organisations’ activities promoting public health and well-being. The strategic objective of STEA’s assisted activities is, among other things, to reduce inequality and increase equality and inclusion. In 2018, STEA granted targeted operating grants and project grants totalling EUR 269.3 million.

The population’s experiences in health and well-being differ – increasing numbers of young people experiencing anxiety

The population’s experiences of quality of life vary in different parts of the country. According to the FinSote study, the proportion of people aged 20–64 who consider their quality of life to be good is highest in Helsinki and Uusimaa (69%) and lowest in Central Ostrobothnia (56%). Four out of five in Helsinki and Uusimaa believe they can work until retirement age, while one in three in North Karelia believe that they cannot work that long. In contrast, the lack of mental well-being of young people of upper comprehensive school age in the Helsinki and Uusimaa region is common when measured using many indicators.

According to school health promotion studies, the majority of children and young people are satisfied with their lives, but the proportion of pupils in grade 8 and 9 experiencing moderate to severe anxiety as well as students in the 1st and 2nd year of upper secondary school has increased throughout the country in recent years.
At the same time, the proportion of pupils who feel that their state of health is average or weaker than average continues to grow. One in five pupils in the 8th and 9th grades of comprehensive school considered their state of health average or weaker than average.

**Smoking has decreased, but snuff use is becoming more common, especially in young men**

According to population studies, the health behaviour of the adult population has progressed in a favourable direction: the share of those who do not engage in leisure-time physical activity is reduced, and binge drinking and smoking are becoming rarer in all age groups among young people. 15 per cent of Finns aged 20–64 smoked daily in 2018. However, there are still major differences in smoking between population groups.

Despite the decrease in smoking, the daily use of snuff among young men in particular has become more common. In 2018, 5% of men aged 20–64 used snuff daily. The use of snuff has become more common especially among young people studying in vocational institutions. According to the School Health Promotion Study, less than a tenth of boys use snuff daily in upper comprehensive schools, but around one fifth use snuff daily in vocational institutions. One fifth of first and second year students in vocational institutions also reported experimentation with illegal drugs. The students in vocational institutions in Helsinki and Uusimaa, Pirkanmaa and Päijät-Häme most commonly experiment with drugs.

**Excess weight and obesity are becoming more common in all age groups**

In 2018, almost one in four children and young people were overweight. According to information based on child health clinics and school health care visits, 25% of boys under school age and 15% of girls were overweight or obese. The corresponding share for boys of upper comprehensive school age was already 29 per cent, and for girls 21 per cent. (THL, 2019b.)

Based on self-reported data, one fifth of the adult population aged 20–64 are obese (BMI ≥ 30 kg/m2). According to the FinHealth 2017 study, 72% of men and 63% of women aged over 30 were at least overweight. Almost one in two adults has excessive abdominal fat, which is particularly harmful to their health. (Koponen et al., 2018.)
Health protection services

There are regional differences in the implementation of a national vaccination programme and other types of combat against infectious diseases. Nationally, the influenza vaccination coverage of elderly people has improved but still remains under the European Council’s 75% target level. Despite the increasing use of drugs, the number of new hepatitis C infections has remained stable in recent years. More than half of the infections are related to intravenous drug use. The consumption of antibiotics has decreased in recent years throughout the country. Similarly, the number of cases of diarrhoea caused by Clostridium difficile have decreased by more than 20% since 2015.

Improved influenza vaccination coverage for elderly people

There are significant regional differences in the implementation of a national vaccination programme and other types of combat against infectious diseases. The vaccination coverage of young children is good at the national level, but there are regional variations in the coverage for different vaccinations. Most variations occur in influenza vaccinations and girls’ HPV vaccinations. In the period 2017–2018, approximately 48% of those aged 65 or over received an influenza vaccination. Vaccination coverage has increased by eight percentage points compared to the 2014–2015 period. Despite the increase in influenza vaccination coverage, this share is below the 75% target set by the European Council. Regional vaccination coverage varies from 34% in Vaasa to 57% in South Karelia.

According to the HPV vaccination programme, 59% of girls across the country have taken HPV vaccine which provides protection against multiple types of cancer. The coverage is lowest in Central Ostrobothnia (47%) and highest in North Savo (70%).

The number of new hepatitis C infections has remained stable in recent years

Less than 1,200 hepatitis C infections (incidence 21 / 100,000 inhabitants) were reported in 2018, which is almost the same as in previous years. One third of the infections were in Helsinki and Uusimaa. The incidence of hepatitis C infections was highest in the hospital districts of West Ostrobothnia (31 / 100,000 inhabitants) and Central Ostrobothnia (6 / 100,000 inhabitants). Approximately two-thirds of the infections were diagnosed in men and focused on those aged 20–39 (THL. Hepatiitti C -tapausten esiintyvyys Suomessa).

Slightly more than half of the hepatitis C infections were related to injecting drugs. The highest number of infections received through injection was recorded in the North Savo region (22 / 100,000 inhabitants) and the lowest in the South Ostrobothnia area (5 / 100,000 inhabitants). According to a study on the use of waste water in large cities, published by the Finnish Institute for Health and Welfare in March 2019, and a report on the use of illegal drugs (THL, 2019c), drug use and experiments with drugs will become more common. At the same time, the availability of services for people with substance abuse problems varies greatly between different regions of the country. In the Helsinki Metropolitan Area, a wide range of services are available for people with substance abuse problems, and for example, health advice counters for drug users are available in all municipalities.

Reduced consumption of antibiotics

In recent years, the consumption of antibiotics (ATC code J01, bacterial medicines) has decreased in all hospital districts. The annual consumption of bacterial medicines in 2018 was highest in the areas of Kymenlaakso and Central Finland. In international comparison, bacterial medicines are less commonly consumed in Finland than in the EU countries on average and almost at the level of the other Nordic countries (ECDC, 2019). In 2018, an average of 20 doses of antimicrobials (J01) were used annually per 1,000 inhabitants in Europe. The corresponding figure was 15.5 in Finland.

