

# Finland

## Health system summary 2024

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**This Health System Summary is based on the *Finland: Health System Review (HiT)* published in 2019 but is significantly updated, including data, policy developments and relevant reforms as highlighted by the Health Systems and Policies Monitor (HSPM) ([www.hspm.org](http://www.hspm.org)). For this edition of the Health System Summary, key data have been updated to those available in September 2024 unless otherwise stated. Health System Summaries use a concise format to communicate central features of country health systems and analyse available evidence on the organization, financing and delivery of health care. They also provide insights into key reforms and the varied challenges testing the performance of the health system.**

## Main sources:

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Health Systems and Policy Monitor (HSPM) – Finland (2024). European Observatory on Health Systems and Policies, <https://eurohealthobservatory.who.int/monitors/health-systems-monitor>.

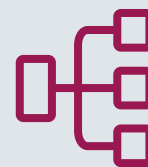
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# How is the health system organized?



The government has strengthened its steering role in health through financing mechanisms and centralization

## Organization

Since January 2023, the health system in Finland has been organized into 21 Well-being Service Counties (WSC), the city of Helsinki, and the HUS group (former hospital district of Helsinki and Uusimaa). The WSCs, which are governed by democratically elected councils, are financed from the state budget.

The WSCs are responsible for organizing primary and secondary health care as well as social and rescue services for their residents, and setting and collecting user fees. In addition, each of the WSCs belongs to one of five collaborative areas, organized around five university hospitals. The collaborative areas centralize the organization of tertiary-level services provided in the university hospitals, and distribute responsibilities between university hospitals for highly specialized care, such as treatment of rare diseases. The Uusimaa region comprises of four WSCs and the City of Helsinki, which are responsible for primary health care, social services and rescue services. Specialist care for the four WSCs and for the City of Helsinki is delivered by the HUS group.

Municipalities, which were responsible for organizing health care and social services until the end of 2022, remain responsible for public health functions, such as environmental health and health protection. Municipalities and the WSCs are required to collaborate on health promotion and well-being programmes.

Legislation and general policy guidelines for health care and social services are prepared at the national level by the Ministry of Social Affairs and Health (MSAH) (Box 1). The MSAH is also responsible for general steering, planning and development of health care and social welfare in Finland. The Ministry of Finance is responsible for the financial steering of the WSCs, including the regulation of budgets and borrowing, and audits. The Finnish Institute for Health and Welfare (Terveyden ja hyvinvoinnin laitos, THL) is responsible for technical expertise (collating and disseminating information, producing guidelines, undertaking research and development projects), health and health system monitoring and, since 2023, evaluating performance of the counties.

### Box 1 Capacity for policy development and implementation

The strategic role of the central government in policy implementation has been strengthened since the 2023 administrative reform, as it steers the WSCs in how they organize services through recommendations, and oversees task-sharing between the counties through collaborative area agreements. Centralized stewardship also occurs via nationally funded projects that often reflect the government's strategic development priorities. WSCs are self-governing bodies and have decision-making powers within their mandate, including decisions on funding allocation and health care provision. However, the Ministry of Finance, MSAH and the Ministry of the Interior play an important role in setting the policy priorities. As the bulk of financing comes directly from the state budget, the Ministry of Finance plays a large role in steering the WSCs finances and approving their investment plans.

Given that WSCs are fairly new entities, their capacity for policy development and implementation is not yet clear. However, it seems that in the initial years of the reform WSCs are mainly focused on policy measures to adhere to the requirement to balance their budgets by the end of 2026 (as so far, all counties are running deficits). The strengthened financial steering of the counties marks a major shift in the stewardship of health and social services in Finland as the WSCs budgets are now part of the state budget.

## Planning

Since 2023, national steering has taken place through annual negotiations of the central government with the WSCs, for example, on their performance, financial sustainability, service delivery strategies and investment plans. In addition, the WSCs also need to agree on the distribution of work within their collaborative area, particularly for highly specialized care and services.

The exact planning mechanisms for health workforce and service provision within WSCs are still in

development. However, there are several tools that support knowledge- and data-driven decision-making and resource planning in the counties and at the national level.

THL plays an important role in supporting planning and stewardship at the national, regional and local level through its technical and research activities. In the new health and social care system structure, THL also has a statutory role to evaluate the performance of the WSCs annually.

## Providers

WSCs represent the largest publicly funded health care provision mechanism in Finland, as they finance and organize health services at all levels of care. The counties run health centres themselves but can also purchase services (both primary and specialist care) from private providers. Secondary care is delivered by hospitals and their polyclinics at different levels, varying from district hospitals to central and university hospitals. Emergency care is provided by hospitals' emergency departments. Five university hospitals provide tertiary care for their respective populations or according to their areas of responsibility.

Health services are also provided in the private sector, particularly primary care, ambulatory specialist care and elective surgery. Most often private practitioners work at the premises of large health care companies but are self-employed and can, in principle, set their own prices. Private providers also play a major role in the provision of occupational health care. Employers are obliged to organize preventive occupational health care but most employers also purchase ambulatory care for employees. Students in higher education have their own not-for-profit health scheme called the Finnish Student Health Service (FSHS) and the services are provided by FSHS clinics.

# How much is spent on health services?



Structural reforms have affected payment mechanisms, leaving WSCs underfunded

## Funding mechanisms

Finland has multiple channels for health financing. In 2023, the financing of the health system was centralized at the national level. Previously, municipalities levied taxes which were supplemented by state grants and user fees. Under the new system structure, WSCs are funded by central government according to a special formula. Initially, the central

transfers for WSCs were based on the 2022 municipal costs for funding health, social and rescue services; thereafter, they are set to increase annually to take into account estimated changes in service needs, cost levels and WSCs' responsibilities. The funding is adjusted retrospectively to correspond to 80% of the average actual costs at the national

level. Approximately 80% of the funding is allocated based on a coefficient for health and social care needs while the remaining share includes funding per capita and other factors (such as bilingualism, foreign languages and population density). A small proportion comes from the revenue from co-payments and sales.

In the first 2 years of the reform implementation all WSCs have run up deficits (ranging from €50 million to over €100 million (Yle.fi, 2024)) due to a number of factors, such as rapid cost inflation, renegotiations of health workforce wages, and potential underreporting of real costs by municipalities (see section on *Reforms*). The need for counties to balance budgets within a relatively short timeframe (by the end of

2026) may affect their ability to adequately finance service provision.

Other health financing channels include the compulsory contributions to the national health insurance (NHI) scheme, the occupational care scheme, voluntary health insurance, FSHS expenditure for students in higher education, and households' direct out-of-pocket (OOP) payments.

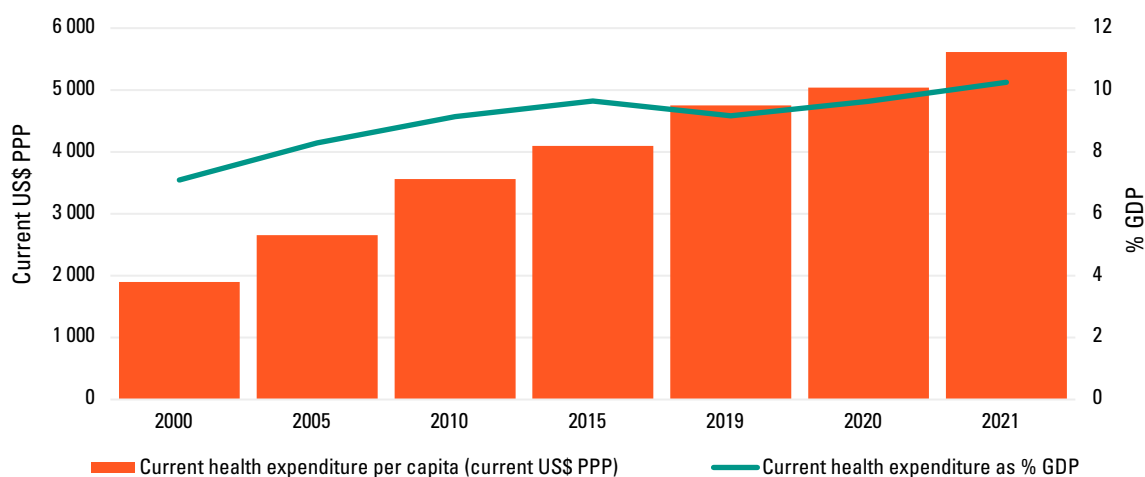
The NHI scheme is funded by the state, employers, employees and self-employed people through payroll contributions. The NHI scheme reimburses outpatient prescription medicines, a share of private health care services, and travel to obtain health care. In 2024 the NHI reimbursement for the use of private services increased markedly (Kela, 2024a).

## Health expenditure

In 2021 current health expenditure in Finland amounted to US\$ 5613 per capita (adjusted for differences in purchasing power), slightly above the EU/EEA/UK average (Figs. 1 and 2). As a share of GDP, health spending increased to 10.3% in 2021, reflecting the injection of additional funds in response to the COVID-19 pandemic and population ageing. Public expenditure on

health per capita has been growing steadily between 2016 and 2021. Preliminary data from THL shows a further increase in 2022; however, the annual growth rate has slowed to 1.5%, compared to 3-5% in 2019-2021 (THL, 2024a). In 2021, the state accounted for 67% of current health expenditure, 13% was contributed by the NHI and 20% by private sources.

