Finland

Health Care & Long-Term Care Systems

An excerpt from

the Joint Report on Health Care and Long-Term Care Systems & Fiscal Sustainability,

published in October 2016
as Institutional Paper 37
Volume 2 - Country Documents

Economic and Financial Affairs
Economic Policy Committee

Finland

Health care systems

1.9. FINLAND

General context: Expenditure, fiscal sustainability and demographic trends

General statistics: GDP, GDP per capita; population

In 2013, Finland had a GDP per capita of 27.9 PPS (in thousands), very similar to the EU average.

Population was estimated at 5.4 million in 2013. According to projections, total population in Finland is projected to increase from around 5.4 million in 2013 to 6.2 million in 2060.

Total and public expenditure on health as % of GDP

Total expenditure ([91]) on health as a percentage of GDP (9.4% in 2013) has increased over the last decade (from 7.4% in 2001, although it has been relatively flat since 2009), below the EU average ([92]) of 10.1% in 2013. Public expenditure has increased, though to a smaller extent: from 5.3% in 2001 to 7.1% of GDP in 2013. It is also below the EU average of 7.8% in 2013. According to the authorities, the main factors explaining the growth of health expenditure are the increased costs of specialised care and pharmaceuticals.

When expressed in per capita terms, total spending on health at 2,951 PPS in Finland is below the EU average of 2,988 in 2013, while public spending on health care is slightly higher: 2,221 PPS vs. an average of 2,208 PPS in 2013.

Expenditure projections and fiscal sustainability

As a consequence of demographic changes, health care expenditure is projected to increase by 0.7 pps of GDP, below the average growth expected for the EU (0.9) ([93]), according to the Reference Scenario. When taking into account the impact of non-demographic drivers on future spending growth (AWG risk scenario), health care expenditure is expected to increase by 1.3 pps of GDP from now until 2060 (EU value: 1.6).

High risks appear in the medium term from a debt sustainability analysis perspective due to the relatively high stock of debt at the end of projections (2026), and the sensitivity to possible shocks to nominal growth, interest rates and the government primary balance. Jointly simulated shocks to growth, interest rates and the primary balance point to an 80% probability of a debt ratio in 2020 greater than in 2015. Finland faces medium sustainability risks over the long run. These are primarily related to the unfavourable initial budgetary position compounded by the projected impact of age-related public spending (notably healthcare and long-term care). ([94])

Health status

Life expectancy at birth (84.1 years for women and 78.0 years for men in 2013) is close to the respective EU averages (83.3 and 77.8 years of life expectancy in 2013). ([95]) However, healthy life years, at 56.2 years for women and 57.3 years for men, were below the EU averages of 62.1 and 61.5 in 2012. The infant mortality rate of 1.8‰ is lower than the EU average of 3.9‰ in 2013, having gradually fallen over most of the last decade (from 3.2‰ in 2001), although it has been relatively flat since 2010, until it fell finally below 2‰ in 2013.

As for the lifestyle of the Finnish population, the data indicates a constant fall in the proportion of the regular smokers (from 23.8% in 2001 to 15.8% on 2013), below the EU average of 22.0 in 2013). Over the same period the proportion of the obese in the population has increased (from 11.4% in 2001 to 16.6% in 2011). Alcohol consumption has increased since 2001, when it was 8.9 litres per capita, to 9.0 in 2013, although still below the peak of 10.5 in 2007 and the 2013 EU average of 9.8.

([91]) Data on health expenditure is taken from OECD health data and Eurostat database. The variables total and public expenditure used here follow the OECD definition under the System of Health Accounts and include HC.1-HC.9 + HC.R.1.

([92]) The EU averages are weighted averages using GDP, population, expenditure or current expenditure on health in millions of units and units of staff where relevant. The EU average for each year is based on all the available information in each year.

([93]) The 2015 Ageing Report: http://europa.eu/epc/pdf/ageing_report_2015_en.pdf

([94]) Fiscal Sustainability Report 2015: http://ec.europa.eu/economy_finance/publications/eeip/pdf/ip018_en.pdf

([95]) Data on health status including life expectancy, healthy life years and infant mortality is from the Eurostat database. Data on life-styles is taken from OECD health data and Eurostat database.

System characteristics

Coverage

Finnish municipalities and their co-operation networks are required to provide social and health care services, including essential public health services and actions, to their resident citizens.

The provision of health care by the municipalities is complemented by the Finnish statutory health insurance, which covers the entire population, and includes both medical care insurance and earned income insurance.

KELA, the Social Insurance Institution of Finland is in charge of health insurance. This insurance reimburses patients for tests and treatments prescribed by private doctors and dentists as well as for any charges paid according to statutory reimbursement rates. Costs in excess of the statutory reimbursement rate are paid by patients. The insurance is financed 50/50 from taxation and contributions. Contributions to this insurance are deducted from the taxable income, benefits and/or pension of the insured.

Earned income insurance covers other benefits such as allowances for sickness, rehabilitation, special care, and maternity/paternity.

Administrative organisation and revenue collection mechanism

From a financial point of view, the Finnish health care system has three main parts: municipal health care services (primary and specialised health services), private health services and occupational health services.

An integrated but decentralised system of municipal health care services, funded on the basis of taxes (central and local taxes and for a small part client fees), provides full population coverage. On the basis of legal provisions (harmonised legislation and guidelines), the 320 municipalities (in 2013, compared to 415 in 2008) are responsible for providing or funding a wide range of health services (including health promotion, disease prevention and rehabilitation) for their residents (still less than 10 000 in the majority of municipalities). Primary care is provided by individual municipalities or by groups of municipalities whereas the specialised health care is organised through federations of municipalities. In 2014, 50% of the population used the services of a GP and 68% GP or other services of the multiprofessional municipal public health centres. This is coupled with a compulsory national medical insurance (run by KELA, the Social Insurance Institution) covering all residents ([96]), financed through the state (50 55%) and the insured (50 45%). This covers part of patients' expenditure on outpatient drugs, transportation costs but also part of private health care (mainly outpatient visits and ambulatory care in big cities). Use of private health services represented 5.9% of total health expenditure in 2013. In addition, employers provide/buy occupational health services predominantly preventive and first aid care, but also basic outpatient care for common illnesses in the case of larger companies. The role of compulsory occupational health care is significant, as it covers around one third of the total population. Supplementary private health care insurance is available but has only a minor role. In 2013, the share of primary and occupational health services was 17.3% and that of specialised care 38% of total health expenditure.

Role of private insurance and out of pocket co-payments

Preventive and promotive services are mostly free of charge and used widely. However, users pay an out-of-pocket fee for the use of ambulatory and hospital services, including laboratory tests and scans. The maximum fees are set by central government every six months. Users are further protected by an annual ceiling, above which they are able to use of all municipal health services without further fees.

