

Finland

Questionnaire on Health and Long-Term Care for the Elderly

ACCESS

1.1 HEALTH CARE¹

1.1.1 Mechanisms for guaranteeing access

Briefly outline the general structure and characteristics of the health system (e.g. universal entitlement, or insurance based on compulsory affiliation). Describe the mechanisms for ensuring that it provides universal access? Describe the objectives of your system in terms of scope and coverage. Questions relating to scope could include:

- Limitations in the type of healthcare which is covered e.g. on the basis of an assessment of the most urgent medical needs;
- does the system cover the entire cost of treatments or what contributions /co-financing are to be provided by the patient?

Questions regarding coverage could include:

- does the system comprehensively cover the whole population?
- Which groups are not covered or only partially covered?
- Are there separate provisions on the basis of income or means/ability to pay?

Describe any specific provisions relating either to the scope or coverage of the system aimed at facilitating access to healthcare for older people². Either in this section or under question 1.2.2, describe how policies for the provision of healthcare to the elderly and policies for long-term care are co-ordinated and integrated.

¹ All care provided or supported by the state in support of people's health protection, maintenance, rehabilitation or convalescence.

² Older people should, for the purpose of answering this questionnaire, refer normally to people of 65 years of age and over. However, it is clear that some Member States make distinctions regarding access to certain categories of benefit and entitlement at other ages (e.g. Ireland gives free healthcare and related benefits to people aged 70+). In addition, it is clear that demand for long-term care is concentrated in people of higher age groups as is the peak demand for healthcare. Where Member States wish to provide information by reference to age brackets other than 65 and older, they should do so while making clear the criteria they are using.

The aim of Finnish health care is to guarantee everyone health care and medical services irrespective of where they live and their financial standing. Health care in Finland covers all residents (5.2 million). The Constitution states that public authorities shall guarantee for everyone, as provided in more detail by an Act of Parliament, adequate social, health and medical services and promotion of the health of the population.

Municipalities are responsible for producing health services for their residents in Finland. Thus health services organized by them are the base of the health care system in Finland. There are approximately 450 municipalities in Finland. The range of population varies from less than 1 000 inhabitants to about 500 000, the average size being about 11 000 inhabitants. In addition, the system comprises private and occupational health services.

The compulsory sickness insurance, that automatically covers all persons residing permanently in Finland, refunds part of the costs of private sector services as well as costs for medicines and transportation. It also provides income maintenance in case of maternity and short-term illness.

Public Health Care

Primary health care is provided in health centres. Health centres offer a wide variety of services: outpatient medical care, inpatient care, preventive services, dental care, maternity care, child health care, school health care, care for the elderly, family planning, physiotherapy and occupational health care. Legislation does not require municipalities to actually produce health services themselves. A great part of the services are acquired by the municipalities from other municipalities, and a small but slightly increasing part from private providers.

Within the public health service system, patients need a referral to a specialist with the exception of emergencies.

Municipalities are also obliged by law to arrange specialised medical care for their inhabitants. Specialized care (secondary and tertiary care) is provided at the hospitals, through outpatient and inpatient units, owned by federation of municipalities. The range of specialized care varies according to the type of hospital. There are 5 university hospitals, 15 central hospitals and around 40 other smaller specialized hospitals. Federations of municipalities, i.e. hospital districts, own all of these. There are 20 hospital districts. The catchment population of hospital districts varies from 70 000 to 1 400 000 inhabitants, and 12 of them have a population of less than 200 000 persons. Each municipality must be a member of a hospital district federation.

In general, the legislation does not in great detail regulate the range, content and organisational mode of providing services. Legislation provides a framework for the provision of services which allows for divergent local solutions. The needs of the patient (e.g. urgency of medical condition) is the most important factor when the doctor makes a decision on care.

Occupational Health Care

Occupational health care is an important part of the overall health care system. It aims to ensure lasting health and working capacity of the employees throughout their working life, and also to promote workplace quality and safety. The occupational health care legislation has been revised to take account of the needs of the ageing workforce for instance, and changes in working life.

Employers are required to finance occupational health care for all employees so as to prevent and combat any health hazards and ill effects of their work and working conditions, and to protect and promote worker safety, working capacity and general health.

Services of the out-patient care type and other voluntary health care can be incorporated into occupational health care, in addition to the mandatory preventive care of the employer. Entrepreneurs and other self-employed people can arrange occupational health care for themselves on a voluntary basis. Over 90% of all wage-earning and salaried employees are now covered by occupational health services. Adequate services also help to promote continuing health and functional capacity among those who have already retired.

Rehabilitation

Responsibility for arranging rehabilitation is divided among several parties in the Finnish system. The social welfare and health care services, the social insurance system and the labour administration all play their part. Rehabilitation can be arranged on either a statutory or a discretionary basis. Statutory rehabilitation may be mandatory as far as the provider is concerned, meaning that services must be arranged for everyone who fulfils the conditions laid down in the law. Examples are the occupational rehabilitation, medical rehabilitation for the seriously disabled, rehabilitation under the Motor Vehicle (Third-Party Liability) Insurance Act and Military Injuries Act, and various services for the disabled arranged by the Social Insurance Institution (Kela).

All other forms of rehabilitation provided by the social welfare and health services, special teaching arrangements in comprehensive school, special vocational teaching and occupational rehabilitation arranged by the labour administration are statutory but dependent on available resources. The number of people provided with rehabilitation, and its scale, depend on how much central or local government allocates for the area concerned, and how large the appropriations for such services are in the annual State Budget. Rehabilitation within the employment pension scheme is statutory but discretionary, in other words the employment pension institutions decide who is granted compensation for rehabilitation.

The main responsibility for rehabilitation and maintaining functional capacity among the ageing rests with the municipal social welfare and health services. Rehabilitation forms part of the care and other services provided for the ageing. An important additional resource in rehabilitation among old people is the provision for front veterans and war invalids, most of which is arranged in the country's roughly 90 rehabilitation institutions.

Sickness Insurance

The statutory sickness insurance compensates for a proportion of the costs of private health care services, medical treatment and travel due to illness. The compensation is paid on care costs in excess of the 'own risk' deductible, which patients have to pay themselves. The compensation for doctors' fees and test and treatment costs is made on a sum in accordance with sickness insurance rates approved by the Social Insurance Institution (Kela). The scheme does not pay compensation for the medical care fees charges by public health centres or for other public health care fees. No compensation is paid for the daily fees of hospitals, either.

As a general rule, the compensation for the costs of prescribed medicines paid for by the patient in excess of EUR 8.41 is 50% (2002 level). However, 100% or 75% is compensated in the case of medicines prescribed for certain severe, chronic diseases, and 75% for clinical food products, on the part of the cost in excess of EUR 4.20. If the uncompensated sum of the costs of medicines paid by the insured exceeds EUR 594.02 in one year, the entire excess

sum is repaid if it is over EUR 16.82. On average, the Finnish sickness insurance scheme compensates 58% of all costs of prescribed medicines.

Sickness insurance compensates 100% for patient travel costs in excess of EUR 9.25 for a one-way journey. If the patient needs to be accompanied, this companion's travel costs are also compensated. In addition, full compensation is paid for the uncompensated travel costs of patient + companion according to the standard rate if they total more than EUR 157.27 per calendar year. In 2000 sickness insurance compensated altogether 87% of travel costs applied for.

60% of the amount of doctors' fees in accordance with the approved rate is compensated, and 75% of the costs per approved rate of prescribed tests and treatment in excess of EUR 13.46. In 2000 sickness insurance compensated 36% of the private doctors' fees paid by permanent residents of Finland.

The sickness insurance scheme compensates employers, entrepreneurs and other self-employed people for some of the costs of providing statutory occupational health care and other health services.

Employers are entitled to compensation for necessary, reasonable costs of providing statutory occupational health care. If employers provide other medical and health care for employees, they are also entitled to compensation for necessary, reasonable costs. 50% of eligible costs in various reimbursement categories are compensated, though not beyond a calculated maximum per employee.

Under a temporary amendment in the revised Sickness Insurance Act that took effect this year, employers are compensated 60% of the costs of workplace assessment work based on workplace visits by occupational health care professionals and any experts they need, carried out to develop and monitor the work, working environment and working community, and of the costs of drawing up and revising their occupational health care action plan.

Entrepreneurs and other self-employed people are entitled to compensation for the costs of occupational health care that they arrange for themselves. They are paid 50% of the costs up to a case-specific maximum.

Compulsory sickness insurance can be complemented by private sickness insurance.

Dental care

The scope of public dental care has been gradually extended, the latest change took place in April 2001. During the transitional period of April 1 – December 31, 2001, municipal dental care was extended to all those born in 1956 or later, and during the period January 1 – November 30, 2002 to all those born in 1946 or later. From the beginning of December 2002, age limits will no longer apply. Many municipalities already provide dental care for their residents. The reform will primarily improve the situation of people in the larger municipalities. In addition to direct provision, municipalities can also purchase services from another municipality or the private sector.

