



Quality in and Equality of Access to Healthcare Services

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Country Report for Finland

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Abbreviations

CI	Confidence Interval
ETENE	The National Advisory Board on Health Care Ethics
FPF	Finnish Pensioners' Federation
HfA	Health for All
HiAP	Health in All Policies
LAFOS	Labour Force Service Centre
MSAH	Ministry of Social Affairs and Health
NAP	National Action Plan
NGO	Non-Governmental Organisation
NHI	National Health Insurance
OECD	Organisation for Economic Co-operation and Development
RAY	Finnish Slot Machine Association
SII	The Social Insurance Institution
STAKES	The National Research and Development Centre for Welfare and Health
WHO	The World Health Organization

1 Introduction

Universal access to health services for all residents has been a fundamental principle in the Finnish health policy for several decades. Equity in access to adequate health and medical services is guaranteed to all residents in the Constitution. The stated goals of Finnish health policy are equal distribution of health and diminishing health differences between socioeconomic and other population groups. The objectives include levelling health care costs, equal access to health services, use of services according to need, and provision of high quality services for all.

Finland has a highly diversified health care system, in which the municipalities are responsible for arranging public health care and social services for their residents and governmental steering is weak. In outpatient health services, equity issues arise from the existence of several care pathways (i.e. public outpatient health services, occupational health services, and private health services) and differential ways of financing these services. In public sector specialist care there is a relative lack of supply of outpatient services in relation to need and the impact of private sector outpatient services is thereby large in access to non-emergency specialist care and elective surgery.

Several far-reaching initiatives have been introduced by the Government in recent years to tackle many of these issues, including a law that defines maximum waiting times for public non-emergency care, uniform national guidelines that define the limits of access to non-emergency specialized care, the extension of publicly funded dental care to the whole population, and generic substitution of prescription medicines to control health care spending. Many of these reforms are recent, and their impact on equity in access has not yet been evaluated in general or in relation to the population groups of interest for the current study. At the same time, some initiatives have increased barriers in access to health care. Such actions have included rises in public health care user fees and exclusion of many new drugs from the reimbursement scheme, which have increased out-of-pocket health care spending.

1.1 Country profile

Every resident in Finland has the right to health services regardless of ability to pay or place of residence. The Constitution states that public authorities shall guarantee for everyone adequate social, health and medical services and promote the health of the population. The right to services does not depend on citizenship, but on residency.

Key legislative acts on the provision of health and social services include the Primary Health Care Act (66/1972) and the Act on Specialised Medical Care (1062/1989), the Act on the Status and Rights of Patients (785/1992), and the Social Welfare Act (710/1982). These are complemented by specific legislation in the areas of social welfare and health care. In general, legislation contains no detailed provisions on the scope and content of social welfare and health-care activities or the way in which these should be implemented. In order to support integration within health care, the government has initiated work to combine the Primary Health Care Act and the Act on Specialised Medical Care into one comprehensive act.

In 2002, the Finnish Government made a Decision in Principle on securing the future of health care (MSAH 2002), which has led to reforms in access to care and to a centralisation of care provision (for details, see section 2.9).

In practice Finland has three different health care systems having public funding: municipal health care funded by taxes (71% of outpatient physician visits in 2005, for details see section 1.1.1), private health care partly funded by National Health Insurance NHI (16% of outpatient physician visits, see section 1.1.2) and occupational health care partly funded by NHI (16% of outpatient physician visits, see section 1.1.3). Persons in working life usually have the possibility to choose between these systems. For poor unemployed people, the municipal health care system is in practice the only choice. There are significant differences between the systems: for example on scope of the services, user-fees and waiting times.

In Finland, the largest share of health care services is provided by municipalities. The municipal health centres are the main providers of primary care services, and the hospital districts, which are owned and governed by the municipalities, are the main providers of specialist services. At the moment (January 1st, 2007), there are 416 municipalities with on average 12 000 inhabitants¹. According to the legislation, municipalities have the responsibility for arranging basic services such as education and social and health services for their inhabitants. For the funding of these services municipalities have the right to levy taxes and to collect out-of-pocket user fees, which cover just under one tenth of municipal social welfare and health expenditure. Municipalities also receive central government transfers to even out financial inequalities between municipalities and to ensure equal access to services throughout the country. Central government transfers account for less than one-fifth of all municipal revenues.