Most municipal health services (primary, outpatient specialist care, hospital day case and inpatient care, dental care, physiotherapy) involve a fee at the point of use. Children and those who have reached an upper limit for out-of-pocket payments are exempted from cost-sharing. Use of child clinics, including vaccinations, and maternity services is free of charge. The occupational health care is free of charge to the employee. Under the

([96]) This is a part of the national health insurance scheme that covers both the medical insurance and the sickness and parenthood allowances scheme.

national medical health insurance the cost-sharing applies to pharmaceuticals and many private health care services (see the previous paragraph). Eyeglasses and contact lenses are, for example, not funded or provided by local or state authorities.

Reimbursement for pharmaceutical outpatient prescriptions is calculated as a percentage of the medicine's reference price. Patients enjoy a fixed deduction due to any travel expenses as well as the cost of prescribed medicines. Again, an annual ceiling is set on the maximum amount that patients pay for prescriptions and travel expenses.

11.4% of the population buys supplementary private insurance (to cover the services not covered by public provision/ funding) and 11.5% buys complementary health insurance to cover cost-sharing. If cost-sharing is fully covered by private insurance it may lose the ability to reduce overconsumption and/or encourage some services more than others, although complementary insurance is taken by a relatively small share of the population.

In 2013, private expenditure and out-of-pocket expenditure were 24.7% and 18.5% of total health expenditure and therefore above the EU average (22.6% and 14.1%). Both have fallen since their 2001 values of 27.8% and 21.6%.

To improve access and reduce the waiting times for primary care, legislation was introduced which establishes the right to immediate access to health centres by phone or a visit during working hours and evaluation of the person´s health care needs within 3 working days. To reduce waiting times for hospital surgery, which was seen as a problem in Finland, legislation provides that a non-urgent referral must be assessed within 3 weeks and hospital treatment provided within 6 months. When this is not possible, patients can be treated in another hospital district or in the private sector at the authorities' expenses. In many areas there are phone services and web pages in place to help patients access the system. Waiting times have seen a reduction since these systems have been implemented. Some hospital districts provide online data on waiting times. In addition, the National Institute for Health and Welfare publishes general statistics on waiting times.

Types of providers, referral systems and patient choice

Primary care is provided by general practitioners (GPs) in municipal public health centres while outpatient specialist care is provided in outpatient hospital departments. In larger cities the public health centres also provide outpatient specialist services. Federations of municipalities form hospital districts (20 districts in total excluding the Åland Island) and own public hospitals. About 89% of all hospital beds are public. The 20 hospital districts are further grouped into 5 tertiary care regions around universities with medical schools. Private provision, often through group practices, mostly concerns outpatient specialist and simple ambulatory services, and typically takes place in urban areas. Private physicians can, however, refer patients to public hospitals. Of physicians, 70% work in the public and 30% in the private sectors. Of all physicians working in the public sector, 24% work also on a part time basis in the private sector outside office hours. The proportion of GPs who work in the public health centres and have a private practice outside office hours is 12%.

The number of licensed physicians per 100 000 inhabitants in Finland is, at 302 in 2013, far below the EU average of 344 in that year. It has increased continuously since 2001. The number of general practitioners (GPs) per 100 000 inhabitants was 120 in 2013, above the EU average of 78.3. The number of nurses per 100 000 inhabitants (1412 in 2012) was far above the EU average of 829.

Authorities acknowledge shortages of staff in some specialties and in some geographic areas. A shortage of GPs in certain municipalities may explain longer waiting times to see a GP. Staff supply is regulated in terms of quotas for medical students but not in terms of the location of physicians. The GP shortage has been addressed by redistribution of professional responsibilities in primary care between physicians and public health nurses. The effectiveness of this measure is unclear at this stage.

Authorities have made some efforts to use primary care vis-à-vis specialist and hospital care. While residents are free to contact a GP, there is in municipal health care a compulsory referral system from primary care to specialist doctors i.e. GPs act

like gatekeepers to specialist and hospital care. However, in some areas, shortages in GPs may have led to perceived long waiting times for GP visits and therefore led to unnecessary visits to specialists or emergency departments.

Choice of GP, specialist and hospital is allowed but limited. Increasing patient choice is, in fact, a priority of national authorities.

The number of acute care beds per 100 000 inhabitants (281 in 2013) is well below the EU average of 356 for that year. It has consistently decreased in recent times (341 in 2003) and stands as one of the lowest in the EU. There appears to be no regulation in terms of increases in hospital capacity or equipment capacity. Hospitals have autonomy to recruit medical staff and other health professionals. Private hospitals are free to establish and expand their capacity in compliance with quality and safety requirements.

Treatment options, covered health services

The Ministry of Social Affairs and Health defines general policy guidelines and regulation, but there is not a defined basic benefit package. The Council for Choices in Health Care at the Ministry of Social Affairs and Health provides recommendations on which treatments and other health technologies methods are included in the range of health services provided by public funding in Finland.

Price of healthcare services, purchasing, contracting and remuneration mechanisms

Public sector physicians (GPs and specialists) are paid a salary. The pay scale for medical staff and other health professionals is set at national level. The labour unions negotiate with the Commission for Local Authority Employers over salaries. The Government does not have a role in this procedure. Physicians are not eligible to receive bonuses regarding their activity or performance, although a small share of the salary of dentists and primary care physicians is paid following a fee-for-service principle. Of physicians 70% work in the public and 30% in the private sectors. Physicians who work in the public sector may also practice in the private sector based on the approval of the (public) employer. Of all physicians working in the public sector, 24% work also on a part time basis outside their office hours in the private sector. The proportion of GPs who work in the public health centres and have a private practice outside office hours is 12%. This is considered to be a measure to increase access.

The municipalities remunerate the hospital districts for their services. In most hospital districts some type of payment per case basis using DRGs is in use. Hospital remuneration methods are negotiated at local level.

When looking at hospital activity, inpatient discharges (1,731 per 100 000 inhabitants in 2013) are above the EU average (1,649) while the number of day case discharges, at 5,323 in 2013, is below the EU average of 7,031. The proportion of surgical day case discharges amongst all procedures conducted was 23.5% in 2013, being below the EU average (30.4%). Acute average length of stay (6.8 days in 2013) is below the EU average (6.3 days in 2013).

The market for pharmaceutical products

The authorities have implemented a large number of policies to control expenditure on pharmaceuticals. Initial price is based on clinical performance, economic evaluation, the cost of existing treatments and international prices (NL, BE, ES, IE, IS, UK, IT, AT, EL, LU, NO, PT, FR, SE, DE, and DK). The government has used price freezes and cuts and there is a positive and a negative list of reimbursed products which is based partly on health technology assessment information when available. Authorities promote rational prescribing of physicians through treatment guidelines complemented with monitoring of prescribing behaviour and education and information campaigns on the prescription and use of medicines. The structure of co-payments changed in 2006 so that the co-payment is now a share of the medicine's cost rather than a fixed amount for any "visit" to the pharmacy, which appears to have encouraged patients to buy excessive quantities of medicines. There is an explicit generics policy. Prescription by active element is in place although its application is rare. Nevertheless, pharmacies are obliged to dispense the cheaper product and replace the prescription by a generic medicine if available. Generics face a fast track registration and lower registration fees. Patients aware of the generic substitution appear to

request cheaper medicines and electronic systems allow doctors (and therefore the patients) to access the prices of medicines when prescribing medicines. Generic substitution is particularly important when patients have to incur a large share of the cost. In April 2009, reference pricing was introduced. The reimbursement is based on the reference price that is the price of the cheapest substitutable product plus a small premium. If the patient chooses a product whose retail price exceeds the reference price, he/she must pay the share above the reference price. Both generic substitution and reference pricing systems have had notable downward effects on the pharmaceutical expenditure. Authorities (through KELA, the Social Insurance Institution) monitor the general consumption of prescribed medicines closely and evaluate the budgetary impact of generic substitution.