The proportion of patients who received antimicrobial medication for an unspecified upper respiratory tract infection in basic health care ranged from 1% in South Ostrobothnia to 16% in North Karelia.
Reduced cases of diarrhoea caused by Clostridium difficile

The toxin-producing Clostridium difficile is the most common cause of hospital diarrhoea, and the disease is almost always preceded by antimicrobial treatment. Between 2015 and 2018, the number of Clostridium difficile cases\(^1\) has decreased by approximately 21% to more than 4,000 cases (incidence 78 / 100,000 inhabitants). Of the cases, nearly 60 per cent were women and nearly half of them were over 75 years old. The variation between the different hospital districts was considerable (54–134 / 100,000 inhabitants). This may be related to regional differences in sampling activity, diagnostic methods, response measures or epidemic situations. (THL. Tartuntataudit Suomessa, 2018.)

Regional differences in the prevention of infectious diseases in specialised medical care

The influenza vaccination coverage of specialised medical care unit personnel (nurses and doctors) varies greatly by region (57–95%). The consumption of hand sanitiser in the inpatient wards of somatic specialised medical care was lowest in Kanta-Häme and highest in East Savo (variation 40 to 97 litres / 1,000 treatment days). The number of hygiene nurses in proportion to the number of beds was smallest in Kanta-Häme and largest in East Savo.

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1 Source: Sotkanet (in english)
Somatic specialised medical care and emergency care

Specialised medical care is increasingly focusing on outpatient care. The number of outpatient visits has increased by more than a third over the last ten years, and simultaneously, inpatient care numbers have decreased. The number of day surgery operations has increased. Waiting times and the number of people waiting have increased in most hospital districts. The number of specialised medical care emergency room visits has increased significantly. Reasons for this include the reorganisation of emergency clinics, changes in recording practices in joint emergency clinics and possibly a shortage of resources in basic services.

Changes in the organisation of services

The last year’s legislative amendments have influenced the structure, division of labour and activities of specialised medical care. The key changes concern the organisation of emergency medical care and emergency services (Regulation on Emergency Response 782/2014) and the centralisation of service production in larger hospitals (Regulation on Centralisation 582/2017). The number of accident and emergency centres has been reduced, and on the other hand, the number of joint emergency service centers, where both general practitioners and specialists work together, has been increased. Because of the regulation on centralising services, treatment of the rarest diseases and demanding operations have been concentrated at university hospitals. In order to ensure sufficient numbers of certain operations some other surgical treatments have also been centralised at larger hospital units. These include, for example, joint replacement surgery, back surgery, surgery of certain cancers, and childbirth. Public hospitals and the private health care sector have also developed and implemented new ways of cooperation and division of labour.

Increasing waiting times

In 2018, approximately 1.27 million referrals were received for specialised medical care, an increase of 12% from the previous year. The relative number of referrals to specialised medical care was at the same level as in 2017 (0.2 referrals/resident). Almost all referrals were processed in the course of the three weeks, and in 2018, referrals were processed in more than three weeks in only one per cent of the cases. There were substantially longer processing times in three hospital districts.

Waiting times for somatic specialised medical care increased in all except three hospital districts between 2017 and 2018. The median waiting times were 38–55 days in 2018. The number of people waiting more than six months increased throughout the country from 2015 (2.0/1,000 inhabitants) to 2018 (3.2/1,000 inhabitants).

Increased focus on outpatient care in services

In 2018, there were 7.2 million visits to somatic specialised medical care for the adult population. The increase in the number of outpatient visits continued: between 2015 and 2018, the increase was 11%. At the same time, the number of patients and treatment periods in inpatient care decreased. The number of day surgery visits has remained at the same level for the past ten years, with variations between 2009 and 2018 from 186,000 to 205,000. In 2018, the number of day surgery appointments totalled 204,000, an increase of four per cent from the previous year. (THL, 2019d.)

The decline in inpatient treatment periods continued, and the decline was approximately three per cent between 2015 and 2018. In most hospital districts, inpatient care periods decreased, but in six hospital districts they increased by up to seven per cent. The duration of treatment periods has remained at the same level between 2015 and 2018, i.e. approximately four treatment days per treatment period. (THL, 2019d.)

The number of emergency visits to specialised medical care will increase with joint emergency services

The number of emergency room visits to somatic specialised medical care began to increase in 2013. The number of visits has increased by 33 per cent between 2013 and 2018. Joint emergency services have had a significant impact on the recording of visits. The figures are therefore not comparable with previous years.
Most of the emergency room visits were recorded to acute medicine, internal medicine and surgery. (THL, 2019d.) Training in acute medicine as a specialisation started in the beginning of 2013, which has, for its part, changed the working methods at emergency rooms.

16% of the patients treated at the emergency room returned to the emergency room within 48 hours. There have been no major changes in these numbers in recent years.

**Response times of pre-hospital emergency care slightly shorter**

Emergency care tasks have been monitored since 2016. The number of pre-hospital emergency medical care missions was largest in Kainuu, North Karelia, Northern Savo and South Savo (over 200 missions/1,000 inhabitants; an average of 145 missions in the entire country). On average, the response time to reach patients was seven minutes in urban settlements and 14 minutes in areas outside the urban settlements in emergency care tasks which were considered to be of high risk. The longest median time to reach patients, 20 minutes, was in Lapland. The time to reach patients has become slightly shorter in most hospital districts, both in and outside urban settlements.

**Cross-border use of hospital services has increased only slightly**

In 2018, 7.3 per cent of specialised medical care patients were treated in the area of another hospital district. The figures varied from 3.6% in the Hospital District of Southwest Finland to 15.5% in Vaasa.