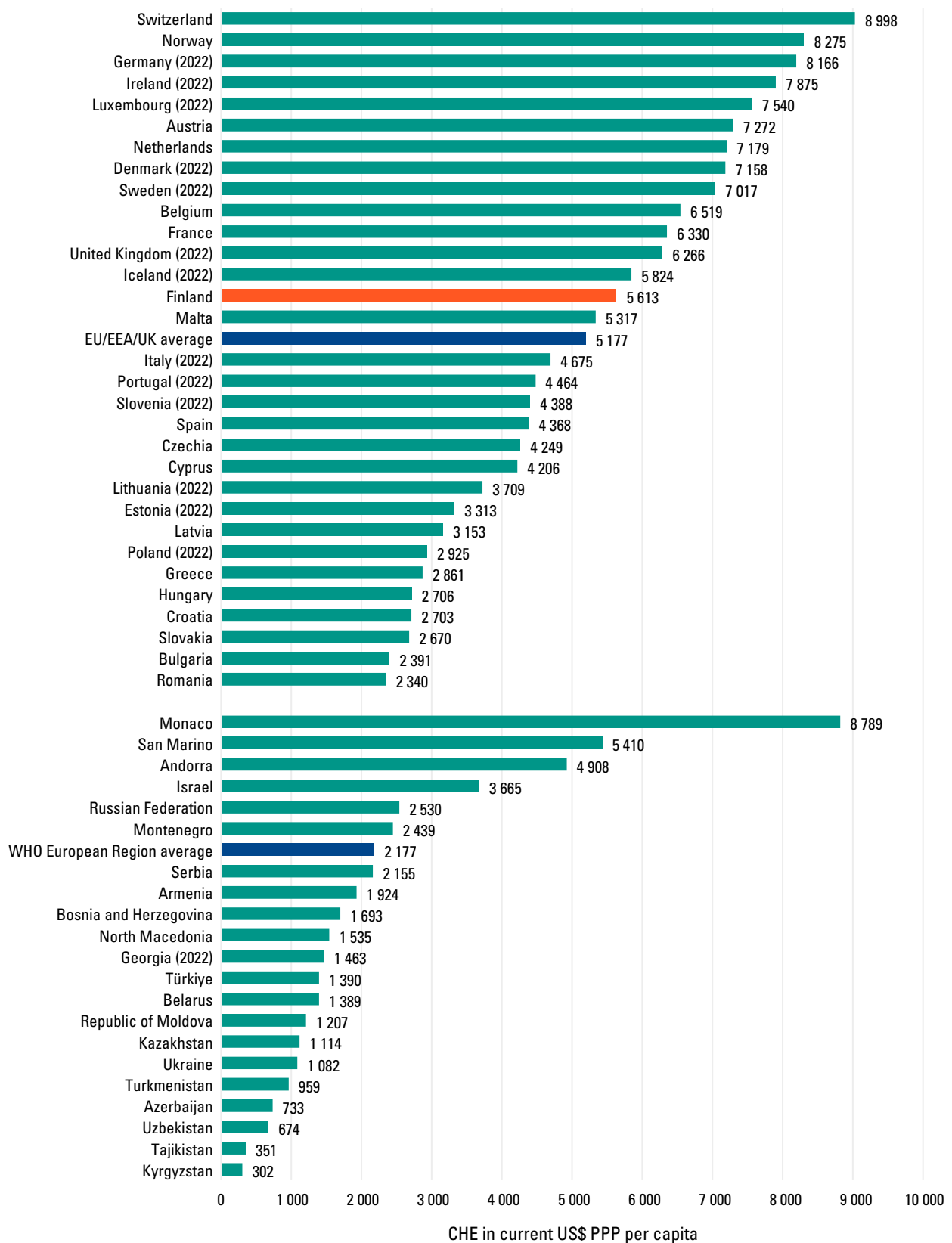
**Fig. 1** Trends in health expenditure, 2000–2021 (selected years)



**Notes:** GDP: gross domestic product; PPP: purchasing power parity.

**Source:** WHO, 2024.

**Fig. 2** Current health expenditure (US\$ PPP) per capita in WHO European Region countries, 2021 or latest year available



**Notes:** CHE: current health expenditure; EEA: European Economic Area; EU: European Union; PPP: purchasing power parity; UK: United Kingdom.

**Source:** WHO, 2024.

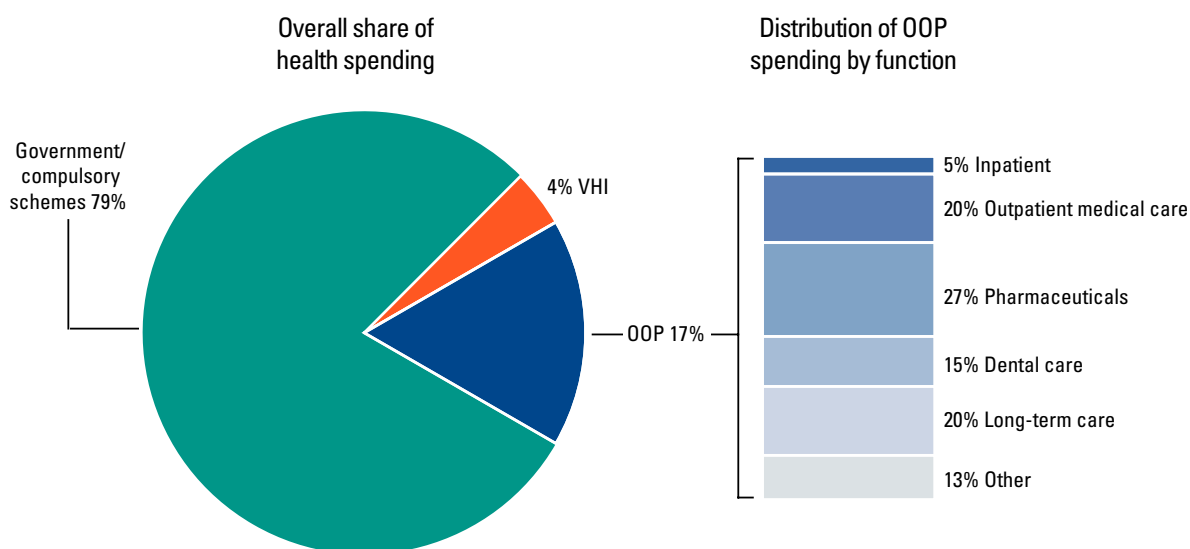
## Out-of-pocket payments

In 2021, out-of-pocket payments constituted 17% of current expenditure on health, slightly above the EU average of 15%. Pharmaceuticals account for the largest share of OOP spending, followed by outpatient care, long-term care and dental care (Fig. 3). User fees exist across all areas of health care services, but certain preventive services are provided free of charge. Maximum charges for health services are regulated by the Act on Client Charges in Healthcare and Social Welfare and the corresponding biannual Government Decree.

Mechanisms for financial protection are still limited,

despite changes to user fees policy in 2021, which reduced annual caps on OOP spending, introduced some exemptions for specific population groups (such as children) and certain services (for example, nurse visits, psychiatric treatment in primary care and selected services in support centres for certain vulnerable groups) and an option to apply for income assistance for people with very low income. Some 20% of the population has private voluntary health insurance (VHI) to cover out-of-pocket payments in public and private services and outpatient medicines.

**Fig. 3** Composition of out-of-pocket payments, 2021



**Notes:** OOP: out-of-pocket; VHI: voluntary health insurance.

**Sources:** OECD, 2024.

## Coverage

Population coverage in Finland is comprehensive for residents, but employed people enjoy better access to ambulatory services through the occupational scheme, which is free of charge at the point of use and often has lower waiting times because the services are purchased from the private sector. The coverage for undocumented migrants has expanded to include non-emergency care in 2023, but the retraction of this measure is currently being considered.

The main gaps in coverage relate to relatively high user charges and caps as well as long waiting lists for

certain services (Box 2). With the creation of WSCs, health services coverage is expected to become more uniform, as the capacity of municipalities to deliver a full range of services was often uneven, particularly in primary care. User charges are high and apply to most publicly financed services, with exemptions for certain population groups and services, and caps amounting to €762 for health services, €627 for medicines and €300 for travel costs (with children included within one parent's ceiling). In the occupational scheme, services are free of charge.

## Box 2 What are the key gaps in coverage?

In recent years, debates on the scope of publicly financed health care have addressed services, such as fertility treatment for female couples and single women, vasectomies and very expensive treatments of hereditary diseases and cancer. There are also certain services such as gynaecology, ophthalmology and adult dental care that are mainly provided through the private sector. While the formal scope of coverage is broad, the actual availability of services may sometimes be limited. Long waiting times have been an issue in non-urgent primary care.

Co-payments in Finland are large, complex and apply to a wide range of publicly financed services. For example, there is a €50 deductible for prescribed outpatient medicines, after which a percentage co-payment of 40%, 65% or 100% applies, with the latter accompanied by a flat fee of €4.50 per purchased medicine. Once the ceiling of €627 is reached, a further flat fee of €2.50 per medicine is applied. In 2024, total annual cost ceilings for co-payments added up to €1689.







In 2024, the government is considering an increase in user fees and reducing the scope of service coverage as part of the drive to balance public finances. The recorded level of catastrophic health spending has been relatively high in Finland (see section on *Accessibility*) and according to recent national population surveys, around one third of patients reported that high user charges had made it difficult to access health services (THL, 2023).