Pharmaceutical spending as a proportion of current health spending fell from 16.9% in 2005 to 13.9% in 2013. It is below the EU average of 14.9% for that year. Pharmaceutical spending remained on the same level in 2014, but increased 5% in 2015.

eHealth, Electronic Health Record

The coverage of electronic patient records has been 100 % in Finland for many years now. Finland has also introduced a nationwide harmonised electronic patient record (Patient Data Repository), an electronic prescription, a citizens' health portal (My Kanta pages) and a national medicine record (Pharmaceutical Database). These initiatives have been a part of the National Archive of Health Information –project (Kanta).

The electronic prescription is in use by both public and private organisations and the coverage is in public organisations nearly 100 %. Electronic prescription is mandatory as of 1.1.2017. All public organisations are connected to the Patient Data Repository and private organisations are starting to participate in 2016. This allows sharing of data between healthcare providers securely and with patient consent. Citizen's health portal enables patients to inspect their electronic prescriptions and health records, log data, give consent and denials and make advanced directives (e.g. living will). The national medicine record provides regularly updated information for physicians and pharmacies about e.g. the cost, reimbursement eligibility and substitutability of pharmaceuticals. Modernisation of electronic health record systems and other health/hospital/patient access systems is moving forward. Finland also has a national eHealth - strategy for information management and ICT-development.

Health and health-system information and reporting mechanisms/ Use of Health Technology Assessments and cost-benefit analysis

Finland has an extensive information management and statistics systems and comprehensive data is gathered on physician and hospital activity and quality and health status. Hospital benchmarking data is available allowing for costs and efficiency comparisons. Existing clinical guidelines and practice protocols are coupled with the monitoring of physician activity and feedback to physicians (for example on their prescription behaviour) to encourage compliance with those guidelines. Through surveys, authorities are planning to collect information on patient's experience and satisfaction with the care obtained. They also want to make information publicly available.

The Centre for Health Economics (CHESS) at the National Institute for Health and Welfare undertakes high-quality health economics research on issues relevant for health policy. CHESS focuses on quality and efficiency of health services, financing and provision of health services and evaluation of health services system. The Finnish Office for Health Technology Assessment (Finohta) produces, supports and coordinates health care technology assessment in Finland. It disseminates assessment results and experiences, both national and international, within the health system. The Pharmaceuticals Pricing Board confirms the reimbursement (including the level of reimbursement) and a reasonable wholesale price for pharmaceuticals.

The Parliament, the Government through the Ministry of Health, and municipalities set public health priorities in terms of outcomes and the reduction of health inequalities. For example, a shared project of the National Institute for Health and Welfare and the Finnish Institute of Occupational Health (the TEROKA project) aims aimed to develop information on health

inequalities and to promote the reduction of inequalities. As section 1 suggests there are indeed a number of risk factors that can translate into an important burden of disease and financial costs. Authorities have strongly emphasised health promotion and disease prevention measures in recent years as well as emphasising the important contribution other policy areas can make to improve the health of the population ("Health in all Policies"). Recent legislation will define more explicitly the promotion and preventive services to be provided at municipal level. Promotion and prevention are seen by authorities as a means to ensure long-term sustainability of the health budget: they reduce the development of disease; the need for care; and, the consequent need for funding.

Public expenditure on prevention and public health services as a % of GDP was above the EU average 0.28% vs. 0.19% in 2013. This was also the case as a % of total current health expenditure (4.3% vs. the EU average of 2.5% in 2013).

Recently legislated and/or planned policy reforms

On April 5 2016 the Finnish Government published it's detailed position, which will guide the drafting of legislation on three interconnected reforms: (1) the reform of the organisation of health and social services, (2) the reform relating to freedom of choice and multisource financing, and (3) the regional government reform, i.e. the establishment of 18 independent counties governed by elected county councils.

The goals of these reforms are to (1) reduce the currently forecasted public finance sustainability gap by EUR 3 billion by 2030, (2) guarantee equal access to high quality services everywhere in the country and (3) reduce health inequities.

The health and social reform is based on a client-centred integration of health and social services as the key measure for narrowing health and wellbeing disparities, improving the effectiveness of the services in an equal manner and bringing cost savings. A single strong organiser, county, will be responsible for services, steering, official activities, evaluation of regional impact, cost-effectiveness and quality services as well as supporting the users' freedom of choice. Freedom in the choice of choice of services, the details of which are decided later in the legislative process, will enable users themselves to make choices between the providers.

The county will have a single budget and a single financial management and it will produce the necessary health and social services itself or together with other counties, or it may rely on private or third sector in the provision of services. Counties will be financed by the central government and the current multisource financing will be simplified. The relevant perspectives of European Union law and the realisation of fundamental rights will be taken into account in the legislative drafting.

Counties will ensure that the organisation and provision of services are genuinely separated and performed by different organisations (legal persons). Freedom of choice will significantly promote competition in the provision of services. Integration of information systems will increase information flows between different providers. Consequently, the integration of service chains will improve. Essential public health functions, including health promotion and disease prevention, will be ensured.

The decision entails a major shift of paradigm and will require additional planning to that already carried out at earlier phases of the reform preparations. The requisite constitutional assessment of different funding alternatives will be carried out as a part of the drafting of the new legislation. The government bills on the reform will be passed to the Parliament in 2016 and 2017, and enacted in 2019. Improved cost management will be a key principle when preparing legislation and implementing the reform. Successful and skilful change management will be a prerequisite for achieving the targets and thus will receive particular attention during the reform implementation.

Challenges

The analysis above shows that a wide range of reforms have been implemented over the years, to a large extent successfully (e.g. to reduce waiting times, to improve hospital efficiency, to improve data collection and monitoring, to control pharmaceutical expenditure), and which Finland

should continue to pursue. The main challenges for the Finnish health care system are as follows:

- To ensure greater coherence between the sources of financing so that they reinforce equity and efficiency in the system.
- To ensure consistency in the provision of health care by different municipalities, ensuring equity of access and cost-effectiveness.
- To enhance primary care provision by increasing the numbers and spatial distribution of GPs and nurses and by rendering referral system to specialist care more effective.
- To consider whether it is worth introducing some element of performance related payment physicians' remuneration (e.g. through the use of mixed payment schemes) to encourage health promotion, disease prevention and disease management activities or the treatment of vulnerable populations and increase outpatient output and render primary care more attractive. More generally, to ensure sufficient numbers of staff in view of ageing of staff and population.
- To increase hospital efficiency by increasing the use of day case surgery and increasing the supply of follow-up care for long-term care patients so as to reduce the unnecessary use of acute care settings for long-term care patients. In addition, measures pursued in recent years should be consolidated to reduce duplication and improve efficiency and quality in the hospital sector (e.g. concentration and specialisation of hospitals within regions).
- To ensure a greater use of health technology assessment to determine new high-cost equipment capacity as well as the benefit basket and the cost-sharing design across medical interventions as is currently done with medicines.
- To further enhance health promotion and disease prevention activities i.e. promoting healthy life styles and disease screening given the recent pattern of risk factors (diet, smoking, alcohol, obesity) in various settings (at work, in school).
- To tackle the increased waiting times found in some areas, especially by distributing healthcare staff more efficiently.
- To track the sustainability of the healthcare system and ensure that the medium and long-term risks are accounted for. All the potential cost-drivers should be considered and dealt with.