In 2018, the average share of patients living in another hospital district was 7.2%. No significant changes have taken place in the numbers at the national level. The figure varied from 3.7% in South Karelia to 22.7% in Central Ostrobothnia. In the East Savo Hospital District, the share of residents of other districts in the central hospitals was also significant, 12.1 per cent. The share of patients admitted to university hospital districts who originally reside in another hospital district is among the highest in the country, with the exception of the Helsinki and Uusimaa Hospital District, where the treatment volumes are large due to the large population size.

**Variation in patient injury notifications**

The number of resolved patient injuries to be compensated varied between hospital districts. In the entire country, patient injuries increased by more than three per cent between 2015 and 2018. The number of resolved and compensated injuries in 13 hospital districts was higher than the national average (153 patient injuries/100,000 treatment periods). In eight hospital districts, patient injuries decreased, at best by 28 per cent. The number of reported patient injuries does not necessarily indicate the quality of treatment at an individual hospital, as the counselling activity of patient injury notifications varies. A higher number may also indicate an open culture in the organisation.

**Productivity improved in central hospitals**

The net operating costs of specialised medical care amounted to EUR 6.9 billion in 2018. In the entire country, the increase was 3.9 per cent between 2015 and 2018. The costs decreased in five hospital districts and increased by more than 10% in four hospital districts. The net operating costs of specialised medical care per inhabitant were EUR 1,081 to EUR 1,825, with an average of EUR 1,248. According to forecasts, the costs of specialised medical care will increase by approximately 11 per cent and the costs of specialised medical care and basic emergency room care will increase by approximately 9 per cent between 2017 and 2030.

In five hospital districts, the calculated cost per capita of hospital districts was more than 10% higher than the national average. The increase in costs due to inefficiency, compared to the national average, was up to EUR 151 per inhabitant. (THL, 2020b.)

Between 2014 and 2018, the productivity of specialised medical care in public hospitals increased by five per cent in central hospitals and decreased by six per cent (THL, 2020b). Due to the costs of teaching, research and nationally centralised treatments, these hospital categories are not directly comparable.
Primary health care

The coverage of primary health care services is good. The number of outpatient physician visits has decreased. The reason for this is probably the transfer of tasks to nurses and, to some extent, a shortage of physicians. In addition, e-service appointments dealing with matters online and telephone contacts have increased. An increasing number of emergency room visits have been made. It can be caused by the inadequacy of primary services and more widespread joint emergency services. In primary health care, inpatient care days have decreased by almost a quarter.

The use of primary health care services has remained at the same level in recent years

In 2018, three out of four people (3.9 million people) living in Finland used outpatient care services in primary health care. The share has remained almost unchanged since 2015. There were over 25 million visits, of which approximately one quarter were to a physician. The number of visits by a nurse or public health nurse was 1.7 times higher than the number of doctors’ appointments, but regional variation was great. Between 2015 and 2018, the number of visits and clients increased by 2%, while the number of doctors’ appointments decreased by 8%. Online and telephone activity increased by as much as 12 per cent (Figure 5). Over one fifth of all outpatient care events in primary health care were electronic visits or phone calls. This share also varied considerably between the regions.

Outpatient medical visits were the largest service group for outpatient primary healthcare in 2018, 43 per cent of all visits. There were 2.6 million patients in outpatient care in health centres and a total of 10.8 million visits. Of the five million visits to inpatient care, one million had been classified as urgent (on the same day), 0.6 million as those occurring within a week and 3.4 million as non-urgent. From 2015 to 2018, the number of doctors’ appointments decreased by eight per cent and the number of visits to other professional groups increased by four per cent (Figure 5). The development may be partly due to a shortage of doctors, but the transfer of tasks to nurses has also influenced the matter.

According to a survey conducted with service providers, 56 per cent of 16–64-year-olds can use occupational health care services; regional variation is significant (Takala et al., 2019). The offer of services for student health care, occupational health care and by private physicians varies considerably by region. This means that the overall picture of the use of services in the regions and the underlying availability of services according to the needs is inadequate.

The greatest change has occurred in inpatient care for primary health care, which has decreased in recent years: The number of patients decreased by 2.6 per cent and the number of days of treatment by 23.7 per cent (Figure 5). This is mainly explained by the structural change in the services for elderly people.

The shortage of doctors has worsened

According to a comparison by the EU, there were considerably more general practitioners working in Finland (including specialists in general medicine) relative to the population than in the Nordic countries and Europe in general (Eurostat, Healthcare laboratory statistics – physicians). However, in October 2018, 5.7 per cent, or 228, of health centre physician’s positions were unfilled. The number of physicians working at health centres was 6.8 per 10,000 inhabitants. This varied from 5.5 to 8.6 by region, which seems to be a great variation in terms of equal access to services. (Lääkäriliitto, 2019.)

According to a survey conducted at health centres, approximately one quarter of the health centre physicians in 2019 were specialists in general medicine, one fifth specialising in general medicine, nearly one quarter physicians were on mandatory training in primary health care, and more than one fifth were general practitioners. There were also doctors and students in other specialities. A large share of those in training (48%) increases the workload of specialists in general practise in health centres. (Syrjä et al., 2019.)

Less than half of the patients were given a doctor’s appointment within one week of contact

In October 2018, almost three per cent of the visits exceeded the maximum period (3 months) of access to a non-urgent doctor’s appointment under the care guarantee. The differences between the regions were considerable, and there were also slightly more missed deadlines than in October of the previous year.
The assessment of the need for treatment in accordance with the Health Care Act had only been recorded in 15 per cent of all outpatient doctors’ appointments in 2018.

In October 2018, less than half of the patients (44 %) were given a non-urgent outpatient doctors’ appointment within one week of contact. The proportion of patients who were given an appointment within a week varied from 32% to 81% by region.

Management by knowledge requires good record-keeping and needs to be improved not only in terms of assessing the need for treatment but also in terms of the reasons for visiting an outpatient doctor, as these had been recorded in only 72% of visits, and regional variation was significant.

