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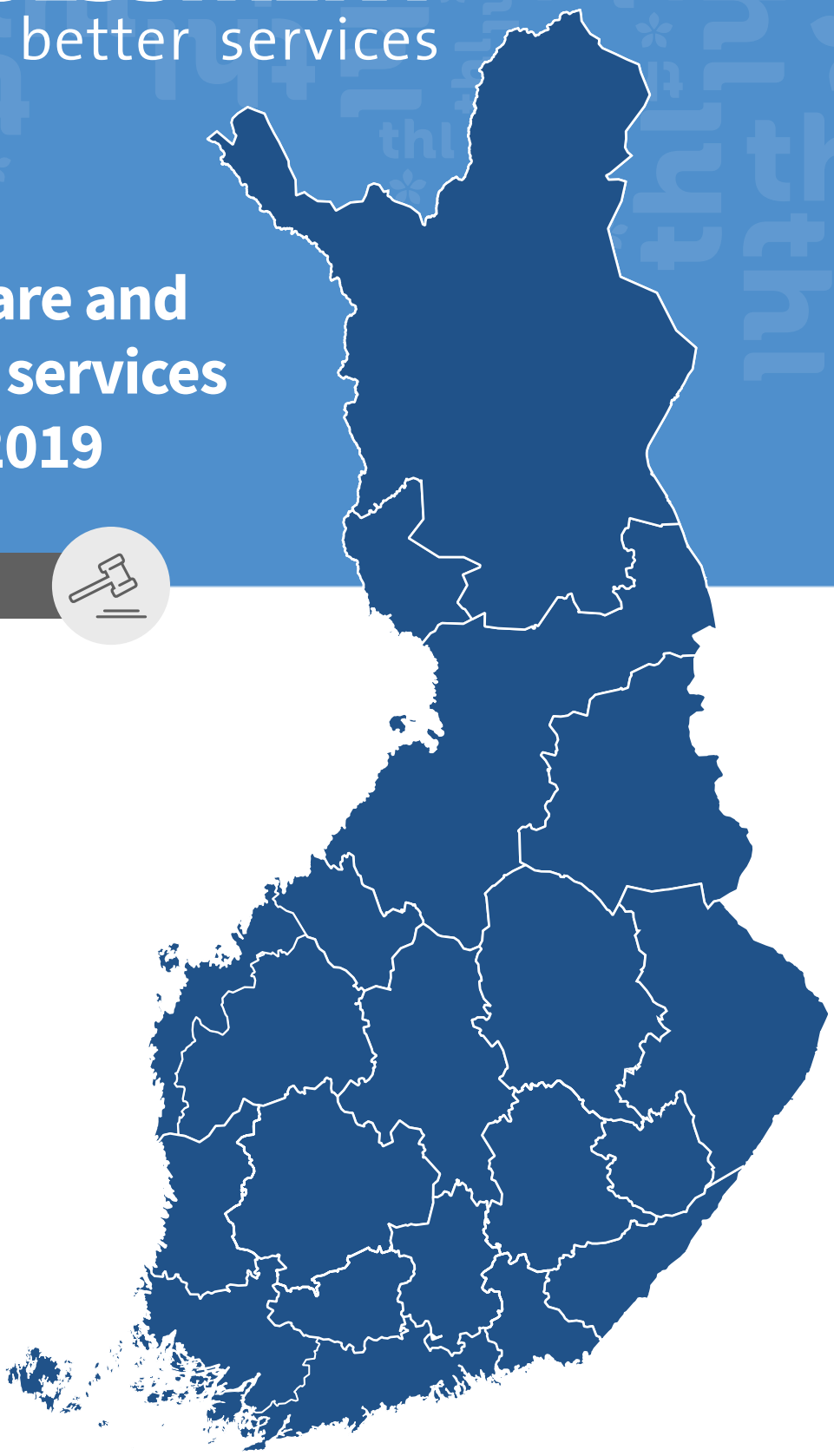
Social welfare and health care services in Finland 2019



POLICY BRIEF 2/2021

Expert evaluation

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Introduction

In 2017–2020, the Finnish Institute for Health and Welfare assessed the current state of social welfare and health care provision by region and nationally by commission of the Ministry of Social Affairs and Health. In the government proposal submitted to the Parliament on 8 December 2020 (HE 241/2020 VP), the task of assessing the organisation of social welfare and health care services in future well-being areas is laid down as a statutory task for the Finnish Institute for Health and Welfare.

The services examined in the evaluation concern themes of national importance and current issues. Mental health disorders have become a public health challenge, and the crisis of care for elderly people has highlighted the problems of both private and public sector operators in services for elderly people.

The purpose of this evaluation is to deepen the understanding of the availability and quality of basic mental health services and the successful coordination of services for elderly people and health services as part of the national social welfare and health care system. This follow-up evaluation describes changes made or planned in our country and the development measures to improve the availability and quality of basic mental health services. In addition, actions to coordinate services for elderly people and health services will be examined.

The national situational picture is formed by combining the situational pictures of the different regions in the country. In addition, reports and studies carried out in 2019 and 2020 have been utilised.

The ongoing projects of the Social and Health Centre of the Future programme and the restructuring programme supporting it will develop both basic social services and health services. The programmes aim to reform the operating methods of social welfare and health care and to develop customer-oriented service entities. These development projects continue to balance regional disparities and move the regions towards more integrated operating models.

The national evaluation of the availability and quality of basic mental health services and the coordination of health services and services for elderly people is aimed at supporting national and regional decision-makers, office holders and experts.

In Helsinki, 9 March 2021

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Expert evaluation

Ageing population and increasing concentration in growth centres

The Finnish population is ageing rapidly. According to the forecast, one in seven Finns will have reached the age of 75 in 2030. At the same time, the population is declining almost throughout the country, and more and more areas occupied by elderly people will develop in Finland. There, in addition to increasing service needs, the development of tax revenue will be poor. The largest population growth is recorded in Uusimaa, where the number of foreign-language speakers will also increase in the coming years.

Mental illnesses have become the most common reason for retiring to receive disability pension, and the percentage of working-age people who have received sickness allowance for reasons of mental health has also increased throughout the country. In the future, the increase in the number of elderly people will further increase the need for services related to morbidity and the pressure of rising social welfare and health care costs. In 2019, the net operating costs of social welfare and health care services increased more sharply than in previous years. In particular, the costs of specialised medical care increased more rapidly than in previous years.

The financial situation of municipalities deteriorated to a record low in 2019

In recent years, the weakening of municipal finances has accelerated the need for municipalities and joint municipal authorities to adapt the economy. In 2019, the financial situation of municipalities was at a record low, which made it difficult for municipalities to finance social welfare and health care services. Only one in five municipalities had a balanced economy; two years earlier, the economy was in balance in more than 80 per cent of Finnish municipalities. The smallest municipalities are in a particularly difficult situation.

The finances of hospital districts have also deteriorated rapidly. In 2019, the result for the financial year was negative in 15 hospital districts. Two years earlier, the result was negative in only three hospital districts. The hospital districts' finances have also been strained by the prolonged and busy hospital construction and renovation debt. Information system projects that enable knowledge-based management, integration and customer inclusion are also under way in different parts of the country as required by the social welfare and health care services reform. In recent years, Apotti, the largest ongoing information system project for social welfare and health care, has gradually expanded in the Helsinki and Uusimaa region.

Consistent operating models and processes have been actively developed

The number of basic social welfare and health care service providers has decreased in recent years, and the number of integrated joint municipal authorities for social welfare and health care, based on voluntariness, has increased. In administratively integrated areas, the coordination of services is more visible than in other regions as target-oriented efforts to harmonise operating models and promote smooth cooperation between basic and specialised levels. For example, palliative care and terminal care provided in services for elderly people both at home and in residential service units is implemented more equally from the perspective of the population, as the services are organised by a single operator in the area on the same principles and operating models. It also appears that in areas administered by regional joint municipal authorities, the network of hospitals-at-home is geographically more comprehensive, and the specialised-level consultative support for the basic level is smoother. However, there are also areas in the country with several providers where staggered care, service chains and consultation practices are functional and the joint training of professionals strengthen the coordination and customer-orientation of the services. In order to ensure equal services in these areas, there is need for increasing amounts of joint development.