Table 1.9.1: **Statistical Annex – Finland**

General context												EU- latest national data		
GDP	**2003**	**2004**	**2005**	**2006**	**2007**	**2008**	**2009**	**2010**	**2011**	**2012**	**2013**	**2009**	**2011**	**2013**
GDP, in billion Euro, current prices	152	158	164	173	187	194	181	187	197	200	203	9289	9800	9934
GDP per capita PPS (thousands)	27.0	28.9	29.3	30.4	32.1	31.7	28.3	29.2	29.6	29.0	27.9	26.8	28.0	27.9
Real GDP growth (% year-on-year) per capita	1.8	3.8	2.6	4.0	4.9	-0.2	-9.0	2.9	2.3	-1.5	-1.8	-4.8	1.4	-0.1
Real total health expenditure growth (% year-on-year) per capita	6.4	4.6	5.3	2.9	1.1	3.2	0.4	0.9	1.8	0.0	1.5	3.2	-0.2	-0.4

Expenditure on health*												**2009**	**2011**	**2013**
Total as % of GDP	8.2	8.2	8.4	8.3	8.0	8.3	9.2	9.0	9.0	9.1	9.4	10.4	10.1	10.1
Total current as % of GDP	7.8	7.9	8.1	7.9	7.6	7.9	8.7	8.6	8.5	8.7	8.6	9.8	9.6	9.7
Total capital investment as % of GDP	0.4	0.4	0.4	0.4	0.4	0.4	0.5	0.4	0.4	0.4	0.8	0.6	0.5	0.5
Total per capita PPS	1983	2088	2217	2295	2382	2544	2611	2633	2746	2817	2951	2828	2911	2995
Public as % of GDP	5.9	6.0	6.2	6.3	6.0	6.2	6.9	6.7	6.7	6.8	7.1	8.1	7.8	7.8
Public current as % of GDP	5.6	5.7	5.9	5.9	5.7	5.9	6.5	6.3	6.3	6.5	6.5	7.9	7.7	7.7
Public per capita PPS	1314	1400	1489	1556	1614	1721	1751	1766	2047	2113	2221	2079	2218	2208
Public capital investment as % of GDP	0.3	0.3	0.3	0.4	0.3	0.3	0.4	0.4	0.3	0.3	0.6	0.2	0.2	0.1
Public as % total expenditure on health	72.8	73.3	73.8	74.9	74.4	74.5	74.8	74.2	74.5	75.0	75.3	77.6	77.2	77.4
Public expenditure on health in % of total government expenditure	12.9	13.1	13.7	14.0	13.9	14.2	14.1	14.2	14.3	14.5	:	14.8	14.9	:
Proportion of the population covered by public or primary private health insurance	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	99.7	99.7	98.7
Out-of-pocket expenditure on health as % of total expenditure on health	21.9	21.4	21.0	20.1	20.4	20.1	19.9	20.6	20.1	19.6	18.5	14.1	14.4	14.1

Note: *Including also expenditure on medical long-term care component, as reported in standard internation databases, such as in the System of Health Accounts. Total expenditure includes current expenditure plus capital investment.

Population and health status												**2009**	**2011**	**2013**
Population, current (millions)	5.2	5.2	5.2	5.3	5.3	5.3	5.3	5.4	5.4	5.4	5.4	502.1	504.5	506.6
Life expectancy at birth for females	81.9	82.5	82.5	83.1	83.1	83.3	83.5	83.5	83.8	83.7	84.1	82.6	83.1	83.3
Life expectancy at birth for males	75.1	75.4	75.6	75.9	76.0	76.5	76.6	76.9	77.3	77.7	78.0	76.6	77.3	77.8
Healthy life years at birth females	56.5	53.1	52.5	52.8	58.0	59.5	58.6	57.9	58.3	56.2	:	:	62.1	61.5
Healthy life years at birth males	57.3	53.3	51.7	53.2	56.8	58.6	58.2	58.5	57.7	57.3	:	:	61.7	61.4
Amenable mortality rates per 100 000 inhabitants*	70	64	62	60	57	54	54	51	114	115	:	64.4	128.4	:
Infant mortality rate per 1 000 life births	3.1	3.3	3.0	2.8	2.7	2.6	2.6	2.3	2.4	2.4	1.8	4.2	3.9	3.9

Notes: Amenable mortality rates break in series in 2011.

System characteristics												EU- latest national data		
Composition of total current expenditure as % of GDP	**2003**	**2004**	**2005**	**2006**	**2007**	**2008**	**2009**	**2010**	**2011**	**2012**	**2013**	**2009**	**2011**	**2013**
Inpatient curative and rehabilitative care	2.28	2.20	2.21	2.12	2.00	1.99	2.32	2.31	2.39	2.43	2.49	3.13	2.99	3.01
Day cases curative and rehabilitative care	0.12	0.10	0.11	0.10	0.10	0.10	0.10	0.11	0.11	0.12	0.13	0.18	0.18	0.19
Out-patient curative and rehabilitative care	2.01	2.16	2.24	2.34	2.28	2.47	2.66	2.67	2.71	2.80	2.79	2.29	2.25	2.24
Pharmaceuticals and other medical non-durables	1.29	1.32	1.35	1.22	1.19	1.23	1.30	1.25	1.20	1.21	1.20	1.60	1.55	1.44
Therapeutic appliances and other medical durables	0.21	0.21	0.21	0.22	0.21	0.20	0.22	0.22	0.22	0.21	0.21	0.31	0.31	0.32
Prevention and public health services	0.39	0.40	0.43	0.43	0.43	0.45	0.49	0.48	0.52	0.54	0.51	0.25	0.25	0.24
Health administration and health insurance	0.12	0.12	0.11	0.12	0.10	0.11	0.10	0.09	0.08	0.08	0.08	0.42	0.41	0.47
Composition of public current expenditure as % of GDP														
Inpatient curative and rehabilitative care	2.03	1.96	1.99	1.90	1.79	1.78	2.08	2.08	2.16	2.21	2.27	2.73	2.61	2.62
Day cases curative and rehabilitative care	0.12	0.09	0.10	0.08	0.08	0.08	0.09	0.09	0.09	0.10	0.10	0.16	0.16	0.18
Out-patient curative and rehabilitative care	1.42	1.57	1.65	1.75	1.71	1.88	2.00	2.00	2.04	2.11	2.14	1.74	1.71	1.80
Pharmaceuticals and other medical non-durables	0.63	0.67	0.68	0.66	0.64	0.67	0.72	0.69	0.67	0.68	0.63	0.79	1.07	0.96
Therapeutic appliances and other medical durables	:	:	:	:	:	:	:	:	:	:	:	0.13	0.12	0.13
Prevention and public health services	0.23	0.24	0.26	0.27	0.28	0.28	0.29	0.28	0.31	0.32	0.28	0.25	0.20	0.19
Health administration and health insurance	0.19	0.18	0.17	0.18	0.16	0.16	0.15	0.14	0.12	0.13	0.12	0.11	0.27	0.27