**Costs have increased moderately in outpatient care**

The net operating costs of outpatient care in primary health care (oral health care excluded) were EUR 2 billion (EUR 366 per inhabitant) in 2018. This includes outpatient services in primary health care, occupational health care, school health care and school psychologist activities as well as mental health offices maintained by basic health care or other similar activities. The differences between regions were considerable (EUR 298–512 per inhabitant). The increase in the entire country was 2.7 per cent from 2015 to 2018. The costs decreased in six regions and increased by more than 10% in five regions.

The net operating costs of inpatient care in primary health care totalled EUR 0.9 billion (EUR 156 per inhabitant). The regional variation in the costs per inhabitant was considerable (110–242 euros/inhabitant). From 2015 to 2018, costs decreased by 12% across the country, and increased in only three regions.
Oral health care

More than half of the patients in Finland are given a non-urgent basic healthcare dental appointment within three weeks of initial contact. More than one third of the population use oral health care services in public health centres. However, access to oral health care services varies considerably by region. Customers are satisfied with the public services they receive. The share of those using public oral health care services has remained almost unchanged, and visits to private dentists have decreased. Since 2015, dental and oral examinations by dentists have been eligible for Kela (Social Insurance Institution) compensation once in two calendar years.

In 2018, 5.1 million oral health care visits were made to health centres, and there were 1.9 million health centre clients. Finns can also use private services, for which the customer receives a Kela compensation. However, compared to 2015, the number of dental visits reimbursed by Kela has decreased in all regions and by a total of 16 per cent in the entire country. There are few private services available in some areas, which may increase the use of public services (Suomen Hammaslääkäriliitto, 2018a).

More than half of the patients in Finland got to see a dentist within three weeks

In 2018, health centres had less than 2,000 dentist positions, of which 5.8% were unfilled. The shortage of dentists varies greatly by region; at most one out of four positions was unfilled, which affects access to treatment. More than half (55%) of primary health care dentist appointments were arranged within three weeks of assessing the need for treatment. Again, regional variation was considerable (12–80%).

According to a national population survey, nearly one in five respondents found dental services insufficient. In the national customer feedback survey, the respondents indicated that they were very satisfied with access to service within a reasonable time; they were also very satisfied with the services in other terms, and there were little differences between the regions.

Purchasing services used in several health centres

Health centres purchased dental workforce from the private sector or another health centre. 39 per cent of the health centres purchased work for basic dental care for a total of 84 working years, 77 per cent for specialised dental care for a total of 22 working years, and 64 per cent for emergency services outside working hours for a total of 55 working years (Suomen Hammaslääkäriliitto, 2018b). In October 2018, 39 dental clinics had been outsourced, with less than 200,000 inhabitants using their services.

Orthodontic care varies by region

The oral health of children aged 12 years is good in Finland. Among the children who visited dentists, 62% had healthy teeth (45–79%). In this age group, the DMF index for the number of cavities, fillings and tooth extractions varied by region (0.5–1.6%). The lack of national guidance and children not being directed for treatment may partly affect the differences in the DMF index.

The share of 12-year-olds receiving orthodontic treatment has decreased in recent years, and in 2018 almost one third in the age group had received orthodontic treatment. Although the aim has been to create uniform and equal criteria for accessing treatment (e.g. the SUHAT project), the situation varies by region (20–39% received orthodontic treatment).

The oral health status of the adult population is represented by the statistic that 65% of dental patients did not need treatment for caries or periodontitis. Again, the differences between the regions were great (41–80%). In recent years, there has been a slight decrease in the proportion of patients whose appointments have been divided into six or more dental appointments and who require extensive care, ranging from 4.6% to 10% by region. Taking into account treatment appointments with other oral health care professionals, the percentages and variations were higher (5.9–14%).
Oral health is maintained and improved primarily through good self-care and its support. In 2019, 41% of children of secondary school age brushed their teeth less often than twice a day (regions, 35–48%). According to the World Health Organization (WHO) survey (Inchley et al., 2016) children in Finland aged 11, 13 and 15 brush their teeth significantly less than their peers in other Nordic countries.

**Increasing costs in public services and decreasing costs in private services**

The net operating costs of public oral health care amounted to EUR 448 million in 2018. Per capita, the average cost of oral health care was 81 euros. The costs of public oral health care have increased by five per cent from the previous year, and the costs of private dental care have decreased by two per cent. The costs of private dental care were EUR 63 per inhabitant.
Services for children, young people and families

The differences in the structures, content, resources and operating models of the service system are obvious, and the services are not equally available to children, young people and families. Needs for change and development needs have been identified in the regions, and changes are under way. The focus still needs to be shifted towards earlier support, and the service system should be developed as a whole instead of developing its parts. The failure of basic services has increased the need for specialised services and increased the costs of the entire system.

Family centres in operation or planned in each area

Between 2016 and 2019, family centres have been developed in the entire country as extensive, multidisciplinary service entities which cross the boundaries of administrative branches. Jointly agreed national policies and criteria have guided and unified the development work. In spring 2019, there were 138 family centres and 500 open, low-threshold meeting places. Small municipalities have one family centre of their own or a centre shared with other municipalities, while large municipalities have several family centres. Services are becoming more accessible, as they are offered in various service points as well as electronically and at home. (Pelkonen et al., 2020.)

As a result of the transformation work which is supported on a national level, assistance and support in line with the needs of families have become reinforced and provided earlier. Support for parenting and the parents’ relationship as well as assistance in the case of a separation have been reinforced in almost all regions, and prevention of domestic violence in two out of three regions. Early support, care and rehabilitation were improved in almost all regions, whereas a systematic family centre model focusing on the child, adolescent and family is only taking shape in a few regions. (Pelkonen et al., 2020.)

The organisation of school social worker’s and psychologist’s services as part of the region’s social welfare and health care services will support the set of services for children and young people

The great variation and uneven quality in the availability of school social worker’s and psychologist’s services has led to a disparity between pupils and secondary level students. In school and student health care, the emphasis of medical examinations has for years been on psychosocial well-being, as methods have been sought to help children and young people with mental health problems. However, according to legislation, the treatment of illnesses is not included in school health care, school social worker or psychologist’s activities. The resources are thus only dimensioned at the basic level for preventive work. At the same time, consultative specialized medical care support at the basic level is poor.