In integrated areas, a common knowledge base streamlines operations and also enables better knowledge management. In areas where the provision of services is more fragmented, the information system entity is also more fragmented. Knowledge management in these areas is hampered by an incomplete view of the regional service package and the lack of common monitoring indicators.

Problems with the availability of personnel have expanded to several professional groups

The growing challenge of the service system is that the availability of social welfare and health care personnel is becoming more difficult in an increasing number of professional groups. For example, the development of the personnel structure of services for elderly people has not fully followed the change in the service structure. Medical expertise and expertise in nursing are insufficient. Home care and services to be taken home have been strengthened in line with national objectives, but at the same time, customers in home care are increasingly difficult to treat, as service criteria have become stricter in many areas. In relation to the customers' service needs, the number and competence of the personnel are inadequate in many places.

The lack of senior specialists in mental health is also common. In particular, there is a shortage of psychiatrists, psychologists and psychotherapists. This makes it difficult both to achieve an appropriate division of labour between different professional groups and to develop services.

The structure of basic mental health services is fragmented, which impairs the equal availability and quality of services

The range of mental health services, operating methods, resourcing and competencies vary considerably between the regions, particularly for services for children, young people and families. In many places, the deficiencies of the services also impair the timeliness of care. As the start of care is delayed, problems are often aggravated. In fact, the need to strengthen seamless care chains and service entities has been identified nationally in order to ensure that care and services progress without interruptions from the customer's perspective and without work overlapping for different professionals from the organisational point of view. By allocating resources to preventive and low-threshold services, a customer-oriented approach and clear service processes, even a small contribution can help improve effectiveness. In the longer term, they will reduce the total costs of social welfare and health care services.

Boundaries that hinder the functioning of service entities can be identified particularly in areas where the provision of services is distributed between several operators. Fragmentation of services also undermines the functionality and continuity of basic and specialised care chains. Special-level support to the basic level varies by region, and care chains have often been built from the perspective of the specialised level. This does not always meet the needs of basic-level operators and does not safeguard the timeliness and continuity of customer care.

In the coming years, there will be an increasing need for strengthening mental health services. Despite differences in administrative solutions, the regions have a coherent objective of shifting the focus of services to the basic level, increasing coordination between basic and specialised levels, strengthening early support and increasing evidence-based interventions. Confirmation of the functionality of the mental health services as a whole has been sought by means of customer and service guidance, by increasing competence, introducing specialised services to the basic level, taking possession of service packages that require many different services, by means of multidisciplinary customer plans and knowledge-based management. Family centre models have already moved forward in all areas, and family meeting places and early support have also been increased.

The use of technology has become more common in mental health services. New digital services and their extended use have been able to reduce regional differences in access to services due to geographical distances and the availability of professional staff.

There is no equal access to services for elderly people, but they are moving in the right direction

Services provided in homes and residential service units are not available on an equal basis. There are differences both between regions and within them, and also between different units operating in the same municipality. Equal access to services is most likely in administratively integrated areas. On average, the net operating costs of services for elderly people increased by approximately 2 per cent from 2017 to 2019 in proportion to the population of a similar age. The cost development of services differed between integrated and non-integrated areas. In areas with regional providers, these costs were mainly reduced, particularly in 24-hour residential services.

In 2019, an exceptionally large number of reports on irregularities concerning institutional housing and home care for elderly people were submitted to the supervisory authorities. Several decisions to suspend the operation of private assisted living units were made. The shortcomings observed in monitoring were related to, for example, medication safety, the organisation of health care services and the adequacy of personnel in relation to the customers' service needs. These reflect the inadequacy of both health care competencies and the coordination of health services and services for elderly people.

The diversification of assisted living service units poses a challenge to production control. The unambiguous interpretation of the number of carers applies to enhanced assisted living only. The fragmentation of the service system and the shortcomings in the legislation steering the services are thus an obvious risk to the equality of services, and they also undermine the confidence of the service users and their family members in the service system.

Population and the operating environment

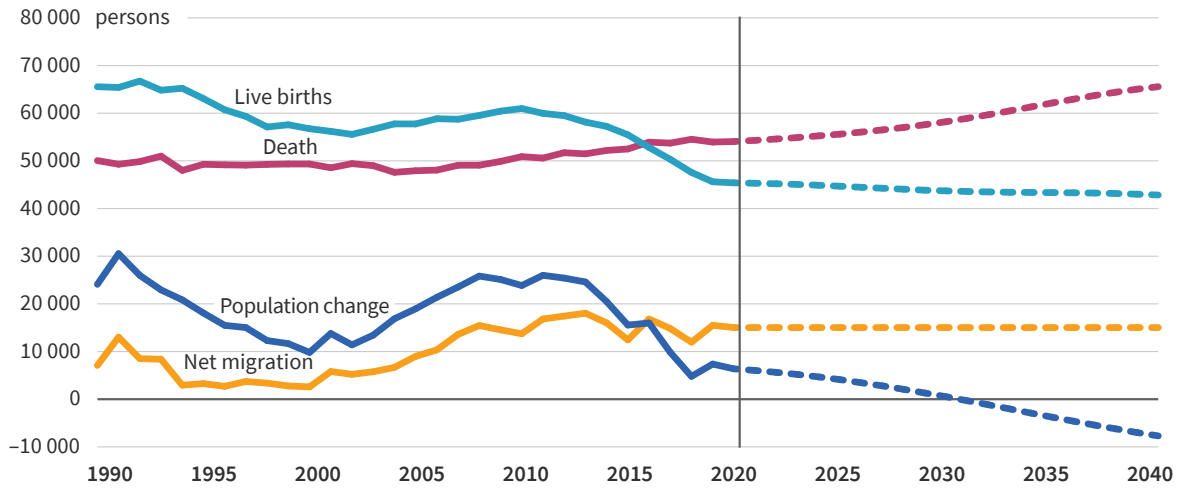
Population

Population growth focuses on the largest cities

In 2019, there were 5.5 million inhabitants in Finland, and the population increased by 7,300 people. Population growth was hit by the lowest birth rate in history and an increase in mortality.[1] The population grew in the hospital districts of Helsinki and Uusimaa, Pirkanmaa, Northern Ostrobothnia and Southwest Finland, and decreased in 15 areas. The population in Helsinki and Uusimaa increased mainly due to the increase in the number of foreign-language speakers.

According to Statistics Finland's forecast, the population will decline in 2031 (Figure 1). According to the forecast, the mortality rate will exceed the birth rate in just over ten years in all municipalities.[2] Due to migration, the population is predicted to grow in 2040 only in the Uusimaa region. In the next few years, other major urban areas will also grow, but more moderately. The population will decline the most rapidly in areas with a large number of small municipalities.[3]

Figure 1. Population change 1990–2019 and forecast 2020–2040.



▲ The figure shows both actual and forecast data on live births, deaths, net migration and population changes between 1990 and 2040. The projected development is indicated by a dashed line. The figure is based on population statistics of Statistics Finland.

In Finland, preventable diseases kill more often than in other EU countries

The health of Finnish people has improved. Morbidity indices fell in all regions, and the number of years lost due to premature deaths was increasingly reduced. The population was healthiest in the hospital districts of Helsinki and Uusimaa, Vaasa, Pirkanmaa and Southwest Finland, and least healthy in the regions of North Savo, Western Ostrobothnia and Kainuu. The number of years lost due to premature deaths was highest in the hospital districts of South Savo, Kainuu, East Savo and Lapland, while it was the lowest in the areas of Vaasa and Central Ostrobothnia.