Sickness Insurance refunds of dental treatment expenses were also extended in April 2001 to cover those born in 1946 or after. All age limits will cease to apply in December 2002.

Financing and Patient co-payments

Public Health Care

Health services are mainly financed by the public authorities through taxes. Municipalities are primarily responsible for financing and municipalities have the right to collect taxes. The state participates by paying a general, not earmarked, subsidy to the municipalities, which averages 25,36 % of costs. The subsidy payable to a particular municipality depends mainly on the age structure and the number of invalidity pensions (assessment of the overall state of health). In addition, add-ons to subsidy are given to some archipelago municipalities and also to remote municipalities.

The household share of the financing of the total health expenditure is relatively high, i.e. around 20 per cent. Patient fees (later also client fees) cover around 9 % of public health care costs. Patient fees are paid for curative visits to health centers, out-patient care at hospitals and for hospital treatment as well as for dental care provided at health centers. Municipalities are free to set the fees although subjected to a given maximum. In practice most of the fees are consistent in the whole country. Since 2000 the annual total of patients fees for public health care may not exceed €590. When the limit is attained, the subsequent fees for certain services are abolished (with the exception of inpatient care, where the charge is in that case 12 €/day). The introduction of the personal annual limit of municipal health care costs has contributed to a slight reduction in client fees as a source of funding for health care expenditure.

Table 1. Operating expenses of municipal health care and revenue from patient fees in 1994-1999 at 1999 prices.

	1994	1996	1998	1999
Specialised medical care				
Expenditure, € million	3 030	3 145	3 278	3 296
Revenue from patient fees, € million	228	217	182	191
Revenue from patient fees, % of total expenditure	7,5	6,9	5,5	5,8
Primary health care				
Expenditure, € million	2 138	2 191	2 156	2 180
Revenue from patient fees, € million	255	255	239	246
Revenue from patient fees, % of total expenditure	11,9	11,6	11,1	11,3
Institutional care for older persons				
Expenditure, € million	669	687	632	640
Revenue from patient fees, € million	113	123	122	127
Revenue from patient fees, % of total expenditure	16,9	17,9	19,3	19,8

Sickness Insurance

Sickness insurance is financed with contributions from employers, the insured and the state. Finnish sickness insurance includes not only compensations for medical care but also ‘earned income insurance benefits’, i.e. a daily allowance to compensate for loss of income because of illness, parent’s benefits, rehabilitation allowance, and occupational health care arranged and financed by the employer.

The employer’s contribution is 1.60 % of payroll (the state employer pays 2.85%). The insured pay 1.50 % of annual taxable income. Pensioners pay an additional premium of 0.4 % on their pension income.

Table 2. Sickness insurance expenditure in 1994 –1999, including medicine, private health care, private dental care and travel cost reimbursements, € million

1994	1996	1998	1999
1049	1261	1414	1494

Since 1998 the government has made a ‘guarantee payment’ to safeguard the solvency of the sickness insurance fund, and since 1999 some VAT revenues have been allocated for financing sickness insurance. Of the total expenses, the insured pay 52%, employers 37% and the government 11%. In Finland, the insured pay fairly high ‘own risk’ deductibles on the cost of medication prescribed by doctors and on fees for private medical services. The insured also pay in full for any part of such fees which exceed the approved maximum reimbursable rate for such fees. Thus, in practice, sickness insurance compensates for about one third of doctors’ fees paid by permanent residents of Finland and just over half of the cost of all medication prescribed by doctors.

Sickness insurance expenditure accounts for 8% of the total social security costs in Finland, which are around EUR 36 billion. It is estimated that sickness insurance will continue to account for roughly the same proportion of the social security costs.

Occupational Health Care

Occupational health care is financed on a basis of employer liability for the costs of services provided. Employees cannot be required to pay for care. Employers contribute in two ways: by paying the deductible share (at least 50%) of the costs and by paying into the Social Insurance Institution (Kela) sickness insurance fund a sickness insurance and occupational health care contribution on all salaries and wages they pay which are taxed at source. Consequently, the occupational health care compensation paid out of the fund is financed out of employer contributions.

In 1999, occupational health care cost around EUR 257 million, on which Kela paid out some EUR 118 million in compensation.

1.1.2 Assessment

Are there indicators in terms of performance regarding access to healthcare, e.g.

- **Waiting lists;**
- **Inequalities in regard to access to certain “flagship” or newly emerging treatments?**
- **Regional or income related inequalities;**
- **Specific groups likely to be not fully covered.**

As a part of statistics on inpatient treatment (e.g. surgery) the waiting time of implemented surgical procedures can be calculated.

In Spring 2002, as a part of the National Health Project, the latest waiting-time-related information was gathered. According to estimates presented to the Ministry of Social Affairs and Health this April by Finnish hospital districts, the health service needs an additional EUR 130 million to shorten the hospital and outpatient waiting lists of the public health care system.

Per-capita health care costs across municipalities have been collected and studied since the 1970’s. The discussion has been especially lively during the last ten years. Need variables (such as age structure, and mortality) explain only a fairly small part of the variation in costs.

Data of inequalities in access to care are difficult to obtain due to measurement definitions. Finland has a health care system which covers the entire population and no separate statistics are compiled on access to services of the special groups.

1.1.3 Challenges

What are the main challenges you face relating to the provision of access?

The availability of treatment varies in Finland as everywhere both by type of illness and by geographical region. Availability is affected by varying treatment practices, shortages of skills and variable geographical conditions etc. There is also room for improvement in sharing experiences and information.

1.1.4 Planned policy changes

Describe any planned changes to the overall system or policy mechanisms under consideration.

Based on the work of the National Health Project, the development of the system has been emphasised but no changes to basic responsibilities or organisational systems are proposed. The government has set up the principles of the future of the health care system. These principles will be the basis for the further development of the health service. One of the government's immediate policy measures was the decision to allocate 25 million EUR in 2002 for decreasing the waiting times in the hospital sector.

The principle according to which access to treatment must occur within a reasonable period of time after verifying the need for such treatment, and that in order to promote the more equitable availability of health care services, provisions may be issued by a Decree of the Council of State concerning maximum waiting periods for access to a medical examination and treatment, should be included in legislation on specialised health care, public health and mental health services by the year 2005. Detailed provisions on the maximum waiting periods for examination and treatment should be issued after the Ministry of Social Affairs and Health and the Association of Finnish Local and Regional Authorities have together compiled instructions on the principles for access to the treatment, for placement on waiting lists and on waiting list management.

The aim should be for the patient to receive the preliminary assessment at a health centre, within three days of contacting the service, and the initial assessment of a specialist physician within three weeks of issue of the referral. Patients should have access to medically justified care or treatment measures within the reasonable period specified in treatment recommendations or otherwise warranted by the available evidence, which should normally be within three and no more than six months. If treatment cannot be provided within the time limit at a facility maintained by the local authority or joint municipal board, then the treatment should be procured from another service provider at no extra charge to the patient.

Patients should be placed on treatment waiting lists on the basis of uniform criteria throughout the country. The Ministry of Social Affairs and Health and the Association of Finnish Local and Regional Authorities should co-operate to prepare national recommendations on the principles governing placement on waiting lists and on waiting list management by the end of 2003. Information for the local authority and health care policymakers other stakeholders and members of the public, on the length of waiting lists and on waiting periods, will be enhanced.

The National Research and Development Centre for Welfare and Health and the Association of Finnish Local and Regional Authorities will improve the monitoring system on the national availability of services, the effectiveness of treatment, quality, costs and productivity, and the use and costs of municipal resident health services.

1.2 LONG-TERM CARE

1.2.1 Access to long-term care.

Briefly outline the structures and mechanisms in support of the provision of long-term care (e.g. direct provision via social services; coverage of the need for care via universal coverage, social insurance, social assistance and/or private insurance; supports for informal caring). Are such provisions comprehensive in coverage (aimed at the entire population in need of care or only those otherwise unable to provide); and comprehensive in scope (does it aim to cover all forms of care and their full cost or only some forms of care and part of the cost).

The purpose of services for older persons is to support older people in their daily life, to improve their preconditions for social integration and to ensure the necessary care. For reasons of both quality and efficiency, there has been a shift in emphasis towards a scheme of non-institutional services.

The volume of service housing has continued to grow in recent years, while the coverage of home services has weakened somewhat. Home services focus on people who need more care and services. According to surveys, family members are increasingly taking responsibility for home care. The number of people with dementia has taken a slight turn upwards, which calls for the development of new types of service.