The fragmented system of mental health services for children and young people hampers the timely and equal availability of services – there is nobody clearly responsible for the whole

The services supporting the mental health of children and young people and actual mental health services have been organised in different ways in the country. For example, the educational and family counselling service menu and operating models are very different in different parts of Finland, and these services often operate separately from other services for children, young people and families. The roles and responsibilities between the service sectors are also not clear. There are boundaries between organisations which interfere with the functioning of the system. (Aalto-Setälä et al., 2019.)

There is not enough early mental health support and care available, and the responsibility for treating mild and moderate disorders has not been explicitly agreed upon. Similarly, resources are lacking for therapeutic interventions suitable to be used at baseline. As a result, the system functions inefficiently, problems are prolonged and become chronic as the start of treatment is delayed, and specialised medical care becomes blocked. (Aalto-Setälä et al., 2019.)
Services for children, young people and families

The challenge is the need for additional resources both at the early stage and at the demanding level

From the perspective of the adequacy of the resources of the service system, the challenge is to allocate resources simultaneously to basic preventive support and early care as well as to children and young people who are difficult to treat. Cooperation and shared responsibility for mental health work for children and young people are also a challenge, which, if non-functional, may have resulted in some of the children and young people in need of support being excluded from the services.

Figure 6: Change in the mental health benefits for young adults, rehabilitation psychotherapy and pharmacotherapy between 2009 and 2018

The share of those receiving rehabilitation psychotherapy and those receiving sickness benefit based on mental health reasons have significantly increased over the past ten years. The different age breakdowns of the figures must be taken into account in the interpretation.

10–15% of children and 20–25% of young people have mental disorders. Although there are indications of an increased anxiety and psychological strain, especially among students, there has been no significant increase in psychological disorders in recent decades. Instead, there has been a significant increase in referral to specialised medical care services and appointments. (Ranta et al., 2018; Huikko et al., 2017.)

In 2017, approximately 9% of children under 13 years of age and 17% of children aged between 13 and 17 who were receiving either outpatient or in-patient psychiatric care were not living at home. One in three children and over half of 13 to 17-year-olds living in state-run care facilities or in foster care were also a patient in adolescent psychiatric services (Heino et al., 2018). These figures also indicate the need to examine the organisation of services as a whole and the need to assess the coordination and timeliness of services.

In practice, no party is responsible for promoting the mental health of children and young people, preventing disorders and treating them as a whole, and it is not led by any party. Basic services are still too fragmented in terms of structure and functionality, and no effective methods suitable for the baseline are in comprehensive use throughout the country. The criteria for non-urgent treatment define treating mild and moderate mental disorders as the basic-level task. However, health centres which are legally responsible for this do not have the necessary operating structures and models or the human or competence resources. School physician and psychologist resources are also insufficient in many municipalities. (Aalto-Setälä et al., 2019.)
The number of outpatient visits to adolescent psychiatric services in specialised medical care has increased in all regions. At the same time, fluctuation between the regions has increased. Development of the whole country is represented by a line, and regions are indicated with circles. The number of outpatient visits has been proportional to the population aged 13–17 in the region and is reported as a number per thousand people of the same age.

**Increased psychological strain of students tests the adequacy of services**

The municipality is responsible for student health care services for secondary level students, which include early detection of mental health disorders and substance abuse problems as well as basic care. The reports state that health care services in student health care are not provided as a uniform entity in all municipalities, and there are shortcomings particularly in the organisation and availability of mental health and substance abuse services. There is also room for improvement in the competence and resources of student health care. In the background, there are similar problems as in basic mental health services for children and young people. (Aalto-Setälä et al., 2019.)
Mental health, substance abuse and social services for adults

In particular, the availability, accessibility, effectiveness and quality of basic substance abuse and mental health services vary in different regions of the country. In addition to sufficient and correctly targeted resources, it seems necessary to clarify the responsibility for care and coordination, strengthen the cooperation models of different actors, improve the availability of effective psychosocial services and increase basic level competence. In connection with the transfer of basic income support from municipalities to Kela (Sosial Insurance Institution), accessing substance abuse and mental health services could also become more difficult as the connection to the social and health care services system deteriorated.

The Kela transfer of social assistance unified the grounds for granting basic social assistance – preventive and supplementary social assistance compensate for the deterioration of means-testing to varying degrees

The processing and approval of basic social assistance applications and the related payments were transferred from municipalities to Kela in early 2017. Compared to the previous year in 2017, the number of households and persons receiving social assistance increased by approximately 17%. In connection with the reform, the number of households receiving supplementary social assistance granted by municipalities decreased by approximately 25 per cent after certain shares were transferred to be paid from basic social assistance. On the other hand, the number of households receiving preventive social assistance increased by approximately 20 per cent in connection with the change.

The audit report of the National Audit Office of Finland (VTV, 2020) states that the transfer of basic social assistance to Kela met the objectives for those customers of social assistance who do not need special services and whose application does not require special means-testing. However, the change weakened the connection between social work and the work for granting basic social assistance and complicated the referral to services of customers in need. Social assistance is a last-resort form of income security. The individual means-testing has not been sufficiently taken into account in legislation and the implementation of the reform. In this respect, electronic systems do not provide sufficient solutions.

As a result of the Kela transfer, the identification of the diverse problems faced by social assistance clients may have been impaired, as there was less contact with social work (Vaalavuo, 2016). For example, the use of social assistance for people aged 18–34 in the three municipalities of the Helsinki Metropolitan Area was clearly linked to mental health and substance abuse problems (Vaalavuo et al., 2020).