Sources: EUROSTAT, OECD and WHO

Table 1.9.2: **Statistical Annex - continued – Finland**

												EU- latest national data		
Composition of total as % of total current health expenditure	**2003**	**2004**	**2005**	**2006**	**2007**	**2008**	**2009**	**2010**	**2011**	**2012**	**2013**	**2009**	**2011**	**2013**
Inpatient curative and rehabilitative care	29.3%	28.0%	27.5%	26.8%	26.2%	25.2%	26.7%	27.0%	28.0%	28.1%	28.8%	31.8%	31.3%	31.1%
Day cases curative and rehabilitative care	1.6%	1.2%	1.3%	1.2%	1.2%	1.2%	1.2%	1.2%	1.3%	1.4%	1.5%	1.8%	1.9%	1.9%
Out-patient curative and rehabilitative care	25.9%	27.5%	27.8%	29.6%	29.9%	31.3%	30.6%	31.2%	31.8%	32.3%	32.3%	23.3%	23.5%	23.2%
Pharmaceuticals and other medical non-durables	16.6%	16.8%	16.8%	15.4%	15.6%	15.6%	15.0%	14.6%	14.1%	14.0%	13.9%	16.3%	16.2%	14.9%
Therapeutic appliances and other medical durables	2.7%	2.7%	2.6%	2.7%	2.7%	2.5%	2.5%	2.6%	2.5%	2.4%	2.4%	3.2%	3.3%	3.3%
Prevention and public health services	5.0%	5.1%	5.3%	5.4%	5.6%	5.7%	5.6%	5.6%	6.1%	6.2%	5.9%	2.6%	2.6%	2.5%
Health administration and health insurance	1.5%	1.5%	1.4%	1.5%	1.3%	1.4%	1.2%	1.1%	0.9%	0.9%	0.9%	4.2%	4.3%	4.9%
Composition of public as % of public current health expenditure														
Inpatient curative and rehabilitative care	36.1%	34.2%	33.7%	32.3%	31.7%	30.4%	32.2%	33.0%	34.1%	34.1%	35.1%	34.6%	34.1%	34.0%
Day cases curative and rehabilitative care	2.1%	1.6%	1.7%	1.3%	1.4%	1.4%	1.3%	1.4%	1.5%	1.6%	1.6%	2.0%	2.1%	2.3%
Out-patient curative and rehabilitative care	25.3%	27.4%	27.9%	29.7%	30.3%	32.1%	31.0%	31.7%	32.2%	32.6%	33.0%	22.0%	22.3%	23.4%
Pharmaceuticals and other medical non-durables	11.2%	11.7%	11.5%	11.2%	11.3%	11.4%	11.1%	10.9%	10.6%	10.5%	9.7%	10.0%	13.9%	12.5%
Therapeutic appliances and other medical durables	:	:	:	:	:	:	:	:	:	:	:	1.6%	1.6%	1.6%
Prevention and public health services	4.1%	4.2%	4.4%	4.6%	5.0%	4.8%	4.5%	4.4%	4.9%	4.9%	4.3%	3.2%	2.7%	2.5%
Health administration and health insurance	3.3%	3.2%	3.0%	3.1%	2.8%	2.7%	2.3%	2.2%	2.0%	2.0%	1.9%	1.4%	3.5%	3.5%

												EU- latest national data		
Expenditure drivers (technology, life style)	**2003**	**2004**	**2005**	**2006**	**2007**	**2008**	**2009**	**2010**	**2011**	**2012**	**2013**	**2009**	**2011**	**2013**
MRI units per 100 000 inhabitants	1.30	1.40	1.47	1.52	1.53	1.56	1.57	1.86	2.02	2.16	2.21	1.0	1.1	1.0
Angiography units per 100 000 inhabitants	:	:	:	:	2.0	:	2.3	2.4	2.1	2.0	1.9	0.9	0.9	0.8
CTS per 100 000 inhabitants	1.4	1.4	1.5	1.5	1.6	:	2.0	2.1	2.1	2.2	2.2	1.8	1.7	1.6
PET scanners per 100 000 inhabitants	0.1	0.1	0.1	0.1	:	:	0.1	0.1	0.2	0.2	0.2	0.1	0.1	0.1
Proportion of the population that is obese	12.8	14.0	14.1	14.3	14.9	15.7	14.9	15.6	16.6	:	:	14.9	15.4	15.5
Proportion of the population that is a regular smoker	22.2	23.0	21.8	21.4	20.6	20.4	18.6	19.0	17.8	17.0	15.8	23.2	22.4	22.0
Alcohol consumption litres per capita	9.3	9.9	10.0	10.2	10.5	10.3	10.0	9.7	9.8	9.2	9.0	10.3	10.0	9.8

Providers	**2003**	**2004**	**2005**	**2006**	**2007**	**2008**	**2009**	**2010**	**2011**	**2012**	**2013**	**2009**	**2011**	**2013**
Practising physicians per 100 000 inhabitants	256	259	263	268	269	272	283	299	299	301	302	329	335	344
Practising nurses per 100 000 inhabitants	:	1213	1257	1315	1340	1314	1356	1386	1408	1412	:	840	812	837
General practitioners per 100 000 inhabitants	:	:	:	:	:	:	102	113	117	115	120	:	78	78.3
Acute hospital beds per 100 000 inhabitants	341	338	334	327	320	311	304	302	296	292	281	373	360	356

Outputs	**2003**	**2004**	**2005**	**2006**	**2007**	**2008**	**2009**	**2010**	**2011**	**2012**	**2013**	**2009**	**2011**	**2013**
Doctors consultations per capita	4.2	4.2	4.3	4.3	4.2	4.3	4.2	4.3	2.8	2.7	2.6	6.3	6.2	6.2
Hospital inpatient discharges per 100 inhabitants	20.8	20.5	20.1	19.6	19.0	18.8	18.4	18.2	18.0	:	17.3	16.6	16.4	16.5
Day cases discharges per 100 000 inhabitants	5,051	5,191	5,552	5,403	5,429	5,434	5,332	5,473	5,547	:	5,323	6368	6530	7031
Acute care bed occupancy rates	:	:	:	:	:	:	:	:	:	:	:	72.0	73.1	70.2
Hospital curative average length of stay	7.1	7.1	7.1	7.2	7.2	7.1	7.1	7.0	6.9	6.9	6.8	6.5	6.3	6.3
Day cases as % of all hospital discharges	19.5	20.2	21.6	21.6	22.2	22.4	22.4	23.2	23.6	:	23.5	27.8	28.7	30.4

Population and Expenditure projections

Projected public expenditure on healthcare as % of GDP*	**2013**	**2020**	**2030**	**2040**	**2050**	**2060**	**Change 2013 - 2060**	**EU Change 2013 - 2060**
AWG reference scenario	7.8	8.1	8.4	8.5	8.5	8.5	0.7	0.9
AWG risk scenario	7.8	8.1	8.6	8.9	9.1	9.1	1.3	1.6

Note: *Excluding expenditure on medical long-term care component.