In May 2001, the Ministry of Social Affairs and Health and the Association of Finnish Local and Regional Authorities issued a recommendation to the municipalities on the quality of care and services provided for older persons. The municipalities were to prepare a strategy on care for the elderly, including programs for developing the service structure on the basis of local needs and resources.

The Constitution of Finland stipulates that the public authorities must provide each person with sufficient social welfare and health services, in accordance with the provisions enacted elsewhere. Moreover, the Constitution includes, e.g. the principle of equality and stipulations forbidding discrimination. People are equal before the law and unless there is an acceptable reason, no one may be placed in a different position owing, for example, to his/her age.

Everyone has the same rights to receive the services he/she needs, irrespective of age, gender, income or wealth. Finland has no separate legislation on social welfare and health services for older persons. Their right to services are prescribed in the general national legislation.

The municipality is responsible for providing its residents with social welfare and health services. The municipality can produce these services itself or together with neighbouring municipalities. The municipality can also purchase service from private enterprises or bodies operating on business principles, from bodies operating on a non-profit basis, or from other municipalities or joint municipal boards. About 90% of services for older persons are provided by the public sector. Lately the proportion of social services purchased from private service-providers is on the rise. The Social Welfare Act (710/1982) contains provisions on the responsibility to provide social welfare and its administration. The most important service forms of social welfare are home services (home help care and various auxiliary services), service housing, care in homes for the elderly and support for informal care.*

- The terms do not necessarily correspond to the European idea of an old people's service system

*The definition of long term care**

The criteria for long-term care differ to some extent in out-patient and institutional care. In out-patient care (home services and home nursing) the client is defined as a client of long-term care if he or she is in need of continuous care. The definition of the continuity of care is not statutory in out-patient care, i.e. it varies to some extent from one municipality to another, but it usually denotes the need for help or care at least once a week. Persons whose institutional care can be expected to last longer than three months are considered to be in long-term institutional care. Persons not expected to be in institutional longer than three months are considered to be in long-term institutional care if their treatment has lasted three months and their functional capacity is considered to have deteriorated enough to require continued institutional care. The patient fee systems are tied to the continuity of care. The patient fees for long term care are income related both in home nursing and home care and institutional care.

Institutional care

Statutory institutional care services include the institutional services provided in old people's homes, in the inpatient wards of municipal health centres and in specialised care units. In addition, long-term institutional care is given in various types of nursing homes and homes for disabled war veterans. NGOs and private enterprises also provide institutional care for old people. Nearly all the municipal health centres have a hospital or an inpatient ward. The hospital treats people who have fallen ill suddenly and provides care for patients transferred there for follow-up or rehabilitation after specialised care. A large patient group is older people receiving long-term care.

Usually the person or her/his family express their need to receive care in the institution. The decision on long-term institutional care is usually the responsibility of a local working group, which normally includes at least a health visitor and/or home helper, the doctor responsible for long-term care in the municipality, and the social worker for older people's welfare. A psychologist and a physiotherapist, for example, can also take part in the working group.

Home help services and home care services

Home help services and home care services work together in close collaboration. They provide assistance when the client, owing to illness or reduced functional capacity, needs help at home in order to cope with routine daily activities. Home help services are provided by home helpers or licensed practical social and health care nurses. Aside from assistance with everyday chores and personal care, these workers monitor an older person's state of health, and they also provide guidance and advice in questions pertaining to services. The work concentrates on personal assistance and care to an increasing extent, and in many municipalities, services are provided in the evening and on weekends as well.

For home care the municipal health centre employs separate workers. The home care services provided include giving care, taking samples and performing tests. Today, even demanding nursing care can be given at home. Support for family members is another aspect of home care services.

Service housing/ intensified service housing

Service housing means living in a specially equipped or ordinary apartment, with daily home services provided. Service housing may be arranged on the premises of an institution or in a service house, ordinary rental residence or in an apartment owned by the client. Intensified service housing has staff on night duty as well. Service housing includes both one's dwelling and the provision of services. Service housing is produced by municipalities, NGOs and private entrepreneurs. The features of life in service housing are

structural solutions promoting barrier-free living, the availability of security services and other services, and assistive technology. The resident pays rent or a maintenance fee for his/her home, selects the services needed and pays for them separately according to their use. Service housing is usually based on a rental agreement. Some two thirds of service housing residents live in municipally owned “service homes”, and one third in homes acquired from private service-providers.

Auxiliary services mean services that promote coping in daily life activities and in social interaction. Meals on wheels, day activities, transport services, escorting services, various emergency telephones, laundry services and cleaning services are examples of auxiliary services.

Table 3 Services for older people 1988 – 2000 in Finland*

Municipal service provision and outsourcing	1988	1995	1999	2000	Change %
Percentage of service recipients among all over- 65-year-olds (%)					1995-2000
Home help services	19,3	11,8	11,0	10,7	-9,3
Auxiliary services	15,1	13,4	13,5	13,5	0,7
Support for informal care	1,8	1,5	1,7	1,8	20,0
People living in service housing	0,9	1,9	2,6	2,7	42,1
Homes for the older people	4,4	3,5	2,7	2,7	-22,9
Long –term care at health centres	1,6	1,9	1,7	1,7	-10,5
Long-term care specialised care	2,2	0,2	0,1	0,1	-50,0
Long-term institutional care, total	7,3	5,4	5,1	5,0	-7,4
Percentage of service recipients among all over- 75-year-olds (%)					
Home help services	46,2	28,8	25,4	24,4	-15,3
Auxiliary services	36,1	32,6	31,2	30,8	-5,5
Support for informal care	4,2	3,8	4,0	4,2	10,5
People living in service housing	2,1	4,6	6,0	6,2	34,8
Homes for the older people	10,5	7	6,3	6,1	-12,9
Long –term care at health centres	4,1	4,0	4,0	3,9	-2,5
Long-term care specialised care	3	0,3	0,2	0,2	-33,3
Long-term institutional care, total	17	12	12,0	11,4	-5,0

* (Source: Vaarama M., Voutilainen P., Kauppinen S. Ikääntyneiden palvelut. Sosiaali- ja terveydenhuollon palvelukatsaus 2002. Stakes. Raportteja 268/2002. Saarijärvi 2002

Regular use of care services begins at around the age of 76 in home care and around 81 in institutional care. Over 75-year-olds are the main users of care services. Low functional capacity and housing unsuited to this capacity prompt the need for services. About 70% of over 75-year-olds living at home manage without needing any social care services.

In 2000 altogether 59,000 over 65 year olds were looked after in service housing and long-term institutional care. The number of clients needing institutional care and service has risen about 15% in the last ten years. A crucial development is that the number of people in service housing has tripled. Another is that care in old people’s homes has been replaced by specialised care in service housing. The social services have invested in such housing rather than in traditional old people’s homes. Home help and home nursing services together make up ‘home care’, which is the core of the new service strategy aimed at ensuring that ageing people in poor condition can continue to live at home.

Access to services is known to vary from one municipality to the next. Rural municipalities offer more comprehensive home care than towns, but the latter provide more long-term care at health centres.

Support for informal care

In Finland, family members are an important source of support and assistance for older people. The informal care allowance is one of those social welfare services which Social Welfare Act obliges municipalities to provide. A Decree for the Support of informal care includes more detailed provisions on, for instance, the agreement that must be made concerning informal care, the amount of and grounds for the allowance paid, and the carer's free time. The informal care allowance can be granted in the form of money, services or both.

The informal care allowance is granted on the basis of a contract between the municipality and the carer. Attached to this contract is a plan on care and services, which specifies which services will be provided by whom and which must be agreed by the municipality, the care recipient and the carer. The care can also be given by a person who is not a family member. The minimum amount of the Informal Care Allowance is 211,17 EUR per month in 2002. The main criteria for eligibility for the allowance are the need for help and care on the part of the elderly and the binding nature of the care.

A carer who has made an agreement with the municipality is entitled to an employment pension accrual, on the condition that the carer is not already pensioned. The informal care allowance is rather seen as an encouragement and a certain degree of support so that carers will continue, but it is not considered as wages. However, the informal care allowance is taxable income. The recipients of the informal care allowance are entitled to two free days a month, during which the municipality has to provide substitute care.

Assistive devices and rehabilitation

The service concerned with older people's assistive devices is usually the responsibility of the municipal health centre. The service maintains a store of the technical aids needed for care and mobility; people can then borrow the assistive devices they need free of charge. Municipal health centres give people with some serious diseases (diabetes, cancer and fistula patients) the disposable equipment they need free of charge, and lend them the devices needed for their care.

Rehabilitation is provided by virtue of several different legislative instruments. For older people, the most important types are the medical rehabilitation provided by municipal primary health services, and the rehabilitation that the State funds for veterans and disabled war veterans.