Fragmented and multilevel mental health services render it more difficult to access the services – in addition to the needs, operating models are also a factor behind regional differences in the use of services

Mental health services for adults are provided at the basic level in such areas as primary health care, occupational health care, mental health care units and penitentiary health care. Cooperation between basic mental health services and psychiatry in specialised medical care has been developed for a long time, and various regional solutions have developed in Finland.

In mental health disorders, the assessment of the patient’s need for treatment and the sufficiently rapid initiation of treatment still pose challenges in most of the country. There are few effective psychosocial treatments, such as short-term therapies, available at the basic level. There is room for improvement in the functioning of care chains, introduction of specialised medical care at basic level, consultation practices and basic level competence. (Suvisaari, 2019.)

In 2017, 559 outpatient visits to mental health services were made per 1,000 Finnish adults. Regional variation was great. There were also large differences in the use of psychiatric institutional care by region, especially in the age group of young people. In ten years, the number of institutional days in juvenile psychiatry (18–24 years) decreased by an average of 24 per cent in the whole country and by 36 per cent in adult psychiatry (25–64 years).
There is no equal access to services for substance abuse problems and illnesses

The system for substance abuse problems and illnesses is very fragmented and multilevel, and it is organised in many different ways. The services range from reducing harm to rehabilitation. System differences are reflected in the different availability of services. There are clear differences in the emphases of outpatient and institutional care in substance abuse treatment. In some regions, drug use is still hidden, and services have not been developed.

Early support services aimed at reducing adverse effects are insufficient, and the range of services is not sufficiently versatile. In particular, there is room for improvement in reaching marginalised and hard-to-reach substance users. Access to services is difficult due to their fragmented nature. Unused opportunities can also be found in cooperation between health and social welfare services and employment services.

Adverse effects of substance abuse are increasingly visible in social welfare and health care services

The total consumption and harmful effects of alcohol have decreased since 2008, but the positive development stopped in 2018. The adverse effects associated with substance use have also increased. The number of deaths due to alcohol was 7% higher than in 2017. In 2018, 133 more people died of alcohol-related causes compared to 2017. 188 people died of drug poisoning in 2018, which is 13% more than in 2017. The increase in deaths in the youngest age groups is worrying. (THL, 2020c.)

Between 2014 and 2018, the number of outpatient visits to specialised medical care, related to alcohol-related diseases, increased by 18 per cent, and the number of patients increased by approximately 16 per cent. In the same period, the number of treatment periods where alcoholism was the main diagnosis increased by less than three per cent; correspondingly, the number of patients treated for alcohol-related illnesses in inpatient wards fell by approximately two per cent and the number of their treatment days fell by more than one fifth. (THL, 2020c.)

Between 2014–2018, the number of outpatient visits to specialised medical care, related to drug-related diseases, increased by approximately 23 per cent, and the number of patients increased by approximately 33 per cent. In the same period, the number of treatment episodes where drug-related disease was the main diagnosis increased by almost 63%; similarly, the number of patients treated for drug-related diseases in inpatient wards increased by approximately 71% and the number of their treatment days increased by approximately one third. (THL, 2020c.)

The costs of substance abuse are not limited to the costs of the special services

In 2018, the share of special services for substance abuse was only one per cent of the net operating costs of social welfare and health care activities. However, some of the costs arising from mental health disorders and substance abuse disorders are allocated to specialised medical care, primary health care and social services. In addition to social welfare and health care services, the costs incurred by society from the use of intoxicants consist of social security, pensions and sickness benefits, maintaining order and safety, and the costs of the justice system and penitentiary care. (THL, 2020c.)
Services for persons with disabilities

The total number and costs of services granted to persons with disabilities are on the increase. The share of transport services of all transport services, granted under the Social Welfare Act, has decreased. The regions are divided into two groups based on the development of transport services under the Social Welfare Act. The number of persons receiving transport services under the Disability Services Act has also decreased, but the costs have remained the same. Clearly, more than half of the transport services provided under the Disability Services Act have been granted to elderly people. Disabled people’s sheltered housing has become more common in recent years. Long-term institutional housing for persons with intellectual disabilities has decreased dramatically and has been replaced with various housing services. The clear focus of housing services is on units providing 24-hour care.

The social welfare and health care services needed by persons with disabilities are primarily organised as part of the general service system, i.e. the starting point is general services intended for all. If these are not sufficient or suitable for the needs, the services will be supplemented on the basis of the Disability Services Act and the Act on Intellectual Disabilities. The better the environment and services address people’s different functional limitations, the less special services are needed (Sirola & Nurmi-Koikkalainen, 2014). The number of users of special services for persons with disabilities is estimated at 100,000 to 110,000 (Nurmi-Koikkalainen, 2013).

The number and costs of services provided on the basis of disability are increasing

A total of 188,500 customer-specific decisions were made on disability services; the differences in proportion to the number of inhabitants are approximately double between regions. Since 2015, the number has increased by approximately three per cent, although there is a dispersion between the regions. However, this number does not reflect the number of individuals, as one person may have access to several different services. In 2018, the average expenditure per inhabitant for services and financial support measures under the Disability Services Act was EUR 128; the differences between regions are approximately triple at their largest. Compared to 2015, expenditure has increased in almost all regions, with an average increase of 13%.

The number of people using transport services has decreased

In terms of customer numbers, the transport service is the largest service under the Disability Services Act. In 2018, some 96,000 customers benefited from transport services for severely disabled people; the number has decreased in almost all regions by an average of four per cent. Of the service recipients, two out of three had reached the age of 65; the share has remained the same in recent years. In 2018, the average cost of transport services was EUR 28 per inhabitant, although regional differences are more than double. However, the cost level has remained the same compared to 2015.

Approximately 19,500 customers received services supporting mobility in accordance with the Social Welfare Act; the number has decreased by an average of 10 per cent. However, around half of the regions have seen an increasing trend. These transport decisions accounted for 17% of all transport service decisions, which has decreased by 1% compared to 2015.