## Paying providers

Purchasing mechanisms between WSCs and providers are still being refined and there is likely to be variation between the counties in how they allocate financing for their own service delivery and the payment mechanisms they use for contracted private providers. As there is not always a clear purchaser–provider split, at this stage WSCs can use global budgets for both primary care and specialist services. However, this is likely to be an

interim solution. Previously, municipal funding for hospital districts providing specialist care consisted of a fixed part, accounting for population size, and a part based on service use. Most hospital districts used diagnostic-related groups (DRGs) at least for a part of the funding. In addition, bed-day costs or treatment package pricing were also applied. Fig. 4 shows an overview of provider payments currently in use.

**Fig. 4** Provider payment mechanisms in Finland

					
GPs	Specialists	Acute hospitals	Hospital outpatient services	Dentists	Pharmacies
Public sector: salary Private sector: fee-for-service	Public sector: salary Private sector: Fee-for-service	Fixed budget and DRGs	Public sector: Fixed budget and DRGs Private sector: Fee-for-service	Public sector: salary Private sector: Fee-for-service	Fee-for-service

**Note:** DRG: diagnosis-related group.

Regarding purchasing of services from private providers, the contracts and payment mechanisms continue to vary between counties with payment types, including capitation and a mix of capitation and fee-for-service in primary care, and various

case-based and fee-for-service contracts for specialized care. Occupational health care services are paid for by employers according to contracts with private providers and may vary according to the contract type.

# What resources are available for the health system?



The rapid reduction in hospital beds suggests a major shift to outpatient care

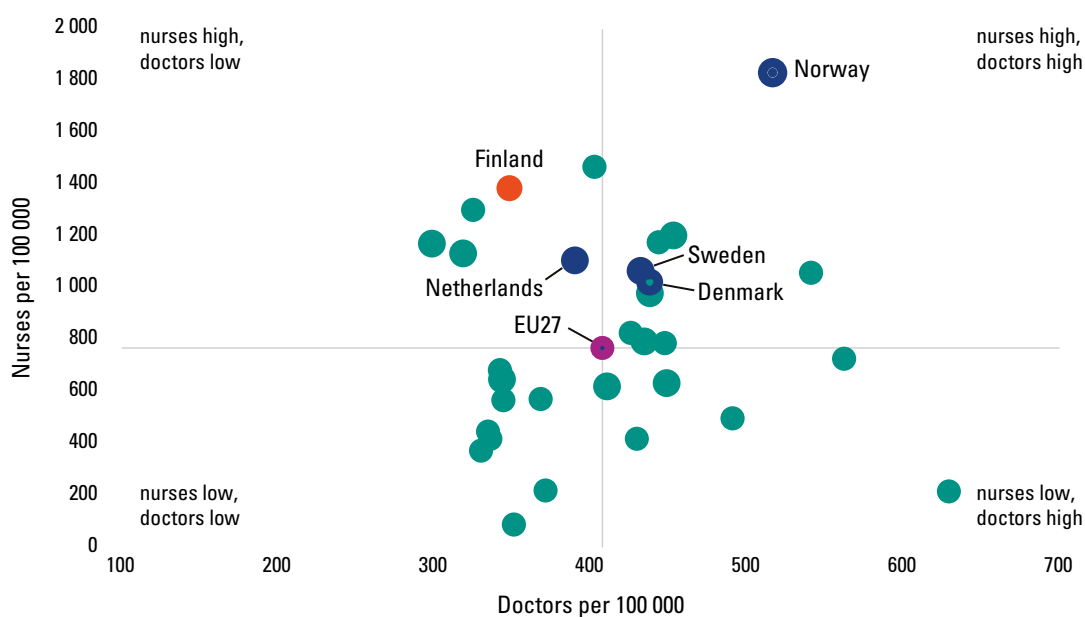
## Health professionals

Up-to-date internationally comparable data for Finland's health professionals is not available. In 2018 (latest year available) there were 348 practicing physicians and 1386 practicing nurses per 100 000 inhabitants. This places Finland relatively high on nurses, and low on doctors in relation to the EU averages (Fig. 5). Most professionals working in the health sector are employed in county-run health services (health centres and hospitals), with only about one in six working in

private medical centres. However, it is common for doctors practicing in public hospitals to also have out-of-hours private practices in private health care clinics. There are concerns that over the past decade the movement of health workers to the private sector has increased, as it allows part-time work and more flexible working hours.

As in other countries, there are regional variations in the distribution of health professionals in Finland,

**Fig. 5** Practising nurses and physicians per 100 000 population, 2022 or latest available year



**Notes:** Data for Finland from 2018; nurse numbers are for practicing nurses (with EU-recognized qualification).

**Source:** Eurostat, 2024.

with the northern districts recording lower numbers (fewer than 200 physicians per 100 000 inhabitants) than the southern ones. Shortages of health workers and rapid population ageing may lead to a gap between the demand and supply of certain professional groups,

particularly nurses (Honkatukia et al. 2024). The health workforce is also ageing, and it has been estimated that by 2030 around one fifth of health care and social welfare personnel in more than half of the WSCs will be retiring (Croell et al. 2023).

## Health infrastructure

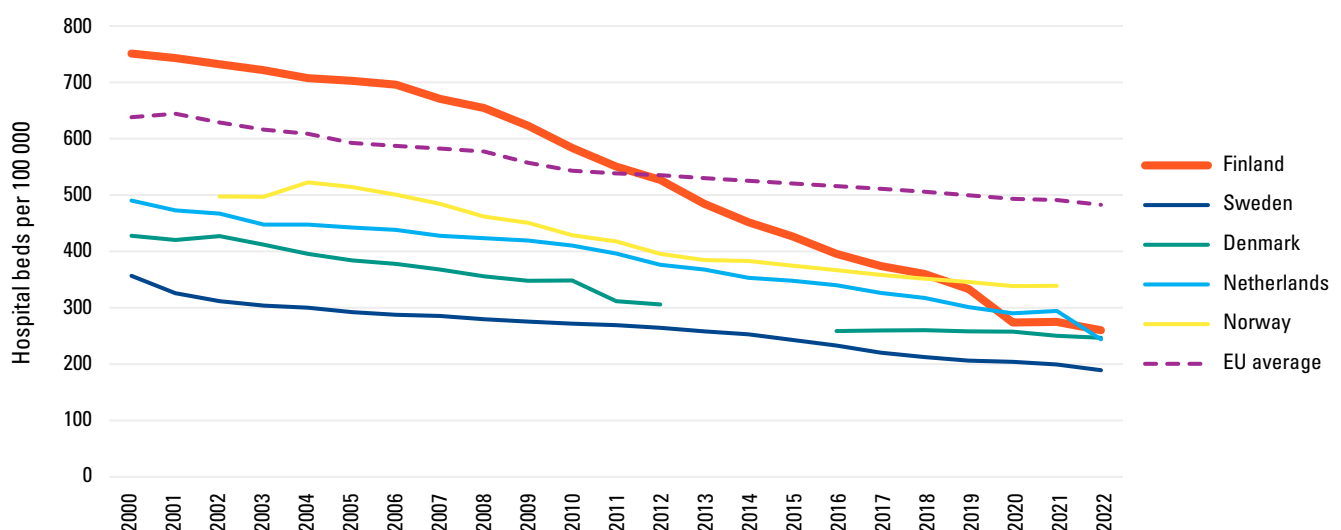
There are about 300 public sector inpatient care facilities in Finland, such as specialist and primary care community hospitals. The number of acute and long-term care hospital beds has decreased markedly, particularly since 2010, overtaking the pace of reduction in the EU on average and bringing the number of beds down to the level seen in other Nordic countries (Fig. 6). This reduction has been achieved mainly by cutting primary care beds, by as much as 40% in some regions between 2006 and 2013. During the same period, specialist care beds decreased in some areas by 20–30% (Mikkola et al., 2015).

A shortage of qualified health workers and limited finances in the aftermath of the 2009 global financial crisis played a role in the reduction of bed numbers, along with the centralization of emergency care

services. The current implementation of the social and health care reform and an increase in digital services can potentially further accelerate this development. In 2022, hospital districts were carrying out or planning investments of over €6 billion on facilities (Maakuntien tilakeskus, 2022). From 2023, the national government has been responsible for steering the investments of WSCs. Further consolidation of highly specialist services has been recommended by a dedicated expert group in 2024, but not yet acted upon.