A seriously disabled person must be reimbursed for the costs of alterations to the flat and obtaining equipment and devices needed in it. The alterations must be necessary for the person's independent living, owing to his or her disability or illness. Usual alterations comprise changes in the bathroom and kitchen, making doors broader, removing thresholds and building ramps. The equipment and devices needed in the home include fixed hoists, safety alarm devices, lifts, telephones, fixed high technology equipment and induction loops. The costs of planning the alterations and removing barriers in the immediate environment are also covered. According to the Act on Services and Assistance for the Disabled the social sector of the municipality purchases these services

Pensioners' care allowance

Pensioners over 65 receiving full disability pension or individual early retirement pension, whose functional capacity has been reduced by illness or disability for at least one whole year, are entitled to pensioners' care allowance paid by the Social Insurance Institution (Kela).

The pensioners' care allowance is intended to make it possible for pension recipients with an illness or disability to live at home, as well as to promote home care and to reimburse pension recipients for extra costs caused by illness or disability. The income and property of the persons does not affect their entitlement to the allowance. Depending on the degree of assistance or supervision needed, and on the amount of extra costs, the pensioners' care allowance is paid in either the lower, higher or special payment category. (50,87 €, 126,65 €, 253,28 € per month).

The lowest care allowance is payable to persons who need regular assistance, guidance and monitoring in their everyday routines, household work and when going shopping or whose illness or impairment entails special costs. An increased care allowance is payable to persons who need daily attentive assistance, regular guidance and monitoring, or whose illness or impairment entails considerable extra costs. The special care allowance is payable to people who are in need of constant care and monitoring or whose illness or impairment entails high special costs. In 2001 almost 108 000 people aged 65+ received care allowance for pensioners. Care allowance is not paid to pensioners receiving long-term institutional care.

1.2.2 Assessment

Are there indicators of performance regarding access to long-term care, e.g. Waiting lists for residential care places;

A personal care and service plan is made for each ageing client in both open and institutional care. This is a document or set of documents that is drawn up jointly by the social services and the client, laying down the services and care that the latter needs. The plan also specifies the client's need for rehabilitation. The plan is checked at regular intervals, and a person is appointed with the responsibility for co-ordinating the services and liaising with the relevant authorities.

The municipalities and service units maintain waiting lists. The need for client placements in the various units in the service system are assessed by what are called SAS (= plan, assess and place) groups. Every effort is made to place the client in the kind of care that suits him/her best. SAS groups are made up of a wide variety of social welfare and health professionals.

Regional or income related inequalities;

Municipalities are responsible for providing the necessary services and for implementing the current legislation. Each municipality should have an up-to-date local policy strategy on ageing in accordance with the new National Framework for High-Quality Care and Services. The municipality should monitor the attainment of targets systematically and publish the results annually.

Because the municipalities decide about their own services and the service structure, there are regional discrepancies in terms of service access. Income in principle only affects the charges made for long-term care, and not whether a person is given access to services.

Specific groups likely to be not fully covered.

There are no such specific groups.

1.2.3 Challenges

What are the main challenges you face relating to the provision of access?

The aim is that as many older people as possible should be able to live independent lives in their own homes, in a familiar social and living environment. Living at home will be supported with rapid-access professional social welfare and health care services. Care should be appropriate and respect the client.

There is variability in the access of long term care provided in different geographical regions. The model of local decision making and the provision of resources introduce variability.

One of the most important factors preventing people from coping at home is dementia. Caring for different types of dementia is thus a special challenge for both home and institutional care.

The main challenges are:

- To reduce regional discrepancies not based on differing needs.
- To increase services for people living normally at home.
- To ensure resources for prevention and rehabilitation in open community care services and institutional care.
- To improve practices for assessing service needs
- To ensure skilled personnel
- To develop ways of producing and financing services that will safeguard availability, for instance the service voucher system
- The development of informal care allowance to family caregivers is one of the challenges within care of the elderly
- Revising policy concerning charges and fees.

One important factor in good quality care and services for older people is a highly qualified staff with high motivation and an interest in improving their own competence even further.

- The long-term target is that all personnel involved in caring for older people should have a basic qualification in social or health care.
- People employed to care for older people should be suited to the job and should ideally possess a qualification that meets the requirements of the social welfare and health care sector.
- Personnel policy should also ensure the continuity of care.

1.2.4 Planned policy changes

Describe any planned changes to the system.

In future years it will be important to invest in preserving the functional capacity of the ageing. All care and services should be founded on co-operation and an approach based on rehabilitation in both home care services and institutional care.

New models and forms of co-operation in rehabilitation are being sought jointly by municipal social welfare and health services, the Social Insurance Institution (Kela), organizations and other service providers. A project aimed at improving geriatric rehabilitation, supported by the charitable Slot Machine Association, was launched jointly by the war veterans' and older persons organizations at the beginning of 2002

The functional capacity of ageing people can be improved with sufficiently intensive physical exercise. Activities are organized jointly by the social welfare and health care services, sports and exercise services and various organizations. The Committee on Development of Health-Enhancing Physical Activity underlines the importance of sufficient physical activity at all stages of the life span

The development of the informal care allowance for family caregivers will be topical in the near future.

The service voucher system is currently being adapted to service systems for older persons.

2 QUALITY

2.1 HEALTH CARE

2.1.1 Standards

Are their national standards related to quality; targets in terms of access to medical professionals, hospital beds? Are patients' rights defined?

Quality recommendations

In accordance with the Target and Action Plan on social and health care for 2000-2003 approved by the Council of State, quality recommendations for municipal quality assurance work are being prepared jointly by the Ministry of Social Affairs and Health, National Research and Development Centre for Welfare and Health (Stakes), the Association of Finnish Local and Regional Authorities and service users. When necessary, the recommendations can also include recommendations regarding grounds for determining the number of staff. Recommendations should be drawn up, in a staggered manner, at least in the following areas: elderly care, mental health services, school health care, housing services for the disabled, and anti-drug work.

In spring 2001 the Ministry of Social Affairs and Health and the Association of Finnish Local and Regional Authorities issued a quality recommendation for elderly care and services for the elderly. The quality recommendation on mental health services was given in November 2001. The quality recommendation for treatment of alcohol and drug abusers and services for assistive devices is under preparation.

The municipalities are not bound by the recommendations, but they can be used as a basis for assessment and further development of municipal services.

Reformed guidelines on the provision of certain specialised health care entered in to force at the beginning of October 2000 recommending i.e. the regional concentration of coronary angioplasty, knee and hip replacements as well as surgery on children and young people suffering from arthritis.

The purpose of the project entitled Current Care lead by the Finnish Medical Society Duodecim and associations of specialised doctors is to draft national evidence based care recommendations that can help raise the standard of care and reduce variation in treatment practices. The recommendations formulated as easy-to-read summaries help doctors in their work and act as a basis for drawing up regional treatment programmes. By the end of 2001, over 30 recommendations had been completed. The newest recommendations dealt with the treatment of schizophrenia, ovarian cancer, the surgical treatment of refractive errors and the treatment of hypertension. All the recommendations are available also in electric form at www portal and G.P's electronic Hand Book.

Patients' rights

Patients' rights are protected by specific patients' rights legislation (1992 Act on the Status and Rights of Patients), and other general health care statutory provisions. According to the Patients' Rights Act every person who stays permanently in Finland is without discrimination entitled to health and medical care required by his state of health within the limits of those resources which are available to health care at the time in question. The patient has a right to qualitatively good health care and medical care. There is no general right for patients to choose their GP at health centre or their hospital. They can, however, choose between private and public providers.

If a person cannot immediately be given treatment considered necessary by a health care professional, the person has to be either referred to wait for access to care or taken to treatment elsewhere, where treatment can be given, depending on his/her state of health. If the person has to wait for treatment, he/she has to be informed about the reason for the delay and the estimated length of it.

A person in need of urgent treatment has to be given medical care regardless his/her place of residence.

2.1.2 Assessment

Describe mechanisms for assessing high levels of quality of treatment and for setting and monitoring high standards in healthcare and long-term care.

What mechanisms are there to assess the quality of medical treatments? What criteria are used in making such assessments?

- Ministry of Finance and The Association of Finnish Local and Regional Authorities: Quality strategy for public services (1998).
- national quality recommendations and Duodecim's activities: see above
- regulation and recommendations for training the medical and health personnel
- reliance on self-regulation by the medical profession
- monitoring systems of the central authorities inc. guidance and inspection activities of the provincial governments
- monitoring systems of the local authorities (to a varying extent)
- statistical data collection from municipalities and service producers
- separate surveys on availability of services, etc.
- certification systems (used to some extent, e.g., in the laboratory and imaging and other hospital sector)
- benchmarking studies of performance of hospitals
- public opinion polls of the availability of services etc. (clients' and voters' views)
- increasing transparency (so far under discussion)

2.1.3 Promoting quality enhancements

What mechanisms exist for developing, promoting and ensuring accessibility to good quality practices? Is there a particular focus on developing, promoting and ensuring accessibility to such practices for healthcare for the elderly?