Finns died of treatable diseases less often than in other EU countries on average. Similarly, mortality due to preventable diseases was more common than average. Nearly 40% of deaths were due to poor lifestyles.[4]

Mental health symptoms and increasing excess weight and obesity threaten the health of Finnish children and adolescents

At the end of 2019, Finland had approximately one million people under the age of 18. The number of families with children has decreased in recent years. The number of children was largest and the birth rate was highest in Western Finland and Northern Ostrobothnia. More than a third of the children were born in the Helsinki and Uusimaa area. The number of children and young people was lowest in East and South Savo. Approximately one in ten children had a foreign background.[5]

Health inequalities between children and young people increased. Health was impaired by anxiety and depression symptoms as well as increased excess weight and obesity.[6] Approximately one tenth of school-aged children had a long-term illness or health problem.[7] The life expectancy increased by 5 years for boys from the beginning of the 21st century and by 3.5 years for girls.[8] The life expectancy of Finns exceeded the EU average. Life expectancy has improved thanks to reduced mortality due to cardiovascular diseases.[4]

Mental strain is also experienced by working-age and older people, and deaths caused by memory disorders increased

By the end of 2019, there were approximately 3.3 million working-age people, and the demographic dependency ratio was the highest since 1922.[9] Despite the improved health of the working-age population, almost one third considered their working capacity to be impaired and doubted whether they could work until retirement age. Finns were most likely to retire to receive disability pension due to mental health and behavioural disorders. Socio-economic status affects the feeling of being in good health and functional capacity.[10]

In 2019, approximately 1.2 million Finns had reached the age of 65. Half of them were at least 75 years old. The proportion of elderly people was highest in East and South Savo, Kainuu and Kymenlaakso. The number of people aged 75 or over is projected to increase by just under 300,000 in ten years. By 2030, the number of elderly people will increase most sharply in the Helsinki and Uusimaa regions. In areas where there is already a large number of elderly people, the number will increase more moderately.[11]

Almost half of the elderly people considered their state of health to be medium or poor. Their perception of their health and quality of life deteriorated as they aged, and the number of people satisfied with their quality of life also decreased. Almost one tenth were mentally stressed, and feelings of memory degradation increased. Almost half of those aged 65 or over had one long-term illness, and one fifth had several. Deaths associated with memory disorders have become more widespread.[4]

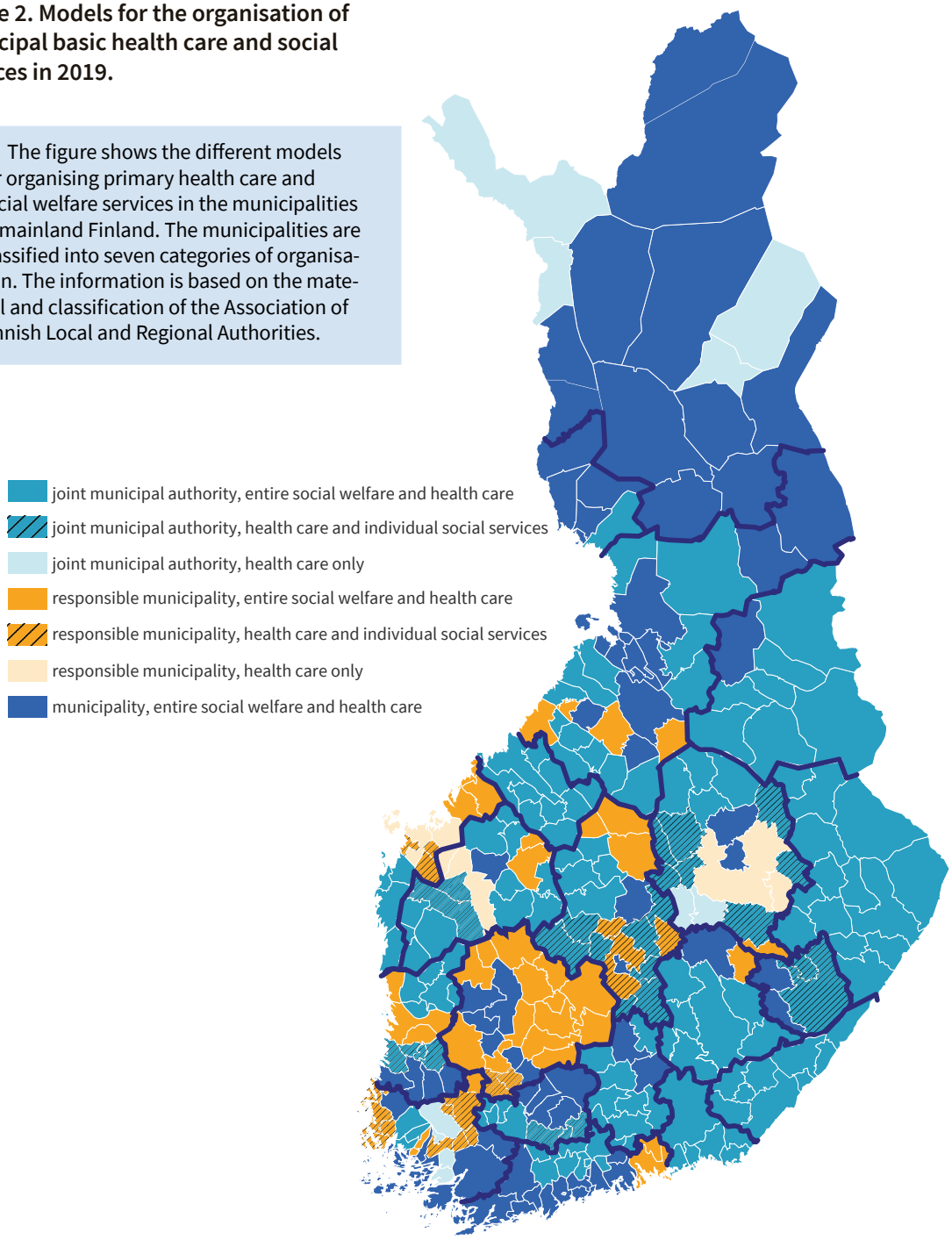
Operating environment

Finland's public social welfare and health care service system secures services for all residents.[12] Municipalities provide services mainly through tax revenue. The use of services and the loss of earnings caused by an illness are compensated from health insurance.[13] Public services are complemented by services provided by private service providers and organisations, which can also be obtained by municipalities where necessary. Employers are obliged to organise for their employees free occupational health care services, which cover the majority of working-age people. Both public and private service provision is supervised by Valvira National Supervisory Authority for Welfare and Health and regional state administrative agencies.

The reform of the service system has become topical due to, among other things, increased costs and productivity requirements, as well as problems with uniform availability and quality. Customer requirements have also increased. Legislation has enabled the creation of several provider parties, which has led to the fragmentation of services.

Figure 2. Models for the organisation of municipal basic health care and social services in 2019.

▶ The figure shows the different models for organising primary health care and social welfare services in the municipalities of mainland Finland. The municipalities are classified into seven categories of organisation. The information is based on the material and classification of the Association of Finnish Local and Regional Authorities.



There were still many organisational models, and new joint municipal authorities were created

In 2019, the organisation of services was still fragmented in the majority of the country (Figure 2). Of the 295 municipalities in mainland Finland, 74 municipalities organised social welfare and primary health care services independently. The service was partly or entirely organised by 61 municipalities using the responsible municipality model. An increasing number of municipalities (160) were part of a joint municipal authority. The number of joint municipal authorities increased, and the number of other organisational models decreased.[14] The majority of joint municipal authorities organised social welfare and primary health care services for the residents of their member municipalities. There were just under ten joint municipal authorities covering an entire hospital district.[15]

In 2019, Kymsote, the Kymenlaakso Joint Municipal Authority for Social Welfare and Health Care, and the Central Uusimaa Joint Authority for Social Welfare and Health Care (Keusote) launched their activities. The country-wide joint municipal authority preparations were launched in the Ostrobothnia region.