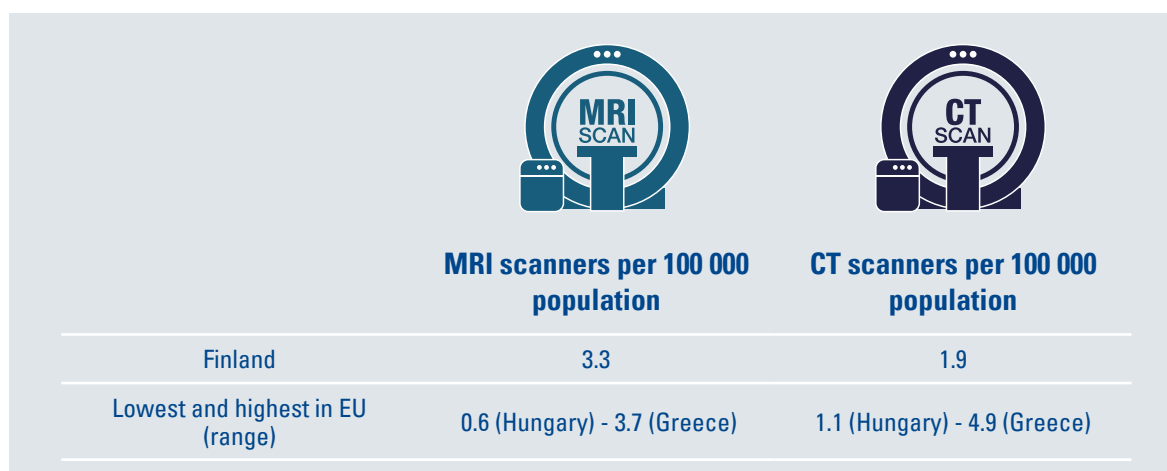
The ratio of mammography machines in Finland remained at around 3 per 100 000 population between 2010 and 2020. The number of CT scanners has decreased from 2.1 to 1.7 per 100 000 population, while the number of MRI scanners has increased from 1.9 to 3.1 over the same period (Fig. 7).

**Fig. 6** Hospital beds per 100 000 population in Finland and selected countries, 2000–2022



Source: Eurostat, 2024.

**Fig. 7** Magnetic resonance imaging (MRI) and computed tomography (CT) scanners in Finland, per 100 000 population, 2022



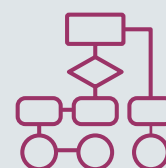
Source: Eurostat, 2024.

## Distribution of health resources

Historically, the central hospitals have been located in the major cities and have been surrounded by a network of district and primary care inpatient facilities in more sparsely populated areas. When evaluated in 2015, marked differences between regions were found; there was a preponderance of small municipality-owned primary care hospital buildings in the eastern and south-western parts of Finland. Since

then, seeking to improve efficiency, these regions have merged hospitals into larger entities and some facilities have been closed or premises rented out for other purposes. This development has accelerated since 2017, following a policy that sought to centralize high-level specialist health care through defining the minimum annual number of childbirth deliveries and certain operations.

## How are health services delivered?



Municipalities play a major role in delivering preventive and health promotion services while primary care has gradually expanded to provide more specialized services

## Public health

Health promotion and disease prevention have been a mainstay of Finnish health policy for decades. At the national level, MSAH is responsible for policy steering and programme financing, while organization, delivery

and core financing of public health services remain mainly at the municipality level. WSCs have a duty to work together with the municipalities on health promotion and disease prevention.

In terms of addressing key risk factors, there have been notable reductions in tobacco and alcohol consumption. The 2016 Tobacco Act sets a 5% target for tobacco and nicotine use by 2030, with further amendments in 2022 banning the marketing of tobacco products and expanding smoke-free environments. In alcohol policy, while overall consumption has been decreasing there is potential for improvements to be reversed. In 2024 the

government introduced policies that increase the availability of stronger alcohol beverages, such as allowing the sale of beverages with up to 8% alcohol content to be sold in grocery stores. On the other hand, little action has been taken to address growing obesity levels and elevated blood pressure. Additionally, the increasing burden of mental health problems and illicit drug use among young people are a growing concern.

## Primary and ambulatory care

Primary care is provided through three overlapping channels: WSC-owned health centres, the occupational health care scheme (which uses a large number of private contracted providers) and private providers which supply services directly to private patients. In addition, the FSHS provides primary health care services, including mental and dental health care services, for students in higher education. Health centres usually employ GPs, nurses and other professionals, depending on the size and needs of the population.

In spring 2020, the NHI reimbursements were extended to cover digital services (Kela 2023). Furthermore, eHealth services and digitalization has seen a rapid expansion across primary care since the COVID-19 pandemic and more recently WSCs have been investing in various digital services (Kärkkäinen et al., 2024). For instance, counties introduced digital clinics which work as a first point of contact for clients, and through which needs assessment as well as certain services can be provided. Both digital platforms (software) and digital services are often supplied by

private providers. The rapid expansion of digital services is a response to the budgetary and recruitment challenges faced by WSCs. Digital services such as chats, remote consultations and digital clinics are also widely used in the private sector, with accelerated provision during and after the COVID-19 pandemic. The increase in the use of digital health services has also been reported in national population surveys in the past few years (THL, 2023).

Ambulatory specialist care is provided in outpatient departments of hospitals or in larger health centres. The latter may collaborate with their local or central hospitals for delivery of specialist consultations and to carry out small procedures, such as endoscopies and stress ergometry (Box 3). There is also a relatively large volume of specialist services provided in the private sector. In 2023 a little over 20% of the population were reimbursed for using private ambulatory services and the most reimbursed specialties in 2023 were ophthalmology, gynaecology and orthopaedics (Kela 2024a).

### Box 3 What are the key strengths and weaknesses of primary care?

Primary care has long been considered the backbone of the Finnish health care system, with GPs routinely expected to provide health care services to a degree typically seen in secondary-level care in other EU countries (Parkkila-Harju, 2018). Multidisciplinary teams in health centres have also seen their duties expand rapidly. However, with fragmentation of service provision and a growing shortage of health professionals, publicly financed health centres increasingly are serving populations with higher and more complex health and social care needs, such as children, older people and other vulnerable groups (Kestilä & Karvonen, 2019). Another persistent issue has been accessibility due to waiting times, as well as cost.

## Hospital care

Inpatient care is organized by WSCs and provided by district, central and university hospitals, alongside a few private hospitals specializing in orthopaedic surgery, cardiology and cancer care. Private providers of ambulatory care may also have operating theatres for day surgery. Inpatient care has been further centralized through the establishment of WSCs and the

designation of highly-specialized responsibilities across five collaborative areas. There has been a long-term reduction in the number of hospitals, inpatient care beds, numbers of hospitalizations and length of stay, reflecting a continuous shift into outpatient settings. However, the coordination of care remains fragmented (Box 4).

### Box 4 Are efforts to improve integration of care working?

Tiirinki et al. (2022) note that integrated care in Finland is fairly advanced due to extensive collaborations between various authorities across sectors. However, previous fragmentation of care between municipalities and hospital districts led to challenges in cooperation and coordination between health and social care as well as between primary care and secondary and specialized care. Following (and in some areas also preceding) the Health and Social Care Reform, vertical and horizontal administrative integration within the system has been strengthened. Efforts have focused on identifying people who need integrated services, defining their care chains and packages, coordinating health and social welfare services with municipal services (e.g. education), and improving information exchange between different providers. With the establishment of WSCs, it was expected that joint management and funding would have a positive effect on integration. However, early challenges to implementation include compatibility of information and communication technology services across the counties, different working cultures and practices as well as difficulties in identifying the people who would most benefit from integrated services (Paatela et al., 2024).

## Pharmaceutical care

Community pharmacies are privately owned by pharmacists. In 2024, there were 639 privately owned pharmacies and 188 subsidiary pharmacies run by pharmacists in addition to their main pharmacy, with a total of over 800 community pharmacies in Finland (Association of Finnish Pharmacies, 2024). The Finnish Medicines Agency (FIMEA) grants permissions to run pharmacies and may allow the pharmacists to

establish additional subsidiary pharmacies in areas where it is not economically viable to run an independent pharmacy. In rural areas, there may be a service point for provision of over-the-counter and pre-ordered prescription medicines. Finland has used electronic prescriptions since 2013. In 2017, e-prescription became the only method of prescribing except in cases of technical failure and emergency cases.

## Long-term care

WSCs organize long-term care either through their own public providers or by purchasing services from private providers. Long-term care is mainly publicly funded but user charges apply. Long term care delivery is based on individual needs, which are assessed by health and social care professionals. National policy emphasises the priority of delivering care at people's

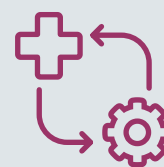
homes where possible. However, because of rapid population ageing, the need for long-term residential care has been increasing. As the number of long-term care beds has not followed population needs, decreasing particularly rapidly since 2009, the availability of long-term residential care has decreased, shifting the burden of care onto families (Forma & Leinonen 2024).

## Dental care

Since 2023 dental care has been organized by WSCs. At the primary level, it continues to be delivered mainly in health centres, which employ over half of all dentists. Their services include prevention and care for oral diseases, as well as referrals to specialist-level care when necessary. Patients have the option to use private services and receive a reimbursement (about

12% of the cost excluding administrative charges) from the NHI (Kela 2024b), with the exception of cosmetic procedures (such as tooth whitening) and prosthodontics. Orthodontic treatment is reimbursed only in specific cases. The services of private dental hygienists are currently reimbursed at an average of about 11% with a dentist's referral.

## What reforms are being pursued?



Sustainable financing for WSCs is the focus of current reforms

More than a decade in the making, the Health and Social Care Reform was passed by the Parliament in the summer of 2021, with health and social care provision moving fully under the responsibility of WSCs from January 2023, and financing being centralized at the national level. Up to this point, health care and social welfare services had been decentralized to municipalities, which were also largely responsible for raising revenues for health. Although the reform galvanized the provision of health care and social welfare at the regional level, even before 2023 some municipalities had established so-called joint authorities aiming to increase efficiency and achieve better integration.