Population projections	**2013**	**2020**	**2030**	**2040**	**2050**	**2060**	**Change 2013 - 2060, in %**	**EU - Change 2013 - 2060, in %**
Population projections until 2060 (millions)	5.4	5.6	5.9	6.1	6.2	6.2	14.8	3.1

Sources: EUROSTAT, OECD and WHO

Finland

Long-term care systems

2.9. FINLAND

General context of long-term care system: expenditure, fiscal sustainability and demographic trends

Finland, member of the European Union since 1995, has a population of around 5.4 million inhabitants, which is roughly 1% of the EU population in 2013. ([368]) It is expected to reach 6.2 million in 2060, a demographic expansion of 15%. With a GDP of around EUR 203 billion, or 27,900 PPS per capita it roughly coincides with the EU average GDP per capita for the most recent year of 2013.

Health status

Life expectancy at birth for both men and women was, in 2013, respectively 78.0 years and 84.1 years and is slightly above to the EU average (77.8 and 83.3 years respectively). However, the healthy life years at birth for both sexes are 56.2 years (women) and 57.3 years (men) are below the EU-average (62.1 and 61.5 respectively), as measured in 2012. At the same time, the percentage of the Finnish population having a long-standing illness or health problem is far higher than in the Union as a whole (47.5% and 32.5% respectively in 2013). The percentage of the population indicating a self-perceived severe limitation in its daily activities has decreased since 2004, and was lower than the EU-average when it was last recorded in 2012 (7.1% against 8.6%).

Dependency trends

In terms of dependency, the number of patients depending on others to perform daily activities is projected to grow from 0.43 in 2013 to 0.62 million in 2060, marking a 44% increase above the EU average of 40% for these years. The proportion of the dependents as a group in the whole population is also foreseen to increase from 7.9% to 9.9% in 2060, a change of 25% below than the EU average of 36%.

Expenditure projections and fiscal sustainability

Long-term public spending on LTC is expected to rise over the course of the next 50 years. ([369]) The AWG reference scenario displays an 86% rise in expenditure from 2.4 in 2013 to 4.6 in 2060, with the EU averaging a 40% rise for those years. However the AWG risk scenario reveals a comparably flatter increase for Finland as the corresponding growth rate is below the EU average this time (136% vs. 149%). Expenditure is still expected to grow in this scenario from 2.4 in 2013 to 5.8 in 2060.

High risks appear in the medium term from a debt sustainability analysis perspective due to the relatively high stock of debt at the end of projections (2026), and the sensitivity to possible shocks to nominal growth, interest rates and the government primary balance. Jointly simulated shocks to growth, interest rates and the primary balance point to an 80% probability of a debt ratio in 2020 greater than in 2015. Finland faces medium sustainability risks over the long run. These are primarily related to the unfavourable initial budgetary position compounded by the projected impact of age-related public spending (notably healthcare and long-term care). ([370])

System Characteristics ([371])

Public spending on LTC reached 2.3% of GDP in 2012 in Finland, above the EU average of 1.0% of GDP.

In Finland, 100% of dependents are receiving formal in-kind LTC services or cash benefits for LTC, far above the EU average of 53%. Overall, 9.5% of the population (aged 15+) receive formal LTC in-kind and/or cash benefits (EU: 4.2%). On the one hand, low shares of coverage may indicate a situation of under-provision of LTC services. On the other hand, higher coverage rates may imply an increased fiscal pressure on government budgets, possibly calling for greater needs of policy reform.

The expenditure for institutional (in-kind) services (including sheltered housing with 24-hour assistance) makes up 34.3% of public LTC expenditure (EU: 61%), 65.7% being spent for LTC services provided at home (EU: 39%).

([368]) This is according to EUROPOP2013 Eurostat data.

([369]) The 2015 Ageing Report: http://europa.eu/epc/pdf/ageing_report_2015_en.pdf

([370]) Fiscal Sustainability Report 2015: http://ec.europa.eu/economy_finance/publications/eeip/pdf/ip018_en.pdf

([371]) This section draws on OECD (2011b) and ASISP (2014).

LTC policy is implemented both at local and national level. The main responsibility for the provision of LTC to elderly and disabled people, including rehabilitation, lies with the municipal authorities, their social welfare, health care service and service organisations. In contrast, at national level, the legislative framework contains the general conditions for the provision of services.

The 303 municipalities have the responsibility to provide health and LTC services for residents. They may exercise this power on their own or in cooperation with other municipalities. As well as directly providing services, municipalities can also commission them from private or public service providers, or provide LTC recipients with service vouchers that can be used to directly purchase services from private providers.

Long-term care can be provided as home care, in the recipients' own homes or in sheltered housing units, as well as, as institutional care in residential institutions for and in the inpatient wards of health centres or hospitals.

Administrative organisation

Residence is the basis for entitlement to LTC services in Finland. Services and income security are provided as part of health and social care. It is the responsibility of municipalities to arrange the delivery of these services to recipients. An individual needs assessment is performed by the municipality to decide whether to grant services. As explained above, municipalities may provide the services directly or alternatively purchase them from other municipalities or private service providers.

Since 2011, recipients of LTC that have received care for more than a year have been granted the right to change the municipality that provides them LTC. The original municipality has to pay for the services arranged in the new municipality.

The municipality grants services on the basis of an individual assessment of needs. The needs must be assessed in a flexible manner, using reliable evaluation methods, and in cooperation with various actors. Based on the identified needs, a service plan is drawn up together with the person and, if necessary, a family member or a friend. After that, an administrative decision is made by a public servant concerning the services that the municipality is responsible for providing.

Types of care

Long-term care benefits are benefits in kind, except informal care support, which is a cash benefit. Benefits in kind include institutional care, home help, informal care support, day care, day and service centres, sheltered housing and family care. The Social Security Institution (KELA) provides the Care Allowance for Pensioners, a cash benefit that aims to support pension recipients with an illness or disability to continue living at home, as well as to help meet extra costs caused by illness or disability. The average allowance is around EUR 100 per month.

Home service and home nursing care support older people with their activities of daily living when they require help due to reduced functional capacity or illness. They are combined in many municipalities as home care and this is supplemented by additional support services.