The social welfare and health care reform and the regional reform promoted the regional development of services

The social welfare and health care reform and the regional reform launched in 2015 promoted the development of regional services by means of extensive national resources and strong steering. The objectives of the reform included reducing welfare and health inequalities, increasing the freedom of choice, safeguarding equal services and reducing costs. The objectives were pursued, for example, by separating organisation and production and using a multiple producer model. Integrated joint municipal authorities had an advantage in launching the social welfare and health care reform and the regional reform, preparing it and utilising its outputs. Preparation of the reform ended in spring 2019 with the resignation of the government.[16]

Completion of reports on the organisation of social welfare and health care services in the Uusimaa region and on the role of municipalities producing social welfare and health care services

A separate report on social welfare and health care services in Uusimaa, the Helsinki Metropolitan Area and Helsinki was completed in autumn 2019. In the report, a model was proposed as the basis for further joint preparation, in which four autonomous regions and the City of Helsinki would be responsible for organising social welfare and health care services in the area. Under the model, the activities of HUS Helsinki University Hospital would be organised in cooperation between the social welfare and health care providers in the area, and the status and responsibilities of HUS Helsinki University Hospital would be regulated by law.[17]

The role of municipalities as providers of social welfare and health care services was examined. In the reform, the responsibility for organising services would be transferred away from the municipalities. However, municipalities would retain the possibility of producing social welfare and health care services by establishing a service production company. According to the report, municipalities did not have a strong desire to provide social welfare and health care services.[18]

Progress was made in information system projects combining specialised medical care, primary health care and social welfare

In 2019, three significant information system projects were under way. The projects sought solutions for knowledge-based management, customer inclusion and integration of specialised medical care, primary health care and social welfare. The Apotti project (apotti.fi) progressed in the Hospital District of Helsinki and Uusimaa and in nine municipalities of the area. Apotti was introduced at the Peijas Hospital at the end of 2018 and subsequently at Vantaa social and health care services. The latest deployments in HUS Helsinki University Hospital and other municipalities will take place in 2021.

The Aster customer and patient information system (asteraptj.fi) included the hospital districts of Central Finland, South Savo, North Karelia and Vaasa. The introduction of the information system will take place between 2023 and 2025.

It was assumed that the rest of Finland would be the deployment area of the UNA Kaari project (unaoy.fi). In 2019, the project prepared an information system procurement. Commissioning is likely to begin in 2022.

The availability of qualified professionals is becoming increasingly difficult in all areas

Over the next ten years, a large number of municipal social welfare and health care personnel will retire. At worst, the percentage in the regions will reach almost 40%.[19]

The availability of qualified personnel was a problem in an increasing number of professional groups. All regions and services were affected. For customers, the shortage of staff was reflected in longer waiting times, reduced availability of services and quality issues. In particular, the availability of preventive and low-threshold services was impaired.

The lack of doctors impaired functional integration between specialised medical care and primary health care. The personnel shortage also impaired the integration between health care and social welfare. The situation was exacerbated by the cooperation procedures launched in some areas. The shared use of personnel was enhanced between primary health care and social welfare services as well as between primary health care and specialised medical care. In some areas, outsourcing was used to improve the poor availability of personnel.[20]

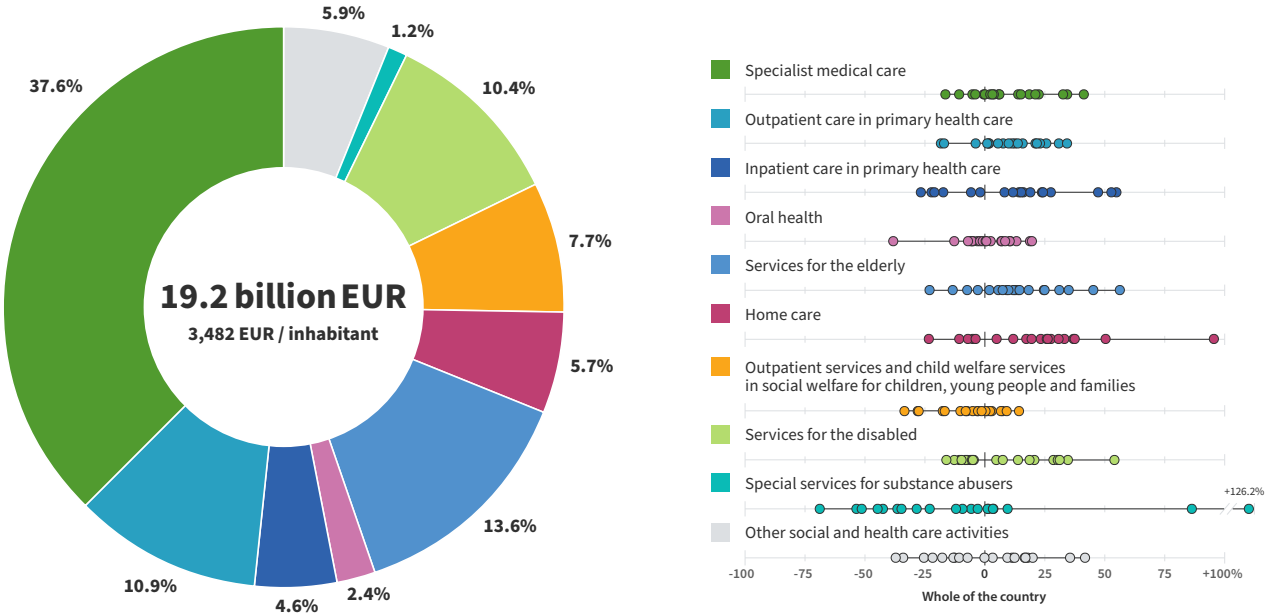
Social and healthcare services funding and costs

Municipal social welfare and health care costs increased in 2019 by almost a billion euros compared to the previous year

In 2019, the net operating costs of social welfare and health care services under the responsibility of municipalities amounted to EUR 19.2 billion, with an average of EUR 3,482 per inhabitant (Figure 3). In a comparison by hospital district, the largest net costs of social welfare and health care services were in East Savo, where they amounted to EUR 4,599 per resident.

In 2019, the net operating costs of social welfare and health care services in the entire country increased more rapidly than in previous years, by 5.1 per cent from the previous year. More than a third of the growth focused on specialised medical care. For several years, the share of social welfare and health care services in municipalities' net operating economy costs have been nearly 60 per cent.[21]

Figure 3. The distribution of the net operating costs of the social welfare and health care services in the whole country by function and the difference between the regions and the national average in 2019.



▲ The figure on the left shows the percentage of the net operating costs of the social welfare and health care services in 2019 for each task in the whole country. The data on the right depict the difference between the costs of hospital districts per inhabitant and the national average. The farther away from the middle of the line that the ball illustrating the area is, the smaller or larger the costs of the area compared to the average costs of the entire country.

Major regional differences in social welfare and health care costs

Between 2015 and 2019, the net operating costs of the entire country›s social welfare and health care services increased in real terms* by an average of 4.3 per cent. The smallest growth was recorded in South Karelia, Helsinki and Uusimaa and in North Karelia, where costs increased by less than 2 per cent. In 2019, the costs per inhabitant in North Karelia and South Karelia exceeded only slightly the national average. Given the large service needs of the population in the regions, the costs were among the lowest in the country. In North Karelia, the costs related to the need were the lowest in the country.[22] The net operating costs of social welfare and health care services per inhabitant in Helsinki and Uusimaa were low compared to the rest of the country, but the need for services was also lower than in the rest of the country. Considering the need for services, the costs were clearly higher than the average in 2019 in proportion to the population of Helsinki and Uusimaa.