In addition to municipal health services, people are able to use private health services and, if working, occupational health services. Occupational health services are free for the user, and use of private health services are partly reimbursed by the statutory National Health Insurance (NHI) scheme (see sections 1.1.2 and 1.1.3). Also outpatient prescription drug costs are reimbursed through NHI.²

In 2005, about 40 % of total health care costs were financed by the municipalities, about 21 % by the state, 17% by the NHI and about 23% by private sources. During the last decades, the most marked change in the financing of health care has been the shift from state to municipalities. There has also been a moderate increase in the amount provided by the NHI. Households' share as a source of financing has remained relatively the same during last 25 years, being 18% in 2005. Interestingly, since 2002 the trend has shifted towards a more centralised funding, i.e. an increase of the state's share of health care funding and a decrease of the funding from the municipalities.

¹ For more information on municipalities in Finland, see www.localfinland.fi

² Information on the National Health Insurance is available at <http://www.kela.fi/in/internet/english.nsf>

The Ministry of Social Affairs and Health (MSAH) directs and guides social and health services at the national level. It defines general social and health policy, prepares major reforms and proposals for legislation, monitors their implementation and assists the government in decision-making. The government decides on general national priorities and proposes bills to be discussed by the Parliament. The Public Health Advisory Board has a strong position in the planning of public health policy. It has a chairperson from the MSAH and 19 members representing public health stakeholders from the administration, health services, researchers, NGOs and labour market organisations. The National Advisory Board on Health Care Ethics (ETENE), residing at the Ministry, has also highlighted equity issues in its activities (National Advisory Board on Health Care Ethics 2001).

The lower tier of state administration consists of five provinces plus the autonomous Åland islands. The provincial state offices promote national and regional objectives of the central administration, and keep contacts with municipalities in their area³. Their social and health departments are responsible for guiding and supervising both public, specialized and primary health care, and private health care, as well as assessing basic services.

1.1.1 Municipal health care system

Municipalities are obliged to organise necessary primary and specialist level health services for their inhabitants. Municipalities can provide services themselves or purchase primary or specialist level services from other municipalities, hospital districts or from private providers. Alternatively, they can provide inhabitants with service vouchers to be used in individual purchase of health and social services. Legislation requires that municipalities must either on their own or jointly through a local federation of municipalities have a health centre for arranging primary health care and dental services. There were altogether 257 health centres in Finland in 2006. Practically all health centres have GP run hospitals or they have an arrangement of using such beds in a

³ More information on State Provincial Offices is available at <http://www.laaninhallitus.fi/lh/home.nsf/pages/indexeng>

nearby health centre. In 2005, municipal health services covered approximately 70% of all outpatient visits to a doctor (GPs and specialists).

Public specialist level services are mainly provided by 20 hospital districts (excluding Åland Islands), owned and governed by the municipalities. Each municipality must belong to one hospital district. Each hospital district has a central hospital, five of which are university teaching hospitals. The hospital districts organize and provide specialist medical services for the population of their member municipalities. The population of the catchment areas of hospital districts varies from 65 000 to 1.4 million. In some cases, large municipalities run specialist level hospital services of their own, in addition to services provided by their hospital district. The autonomous Åland Islands (26 000 inh.) have separate health legislation, and health care organisation in Åland differs from the rest of Finland. The Åland government is responsible for providing health care services, and services which are not provided in the region are purchased from Finland or Sweden.

Municipal health care covers all residents of the municipality. A persons' home municipality is the municipality in which she or he permanently lives and is registered as a permanent resident. If the home municipality can not be defined this way, a persons' home municipality is the municipality to which she or he has the closest relationship, according to, for example, family history. The same regulations apply to persons who have migrated to Finland if the migrant intends to live in Finland permanently and has a residence permit for at least one year (if required).