The implementation of the structural reform and the establishment of the WSCs took place at the time of a polycrisis (including the aftermath of the COVID-19 pandemic, the war in Ukraine and large public debt in Finland), coupled with chronic health system strains such as population ageing and shortages of health workers. WSCs started off with fairly large deficits brought about by inflation, new pay settlements with the health and care workforce, harmonization of the salaries within counties and historic underreporting of health and social welfare costs by the municipalities. In addition, the increasingly common use of temporary personnel hired from private companies to fill gaps in staff shortages has further increased costs

(Croell et al., 2023). To date, the discussion around the reform implementation has largely been focused on the financial problems of the counties. There is a relatively common consensus that the funding model of the counties needs to be re-evaluated and potentially reformed in the coming years, to ensure their long-term financial sustainability (Paatela & Tynkkynen, 2024). Other than these financial challenges, there have not been major concerns regarding the implementation of the reform, suggesting that shifting the organization of services to the regional level has largely been beneficial for the health system.

The WSCs began from very different starting points. The counties where municipalities already acted jointly to deliver services could take advantage of these existing regional structures, while others faced administrative mergers from scratch (Croell et al., 2023, Paatela & Tynkkynen, 2024). The reform has brought a major shift in the balance of power between local, regional and national authorities, as national level stewardship has been strengthened substantially, especially in terms of financial steering. To date, the different actors have been settling into new roles in the system and new ways of working together. The new balance of power between the central government and the WSCs has also raised questions about democracy dynamics given that the bulk of funding and regulation is determined at the national level.

From its conceptual stages over a decade ago the health and social care reform has been characterized by political polarization in relation to how, rather than if, health services need to be centralized. The reform legislation was passed in 2021, paving the way for the creation of the WSCs in January 2023. However, the implementation has now been taken over by a different government, in power since the spring of 2023, which was in opposition during the time the

reform was passed. Differing political visions for the health sector, centralized decision-making and the challenging financial situation of the WSCs are key factors that will affect the long-term strategic planning and steering of the health system.

Other changes that have taken place over the past decade have largely been incremental and mainly focused on modifying existing features of the health system and its regulation (Box 5).

### Box 5 Key health system reforms over the past 10 years

**2015:** Decree on User Fees in Social and Healthcare

**2017:** Decree on the Centralization of Specialist Services

**2015–2019:** Government Proposals for the Regional Government and Health and Social Care Reform (not implemented)

**2021:** The Act on Social and Healthcare Client Fees

**2021:** Health and social care reform passed by the parliament

**2023:** Health and social care reform implementation

## How is the health system performing?



Overall, Finland's health system provides effective and efficient care but accessibility has been a growing problem since the pandemic, particularly due to long waiting lists

## Health system performance monitoring and information systems

A number of national and regional organizations in Finland supervise and monitor the adequacy of services delivered by health care professionals and providers. In addition, THL runs and maintains several systems for assessing different aspects of health system performance. However, they are specific to a particular area, such as waiting times, vaccination rates and hospital efficiencies. National or regional systems providing a comprehensive assessment of health system performance were lacking until recently.

In 2018, MSAH piloted an assessment of health

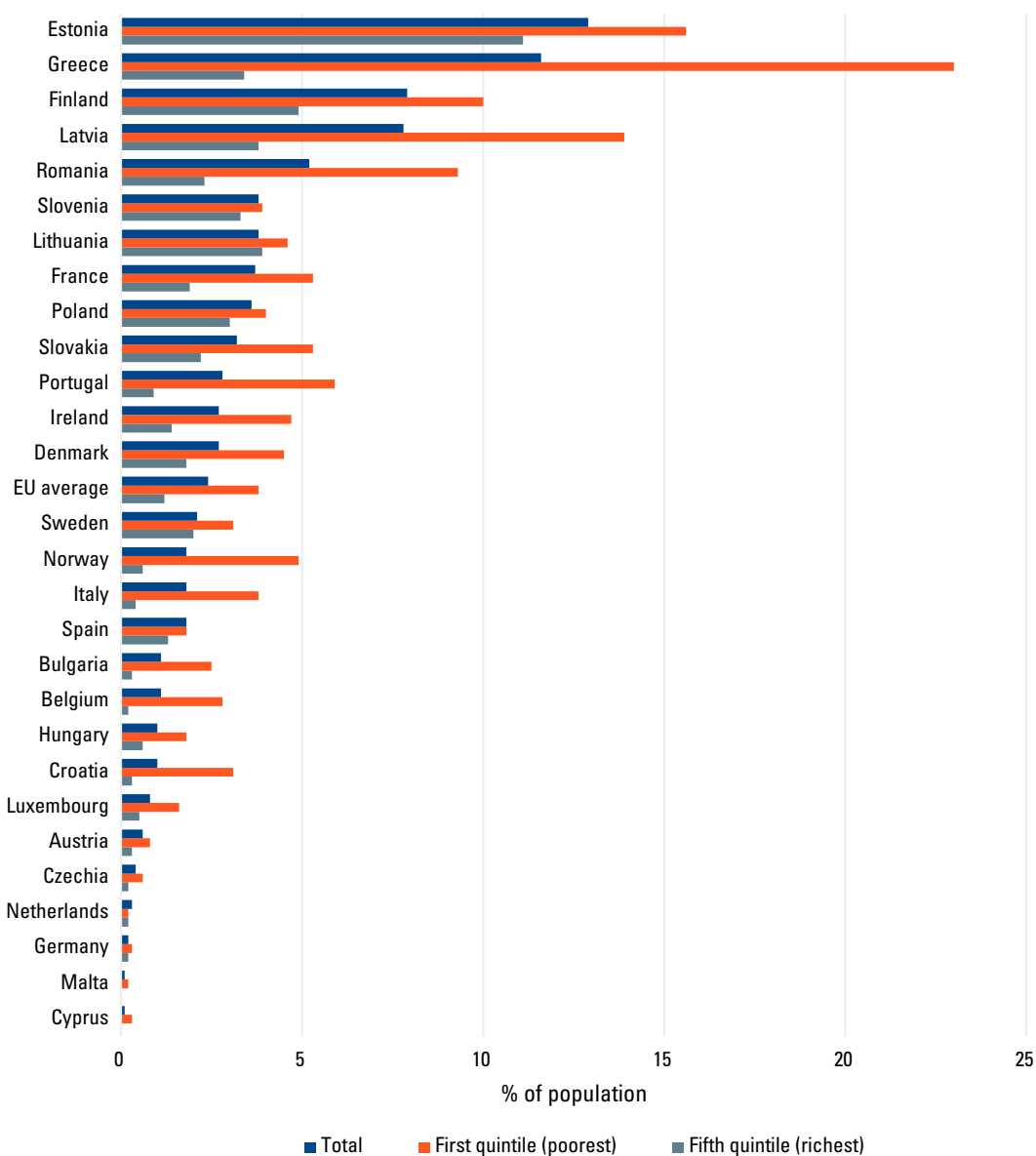
and social care services at the regional level. To complement this, in 2019 THL published the first ever national-level, expert evaluation of the health system (Rissanen, 2019), designed to help national and regional level authorities and decision-makers in their steering and financing of health and social care. The 2021 Health and Social Care reform established this function as a permanent part of THL's remit, with the yearly evaluation reports intended to be used in the annual negotiations between the counties and the government.

## Accessibility and financial protection

According to Eurostat data, in 2023 Finland had the third highest level of unmet health needs in the EU after Estonia and Greece, with 7.9% of respondents reporting not being able to access health care when they needed it (Fig. 8). This is the highest level of unmet need ever recorded in Finland, and it has risen sharply since the pandemic, from 4.6% in 2019. Long waiting lists account for the vast majority of unmet health needs, a finding that is also echoed in national population surveys (THL, 2023). People in the lowest income quintile experience levels of

unmet health needs that are double those of people in the highest income quintile. The gap between socioeconomic groups reflects the fragmentation of the primary health care system in which those in employment are often entitled to ambulatory health care services purchased through the occupational health care scheme and those who can afford it can use private services with little or no waiting times. Amending the maximum waiting times in primary care from 3 months to 2 weeks in the autumn of 2023 resulted in improved access: in March 2024, 71% of

**Fig. 8** Unmet needs for a medical examination (due to cost, waiting time, or travel distance), by income quintile, EU/EEA countries, 2023



**Notes:** EEA: European Economic Area; EU: European Union.

**Source:** Eurostat, 2024.

outpatient care appointments took place within 14 days, compared to 58% a year earlier (THL 2024b).

Finland has relatively high levels of catastrophic spending on health in comparison to other Nordic countries (WHO Regional Office for Europe, 2023). The factors that undermine access and financial protection, with a disproportionate impact on poorer and older

households, were found to be long-standing issues in the governance of coverage policy. Occupational health care, combined with regional variation in waiting times and co-payments, favour people in employment and wealthier households. Co-payments are complex and wide-reaching, while more protection mechanisms are needed (Tervola et al., 2021).