The biggest increase in social welfare and health care costs was recorded in South Savo, Kainuu and Western Ostrobothnia in 2015–2019, where costs increased by more than 10 per cent compared to 2015. In 2019, the costs per inhabitant were among the highest in Kainuu, and the costs were also among the highest in the country when taking into account the need for services. In Western Ostrobothnia, the costs were also higher than the national average in relation to the service needs. On the other hand, in South Savo, where the population's service needs are the highest in the country, the costs were lower than the national average in 2019.[22]

In the cost development of social welfare and health care services and the level of costs in relation to the need for services, there are also signs of municipalities' ability to finance the services for residents in their area. For example, in Päijät-Häme, the costs of social welfare and health care services per inhabitant have increased moderately, and in proportion to the need, the costs have remained among the lowest in the country for several years. In Kymenlaakso, the increase in cost slowed down to a level slower than average during Kymsote's first year of operation in 2019. In these areas, the financial situation of municipalities has been difficult for a long time. The repeated postponement of the social welfare and health care reform and the poor economic situation in municipalities have prompted the regions to find new ways of organising social and health care services for their residents. According to a survey conducted by the Association of Finnish Local and Regional Authorities, a total of 26 out of 295 municipalities in mainland Finland had outsourced a significant proportion of their services to a private service provider.[23] The economic situation has also forced many regions to focus their activities on the organisation of mandatory statutory services.

The state of municipal finances deteriorated to a record low – in 2020, coronavirus subsidies brought temporary relief to the municipalities' financial situation

The increase in the number of elderly people and their percentage of the population will lead to greater social welfare and health care service needs each year. At the same time, municipal finances have continued to deteriorate, which makes it more difficult to finance social and health care services that meet the growing service needs of the population.

In 2019, the results of municipalities' results for the financial year deteriorated as operating expenditure increased more rapidly than their income. The operating margin for municipal finances decreased by approximately EUR 1.3 billion and the annual margin by approximately EUR 0.3 billion. The result for the financial year was in deficit in a total of 225 municipalities. Of the large cities, only Helsinki made a clear surplus. Of the annual margin of municipalities in mainland Finland, the share of municipalities in Uusimaa was almost 60 per cent.[24]

* The costs have been converted to 2019 levels using Statistics Finland›s public expenditure price index.[29]

The number of municipalities with a negative annual margin continued to increase rapidly. The annual margin was negative in 65 municipalities in 2019, with 44 the previous year. More than half of the municipalities with a negative annual margin were municipalities with fewer than 5,000 inhabitants. Based on the annual margin depreciation indicator, only one in five municipalities had a balanced economy in 2019; two years earlier, more than 80 per cent of the municipalities had been in balance.

The municipal loan portfolio continued to increase, to EUR 21.9 billion.[24] Because of the strong deterioration of municipal finances, municipalities were actively engaged in various economic adjustment measures. According to an annual report by municipal employers, 45 per cent of municipalities and joint municipal authorities had drawn up a multi-year programme for balancing the economy, and one in five municipalities and joint municipal authorities had held co-operation negotiations.[25] In addition, more than 50 municipalities increased their tax rate for 2020.

According to a report by municipal employers, in 2020 more than half of the municipalities and joint municipal authorities reported that they had held co-operation negotiations. However, the large, one-off coronavirus subsidies of approximately EUR 3 billion granted by the State and the increase in tax revenue turned the tide of municipal finances more positively than anticipated. According to the final accounts of municipalities, only two municipalities in mainland Finland had a negative annual margin. [26, 27]

Hospital districts' economy has deteriorated rapidly – hospital investments have significantly increased the loan portfolio

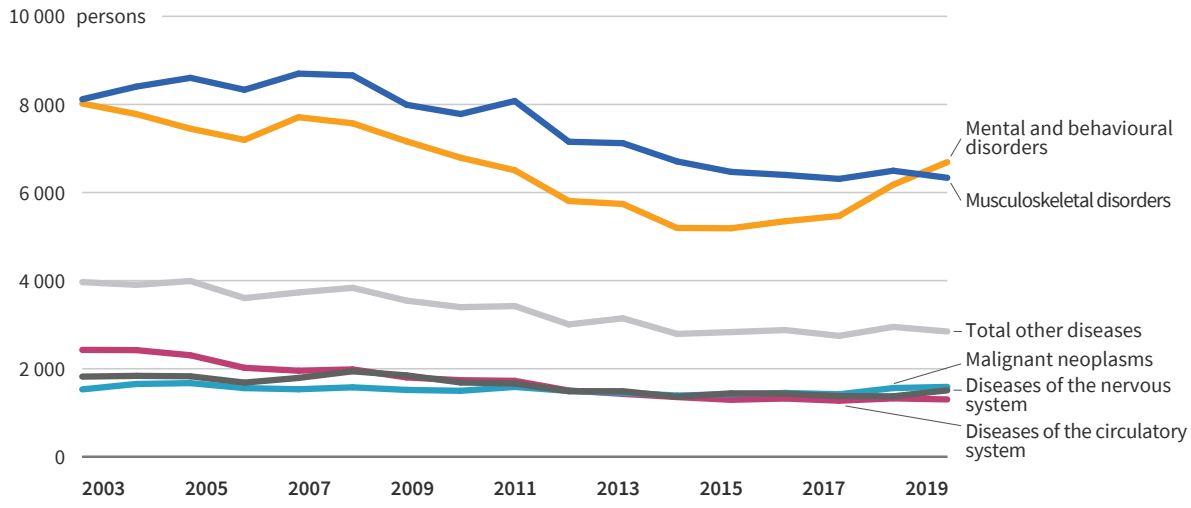
In the hospital districts, the economy has deteriorated rapidly in recent years. In 2019, the result for the financial year was negative in 15 hospital districts, and their total result was more than EUR 70 million negative. Two years earlier, the result for the financial year was negative in three hospital districts. The hospital districts' finances have also been burdened by the prolonged and busy hospital construction. In 2019, net investments in hospital districts increased by approximately EUR 135 million to more than EUR 870 million. At the same time, the loan portfolio of hospital districts increased by nearly EUR 680 million to more than EUR 2.7 billion in total.[24] In 2020, the prioritisation of coronavirus management was reflected in the financial situation of hospital districts, while non-urgent care was postponed depending on the epidemic situation in the areas.[28] The postponement of urgent care and the reduction in demand were reflected in many hospital districts as a reduction in fee income.

Access to and quality of basic mental health services

Physical health of the population has improved – mental disorders have become a public health challenge

For the first time in 2019, mental health reasons were the most common reason for retiring to receive disability pension (Figure 4). The aim of the national mental health strategy is to increase preventive mental health work and mental health skills and to improve mental health services that rehabilitate patients for working life. The availability of mental health services must be brought to the level of other social welfare and health care services. The basic level must have capabilities for the early identification of the most common mental health disorders and the use of treatment methods that have been found effective. Cooperation structures are also needed. In order to complement the services provided by the social welfare and health care centres, we need outreach and low-threshold services that work in everyday life and utilise peer support and types of operation offered by organisations.[30,31]

Figure 4. Those who retired to receive disability pension in 2003– 2019 according to the main illness group.



▲ The figure shows the number of people retiring to receive disability pension for various reasons, in accordance with the Pensions Act in 2003–2019. The figure is based on the employment pension statistics of the Finnish Centre for Pensions.

Responsibility for organising mental health services extends to services promoting mental health for the treatment of severe mental health disorders

Basic mental health services include mental health promotion services, psychosocial support services and, in accordance with the criteria of non-urgent care, primary care responsibility for the most common symptoms and disorders as well as severe disturbances at a stable stage.[32] This evaluation emphasises basic mental health services for children, young people and families, as the services are organised comprehensively throughout the age group. Basic mental health services for the working-age population are available in both primary health care and occupational health care, whose range of services varies and on which little information is available.