1.1.2 Private health services

In addition to health services organised by municipalities, there are many private health care providers mainly focusing on out-patient services. However, there are also a few private hospitals in Finland. Private health services can be purchased directly by individuals but also employers and more rarely, but increasingly, municipalities purchase health services from private providers. More than 30% of all outpatient visits are made in the private sector, but private

hospitals provide only 3.5% of all hospital days in Finland. One in four visits to a doctor is to a private provider. (Kauppinen & Niskanen 2005).

Costs for use of private health services (doctors' fees, dental care costs, and charges for examinations and treatments) are partly reimbursed by the statutory and universal National Health Insurance (NHI) scheme, provided that the user is not in public hospital or residential care. However, reimbursement in NHI is on average only 30%, meaning that out-of-pocket payments are significant. The scheme is managed by the Social Insurance Institution (SII), which falls under the authority of the Parliament. SII has local offices around the country, which handle payments of the reimbursements of medical expenses when private health services have been used. Voluntary additional health coverage through private insurance is rare among the general population. Private insurances have not been popular as the municipal services and NHI reimbursements offer rather good coverage. Main reasons to use private services instead of public services are shorter waiting times and possibility to choose the service provider. Main reason for population to take voluntary insurances is to reduce user-fees of private health care.

During the last ten years, private health services and occupational health services have grown faster than municipal health services. Between 1996 and 2006 the number of physicians in occupational health care has increased 69% and in private health care 62%, while in municipal health centres the increase has been 9% (Finnish Medical Association 2006). A major reason for the strength of the private is the NHI reimbursements. In fact these can be seen as subsidies to the private health care providers (NHI reimburses approx. 30% of user out-of-pocket expenses and 60 % of employers expenses for providing occupational health care, and many employers purchase occupational health care services from private providers). The growth of the private sector undermines the equity principle of Finnish health care.

1.1.3 Occupational health services

Employers are obliged to provide free preventive occupational health care for their employees. Entrepreneurs and farmers are free to choose whether they

join the occupational health care system or not. In addition to compulsory occupational health care, employers can voluntarily arrange additional health care services for their employees, and many employers do offer also curative, generalist level services. The scope of the voluntary services provided varies a great deal between employers. The NHI reimburses employers 50% of the necessary and appropriate costs of occupational health care.

Occupational health services can be arranged by the employer itself or the employer can purchase them from another employer (42% of expenses in 2004), or the employer can purchase services from the municipal health centres (16% of expenses), from private health care providers (29% of expenses) or from other sources (12% of expenses). Small employers purchase services mainly from the municipalities and private health care providers, and large scale employers tend to provide self-produced occupational health services to their staff. (KELA 2007)

In 2004 about 84% of all employees in Finland had access to occupational health care by their employers (KELA 2007). Especially small-sized employers do not arrange services or do not apply reimbursement from NHI. About 90% of employees receiving compulsory occupational health care services received also voluntary services. Employees are not charged for using these services.

1.1.4 National Health Insurance

Social protection in Finland is residence based. The NHI covers all permanent residents of Finland. NHI is compulsory. The main funding of NHI comes from employers and employees (income based insurance fees are collected with taxes). The rest of the funding comes from the state budget.

Permanent residents receive a KELA Card which proves eligibility for social security (including health insurance) in Finland. Reimbursements from NHI usually require a co-payment and they cover private health care (including dental care), outpatient medication expenses (irrespective of whether the medication has been prescribed by a public or private doctor), travel costs to health care providers and house call costs, sickness and disability allowance,

and maternity leave allowance. (The Social Insurance Institution of Finland 2007)

The NHI scheme covers prescribed medicines, clinical nutrients and emollients. The basic reimbursement is 42%, and it covers medications prescribed for treatment of a disease, irrespective of the diagnosis. However, any reimbursement requires that the Pharmaceuticals Pricing Board has approved the pricing of the medicine. The vast majority of prescription drugs have been approved by the Pricing Board but some products have been judged to be overpriced and are not included in the reimbursement system. Some expensive drugs can have limited basic reimbursement in which drugs are 42% reimbursed only to restricted group of patients having a certain condition of a disease (for example the drugs interferon beta, dornase alfa and sildenafil are in this category). Patients with certain chronic conditions (specified in a legislative decree by the Government) needing essential drugs are reimbursed 72% (lower special reimbursement category) or 100% (higher special reimbursement category). The higher reimbursement categories account for about half of total reimbursement expenses.