Less subsidised forms of housing within the disability services have developed slowly

Sheltered housing for people with severe disabilities was organised for some 6,800 clients; the number has increased in almost the entire country, with an average of 19 per cent.

Under the Act on Intellectual Disabilities, a total of approximately 12,400 clients received housing services in 2018; the number has increased in almost the entire country by an average of 10 per cent. The majority (70%) of clients benefiting from housing services received services in which the help and support of professionals is available 24 hours a day (assisted housing); the share of clients of all those receiving housing services has remained almost the same compared to 2015. The rest (30%) of clients benefiting from housing services received services
Services for persons with disabilities

in which the help and support of professionals was available during the day, and services which are targeted at those who manage their daily lives fairly independently. Approximately one half (51%) of the clients of assisted housing receive their services from a unit maintained by organisations or private service providers; however, the regional variations are significant.

The number of people living in institutions for the intellectually disabled has halved since 2015; at the end of 2018, there were 521 long-term clients. The direction of the development has mainly been the same in all regions.

Despite the discontinuation of long-term institutional care, the costs of disability services have increased

The total net operating costs of disability services in Finland totalled approximately EUR 1.9 billion. Since 2015, the costs have increased by EUR 215.7 million (+ 13%). The largest costs, approximately one billion euros, was accumulated from other disability services, including supported and guided housing, personal assistance and transport services under the Disability Services Act as well as sheltered housing. The second-largest costs were incurred from housing services for 24-hour care, EUR 772.2 million. The total costs of institutional care totalled EUR 121.7 million.

Since 2015, the costs of institutional care have decreased by a total of EUR 36.8 million (-23%, a range of -68–15%); however, in four regions, the costs have increased. The costs of housing services for 24-hour care (assisted housing) have increased by EUR 107.1 million (+ 16%, range -3–27%); there has been an increase throughout the country, with the exception of two regions. The costs of other disability services have increased by a total of EUR 145.3 million (+ 17%, range -3–31%); the trend has been increasing with the exception of one region.
Services for the elderly

The number of elderly people living at home has increased. The number of people receiving regular home care has remained the same as the number of patients receiving 24-hour care. Intensive home care has become more common, although the publicly funded services supporting living at home have developed with some difficulty. The availability of services supporting home care varies significantly by region. The majority of personnel in the services for elderly people work in the 24-hour care services, although the majority of the clients are cared for at home. Family care is increasingly offered, but the client numbers are still small. Enhanced sheltered housing has become more common, particularly in the care of elderly people with memory disorders. While technology is increasingly used in services, there are considerable differences between regions.

Despite the priority of living at home, home care has developed with some difficulty

In 2018, nearly half a million elderly people aged 75 or over lived at home. The relative share of those living at home has remained almost the same in recent years, and in some regions, it has even decreased. Three out of four (75%) of those aged 75 or over living at home did not receive any regular support or service. Only one in five regions has made decisions on new solutions for housing for elderly people (THL. Vanhuspalvelujen tila 2018).

Some 56,400 elderly people received regular home care. Although the regions differ, overall, the number of those benefiting from home care and their relative share have remained fairly stable. One in five elderly people receiving regular home care are visited 2–3 times a day. The relative proportions of clients in need of many services have increased in almost every region.

Third of the personnel for the services for the elderly work in home care. However, the differences between the regions are almost double. The share of home care personnel has increased in almost all areas, and the rehabilitation resources of home care have also increased since 2014. However, more than half of the home care units do not have any physical therapists, occupational therapists or geriatric nurses. (Penttinen et al., 2018.)

Some 100,000 elderly people received support services, such as meals, transport and bathing services. The number has increased only slightly, and at the same time, the relative share of the recipients has decreased slightly. 70% of home care units received home hospital services and 61% received 24-hour consultations with doctors. Nocturnal home care was provided by two out of three units, but there are significant regional differences. Approximately one out of three home care units said they needed additional training in end of life care, and approximately one out of three units has a home care team for palliative care. (THL. Vanhuspalvelujen tila, 2018.) There was considerable regional variation also in the pain management competencies and the operating practices of systematic medical examinations (STM, 2019).

Informal care supports living at home

Approximately 25,000 elderly people received support through informal care by a spouse or other close relative; the number has increased by approximately 2,400 people (10%), although the regions have developed at different rates. Approximately half of the areas were below the 5% coverage of informal care. Informal care and the availability of home care for informal care patients vary considerably by region (Kehusmaa et al., 2019). Approximately 1,200 elderly people received family care; the number has increased by approximately 800 people. However, the development of the regions is different; according to statistics, there are no family care clients in two regions. Half of the patients were in short-term family care. (THL. Omais- ja perhehoidon kysely OMPE, 2018.)

Technology supports the coping of elderly people and the personnel

Approximately half (45%) of the home care and ordinary sheltered housing units used technological solutions which increase the customers’ independence, such as video calls and well-being bracelets. Almost half (41%) of home care units used remote or virtual care via a computer, tablet or phone; on the other hand, only half of all home care visits were made remotely. However, the differences between regions in the coverage of the technologies used for home care are significant. (Hammar et al., 2018.) The use of contact devices facilitating the work
The number of elderly people is increasing most strongly in growth centres. In these regions, changes challenge social welfare and health care providers to respond to the increase in care needs in the next few years.

Systematic service needs assessment helps target services throughout the customer relationship

In total, nearly 40,000 elderly people received enhanced sheltered housing; the number has increased both in terms of numbers (13%) and proportionally (0.5%), and there has been an increase in almost all regions. Half of them live in a unit maintained by an organisation or a private service provider. There are major differences between the regions. Nearly all (95%) of the residents of enhanced sheltered housing who had been subjected to a RAI assessment had a memory disorder.

Only approximately 5,400 elderly people (1.1%) received long-term institutional care. This figure has been halved since 2015, and the trend has been the same in all regions. According to the working group discussing the grounds for long-term institutional care for the elderly, 0–1% of the population aged 75 or older need long-term institutional care on medical grounds (STM, 2017). The total share of those receiving 24-hour care has remained almost the same.