The basic mental health service system is fragmented – the services are not available equally to the population

Basic mental health services are organised in many different ways in the country. The interregional and internal review highlighted the variations in management, structures, service menus and resourcing, which does not support the equal availability or quality of the services for the population. In some parts of the country, structures and management had been changed, or change plans had been made.

All regions had a joint coherent objective of shifting the focus of services to the basic level, increasing coordination between basic and specialised levels, strengthening early support and increasing evidence-based interventions. The development of family centres had already made progress towards the objectives. Services for the working-age population were developed in, for example, work capacity projects.

Cooperation between basic mental health services and specialised medical care psychiatric services seemed uncoordinated, and the division of labour was not clear

The operators' shared care and service chains did not exist everywhere, or their embedding work had not been completed. The fragmented service structure on the basic level and variable resourcing made the functioning of the treatment chain more difficult. Special-level support for the basic level was partly inadequate, varying by region and often built from a special-level perspective, which did not support the customers' needs or the timeliness and continuity of treatment. There was not always a clear body responsible for the whole.

In some areas, care and service chain work has a long tradition, and cooperation between basic and specialised levels was successful. In such areas, the possibilities for consultation worked, the staggering of care was followed and the joint training for operators strengthened operational integration. This had made it possible to strengthen basic services and make more appropriate use of resources.

Lack of a common knowledge base and diverse customer information systems posed a challenge to knowledge-based management

Due to the lack of a common knowledge base, it was difficult to form a comprehensive picture of the state of mental health services at a regional level. For administratively integrated organisers, the region's shared knowledge base facilitated knowledge-based management, and the shared use of customer and patient data was flexible, which also supported equal access to services and the quality of services.

Increased use of technology in patient work and cooperation between professionals

E-services for customers had been introduced and planned for each provider. Examples of these include an electronic evaluation of the need for treatment, online therapies and video-mediated appointments. The Covid-19 pandemic in particular accelerated the use of remote services. In cooperation between professionals, electronic consultation and network meetings were utilised remotely. The use of digital tools to reform and harmonise operating practices is part of a multi-regional restructuring project.

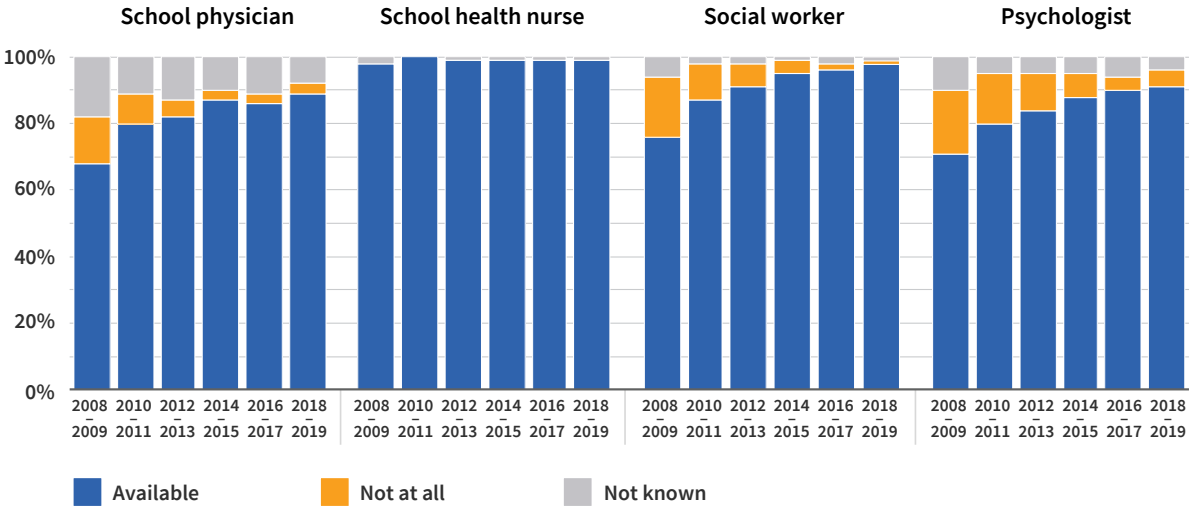
In connection with the most difficult mental health problems, remote services were found insufficient in monitoring the impacts of the spring 2020 pandemic, and the implementation of the services in digital form was not suitable for all population groups.[33, 34]

To be reinforced in early support services

Basic municipal services form the basis of mental health services for children and adolescents. In many areas, low-threshold mental health services for adolescents were available in a separate unit intended for young people. Student welfare services were available in an increasing number of schools, but in the academic year 2018–2019, medical services still were not provided or there was no information on their organisation in 11% of schools, there were no psychologist's services in 9% and only social services in 8%.[35] In addition, there were major regional differences in the preconditions and working methods of social workers and psychologists, which weakened the equality of services. [36, 37]

Low-threshold services for mental health disorders in adults and elderly people were provided by health centres, where the availability of services varied. They are often offered to employees by occupational health care, where the range of services is often broader than in health centres.

Figure 5. Student welfare services available in comprehensive school in 2008–2019, share of schools.



▲ The figure shows the share of comprehensive schools in which students have access to student welfare services. The data are described by professional group for the 2008–2019 academic years. The figure is based on the data of the Finnish Institute for Health and Welfare. [35]

The timeliness of services has been developed in many ways

The timeliness of the services had been improved by developing services without an appointment, by diversifying the contact channels and by using the services of psychiatric nurses, for instance in schools. Youth psychiatry services were brought closer to young people's living environment. The service was also provided at home. In some areas, child psychiatry and social work were performed jointly. In some locations, the services for children and young people had been reinforced on the single contact principle. In areas with long distances, local mental health services were partly extensive and well-resourced. In health centre teams, there were psychiatric nurses receiving patients without an appointment.

Competence should be increased and the use of evidence-based methods should be expanded on the basic level

The quality of the services is largely related to personnel competence. In many areas, mental health skills were reinforced by training staff on evidence-based and effective treatment methods. Especially in services for children and young people, these training programmes were under way.

Basic-level competence was strengthened in several areas by providing specialised-level services also on the basic level. In organisations where the basic and specialised levels were under the same management, specialised-level support was considered a success. Competence had been taken to the basic level, for example, so that specialists in psychiatry and doctors with special qualifications in addiction medicine operated on the basic level in a decentralised manner. Cooperation between hospital districts and universities had been able to improve the competence and availability of personnel. Thanks to a professorship agreement, specialist training in psychiatry and therapeutic training had been provided in one area.

In many areas, concerns were expressed time and again about the insufficient mental health skills and psychogeriatric consultations of the personnel for elderly people's services.

Shortage of experts makes it more difficult to organise appropriate services

The problem with mental health services as a whole has long been a national shortage of specialists in psychiatry. This also applies to psychiatrists for children and adolescents. The shortage of psychiatrists made it difficult to divide labour appropriately between the basic and specialised levels and to develop services throughout the treatment chain. Purchasing services were often used, but there were still too few psychiatrists in places.

The recruitment situation of psychologists seemed better in the vicinity of universities providing education in the field compared to other areas. There were challenges in the availability of psychotherapists in many places. The shortage of health centre physicians impaired the timeliness and availability of basic care. The availability of nurses for mental health services seemed better than in other professional groups.

Integration of health services and services for elderly people

Home care clients in need of increasing services

Health services that are coordinated with services for elderly people support living at home and postpone the need for 24-hour care. The percentage of those receiving regular home care decreased slightly, but the number of visits to individual customers increased. Of those aged 75 or over, approximately one in six received regular home care services (17%, ranging from 11% to 24% by hospital district), and in enhanced assisted living, around one in fourteen (7.3%, ranging from 5.6% to 9.5%) in 2019. (Figure 6.) The proliferation of enhanced assisted living ended in 2019. Various forms of community housing for elderly people are becoming more common.