2.1.4 Challenges

What are the main challenges you face relating to the promotion of quality?

There is a constant need to improve quality of care. Care practices and the availability of treatment vary considerably in various parts of Finland. Treatment feedback for the follow-up and treatment continuation between care units is often not provided or is not sent quickly enough, with a consequent negative impact on the effectiveness of care. The annual cost of duplicated and otherwise unnecessary laboratory and imaging examinations has been estimated at more than EUR 200 million. These problems can be reduced by improving the management and information flow, by increasing co-operation and by developing quality systems.

The statutory obligation to arrange in-service training was repealed in the social welfare and health care sectors in the early 1990s. With respect to in-service training the training agreement annexed to the collective agreement on the terms of service of local government officers and employees is merely a recommendation.

There is a need to improve deficiencies in the continuity in service training undermines the quality of services and causes problems both in the social welfare and health care sector. Training is arranged in a varying manner in different service units. Arrangements for locum cover hamper e.g. participation in training by physicians, particularly in health centres that are responsible for a specific catchment population. There are also problems in the supply of training services and in training methods in the long term care and primary care services.

New methods of treating illnesses, conducting medical research, rehabilitation and preventive care are developed every year. These methods may be often introduced without proper evaluation. Many times new methods proved to be less effective than the methods that they displaced or what was originally expected.

Like elsewhere comparisons of pharmaceutical products, non-pharmaceutical treatment and other methods are like elsewhere performed in non-systematic way. There are deficiencies in the development and assessment of methods suitable for primary health care. With the exception of research into vaccines, the evaluation of preventive health care methods remains in its infancy also in Finland.

The controlled introduction of new methods requires close co-operation between the policy makers, professional experts, health care administration and needs the involvement of general public. Methods that are costly or require major investments should be tested in projects involving a proper comparison with the best available existing methods. Any methods intended for primary health care must be piloted in primary health care. The introduction of new methods needs national approach.

2.1.5 Planned policy changes

Describe any planned changes to the system.

In the memorandum of the National Health Project framework for quality assurance, ensuring expertise of the personnel and other related measures was set.

The preparation of national recommendations on treatment, the provision and updating of versions suited to various users, and the production of centralised training materials on these recommendations continues to be supported from state funds.

Hospital district authorities and primary health care units will improve the co-operation, preparation of regional preventive health care and treatment programmes for common illnesses. These regional care programmes are based on national care recommendations. Preparation of regional programmes for preventive care and treatment can be supported by State subsidy.

Provisions specifying the obligations of employers and employees in respect of in-service training will be included in public health and specialised health care legislation.

The Ministry of Social Affairs and Health will co-operate with the Ministry of Education, the Association of Finnish Local and Regional Authorities and labour market organisations to prepare minimum recommendations for in-service training and recommendations on its implementation.

In-service training of all vocational groups must include training in developing the working environment and public health education. This will promote the procurement of specialised expertise in health centres.

The basic funding for in-service training will be included in the staff budget for the health care service unit.

Maintenance and development of vocational skills is a condition of ensuring welfare services in a changing environment. Combined training and expertise in social welfare and health care will help to support the development of co-operation and the quality of services.

Provisions on in-service training should be included in public health and specialised health care legislation by the end of 2003.

The Ministry of Social Affairs and Health, the Ministry of Education, the Association of Finnish Local and Regional Authorities, the Commission of Local Authority Employers and trade unions should prepare recommendations for the content and implementation of in-service training by the end of 2003.

Introduction of new methods

The controlled evaluation and introduction of new technology may be arranged by the evaluation unit of the Finnish Office for Health Care Technology Assessment, which will identify new methods for evaluation, co-ordinate the selection of subjects and provide methodical support for the evaluation process.

Pharmaceutical costs have risen rapidly in recent years and it would appear that this increase will continue throughout the current decade. Therefore the rational use of medicines through development of a National Pharmaceutical Information Centre is planned.

2.2 LONG-TERM CARE

2.2.1 Standards

Are their national standards related to quality? Are care recipients' rights defined?

Improving service quality and helping ageing people to cope at home are key aims in the Government-approved Target and Action Programme for Social Welfare and Health Care, 2000 – 2003. In connection with this, the Ministry of Social Affairs and Health and Association of Local and Regional Authorities issued the municipalities with a joint quality recommendation for improving the quality of services and care for the ageing in May 2001.

The Act on the Status and Rights of Social Welfare Clients (812/2000) came into force at the beginning of 2001. The aim of the new Act (Social Welfare Clients Act) is to foster a client-oriented approach, support the client's right to good social welfare, and further commitment of the client and welfare personnel to jointly agree on matters. The Act lays down the key legal principles related to client participation, treatment and legal

protection in social welfare matters. It clarifies the implications of fundamental rights in social welfare and specifies the issues covered by data protection. It applies to social welfare provided by both the public and the private sector.

Many municipalities make use of various indicators evaluating older people's functional capacity, on the basis of which plans are compiled and checked. Various measures are used to gauge functional capacity, such as FIM, MMSE, RAI and RAVA.

2.2.2 Monitoring and promotion of quality

Is there a system of assessment and recognition of carers and care institutions?

The Ministry of Finance and The Association of Finnish Local and Regional Authorities: Quality strategy for public services (1998).

In general there is no detailed definition of the quality required of municipal services. No permit is required for the provision of public services. One important factor thought to ensure good quality is that the requirements for the training of social welfare personnel are set down in the decree on the formal qualifications of social welfare personnel. The competence of health care staff, meanwhile, is provided for in the legislation on vocational practice. Municipal social and health services are monitored by the State Provincial Offices, which can if necessary issue an admonition or intervene in municipal operations if these are contrary to law.

The Act on the Monitoring of Private Social Services (603/1996) is applied to private social services generated for a fee by service-providers running a business or practicing a profession. It is not applied, for example, to family care based on a service agreement. The Act contains provisions on the prerequisites both for operational units providing social services and for the personnel working at such units, as well as provisions pertaining to the license required for having activities round the clock and to the compulsory registration of activities other than those operating round the clock. The Act also lays down provisions with regard to the monitoring authorities, the content of monitoring and the means available for the monitoring authorities to intervene if shortcomings are observed. In addition, the Act contains provisions on the registration of service-providers. More detailed provisions on execution of the Act are contained in the Decree on the Monitoring of Private Social Services (1208/1996).

Where informal care is supported, are there policies in favour of quality (e.g. financial support for infrastructure/adaptation of homes; training of informal carers)?

See above.

There are some organisations which represents the interests of carers, supports them, provides training and develop innovative projects. The Finnish Slot Machine Association RAY, subsidises non-governmental organisations, mostly on the basis of projects but it also pays for some structural funding, for instance for the Carers Association. The Parliament has the final word on the spending of RAY funds.

There are also government grants and loans for basic renovations which are administered by the Ministry of Environment.

2.2.3 Challenges

What are the main challenges you face relating to the provision of quality long-term care?

The older people and their relatives are mainly satisfied with the services they receive, but there are some shortcomings as well. The biggest problems are associated with the

inadequacy of services provided at home, the quality of institutional care and work-related fatigue among personnel. Supporting the coping of older persons is a common goal shared by all administrative sectors and stakeholders. The starting point is that good care and services are well-planned and anticipatory, in compliance with the law, able to meet the clients' needs as well as ethical and professional. Resources should be utilised efficiently. The activities should be transparent so that citizens and customers can assess them.

The main challenges are:

- Implementation of the National Framework for High –Quality Care and Services; especially:
 - the quality and quantity of institutional care
 - improving the quality and quantity of services provided at home ensuring proper staff dimensioning and the availability of trained personnel
- The development of the services for persons suffering from different forms of dementia.

2.2.4 Planned policy changes

Describe any planned changes in this regard.

All the above challenges feature in various Government or Ministry of Social Affairs and Health documents and action strategies or programmes. Targets concerning services for the ageing are specifically included in the Programme of Prime Minister Paavo Lipponen's second Government and the 'Strategies for Social Protection 2010 – towards a socially and economically sustainable society' (Ministry of Social Affairs and Health).

Implementation of the quality recommendations for municipalities issued in 2001 is being monitored. In addition, development projects have been launched under the Government-approved Target and Action Plan for Social Welfare and Health Services 2000-2003.

A Committee on Estimation of Labour Demand in Social Welfare and Health Care has proposed (2001) that annual intake in vocational basic education in social and health care should be increased by 8500 – 9000 during the period 2002 – 2010. The Committee proposes that the Ministry of Social Affairs and Health and the Ministry of Education set up a joint working group to plan and estimate the demand for labour and education.