Regionally centralised counselling and customer guidance have mainly been developed at the municipal level; there are five units covering the entire region (THL. Neuvonnan ja asiakasohjauksen toimintayksikkökosyely, 2018). The systematic assessment of the service needs of clients who already receive regular services, together with the uniform criteria for granting services, also supports the equal availability and effectiveness of services. One of the most commonly used evaluation methods is the RAI system. In 2018, approximately 35% of home care and 40% of 24-hour care clients were assessed. According to information published in January 2020, RAI instruments are used in 176 municipalities (60%). (THL. RAI-järjestäjätietokanta.)
Housing service costs of 24-hour care have increased considerably compared to home care

The total net operating costs of services for elderly people amounted to approximately EUR 3.5 billion. The costs have increased by 6.8% since 2015. The largest costs were incurred from housing services for 24-hour care, EUR 1.7 billion, and the second-largest from home care, approximately one billion euros. The costs of other services for elderly people, including ordinary sheltered housing, support for informal care and family care, totalled EUR 450.6 million, and the costs of institutional care totalled EUR 362.7 million.

Since 2015, the costs of institutional care have decreased by one third, totalling EUR 197.8 million, and the costs of 24-hour care housing services have increased by EUR 263.5 million (18%). The developments are similar in all regions. Home care costs have increased by approximately 10 per cent, and in practice this increase applies to the whole country. The costs of other services for elderly people have increased by EUR 64 million (17%); however, in five regions the costs have decreased.
Methods and quality description

A national expert evaluation of social welfare and health care services brings together regional expert evaluations’ observations to create a situation picture of the whole country. The 2018 regional evaluations have used the regional division of hospital districts. In the national expert assessment, the name of the region refer to the geographical area of the hospital district. The social welfare and health care cost-effectiveness indicators (KUVA) have been used as the main source of information for the evaluation. The assessment has been deepened by using reports from the authorities and research institutions as well as the service organisers’ planning and decision documents in regional assessments. A large group of experts from the Finnish Institute for Health and Welfare has been indirectly involved in the assessment.

The assessment is mainly based on publicly available information. Data sources not included in the indicators are mentioned in the text and are referred to in a separate reference. Materials which are not openly available are described below.

National cost-effectiveness indicators and Data Window

The national cost-effectiveness indicators are a collection of some 540 indicators formed by the Ministry of Social Affairs and Health and a large group of experts (Hämäläinen et al., 2019). There are approximately 450 indicators of the collection in production. An expert group set up by the Ministry of Social Affairs and Health is in charge of the maintenance and development of the indicators. The group comprises experts in evaluation, statistics and steering as well as representatives of the regions.

All indicator values of the cost-effectiveness indicator collection are presented in the user interface developed for this purpose, the Data Window. The Data Window extracts indicators in the cost-effectiveness indicator collection from the statistical service and indicator bank Sotkanet (sotkanet.fi) by region. The indicator data will be updated all year round as the data sources update. The objective is that the indicator data used in the evaluation be reliable and up to date. Delays in the annual update of indicators are often due to difficulties in data transmission. Indicators based on survey data are usually updated every two years.

Unpublished sources

Regional cost forecasts for social welfare and health care services 2017-2030

In Finland, the cost development of social welfare and health care is assessed using the growth model for social welfare and health care expenditure (SOME model), which has been regionalised in the Finnish Institute for Health and Welfare. The assessment covers key service forms in institutional and outpatient care as well as different forms of basic health care and specialised medical care. The assessment of the regions’ cost development has focused on the impact of demographic development. The model does not take into account productivity developments or inflation. In the calculation, the costs arising from different services and measures are allocated to the annual age groups of men and women, in which case the population forecast can be used to estimate how the volume of services will develop in the future. The calculation is based on the assumption that the distribution of expenditure within each age group will remain similar, but when the size of the age groups changes according to the population forecast, the total costs of services will also change.

Occupational health care client numbers

The estimate of client numbers in occupational health care is based on the Activities and Quality of Occupational Health Care in Finland 2018 survey by the Finnish Institute of Occupational Health. The Finnish Institute of Occupational Health has provided the Finnish Institute for Health and Welfare with information on client numbers with the regional division of hospital districts, in which the numbers are proportional to the working-age population of the regional.
Methods and quality description

Share of services for elderly people and subjects of RAI evaluations

Data based on the Status of Services for Elderly People survey has been used in the assessment of the services for elderly people. Information on the activities of home care and 24-hour care units has been published in the statistics service of the Finnish Institute for Health and Welfare by region. The figures with the regional distribution of hospital districts have been submitted to the evaluation unit. The same applies to the number of people of a similar age (aged 75 or over) evaluated using RAI instruments. The indicator data is based on the RAI benchmark development data submitted to the Finnish Institute for Health and Welfare. The information is not publicly available.

Restrictions on the quality of data sources

The quality and coverage of the data in the care notification system’s three registers (register of social welfare care notifications, register of health care notifications and register of outpatient care notifications in primary health care (Avohilmo) vary by region. This may be affected by various record-keeping practices and technical problems in transferring data to the Finnish Institute for Health and Welfare. The reliability of the statistics on the operation of social services is also influenced by the accuracy of the information submitted. Some deliveries are known to be inconsistent with statistical definitions, in which case the information also includes other operational data. The reliability of the survey-based operational statistics is influenced by the response activity of municipalities: if large municipalities do not report their operational data, this affects the proportional demographic figures of the indicators and distorts comparison between regions. Annual quality reports for each data collection are available on the website of the Finnish Institute for Health and Welfare.

The materials of the FinSote surveys are only available by counties. In addition, surveys have regional constraints due to coverage of responses. If the constraints are significant, the information has not been used.
Sources and background material used in the assessment

The Data Window indicator data interface used in the assessment

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