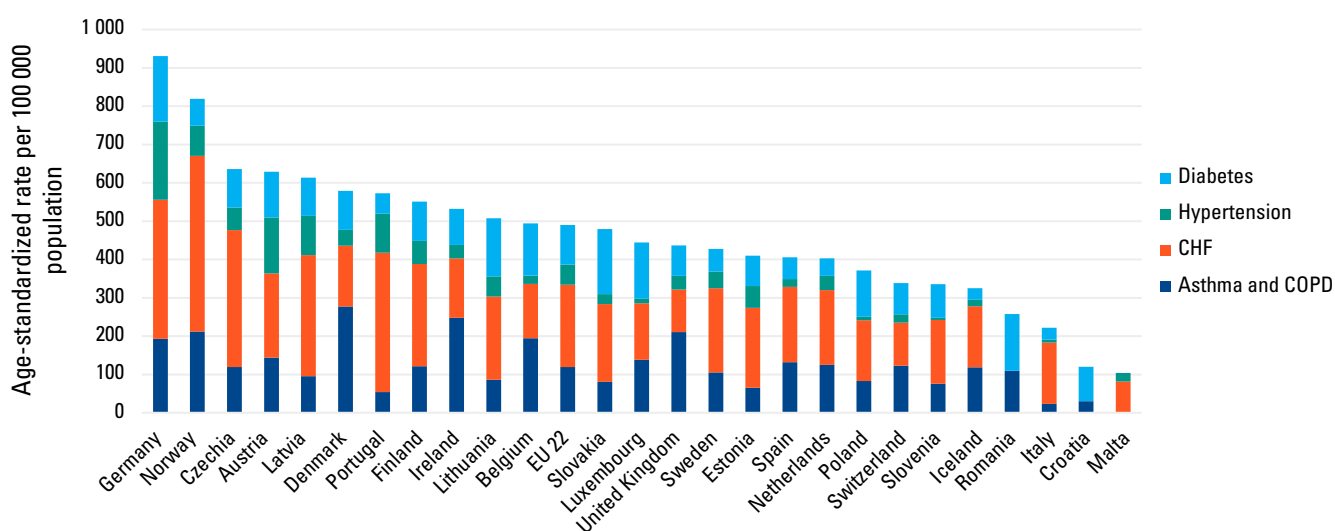
## Health care quality

One indicator reflecting the quality of primary care is avoidable hospital admissions for conditions that could effectively be dealt with in primary care settings. In 2021 Finland had higher rates of avoidable admissions compared to the EU average for asthma and COPD, congestive heart failure and hypertension, but lower for diabetes (Fig. 9). In terms of indicators on the quality of secondary care, the share of mortality within 30 days of hospital admission for acute myocardial infarction (AMI) and ischaemic stroke in Finland stands out among comparable countries with 7.3 and 9.1 per 100 admissions, while rates for haemorrhagic stroke (24.6 per 100 admissions) are similar to those in Denmark

and the Netherlands (Fig. 10).

The Healthcare Act (2010) and subsequent regulations emphasized patient safety and quality of care, which can be measured in various settings (Box 6). Since 2010, all health care providers are obliged to adhere to a quality control plan. The Finnish Patient Safety Association and other stakeholders have been closely involved in this work, emphasizing prevention of adverse incidents and the fostering of a safety-prone cultural change. Increasingly detailed and up-to-date patient safety and care quality-related data are collected by THL and assessed by relevant authorities (such as MSAH and the Ministry of Finance).

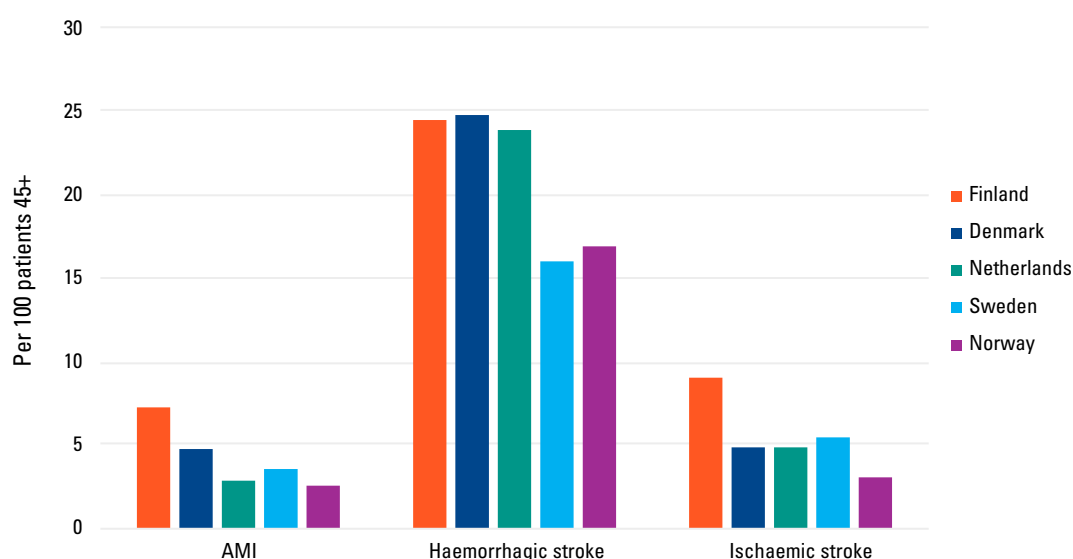
**Fig. 9** Avoidable hospital admission rates for asthma and chronic obstructive pulmonary disease, congestive heart failure, hypertension and diabetes, 2021



**Notes:** CHF: congestive heart failure; COPD: chronic obstructive pulmonary disease. Croatia and Romania: no data for CHF or hypertension; Malta: no data for asthma and COPD or diabetes.

**Source:** OECD, 2024 (data refer to 2021 or nearest year).

**Fig. 10** In-hospital mortality rates (deaths within 30 days of admission) for admissions following acute myocardial infarction, haemorrhagic stroke and ischaemic stroke, Finland and selected countries, 2021



**Note:** AMI: acute myocardial infarction.

**Source:** OECD, 2024 (data refer to 2021 or nearest year).

### Box 6 What do patients think of the care they receive?

Increasing patients' involvement in their own care has been one of the key improvement goals of the Finnish health care system (Linnanmäki, 2017). Patients' viewpoints continue to be reflected using different methods, including:

- specific patient satisfaction surveys on user experience;
- population surveys including questions on patients' opinions of care and public satisfaction with the health system, which show generally high levels of satisfaction and trust in health care providers;
- the HealthFinland (TerveSuomi) national survey on the views of the population on health care and social welfare, and the availability, quality and utilization of services;
- patient forums and panels organized by providers and WSCs;
- expert patients, employed by providers to help their peers to navigate the system and contribute to service development;
- Patient-reported outcome measures (PROMs) and patient-reported experience measures (PREMs), especially for specialized care, are embedded in quality registers.

## Health system outcomes

In Finland, mortality due to treatable causes (deaths that can be mainly avoided through timely and effective health care interventions, including secondary prevention and treatment for people under 75 years of age) has reduced by 18% since 2012 and in 2021 was 70 per 100 000 (compared with 85 per 100 000 in 2012), well below the EU average but generally a little higher than the levels found in the other Nordic countries (Fig. 11). However, Finland has not been able to reduce the differences in treatable mortality between various socioeconomic groups over the past

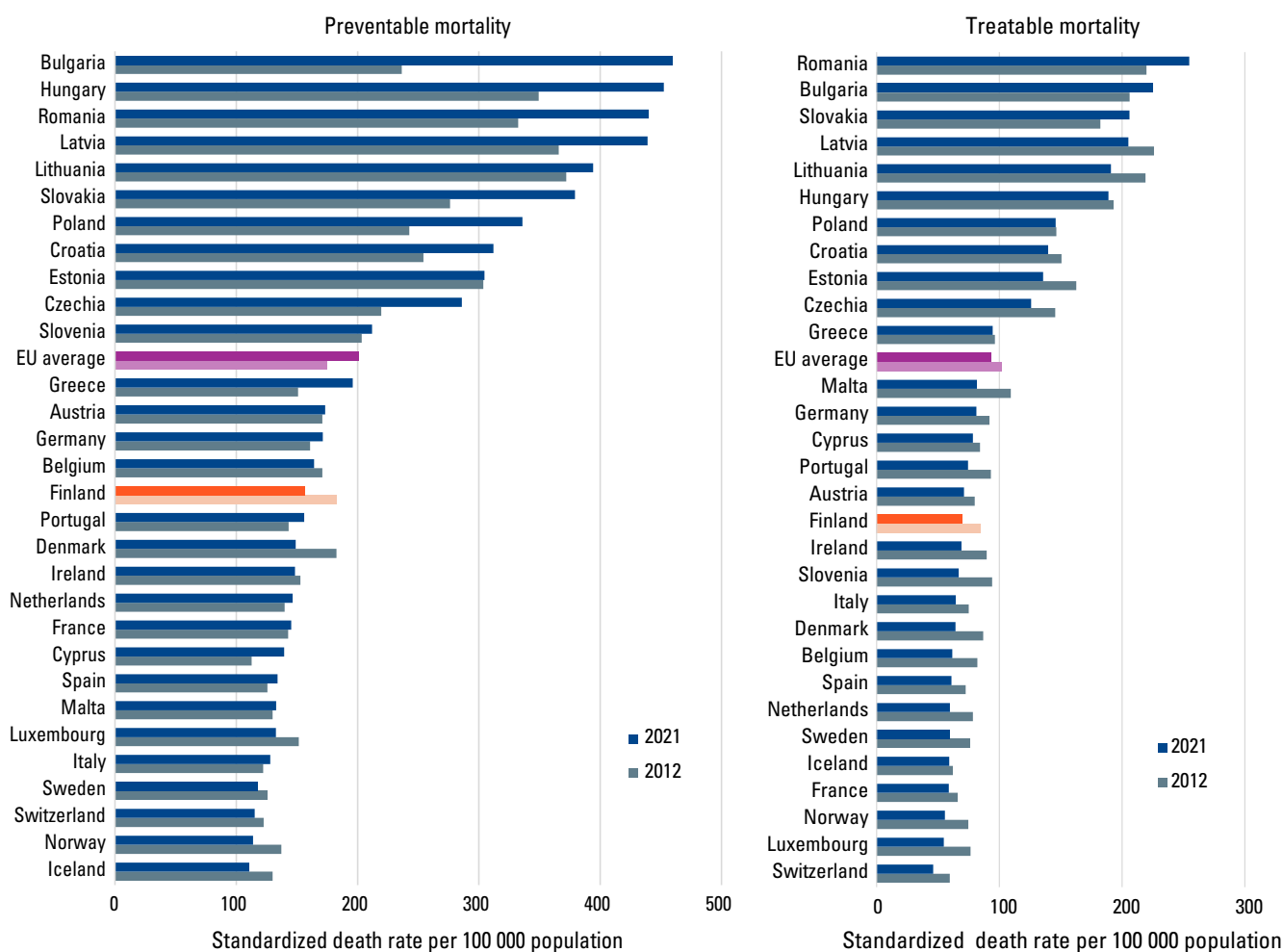
few decades (Lumme et al., 2018). Cardiovascular mortality has decreased substantially from its peak in the 1970s: premature ischaemic heart disease (IHD) mortality (the largest cause of treatable deaths) decreased by a third between 2012 and 2019, from 29 to 20 per 100 000. Most of this improvement is considered to be related to changes in risk factors supported by health policy measures, although in recent decades, treatment of cardiovascular diseases has also improved. Moreover, secondary medicinal prevention of IHD and hypertension, and hospital care