SUSTAINABILITY

3.1 HEALTH CARE

3.1.1 Expenditure and financing

Describe current levels of expenditure on healthcare and recent and projected trends. If it is possible to present separate figures for healthcare for the elderly, please do so; Describe financing mechanisms (social insurance contributions, general taxation, voluntary insurance including tax reliefs where relevant, patient charges). [Note: these may already have been described in the brief system description under section 1.1.1]

The financing structure for the total health expenditure went through considerable changes during the 1990s. Government grants to municipalities were cut, while the municipalities' share as well as household's share in the financing of the health care rose. Municipalities receive block grants from central government for the provision of the health services.

Table 4. Sources of finance (in percentages) for total health expenditure in Finland

	1990	2000*
Central government	35,6	18
Municipalities	34,7	42
Social Insurance Institution	10,6	15
Total Public	80,9	75
Households	15,6	20
Employers	1,4	2
Private insurance	1,7	2
Other sources	0,5	1
Total Private	19,2	25
Grand Total	100	100

* estimated

Compulsory sickness insurance is funded mainly by contributions from employers and the insured themselves. Since 1998 the central government has made a special payment to guarantee the liquidity of the sickness insurance fund, and since 1999 part of the revenue from value added tax has been channelled into financing sickness insurance.

Insurance premiums for voluntary sickness insurance are not tax-deductible.

There is a funding deficit in sickness insurance in Finland. This deficit is at present about one fourth of total sickness insurance expenditure. The fundamental cause of this funding problem is the gradual decline in sickness insurance contributions after the recession at the beginning of the 1990s. At present, the funding deficit is covered with excess funding from the national pension insurance and with government guarantee payments. This funding deficit in fees and benefits will continue to grow for the foreseeable future, in both relative and absolute terms. It is estimated that the deficit will be the equivalent of about one third of sickness insurance expenditure by 2030 on the basis of the actual rules.

3.1.2 Expenditure trends

Give an assessment regarding trends in costs and in required funding. How can this be reconciled with other policy goals, e.g. sustainable public finances, in the light of the ageing of the population?

Recently fairly many projections for future expenditure on health and long-term care have been published. Below three studies are presented. The message of these studies is consistent with some other studies:

- A. There will be pressures on health and long-term care systems. Expenditure increases can be expected.
- B. The main instigators of expenditure increases are
 - rapid introduction of new technologies
 - strong incentives to supply health services
 - a higher demand for health and long-term care due to rising incomes and more educated people.

C. Ageing is not and will not be the main factor for expenditure increases.

D. There is considerable scope for policy (i) to limit spending increases and (ii) to improve the effectiveness of health care. Public health care policy is and will be needed.

The Economic Policy Committee

In October 2001, a working group on ageing populations (AWG) attached to the Economic Policy Committee presented projections for public spending on pensions, health and long-term care (Budgetary challenges posed by ageing populations, EPC/ECFIN/630-EN final).

The aim of the AWG projections was to measure the demographic impact of changing populations on public health and long-term care expenditure. As such the current pattern of expenditures across age groups - as defined by age-related expenditure profiles - were matched to future demographic projections to generate projections of public expenditure. Separate projections for health and long-term care expenditures were run. - The results for Finland were as follows (EU average in parenthesis):

Table 5.

expenditure as a share of GDP in 2000	health care		long-term care		
	increase in expenditure in		increase in expenditure in		
	per cent of GDP between 2000 and 2050		expenditure as a share of GDP in 2000	per cent of GDP as a share of and 2050	
	A	B	A	B	
4.6 (5.3)	1.2 (1.3)	1.8 (1.7)	1.6 (1.3)	1.7 (0.9)	2.1 (1.0)

A per capita

B per worker

According to these results, the demographic impact of ageing populations on health and long-term care systems could lead to significant pressures on the public finances over the long-term.

However, it should be emphasised as it has been done also in the EPC document that the results based on the static age-related expenditure profiles are likely to overestimate the impact of ageing on future aggregate expenditure levels. Increasing life expectancy and associated improvements in the health status of elderly persons are likely to lead to shifts in age-related expenditure profiles over time, both for health and long-term care. It is not difficult to agree with the following summary of the document: "Whilst at any given point in time a large share of the overall resources of health and long-term care systems is devoted to elderly people, this does not necessarily mean the ageing is or will be a key driver of expenditure increases."

Report by the SOMERA Commission

In April 2000, the Ministry of Social Affairs and Health appointed a commission to study the development of social expenditure and ways of securing financing for social security in the

long run as the operational environment of social security changes (SOMERA Commission). Permanent Secretary Markku Lehto of the Ministry of Social Affairs and Health was invited to chair the SOMERA Commission.¹⁾ An English summary of the Commission's report is appended.

The Commission's assignment was to identify how the changing operating environment will affect the functioning of the present social security system in the long term, and how the partly divergent aims of economic, employment and social policy can best be reconciled. Another aim was to study whether the existing organisation and financing structure will continue to work in the long term or whether it should be altered. Forecasting health care costs was a part of the Committee's tasks.

Committee's conclusion

In the opinion of the Commission, it will be possible to secure an adequate standard of comprehensive social protection in the future, also. However, changes in the operating environment are creating challenges for social protection and its financing.

In the Commission's opinion, society can prepare for these coming challenges by systematically improving work ability and functional capacity, extending the time people work during their lives, ensuring a smooth rise in pension contributions, making the various forms of social protection more effective, emphasising the aspects of social protection which encourage activity and initiative, and generally streamlining the financing systems and operating procedures of social welfare and health care services. An appropriate level of social protection will help ensure that society can continue to function smoothly regardless of economic cycles and maintain the level of social cohesion needed for continued competitiveness. Application of these principles will require people to enter working life earlier and continue to work for longer, an increase in the employment rate and a postponement of older persons' need for care and medical services as their functional capacity improves.

Committee's views of the demand for social welfare and health care services

The demand for social welfare and health care services will grow as clients become wealthier, expectations concerning standards rise, individual needs grow more pronounced and more people live alone than in the past. Service needs will also grow because the number of older people will grow as people live longer. It is already known that the need for care and different types of service increases with age. The growth of service needs in this area will depend on whether longer life will ultimately allow people to live healthily for longer, or whether it will entail illness and dependency. Old people today are noticeably healthier and fitter than the previous generation. Improvements in health and functional capacity should hopefully postpone the need for care and services in older age groups. It may also postpone the first use of services and cause services to be used for a shorter period altogether, although even the present system has been shown to reach old people at a very advanced age. The trends in service needs will be further influenced by factors such as morbidity, mental health trends and abuse of drugs and alcohol, which are very difficult to predict.

New technologies will make it possible to organise and produce social welfare and health care services more efficiently. Developments in medical science and treatment technology are also creating new opportunities for medical care and will ultimately improve the range of services on offer. From the point of view of service expenditure, new technology could have two different effects. On the one hand, a technology-based treatment might be more expensive, but on the other hand, the productivity of health care services would improve and give added benefits without raising the costs. This trend may also help elderly people stay healthy, but on the other hand it might lead to longer periods of medical care for the elderly, as effective treatments become available for more and more medical conditions.

Medicine reimbursement expenditure has gone up by an average of 10 per cent per annum over the last ten years, and growth is predicted to continue at the same rate for the next few years. If this is true, expenditure on medicines will continue to grow steadily as a percentage of social protection expenditure.

Trends in social protection expenditure are significantly influenced by the service structure and how operations are organised and produced. In order to curb expenditure growth, measures must be taken to improve the efficiency of both the service structure and service production. Attention must focus on minimising overlap of services supplied by various care institutions, on the operating conditions of the municipalities and on alternative models for producing and financing the services.

As service needs grow, the need for professional staff in the social welfare and health care sector will also grow, starting in the next few years, in fact. At the moment, the average age of staff in the sector is high, and during the next decade 55 000 people will retire from the sector, the equivalent of a quarter of present staff numbers. How to secure the availability of skilled and motivated staff for the sector is a key issue, especially as other European countries are also competing for trained staff in this sector.

Globalisation will be reflected in the labour market for the sector, but also in service production, financing and use. There will probably also be an increase in the importance of foreign operators in the social protection field (insurance companies, financing bodies, service providers).

Background assumptions to the baseline scenario on social protection expenditure

Demographic assumptions

- a. The birth rate will remain at approximately the average level for single-year cohorts of mothers in 1997-2000.
- b. Mortality will continue to fall, but at a slower rate; mortality by age group will stabilise in 2050. Mortality development will match the EU prognosis. Life expectancy will increase from 73 to 80 for men, and from 81 to 85 for women by 2050 (cross-section technique).
- c. Net immigration will be 5 000 people per year.
- d. The demographic projection differs slightly from the EU projection, because this calculation is based on population data for 2000. However, the difference between the prognoses, for example regarding the GDP ratio of social security expenditure, is negligible.