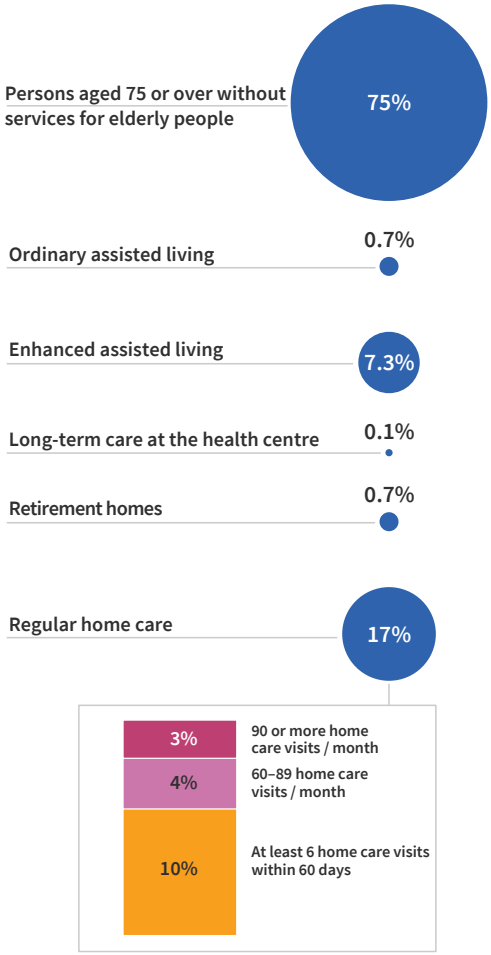


Figure 6. Use of services for elderly people in 2019, shares of those aged 75 or over.

◀ The figure shows how much (%) of the national population aged 75 or over did not receive regular services for elderly people. In addition, the shares of those who have received regular services are indicated by service. The share of those in regular home care is further divided into categories describing the intensity of care. The data are based on the Finnish Institute for Health and Welfare data; the number of people receiving home care services is cumulative full-year data, and the other data describe the situation on 31 December 2019.

Services were coordinated regardless of the organisation model

A fully or partly regionally integrated organisation model also enables functional integration on all organisational levels. In areas where there are several organisers, local integration may be effective, and different management forums may support the harmonisation of operating models.

Cooperation between primary health care inpatient services, rehabilitation and hospital-at-home was increased. The shared use of personnel is restricted by the extensive private production of enhanced assisted living (52% of residents).[38]

The national objective is to promote cost-effectiveness on the basis of knowledge. In data management, some areas used process analyses and forecasting models. The expansion of the RAI system* promoted knowledge-based management.[39] In areas with several information systems, the information was scattered and recording practices varied between organisers.

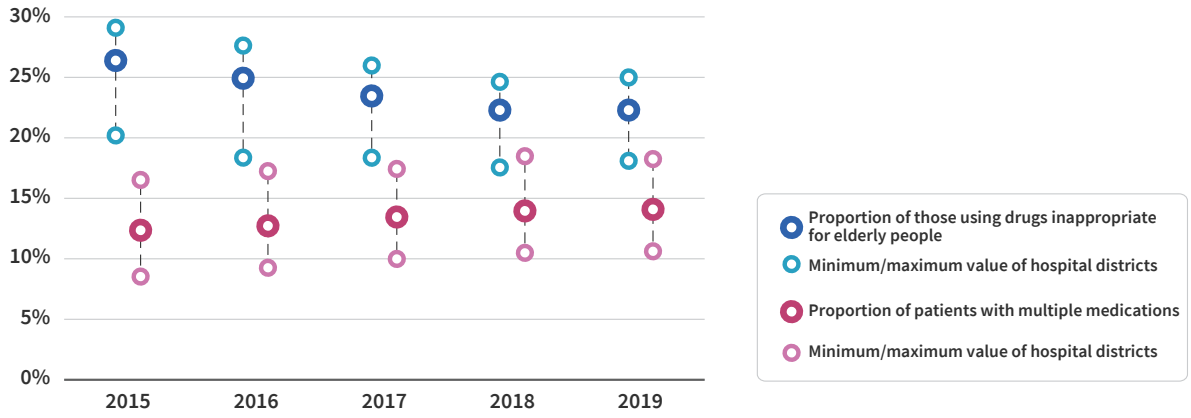
Net operating costs related to the population of the corresponding age increased by 2.1 per cent from 2017 to 2019, but decreased mainly in the regions with regional organisers, particularly in 24-hour residential services.

Multiprofessional cooperation varied in different service forms

Customer orientation and safety require multiprofessional cooperation.[40] It was implemented differently depending on the area; in integrated areas, it was a key approach. Customer and case management cooperated closely with health services, but the support varied both between the regions and within them.

Of all those aged 75 or over, more than one fifth (22%, ranging 18–25%) used medicines that were inappropriate for elderly people**. The share decreased (4.1 percentage points) from 2015 to 2019, even though the proportion of those on multiple medications*** slightly increased (1.8 percentage points). (Figure 7.) The overall evaluation of pharmacotherapy was carried out by the patient's own physician or a designated home care physician, or it was carried out in cooperation with the services and health services for elderly people. Pharmacists and dispensing chemists could also participate in the evaluation. Among other things, the supervisory authority identified shortcomings in the medicine authorisations and management plans for staff. Systematic overall evaluations of nutrition and pharmacotherapy were not carried out comprehensively in regular home care.[41] In 2019, 14 per cent of those aged 75 or over had participated in RAI evaluations, but regional variations were high (0.4–26%). Nutrition therapists and doctors provided support for the evaluation and monitoring of nutrition.

Figure 7. The share of patients with multiple medications and medications that are unsuitable for elderly people in the group aged 75 or over in 2015–2019.



▲ The figure shows in blue the share (%) of patients who have taken medicines that are not suitable for elderly people throughout the country, and the variation between regions over the years. Correspondingly, the proportion of people with multiple medications is indicated in red.

* Resident Assessment Instrument. The RAI system determined the clients' service needs consistently and comprehensively. The RAI system generates data that enables services to be tailored and targeted to those who need them.

** The proportion of those aged 75 years or older who have acquired health insurance-reimbursed medicines that are inappropriate for elderly people (Class D medicines in the Lääke75+ database) in a population of a similar age.

*** Patients taking multiple types of medication have acquired at least ten drugs covered by their health insurance during four months (between August and November).

As the population ages, maintaining and rehabilitating the functional capacity of elderly people is emphasised. Multiprofessional teams for intensified home rehabilitation and discharge teams were used in several areas. The increase in services supporting functional capacity in 2017–2019 did not reduce the treatment periods related to falling, tumbling or hip fractures of patients over 65 years of age.

The development measures pending in the regions support the flow of information between professionals and multiprofessional cooperation. There were information systems that streamlined processes, which made it easier to find a place for further treatment, for example. In addition, there were electronic portals and situation centres supporting data transfer. Effective consultation practices also supported the flow of information. Despite the development measures and regional customer and patient information systems, the current legislation lays down marginal conditions for the full utilisation of the data. The limited viewing rights granted to professionals also complicated the flow of information. These shortcomings were also known to the supervisory authorities.

The staggering of services was developed diversely

The staggering of services according to needs is part of a successful service package. The optimisation reduced, among other things, admissions to the emergency department and inappropriate ward treatments. The functional staggering reduced transfer delay fees**** and made it possible to reduce the number of beds in the wards of health centres and redirect the service provided in the wards.

The staggering of services was streamlined by developing operating models for interfaces, defining service and care chains and introducing operations management systems that support staggering. Patient discharge processes were made more efficient by responsible nurses and multiprofessional teams. In particular, acute care chains were developed, but proactive services were also used to safeguard the integrity of service chains. The cooperation of shared inpatient wards at the basic and specialised level intensified with home care. The findings of the supervisory authorities regarding unnecessary transfers of clients at the end of their lives reflect shortcomings in staggering.