If the older person is not able to live in his/hers own home or in sheltered accommodation (sheltered accommodation, service homes), care can be provided in an institutional care setting. Institutional care can be provided both in specialised nursing homes as well as in the inpatient departments of health care centres ([372]). LTC can only be provided in an institutional setting if there is a medical justification or if there are other reasons why safe care for the recipient needs to be provided in an institution.

Informal care support is aimed at relatives with a caring responsibility for LTC recipients. Decisions on whether to grant informal care support are made by local authorities.

Eligibility criteria

The sections above have shown that Finland offers a very broad coverage to its citizens. For defining eligibility criteria, the country does not seem to have any means-tested criterion (for either in-kind or cash benefit). In addition, users do have a discretionary use of cash benefits.

([372]) Usually reported as hospital beds in international statistics.

The health care system covers all residents of the country according to Section 19 of the Finnish Constitution. There is no single long-term scheme. Long-term care is provided through general social welfare and health care legislation which is supplemented by special legislation (for example on services for older people and on services for people with disabilities). Municipalities are responsible for arranging social and health services that their population requires and as stipulated by legislation. Severely disabled persons have a subjective right to certain services under the Services and Assistance for the Disabled Act. .

As explained above, municipal authorities arrange social services for older people on the basis of an assessment of their individual needs by experts. Citizens above 75 years of age and pensioners on the highest rate of care allowance have the right to have their needs assessed within a specified period of time. The Social Welfare Act was amended in 2006 to include provisions on the municipalities' responsibility and expected delays for the needs assessment (in general within seven days or immediately for urgent cases). Once the need has been established, the municipal authorities in collaboration with the recipient and, if necessary their next of kin, draw up a personal care and service plan that details the services and support measures to be provided..

The Social Insurance Institution also grants care allowances based on need to Pensioners. They are granted to residents over the age of 16, and are in receipt of early-retirement, old-age or disability pension, as well as to those who receive accident compensation allowance or special assistance for immigrants. To qualify for the allowance, the recipients' mobility and ability to perform daily activities independently must have been compromised (whether by illness or injury) for at least one year. This allowance is not subject to means-testing and it is payable at three different rates depending on the level of dependency, as well as costs. As of 2010, it can be paid as well to long-term institutional care recipients.

Recipients can also benefit from tax deductions for the purchase of home care. Conversion of homes to improve the ability of the recipient to perform daily tasks is also available from the public social welfare authorities in line with the Services and Assistance for the Disabled Act. Finally, repair of housing for the elderly and the disabled can also be supported due to social reasons by the housing authorities.

Co-payments, out of the pocket expenses and private insurance

Public LTC services are financed by municipal taxation as well as by central government subsidies and user fees (cost-sharing). While some services are provided free of charge (some services for people with disabilities), other services have a flat fee (some home care services) or are means-tested and determined according to income and family composition (for example for institutional care, which tends to be the costliest). However, the current legislation also allows each municipality some degree of freedom to make their own choices in this field.

Role of the private sector

Private companies and non-profit organisations are important service providers in publicly funded LTC. With respect to housing services (service accommodation and institutional care), private organisations accounted for around 30 % of all clients in 2012, up from around 20 % in 2000. Private organisations primarily focus on serviced accommodation with almost all institutional care provided by municipalities. Finally, the role of the private sector in home help services is relatively minor.

Most of the private sector LTC services are commissioned by municipalities, i.e. selling of services to households directly plays a smaller role. The exception is home help services, although the purchase of these services by households is subsidised.

Formal/informal caregiving

Informal care support is targeted towards family members caring for a dependent relative (an aged spouse or parent, for example). Decisions on who receives informal care support are made by the municipalities.

Support for informal care includes caregiver's allowance, statutory leave for the caregiver (if the care is binding), necessary services to support the care-giver, and pension and accident insurance for

the caregiver. The amount of the caregiver's allowance depends on the municipality, minimum EUR 384.67 (in 2016) per month. Support from municipality requires an agreement between the informal caregiver and the municipality based on an individual service plan.

Prevention and rehabilitation policies and measures

Municipalities are in charge of health promotion and LTC prevention policies for the elderly. These include the provision of information on healthy lifestyles, the prevention of accidents and illness and early detection of reduced capacity to function([373]). Many municipalities also provide a visiting service for elderly living at home, which includes a discussion on the challenges faced by the person and information on the public help available. Separately, each person over the age of 75 is entitled to a social-service needs assessment.

Rehabilitation of the elderly is carried out by the municipalities in co-operation with the Social Security Institution (Kela).

Recently legislated and/or planned policy reforms

There are efforts to decrease the role of institutional care in LTC services. The aim is to decrease the share of over 75 year olds in institutional care from around 4 % currently to around 2–3 % by 2017. Simultaneously the share of elderly receiving home help services and family care is envisaged to increase. The Ministry of Social Affairs and Health has estimated that this would result in LTC costs around 300 mil. euros (14 % of current total LTC expenditure) lower than under the current care structure by 2017. However, the cost estimates are subject to considerable uncertainty and all the scenarios imply an increase in total expenditure from current levels.

The government is set to begin a comprehensive evaluation of the legislation of the social and healthcare fees during the spring of 2017.

([373]) http://www.thl.fi/fi/tutkimus-ja-asiantuntijatyo/tyokalut/iakkaiden-neuvontapalvelut-ja-hyvinvointia-edistavat-kotikaynnit

Challenges

Finland has a comprehensive long-term care system that, in the last few years has been successful in increasing the proportion of care that is administered at home rather than in more expensive institutional settings. However, the high level of expenditure, the lack of means-testing and the inequality in quality and access of services across municipal authorities mean there are still many challenges:

- **Improving the governance framework:** To establish a coherent and integrated legal and governance framework for a clear delineation of responsibilities of state authorities wrt. the provision of long-term care services; To set the public and private financing mix and organise formal workforce supply to face the growing number of dependents, and provide a strategy to deliver high-performing long-term care services to face the growing demand for LTC services; To strategically integrate medical and social services via such a legal framework; To define a comprehensive approach covering both policies for informal (family and friends) carers, and policies on the formal provision of LTC services and its financing; To use care planning processes, based on individualised need assessments, involving health and care providers and linking need assessment to resource allocation; To deal with cost-shifting incentives across health and care.

- **Improving financing arrangements:** To explore the potential of private LTC insurance as a supplementary financing tool; To determine the extent of user cost-sharing on LTC benefits.

- **Providing adequate levels of care to those in need of care:** To adapt and improve LTC coverage schemes, setting the need-level triggering entitlement to coverage; the breadth of coverage, that is, setting the extent of user cost-sharing on LTC benefits; and the depth of coverage, that is, setting the types of services included into the coverage; To provide targeted benefits to those with highest LTC needs.

- **Ensuring coordination and continuity of care:** To establish better co-ordination of care pathways and along the care continuum, such

as through a single point of access to information, the allocation of care co-ordination responsibilities to providers or to care managers, via dedicated governance structures for care co-ordination and the integration of health and care to facilitate care co-ordination.