Economic assumptions

- a. Unemployment will come down to 6 per cent.
- b. The employment rate of the working-age population (15-64) will increase gradually to 71 per cent. This will be influenced by increased uptake of part-time pension and a reduction in unemployment.
- c. Annual inflation will be 2 per cent.
- d. Productivity will increase in real terms by 1.75 per cent a year.
- e. Changes in real labour costs will follow the changes in productivity, keeping functional income distribution (pay + employer's social security contributions / GDP) at about the present level.
- f. Real interest and fund yields:
 - The yield in real terms of fund investments in the employment pension system will average 3.5 per cent (nominal yield 5.5 per cent).

- The interest rate used as the basis for calculation in the employment pension system will be 3.0 per cent in real terms until 2010 and thereafter 3.5 per cent between 2011 and 2050 (nominal interest rate 5 and 5.5 per cent respectively).
- Real interest on bonds and government debt will be 2.5 per cent (nominal interest 4.5 per cent).
- Net yield in real terms on other investments will be 4.5 per cent (nominal yield 6.5 per cent).

Social protection expenditure according to the baseline scenario

In 2001, Finland's social protection expenditure came to over EUR 34 billion, i.e. about 25 per cent of GDP. According to the Commission's baseline scenario, the proportion of social protection expenditure to GDP will rise to about 30 per cent by 2030 due to the deteriorating economic dependency ratio, and will then remain at a fairly high level until 2050.

The GDP ratio of municipal social welfare and health care services is predicted to rise about two percentage points in 2000-2030. Employment pension expenditure as a percentage of the GDP will grow by about six percentage points, but the fall in national pension expenditure will mean total pension expenditure will only rise by about five percentage points.

The baseline scenario of the Commission is based on developments in accordance with legislation in force at present. The assumptions are admittedly open to the criticism of excessive optimism. It is possible that social protection expenditure will in the future rise faster than anticipated. The sensitivity of the baseline scenario to changes in presumed economic, employment and demographic trends is examined in detail in the Commission's background report.

Alternative calculations

The Commission prepared an extensive background report with more detailed discussion of alternatives and calculations relating to the development of social protection expenditure and financing. The background report presents many calculations on social protection expenditure based on a variety of assumptions and expenditure-based and financing-based factors. In addition to the basic calculations, there are sensitivity analyses examining the effect of individual factors on the calculations. The parameters discussed relate to demographics, economic development, social welfare policy and social protection financing.

Report of the Government Institute for Economic Research (VATT report)

The results of the VATT report are as follows (Pekka Parkkinen, Care Expenditure Bomb can Still Be a Myth, Economic Trends, 6/2001).

Base projection

Assuming that each age group of Finns will use the same degree of health and social services by age in the future as in 2000, the volume of these services in 2040 would be around 40 per cent higher than in 2000. Parkkinen has assumed that in the health and social services the price of labour will grow in the long run apparently at the same rate as in the whole economy. In addition, he has assumed that the productivity per employee in the health and social services sectors will not increase. So in 2040 the real prices of these services would be 75 per cent higher than today. This means that the expenditure on health and social services will be in real terms be 2.45-fold in 2040 in comparison to the present level. This would be around 11 per cent of GDP, if economic growth stables at two per cent annually (at the moment 9.8 per cent).

Delayed demand alternative

Parkkinen has assumed in this alternative that the demand for health and social services by the elderly population in the future is postponed, since with extended life span the physical condition of the elderly will improve. Other assumptions are similar to those of the base projection. In the delayed demand alternative, the expenditure on health and social services will be in real terms around 2-fold in 2040 in comparison to the present level. This would be about eight per cent of GDP, if economic growth stables at two per cent annually.

3.1.3 Cost control mechanisms

Describe mechanisms to control spending:

- **the role of charges as a means of controlling demand**

The national client fee policy of social welfare and health care services includes the principles and goals observed in Finland in defining grounds and levels of client fees. The client fee policy includes both the out-of-pocket payments by users of municipal services and the sickness insurance deductible.

The underlying principles of client fee policy and its objectives were last extensively looked at in the early 1990s by the committee on social and health care client fee policy. The principles defined for client fee policy by the committee were as follows:

1. The services are primarily funded by tax revenue.
2. Social justice. In order to achieve this, it was deemed necessary to adjust the fees for continuously used services to the user's ability to pay.
3. Equal treatment of service users regardless of their municipality of residence. This was not seen as preventing variation between municipalities in the level of fees. (Maximum limits of given fee in legislation)
4. Supporting the general objectives set for social and health care. In the committee's opinion, fees, terraced fees or services free of charge can be used as a means of guiding the population to utilise services that are appropriate from the point of view of society as a whole.
5. Increasing the level of municipal independence and responsibility in defining client fees.

The present system of client fees is based on the work of the committee. Services that are free of charge are defined by law, in addition to which there is a decree specifying maximum fees for individual services. The municipalities can make decisions on their own fees within these limits. The degree of national regulation varies between different types of service.

According to section 19 of the Constitution, which entered into force in 2000, "central government must ensure, in the manner more closely stipulated by law, sufficient social and health care services to everyone, and promote the health of the population". That is why the contents of the client fee policy and related solutions must also be looked at in light of the Constitution.

Client fees can have two types of objectives, i.e. ones focusing on financing the service as well as ones mainly aimed at guiding the use of the services. Financial objectives are related to guiding how big a share of the costs is covered by the individual service user or household, and how much is funded jointly by taxpayers or the insured. This also includes the issue of the

equity of financial contributions to service expenditure. Mainly due to the economic recession in the 1990s, financial role of charges has been dominant.

Client fees and deductibles have also been used to have a certain desired effect on the demand, supply and structure of services. The possibilities of affecting the choices and costs of those who need, use and provide services vary between different sectors in social welfare and health care.

Within the health care sector, client fees can mainly be used to have an impact on first-time visits, in which case the client has real power to make decisions. In later stages of the service chain doctors and the incentives directed to the supply, play a crucial role in decisions on service use. In the case of some other health care services, such as dental care, clients have more say.

Several adjustments have been made to the Act and Decree concerning client fees over the years. Changes have been made in the deductible of medicines reimbursed by health insurance, travel expenses and private doctors' fees as well as the costs of examination and treatment, all of them increasing the deductible.

The acts and decrees on client fees have been passed at different times over the years. The changes are often poorly co-ordinated with other client fees, changes in service structure as well as economic and social policy decisions. When client fees have been changed, the focus has often been on a single fee, which is why broader client fee policy perspectives have in many cases been ignored. It has become increasingly unclear what social policy or other objectives are being pursued with the changes in client fees. There is a clear need for clarifying the goals of client fees in the social welfare and health care sector. That is also recommended in the Government's decision on health care system.

- **financial incentives/market mechanisms to ensure cost control in provision**

Market mechanisms in the health and long-term care sectors inc. competition between providers of social welfare and health care services and the removal of obstacles to competition have been discussed in a number of contexts.

Several obstacles to competition arising either from the circumstances or for other reasons have been observed in the sector.

Finland's scattered population and municipal structure (small population base) also tend to undermine the potential for competition. In order to create private service provision, the municipalities will have to work together across municipal borders. What is needed are joint projects, development of quality monitoring, contracts of suitable duration and co-ordinated tendering. It should also be considered, however, that the small municipalities are in a weak negotiating position in procuring services from major service providers. There is a need for more flexible co-operation between municipalities. Municipalities are also finding it difficult to monitor and compare the differences between various service providers' costs and prices.

There are other competition-related problems, too, in the provision of social welfare and health care services. The corporate sector has felt that the Government grants given to municipalities to fund investments give municipal service providers an unfair advantage. However it should be born in mind that municipalities have a statutory duty to provide all services including long-term care, high-cost services, and emerging services. At the moment the policy is to strongly decrease the amount of these investments grants. This will mean that the unfair advantage will be minimal.

Representatives of the private sector also feel that the practice of returning value added tax to the municipalities distorts the competition. They likewise complain that current indemnification practices for traffic and accident insurance give insurance companies a clear financial incentive to have their patients treated solely at municipal health care units and to avoid private-sector hospitals, clinics, laboratories and diagnostic units.

- **mechanisms for raising the sensitivity of health institutions and professionals to cost considerations when deciding on treatments**

- earmarked state grants for various development projects, especially in the field of IT
- national quality recommendations
- benchmarking studies (in the hospital sector)
- increasing transparency
- provider payment mechanisms (e.g. there has been a change towards prospective payment systems in the hospital sector)
- introducing modified provider-purchaser models (in the hospital sector)

- **controlling the cost of materials and products such as pharmaceuticals**

Large material procurements must be opened up to competition (The Act on Public Procurement).