for cardiovascular diseases, including streamlining of emergency care processes, have become more effective. However, the premature mortality rate for colorectal cancer (the second-largest cause of treatable deaths) remained unchanged at 11 deaths per 100 000 people.

In terms of preventable mortality (deaths from causes that could be avoided through public health

and primary prevention policies) Finland's rates in 2021 are 156 per 100 000 population compared with 201 per 100 000 population in the EU on average (Fig. 11). These declined by about 15% between 2012 and 2021 thanks in part to public health interventions (see Box 7). The leading causes in 2021 for Finland in this group are alcohol-related deaths (27 per 100 000) and lung cancer (22 per 100 000).

**Fig. 11 Mortality from preventable and treatable causes 2012 and 2021**



**Notes:** After 2020, deaths due to COVID-19 are counted as preventable deaths, resulting in an increase in mortality from preventable causes for most countries.

**Source:** Eurostat, 2024.

### Box 7 Are public health interventions making a difference?

Overall, public health interventions addressing risk factors for disease in Finland can be deemed to be effective. In particular, smoking has decreased, abstinence from alcohol use and levels of physical activity have increased, and blood glucose and cholesterol values show trends that indicate less cardio-vascular disease in the future. Nevertheless, a number of challenges remain, for example obesity prevalence is on the rise with a quarter of the population having a BMI over 30 kg/m<sup>2</sup> (Koponen et al., 2018). In addition, high prevalence of raised blood pressure and psychological distress, including depression, is a cause for concern.

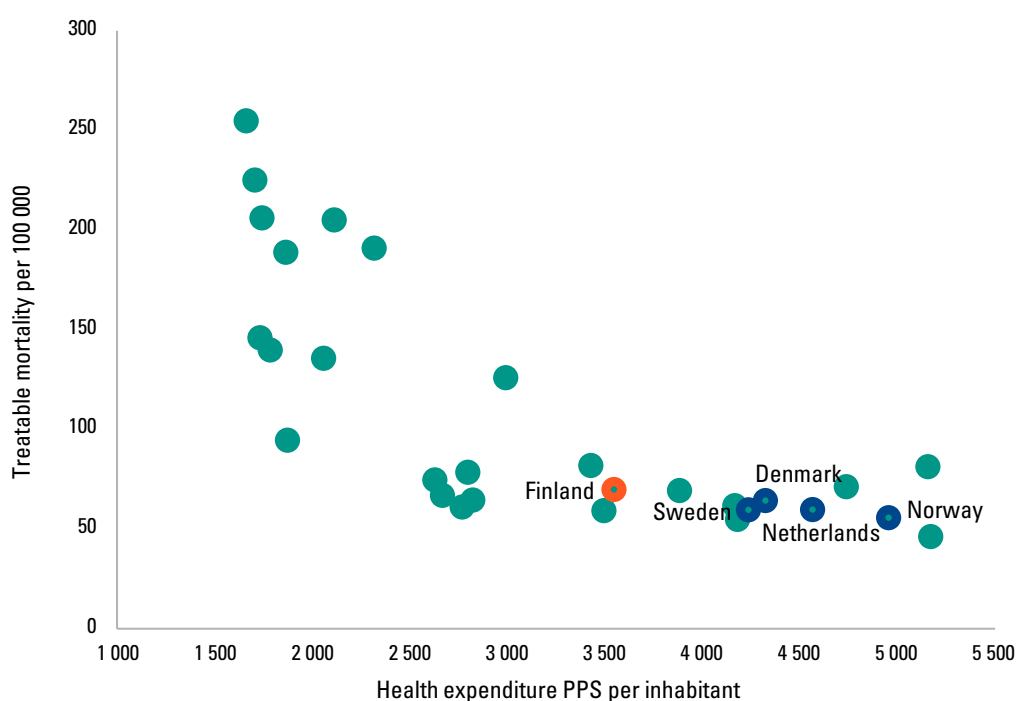
## Health system efficiency

A very cursory way of illustrating how the Finnish health system is performing in terms of input costs and outcomes is to plot current expenditure on health against the treatable mortality rate. On this metric, while spending comparatively less in Finland than the other Nordic countries, the rate of mortality due to treatable causes has been falling consistently and in 2021 is at a similar (albeit slightly higher) level (Fig. 12). In many respects, the structure of the Finnish health care system supports efficiency. Primary care is generally well developed and offer a wide scope of services even though there are issues with access to care. On the other hand, shifting responsibility for health service provision to county level is expected to tackle inefficiencies in resource allocation stemming from high levels of decentralization. However, potential efficiency gains are likely to be realized only in the longer run, when the counties have established their

operations and stabilized their finances.

Although there is now the THLs remit to conduct annual evaluations of WSCs, there is no comprehensive framework for evaluating the efficiency of the entire health system, which would also account for the occupational health care scheme and private health care reimbursed from SHI. Performance assessment is not systematic beyond the hospital sector. Comparative information on efficiency in hospital care has been published as part of official national statistics since 2007. The national hospital information system is managed by the THL and contains data on use, costs and productivity of hospital activities by hospital district (county level from 2023), hospital, municipality, specialty and DRG. Other efforts to improve the efficiency of the health system could lay in targeting pharmaceutical spending, especially given high OOP expenditure for medicines (Box 8).

**Fig. 12** Treatable mortality per 100 000 population versus health expenditure per capita, Finland and selected countries, 2021



Source: Eurostat, 2024.

### Box 8 Is there waste in pharmaceutical spending?

In outpatient care, wholesale prices of prescribed reimbursed medicines are regulated by the Pharmaceutical Pricing Board and retail prices are determined according to the government decree on pharmaceutical tariffs. Reference pricing and generic substitution help authorities to manage and contain pharmaceutical costs, but some inefficiencies have been identified in the system. For instance, reference prices are fixed for every 3 months, while pharmaceutical companies may change wholesale prices every 2 weeks, decreasing the need for price competition. Moreover, pharmacies lack incentives to provide patients with the cheapest alternative because they receive a higher margin for more expensive products and patients receive reimbursement for products within a certain price range, not only the cheapest alternative.

In Finland, pharmacies are private monopolies in their catchment areas and due to national regulation, there is practically no price competition among them. The only exceptions are over-the-counter pharmaceuticals that pharmacies may sell for lower prices by reducing their own margins. So far, there is no clear evidence on whether such competition exists in practice. Kela, the agency managing the NHI, uses soft measures to steer prescribing, such as reminder letters on good prescription practices. Due to the lack of an effective steering mechanism, the use of biosimilars has been low in outpatient care. Recently, generic substitution has been extended to cover biosimilars to increase their use. There is also an ongoing national project aimed at improving the evaluation and guidance on cost-effectiveness in pharmaceutical care as part of Current Care Guidelines.

*Source:* Laukkonen, 2024

## Summing up



The early stages of implementing the health system reform have been used to smooth out Well-being Service Counties' operations but they have also revealed weaknesses in funding

By the latter part of 2024 the Health and Social care reform in Finland has achieved a major level of centralization of service delivery (from municipalities to newly-created WSCs). Generating and pooling revenue for the health system now happen at the national level, while purchasing occurs at county level. Full evaluation of the reform and whether it meets the goals set will require time, but at the very least, the reform has streamlined the structure of the health system and has enabled clearer policy steering at the national level.