- **To facilitate appropriate utilisation across health and long-term care**: To arrange for adequate supply of services and support outside hospitals, changing payment systems and financial incentives to discourage acute care use for LTC; To create better rules, improving (and securing) safe care pathways and information delivered to chronically-ill people or circulated through the system; To steer LTC users towards appropriate settings.

- **Changing payment incentives for providers:** To adapt provider payments for LTC away from the basis of salary; To consider fee-for-service to pay LTC workers in home-care settings and capitation payments; To consider a focused use of budgets negotiated ex-ante or based on a pre-fixed share of high-need users.

- **Prevention:** To promote healthy ageing and preventing physical and mental deterioration of people with chronic care; To employ prevention and health-promotion policies and identify risk groups and detect morbidity patterns earlier.

Table 2.9.1: **Statistical Annex – Finland**

GENERAL CONTEXT

GDP and Population	**2003**	**2004**	**2005**	**2006**	**2007**	**2008**	**2009**	**2010**	**2011**	**2012**	**2013**	**EU 2009**	**EU 2010**	**EU 2011**	**EU 2012**	**EU 2013**
GDP, in billion euro, current prices	152	158	164	173	187	194	181	187	197	200	203	9,289	9,545	9,800	9,835	9,934
GDP per capita, PPS	27.0	28.9	29.3	30.4	32.1	31.7	28.3	29.2	29.6	29.0	27.9	26.8	27.6	28.0	28.1	27.9
Population, in millions	5.2	5.2	5.2	5.3	5.3	5.3	5.3	5.4	5.4	5.4	5.4	502	503	504	506	507
Public expenditure on long-term care																
As % of GDP	1.8	1.8	1.9	1.9	1.9	1.9	2.2	2.2	2.2	2.3	:	1.0	1.0	1.0	1.0	:
Per capita PPS	386.6	425.2	453.7	486.6	531.2	561.9	584.1	608.5	626.7	658.3	:	297.1	316.7	328.5	317.8	:
As % of total government expenditure	:	3.6	3.7	3.8	3.9	3.9	4.0	4.0	4.0	4.0	:	2.1	2.2	2.2	2.1	:
Note: Based on OECD, Eurostat - System of Health Accounts																
Health status																
Life expectancy at birth for females	81.9	82.5	82.5	83.1	83.1	83.3	83.5	83.5	83.8	83.7	84.1	82.6	82.8	83.1	83.1	83.3
Life expectancy at birth for males	75.1	75.4	75.6	75.9	76.0	76.5	76.6	76.9	77.3	77.7	78.0	76.6	76.9	77.3	77.4	77.8
Healthy life years at birth for females	56.5	53.1	52.5	52.8	58.0	59.5	58.6	57.9	58.3	56.2	:	:	62.6	62.1	62.1	61.5
Healthy life years at birth for males	57.3	53.3	51.7	53.2	56.8	58.6	58.2	58.5	57.7	57.3	:	:	61.8	61.7	61.5	61.4
People having a long-standing illness or health problem, in % of pop.	:	40.7	43.2	43.3	41.7	40.6	42.8	44.0	45.4	46.7	47.5	:	31.4	31.8	31.5	32.5
People having self-perceived severe limitations in daily activities (% of pop.)	:	11.8	12.2	12.0	8.8	7.8	8.0	7.9	7.7	7.1	:	:	8.1	8.3	8.6	8.7

SYSTEM CHARACTERISTICS

Coverage (Based on data from Ageing Reports)	**2003**	**2004**	**2005**	**2006**	**2007**	**2008**	**2009**	**2010**	**2011**	**2012**	**2013**	**EU 2009**	**EU 2010**	**EU 2011**	**EU 2012**	**EU 2013**
Number of people receiving care in an institution, in thousands	:	:	:	:	50	69	88	107	109	112	51	3,433	3,771	3,851	3,931	4,183
Number of people receiving care at home, in thousands	:	:	:	:	56	60	63	67	68	70	159	6,442	7,296	7,444	7,569	6,700
% of pop. receiving formal LTC in-kind	:	:	:	:	2.0	2.4	2.8	3.2	3.3	3.4	3.9	2.0	2.2	2.2	2.3	2.1
Note: Break in series in 2010 and 2013 due to methodological changes in estimating number of care recipients																
Providers																
Number of informal carers, in thousands	:	:	:	:	:	:	:	:	:	:	:	:	:	:	:	:
Number of formal carers, in thousands	:	:	:	:	:	:	:	:	:	:	:	:	:	:	:	:

Source: EUROSTAT, OECD and WHO

Table 2.9.2: **Statistical Annex - continued – Finland**

PROJECTIONS

Population	2013	2020	2030	2040	2050	2060	MS Change 2013-2060	EU Change 2013-2060
Population projection in millions	5.4	5.6	5.9	6.1	6.2	6.2	15%	3%
Dependency								
Number of dependents in millions	0.43	0.47	0.53	0.58	0.60	0.62	44%	40%
Share of dependents, in %	7.9	8.4	9.1	9.6	9.7	9.9	25%	36%
Projected public expenditure on LTC as % of GDP								
AWG reference scenario	2.4	2.8	3.6	4.3	4.4	4.6	86%	40%
AWG risk scenario	2.4	2.9	3.8	4.8	5.2	5.8	136%	149%
Coverage								
Number of people receiving care in an institution	51,255	60,085	77,182	94,184	98,120	101,271	98%	79%
Number of people receiving care at home	158,919	181,974	227,561	269,600	278,412	284,619	79%	78%
Number of people receiving cash benefits	308,046	341,068	396,958	442,311	451,892	460,309	49%	68%
% of pop. receiving formal LTC in-kind and/or cash benefits	9.5	10.4	11.9	13.3	13.4	13.6	42%	68%
% of dependents receiving formal LTC in-kind and/or cash benefits	100.0	100.0	100.0	100.0	100.0	100.0	:	23%
Composition of public expenditure and unit costs								
Public spending on formal LTC in-kind (% of tot. publ. spending LTC)	85.9	87.1	88.4	89.3	89.5	89.8	4%	1%
Public spending on LTC related cash benefits (% of tot. publ. spending LTC)	14.1	12.9	11.6	10.7	10.5	10.2	-27%	-5%
Public spending on institutional care (% of tot. publ. spending LTC)	34.3	34.0	33.6	33.6	33.6	33.6	-2%	1%
Public spending on home care (% of tot. publ. spending LTC in-kind)	65.7	66.0	66.4	66.4	66.4	66.4	1%	-1%
Unit costs of institutional care per recipient, as % of GDP per capita	76.5	79.0	80.7	82.6	83.5	85.0	11%	-2%
Unit costs of home care per recipient, as % of GDP per capita	47.3	50.6	54.1	57.0	58.1	59.7	26%	-3%
Unit costs of cash benefits per recipient, as % of GDP per capita	6.1	6.1	6.1	6.3	6.3	6.3	4%	-2%

Source: Based on the European Commission (DG ECFIN)-EPC (AWG), "The 2015 Ageing Report – Economic and budgetary projections for the 28 EU Member States (2013-2060)