The Ministry of Social Affairs and Health is investigating the feasibility of generic substitution. The Ministry is to issue a proposal concerning interchangeable pharmaceuticals.

Concentrating medicines procurement is assessed to secure substantial savings. Medication in outpatient care must also be guided by taking advantage of the uniform basic pharmaceuticals selection in public health care.

- **The role of health promotion, disease prevention and, in particular, the promotion of healthy lifestyles for the elderly.**

The Government adopted in 2001 a Resolution on a Health 2015 public health programme outlining the targets for Finland's health policy for the next fifteen years. Its main focus is on health promotion. The present programme is a continuation of the Finnish national Health for All 2000 strategy. It has been prepared by the Advisory Board for Public Health set up by the Government, which also co-ordinates the implementing and monitoring together with the Ministry. Health 2015 is a co-operation programme that aims at health promotion in all component areas of society, not only for health care but also for other sectors of administration, since public health is largely determined by factors outside health care, such as lifestyles, the environment, quality of products and factors promoting and factors endangering community health. The concepts "settings of everyday life" and "course of life" play a key role in the programme.

The programme presents eight targets for public health, which focus on major problems requiring concerted action by various bodies. They indicate the outcome aimed at in different phases of life and age groups. Furthermore, there are 36 statements concerning the lines of action incorporating challenges and guidelines relating to citizens' everyday environments and various actors in society. Target for the elderly is "average functional capacity among people over 75 will continue to improve, as it has for the last 20 years".

3.1.4 Challenges

Outline the main challenges regarding sustainability of healthcare.

The current service system suffers from structural problems that increase costs, undermine the quality of services and hamper staff recruitment. Some of these problems concern co-operation between specialised health care, primary health care and social welfare and the division of duties between them, some pertain to the organisation of specialised health care and primary health care, while some derive from the operating methods of various parties.

Small service units are vulnerable to staff absences and recruiting problems. Other arguments in favour of larger functional units derive from the objectives for developing and maintaining operational and quality standards, for providing stable funding and particularly securing qualified staff, and for flexible and efficient operation. Operating units of sufficient size also facilitate emergency arrangements.

Geriatric care is a common field for health care and social welfare services, and must be implemented near to a persons social network in a manner ensuring that administrative boundaries lead neither to overlapping functions nor to gaps in service provision. The limits of health care services and social work currently may undermine the realisation of objectives. The responsibility for overall costs is dispersed in municipalities where these functions are separately organised. To ensure a harmonious and functional service from the point of view of the client/patient, it is necessary to develop the instruments for social welfare and health care provision to enhance the chain of service when a client transfers from one part of the service to another.

The availability of staff in the public sector must be ensured. This objective will be achieved by dimensioning training volumes in the best possible manner, by improving working conditions and by making the health care sector more interesting. Working conditions will be developed by improving management, by introducing greater incentives to improve the skill and knowledge maintenance into pay policies, and by promoting co-operation and the division of labour between various staff groups. There must also be opportunities in primary health care to conduct research and development work in addition to patient care. Continuous training and functional quality systems will also improve working conditions and make the sector more attractive to work in.

The development of the health service is leading to a softening of boundaries between various vocational groups and to a more flexible division of duties. This division will have to be reassessed in such areas as basic health care outpatient services, oral health care and mental health work. The duties involved in various nursing and social worker occupations will have to be developed in such areas as home services, mental health work and residential services.

A rapidly worsening shortage of physicians is affecting both basic and specialised health care. The employment situation varies by geographical region and by specialities. Shortage sectors include psychiatry, eye diseases, radiology, anaesthesiology and certain surgical specialities. The most difficult situation is currently in primary health care. There are several health centres in Eastern and Northern Finland with no physicians at all, or where operations depend on a rapid turnover of locum physicians. Rectification of this labour shortage will require both correctly dimensioned training and improvements in working conditions.

3.1.5 Planned policy changes

Describe any planned changes, in particular any initiatives focused on the provision of healthcare to the elderly.

The decision in principle on the development of health care of the Council of State is consistent with the following change-related aims proposed:

Local health care services should be arranged as a functional package as a joint efforts of several municipalities (bigger units than at present). Health care service operating points must be dispersed so that travel constitutes no impediment to the use of health care services.

Local authorities should form broader regional units for municipal occupational health care. The work of these units should be developed to the standard required by legislation.

Tertiary specialised health planning has to be improved by co-operation of Hospital District Federation. By 31 May 2003 the hospital districts will prepare a plan of co-operation and division of duties.

The necessary development measures can be implemented either by combining hospital districts or by expanding functional co-operation and the division of duties between hospital districts.

The Ministry of Social Affairs and Health, the Ministry of Education and the Association of Finnish Local and Regional Authorities will work with the universities to plan and implement management training.

A national programme is planned to develop health care in service training and working environment.

The Ministry of Social Affairs and Health will prepare a reassessment of other stakeholders the need for medical certificates.

Faculties of medicine increase their annual medical student enrolment from the present figure of 550 to 600 new students in 2002. Training of other vocational groups in the social welfare and health care sector is increased in line with the trends outlined by the social welfare and health care sector labour requirement forecasting commission.

The Ministry of Education and the polytechnics should modify health care teaching and training with working life so that the content of training and the skills of graduates meet the needs of working life.

The further training of physicians will be revised for the part of training in health centre and non university hospitals.

3.2 LONG-TERM CARE

3.2.1 Expenditure and financing

In relation to long-term care, give estimates of current cost taking into account as fully as possible the impact across different policy domains.

The cost of services for the ageing have been estimated on a basis of various national statistics. In 2000 not quite 17 million care days were produced in institutional care of the aged, over 12 million (73%) of these in long-term care. Some EUR 1.83 billion (FIM 10.9 billion) was spent on these services. This was 1,4 % of the GDP. However, of all forms of care, the costs of conventional institutional care have fallen most, while the costs of service housing and home

care have risen. In 2000 open community care services accounted for 23% of costs, institutional care for 65% and service housing for 12%.

Table 6. Estimated costs of the most important care services for elderly people (+65) and their cost structure in 2000

	2000	%
Operating costs, € million		
- home help services	315,7	17
- auxiliary services	49,8	3
- informal care allowance	51,0	3
- service housing	219,0	12
- homes for the old people	622,3	34
- long term care in health care	573,7	31
Total	1 831,5	100

Source: Vaarama M., Voutilainen P., Kauppinen S. Ikääntyneiden palvelut. Sosiaali- ja terveydenhuollon palvelukatsaus 2002. Stakes. Raportteja 268/2002. Saarijärvi 2002

Describe, where these exist, specific funding mechanisms for long-term care (e.g. targeted social insurance contributions).

There are no such specific funding mechanisms

3.2.2 Cost control mechanisms

The role of charges in controlling demand for formal care.

See above 3.1.3

Charges are seen primarily as one (limited) source of service funding which can also be used to some extent to influence service supply and demand, and service structure. They should not prevent people from using necessary services. Fees for long-term care are fixed according to payment capacity (income).

How to ensure cost consideration in the planning and provision of long-term care: are there comparative assessments of different approaches (institutional/home-based; formal/informal)? Are there mechanisms for raising the sensitivity of care professionals and decision makers (e.g. social workers) to cost considerations?

See table on the cost data for the different alternatives in section 3.2.1.

Are there mechanisms for assessing long-term care and health care costs in an integrated way.

Municipal personnel can be given guidance in matters related to cost management. Cost consciousness took on a more important role during the recession and after it.

3.2.3 Challenges

Outline the main challenges regarding sustainability of provisions for long-term care.

The rising number and proportion of older persons, the ageing of the working-age population, and the relative deterioration in the economic dependency ratio are the future challenges. One particular challenge is the need to safeguard funding for services paid for out

of taxes in areas suffering loss of population, where there are lot of old people and extensive unemployment. A rise in the employment rate would make funding easier.

Challenge is also to improve the functional capacity of ageing people to reduce the number of years they need care during their longer life span.

The social protection system should ensure that services are provided rationally and on the client's terms. The problem here is that there may be cases where service funding and income transfers, rather than actual service needs, may be the factors determining the content and location of the services a client receives. These same factors may also influence the development of municipal service structures.

The fact that clients who need many services and have multiple health problems 'build up' large sums in fees and 'own risk' deductibles is one of the biggest problems of payment policy, along with the wide variation in out-patient fees in different municipalities.

See above 3.1.4

3.2.4 Planned policy changes

Describe any planned changes.

Public services financed out of taxes will remain the basic strategy. A stronger focus will be placed on preventing health problems, maintaining functional capacity, and rehabilitation. Payment policy will be reformed so as to encourage rational care choices and remove the boundary between institutional and out-patient care.