From the perspective of specialised medical care, the fluency of customer flows was hampered by operating models and service offerings that vary from one provider to another. There were also shortcomings in the clarity of the division of labour between different actors, as well as in the coordination of discharging patients. The organiser-specific service and care chains were not necessarily known at a specialised level, the chains were not defined on a regional level, or they were not realised despite the definitions.

The availability of health services for homes and residential services varied significantly both by region and within regions

Emergency-type acute care services were reinforced in accordance with the National Programme on Ageing Workers (until 2030).[42] Emergency-type services or mobile services were not available in most areas, or their geographical area was limited. Of the home care clients aged 75 or over, approximately one in four (26%, 17–32%) were admitted to inpatient care on an emergency basis in 2019.

The abundance of medical problems requires adequate medical services for elderly people. Almost two-thirds of the clients of regular home care and slightly less than half of the residents in enhanced assisted living visited a health centre physician in 2019. More than half of the residents in enhanced assisted living made visits to specialised medical care, and one in five made at least four visits. In addition, one quarter of them underwent treatment periods in specialised care. [38]

**** The transfer delay fee is an increased daily fee for specialised medical care, for which the hospital district charges the municipality if the patient has to wait in the hospital ward for a placement for further treatment at the basic level. https://www.laakarilehti.fi/ajassa/ajankohtaista/siirtoviiveet-saatiin-hallintaan/

The potential of home care and assisted living personnel for 24-hour consultation with doctors were expanded in many areas. 24-hour consultation was provided by official physicians and outsourced medical practitioners, but supervision observed delays in them. Securing assistance at private residential units in the area was partly inadequate. In some areas, emergency care or the situation centre supported the personnel for elderly people's services in assessing sudden service needs. According to the supervisory authority, the number and structure of personnel did not meet the customers' service needs at all times of the day. There were exceptionally many complaints related to elderly people's services in 2019.

Palliative treatment and terminal care were strengthened

The ageing of the population increases the need for terminal care and palliative care. The hospital-at-home or other similar services played an important role in care provided at home and in residential services. In order to strengthen the availability of services, personnel competence was developed, the service network of the hospital-at-home was expanded and service chains were defined. However, more than one third of the organisers did not have a hospital-at-home.[43] According to an international comparative study, the personnel of care homes had shortcomings in palliative care competencies even in Finland.[44] In order to ensure the quality of services, the coordination of residential services, palliative care and terminal care should be increased.[45] The supervisory authorities also noted similar shortcomings.

The treatment was also supported by separate palliative or terminal care wards, terminal care support units and health centres' inpatient wards. For home care clients, the availability of support department care was better than for residents of enhanced assisted living, but there was less potential for 24-hour consultations with doctors in home care.[46] Teams specialising in palliative care supporting the basic level were still rare. The support provided by palliative outpatient clinics for home care and assisted living varied significantly between regions.

Methods and quality statement

Evaluation knowledge base

The expert evaluation of social welfare and health care services is based on both quantitative and qualitative data. The regional evaluations of 2019 focused on monitoring the changes made and development measures taken in the regions since the 2018 service evaluation in the organisation of services and in the service packages which involve special needs for change in the regions.

Discussions on national and regional monitoring themes conducted with regional representatives in spring 2020 are a key source of information for monitoring. The perspectives that emerged in the discussions were outlined by using documentary material on the management, operating methods, plans and decisions of the organisers and by examining a limited number of indicator data that were mainly included in the national KUVA indicator collection (social welfare and health care cost-effectiveness indicators). The evaluation was also deepened by using the Regional State Administrative Agencies' monitoring observation reports and other calculations and reports from national authorities.

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 national situational picture is based on nationwide studies and surveys, and the situational picture is compared with international data as applicable.

National KUVA indicators and Data Window

The KUVA indicator collection forms the quantitative knowledge base of the evaluation. The KUVA indicators are a collection of some 540 indicators created by the Ministry of Social Affairs and Health in conjunction with a large group of experts.[47] Some 450 indicators of the collection are in production. The formation of approximately 90 indicators is in progress or possible only with the development of data collection. An expert group set up by the ministry is in charge of the maintenance and development of the indicators. The group comprises experts in steering, evaluation and statistics as well as representatives of the regions. The Finnish Institute for Health and Welfare is responsible for the technical production of the indicator set.

The objective is that the indicator data used in the evaluation be reliable and up to date. The timeliness of the KUVA indicators is monitored in the Finnish Institute for Health and Welfare by means of a specific metric. However, the evaluation will focus on 2019, so the goal is to use the 2019 data as much as possible.

All indicator values in the set of indicators are presented in the user interface developed for this purpose, the Data Window.[48] The Data Window extracts the indicators within the KUVA indicators from the Sotkanet statistical service and indicator bank by hospital district and by municipality.

For the sake of consistency, the update of the indicators used in the evaluation and the Data Window will be interrupted for the duration of the preparation of the regional evaluation and the annual steering discussions. The regional evaluation makes use of the information available on the date indicated. Freezing of the knowledge base of the evaluation and the Data Window will be cancelled once the negotiation round between the Ministry of Social Affairs and Health and the regions has been completed. In the 2019 evaluation, the knowledge base was frozen on 7 September and released on 11 December 2020. In our national expert evaluation, we have used data updated since the release.

Transparency and availability of the knowledge base

The evaluation is mainly based on information which is publicly and openly available. The indicator data that are not based on the KUVA indicators are referred to separately in the text.

Information on the qualitative documentation used in the evaluation is available in the source list. The monitoring observation reports are publicly available from the unit responsible for evaluating the service system according to the instructions on the website. Unlike the rest of the knowledge base, discussions with the regions and their materials are not public. Separate discussions are no longer taking place in the preparation of the national expert evaluation, and the observations presented can be read from the regional expert evaluations. These are available on the Finnish Institute for Health and Welfares website at thl.fi/arviointi.*

Data quality and ongoing development work

A number of quality deficiencies were found in the indicator data for 2019, which limited the possibilities of using quantitative data. In surveys, there are area-specific limitations in the coverage of responses. The reliability of the statistics on the activities of social services is influenced by the accuracy of the information provided and by the responsiveness of municipalities; failure to report the operational data of large municipalities affects the figures of the indicators which are proportional to the population and distorts the comparison between regions. 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 the Avohilmo register of outpatient care notifications in basic health care) vary by hospital districts and by region.

Quality defects are due to difficulties in both data provision and reception. High-quality information is an objective shared by social welfare and health care operators. Knowledge-based management will be developed and the production of information will be reformed extensively in the next few years in a programme launched by the Ministry of Social Affairs and Health, **Supporting the development of decision-making and services by knowledge-based management** (Toivo programme). As part of the programme, the Data Window will also be reformed, and the reporting of the data content and quality of the KUVA indicators will be developed.

For more information on the evaluation and the knowledge base, visit: thl.fi/arviointi
Ongoing development (Toivo programme): https://soteuudistus.fi/tiedolla-johtaminen
Indicator values in the Data Window: thl.fi/tietoikkuna
Statistics and indicators bank Sotkanet: sotkanet.fi

*Unfortunately the ducumets are not available in english

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Data Window interface of the indicator data used in the evaluation
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POLICY BRIEF

Social welfare and health care services in Finland 2019

Expert evaluation

The Finnish Institute for Health and Welfare assesses the organisation of social welfare and health care services in different areas of the country and produces region-specific expert evaluations and a national evaluation of their observations.

This national monitoring evaluation for 2019 has focused on deepening the situation picture of the country as a whole, in terms of the availability and quality of basic mental health services, and on describing changes made or planned and development measures to reinforce the services. The second theme highlighted in the situational picture is the successful coordination of elderly people's services and health services as part of the national social welfare and health care system and the measures supporting it. The national situational picture has been formed by combining the situational pictures of the different regions in the country and by using the surveys and studies carried out in 2019–2020.

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