Just before the implementation of the reform, Finland's health system was performing well in terms of overall effectiveness and efficiency, but chronic

challenges such as shortages of doctors, poor accessibility and weaker financial protection were all exacerbated by the COVID-19 pandemic and subsequent geo-economic developments such as the cost of living crisis and the war in Ukraine. In addition, the existing parallel funding and delivery systems remain and contribute to fragmentation and inequity, particularly in access to primary care services. The main challenges going forward are the funding shortages and political pressure to balance public finances, which may hinder the WSCs' abilities to develop strategic steering capacity and new ways of working, and to enhance service provision at a level that matches population needs.

## Population health context

### Key mortality and health indicators

Life expectancy (years)	2023
Life expectancy at birth, total	81.7
Life expectancy at birth, male	79.1
Life expectancy at birth, female	84.4
Mortality	2021
All causes (SDR per 100 000 population)	929.27
Circulatory diseases (SDR per 100 000 population)	303.95
Malignant neoplasms (SDR per 100 000 population)	209.89
Communicable diseases (SDR per 100 000 population)	3.39
External causes (SDR per 100 000 population)	57.34
Infant mortality rate (per 1 000 live births)	1.8
Maternal mortality per 100 000 live births (modelled estimates)*	8.3

**Note:** \* Maternal mortality data is for 2020.

**Sources:** Eurostat, 2024; WHO Regional Office for Europe, 2024.

## References

- Association of Finnish Pharmacies (2024). Apteekit numeroina [Pharmacies in numbers]. <https://apteekkariliitto-2014.sivuviidakko.fi/apteekkitieto/apteekit-numeroina.html>
- Croell K, Hetemaa T, Knape N, Leipälä J, Louet-Lehtoniemi T, Nieminen J, et al. (2023). Organising of healthcare and social welfare in Finland – National Expert Assessment, autumn 2023 ([https://www.julkari.fi/bitstream/handle/10024/147865/URN\\_ISBN\\_978-952-408-201-3.pdf?sequence=1&isAllowed=y](https://www.julkari.fi/bitstream/handle/10024/147865/URN_ISBN_978-952-408-201-3.pdf?sequence=1&isAllowed=y)).
- Eurostat (2024). Eurostat Database. Luxembourg: European Commission.
- Forma L, Leinonen E (2024). Long-term care system profile: Finland. Global Observatory of Long-Term Care, Care Policy & Evaluation Centre, London School of Economics and Political Science. <https://goltc.org/system-profile/finland>
- Honkatukia J et al. (2024). Sosiaali- ja terveystalouden henkilöstötarpeen ennakointi [Anticipating the personnel needs of social and health services]. Helsinki: Prime Minister's Office.
- Kärkkäinen E, Virtanen L, Kainiemi E, Heponiemi T, Vehko T (2024). Digitalisaatio ja sen strateginen johtaminen sosiaali- ja terveystalouden järjestämisessä. Tilannekuva reilu vuosi hyvinvointialueiden toiminnan aloittamisen jälkeen [Digitalization and its strategic management in the organization of social and health services. A picture of the situation more than a year after the welfare areas started operating]. Helsinki: Finnish Institute for Health and Welfare ([https://www.julkari.fi/bitstream/handle/10024/149551/URN\\_ISBN\\_978-952-408-343-0.pdf?sequence=1&isAllowed=y](https://www.julkari.fi/bitstream/handle/10024/149551/URN_ISBN_978-952-408-343-0.pdf?sequence=1&isAllowed=y)) (in Finnish).
- Kela (2023). Yksityisten etälääkäripalveluiden käyttäjämäärä kasvoi räjähdysmäisesti korona-aikana [The number of users of private telemedicine services grew explosively during the COVID-19 pandemic period]. <https://tietotarjotin.fi/uutinen/783735/yksityisten-etalaakaripalveluiden-kayttajamaara-kasvoi-rajahdysmaisesti-korona-aikana>
- Kela (2024a). Recipients of reimbursements for medical expenses/ Specialist doctors. <https://raportit.kela.fi/linkki/91791069> <https://www.kela.fi/medical-expenses>
- Kela (2024b). Amount of reimbursement for dental expenses. <https://www.kela.fi/reimbursements-for-dental-expenses-amount>
- Kestilä L, Karvonen S (2019). Suomalaisten hyvinvointi 2018 [The well-being of Finns 2018]. Helsinki: Finnish Institute for Health and Welfare (THL) (in Finnish).
- Koponen P et al. (2018). Health, functional capacity and welfare in Finland – FinHealth 2017 study. Report 4/2018. Helsinki: Finnish Institute for Health and Welfare (THL).
- Linnanmäki E (2017). Asiakkaan ääni kuuluviin sote-palveluissa [Patient voice in health services]. *Duodecim*.133(18):1623–5 (in Finnish).
- Lumme S, Manderbacka K, Karvonen S, Keskimäki I (2018). Trends of socioeconomic equality in mortality amenable to healthcare and health policy in 1992–2013 in Finland: a population-based register study. *BMJ Open*.8(12), e023680. doi: 10.1136/bmjopen-2018-023680.
- Maakuntien tilakeskus (2022). Sairaanhoidon ja erityishuoltopiirien rakennusinvestoinnit 2022. [Construction investments of hospital and special care districts in 2022. Survey 2022]. Helsinki: The State Centre of the Provinces (in Finnish).
- Mikkola M et al. (2015). National report on social welfare and health care institutional beds. Report 8/2015. Helsinki: Finnish Institute for Health and Welfare (THL).
- OECD (2024). OECD Health Statistics. Paris: OECD Publishing.
- Paatela S, Karreinen S, Tynkkynen L-K. (2024). Ylimmän johdon näkemyksiä integraation etenemisestä ja edellytyksistä hyvinvointialueilla [Senior management's views on the progress of integration and the conditions in welfare areas]. Helsinki: Finnish Institute for Health and Welfare (THL). <https://www.julkari.fi/handle/10024/148468>
- Paatela S, Tynkkynen L-K. (2024). "Sote-uudistus ei oo ollenkaan vielä ohi, vaan se on vasta alkanut" : ylimmän johdon näkemyksiä hyvinvointialueiden toiminnan alkuvaiheista [The social security reform is not over yet, but it has only just begun: top management's views on the initial stages of the operation of the welfare areas]. Helsinki: Finnish Institute for Health and Welfare (THL) (<https://www.julkari.fi/handle/10024/148468>) (in Finnish).
- Parkkila-Harju M (2018). Perusterveydenhuollon kestävä tilanne [The unsustainable situation of basic healthcare]. Helsinki: Finnish Medical Association (in Finnish).
- Rissanen P (ed.) (2019). Sosiaali- ja terveystalouden Suomessa : Asiantuntija-arvio, syksy 2018 [Social and healthcare services in Finland: expert evaluation, autumn 2018]. Helsinki: Finnish Institute for Health and Welfare (THL) (<https://www.julkari.fi/handle/10024/137729>) (in Finnish).
- Tervola J, Aaltonen K, Tallgren F (2021). Can people afford to pay for health care? New evidence on financial protection in Finland. Copenhagen: WHO Regional Office for Europe.

THL (2023). Terve Suomi -tutkimus: Kasvava joukko suomalaisia kokee pitkien jonojen ja korkeiden asiakasmaksujen vaikeuttavan sote-palveluihin pääsyä. [Health Finland study: a growing number of Finns feel that long queues and high customer fees make it difficult to access social security services] Terveystieteiden tutkimuskeskus; 14 December (<https://thl.fi/-/terve-suomi-tutkimus-kasvava-joukko-suomalaisia-kokee-pitkien-jonojen-ja-korkeiden-asiakasmaksujen-vaikeuttavan-sote-palveluihin-paasya>) (in Finnish).

THL (2024a) Health care expenditure has increased for all major health care functions. Terveystieteiden tutkimuskeskus; 28 June (<https://thl.fi/en/statistics-and-data/statistics-by-topic/social-and-health-care-resources/health-expenditure-and-financing>).

THL (2024b). Amendments to care guarantee speeds up access to doctor's appointments in particular – the two-week maximum period is realised increasingly. Terveystieteiden tutkimuskeskus; 4 June (<https://thl.fi/en/-/amendments-to-care-guarantee-speeds-up-access-to-doctor-s-appointments-in-particular-the-two-week-maximum-period-is-realised-increasingly>). <https://thl.fi/en/statistics-and-data/statistics-by-topic/health-care-services/hospital-benchmarking>

Tiirinki H, Sulander J, Sinervo T, Halme S, Keskimäki I. (2022) Integrating Health and Social Services in Finland: Regional Approaches and Governance Models. *Int J Integr Care*. 2022 Sep 14;22(3):18. doi: 10.5334/ijic.5982.

WHO (2024) Global health expenditure database. Geneva: World Health Organization.

WHO Regional Office for Europe (2023). Can people afford to pay for health care? Evidence on financial protection in 40 countries in Europe. Copenhagen: WHO Regional Office for Europe; 2023. Licence: CC BY-NC-SA 3.0 IGO (<https://www.who.int/europe/publications/item/WHO-EURO-2023-8969-48741-72485>).

WHO Regional Office for Europe (2024). European Health for All database (HFA-DB). Copenhagen: WHO Regional Office for Europe.

Yle.fi (2024) Finland's healthcare regions face bleak financial outlook as losses accumulate. YLI News, 8 August, 2024. <https://yle.fi/a/74-20103264>.

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