There is an annual co-payment ceiling (see section 2.4.2), which activates an additional reimbursement, which covers all further costs (not including a co-payment of € 1.50 per medicine).

1.2 Promoting social inclusion through policy action at the system level

The Finnish operating model is based on openness and transparency. Finland is perceived to be the least corrupt country in the world (Transparency International 2006). Typically, the preparation of legislation and strategies takes place in broad-based working-groups, in which are represented the key ministries responsible for preparation and implementation of legislation, labour market bodies, non-governmental organisations, research institutes, the church and expert bodies of the field in question. Citizens are considered to have a

voice in the planning of the legislation and policy strategies mainly through the involvement of non-governmental organisations and labour market bodies.

1.2.1 Finnish National Action Plan against Poverty and Social Exclusion 2003-2005

The Finnish National Action Plan against Poverty and Social Exclusion is based on the model of universal social policy. In principle, all residents are covered by the same social protection schemes and welfare services. The welfare model has been considered to work well in practice and the pursued policy has been widely supported by the citizens. The universal model has been seen not to exclude additional targeted measures to help the most vulnerable groups (MSAH 2006d).

The National Action Plan (NAP) (MSAH 2003) recognised five major objectives

1. Ensuring income security
2. Employment and labour market
3. Housing
4. Education and youth
5. Development of the service system (both in terms of health and social care and in terms of the integration of the two)

High-risk groups requiring special attention were identified as

6. long-term unemployed
7. families with children and young people under the threat of social exclusion
8. people with chronic illness and the disabled
9. the over-indebted
10. people guilty of penal offences
11. migrants under a threat of social exclusion
12. alcohol and drug abusers
13. the homeless

The NAP was evaluated in 2005 and considered to have achieved its goals reasonably well (MSAH 2005). Poverty has long been relatively rare among the Finnish population. There have been no major changes in the proportion of the poor and the number of socially excluded people. However, relative poverty

among families with children has increased during the last decade. An important objective of the Government has been to reduce unemployment and long-term unemployment rates, with the latter having been reduced somewhat. High structural unemployment has remained a problem. Income differences have increased, and the taxation policy trend pursued has significantly contributed to the development. The social income transfers policy that has been pursued has not narrowed the differences. The increase in income differences was most drastic in the years of rapid economic growth. Inequity in health is still a problem and health differences between socioeconomic groups have increased. Despite universal coverage of health services, there are still considerable differences in their availability and use (see section 2.1). (MSAH 2005)

The evaluation considered the NAP to have enhanced and strengthened co-operation between various actors. Cross-sectoral co-operation on issues related to poverty and social exclusion was considered to have increased, but co-operation practices should be developed further. In the 2005 evaluation, especially the NGOs felt that the preparation of NAP and the monitoring of its implementation provide them a new channel for influencing national decision-making. However, a latent risk in that co-operation was seen to be that the primary mission of NGOs to look after the interests of their members can be jeopardized if the NGOs are too closely engaged in advocating for jointly agreed objectives. (MSAH 2005)

A report on the strategies for social protection and social inclusion 2006-2008 was compiled under the direction of MSAH in 2006 (MSAH 2006d). The process involved different ministries, the social parties, the Association of Finnish Local and Regional Authorities, the Evangelical Lutheran Church, representatives of NGOs, several experts, Statistics Finland and the National Research and Development Centre for Welfare and Health (STAKES). It also evaluated how objectives presented in the NAP have been achieved. They were considered to have been achieved reasonably well. However, inequity in terms of health was still a problem, and reduction of health inequalities between the population groups was seen to demand long-term efforts. The abolishment of restrictions

on alcohol import and the reduced taxes on alcohol have increased the harms caused by excess alcohol consumption. (MSAH 2006d)

From the perspective of health care system the NAP made in 2006 describes very briefly current state of health system and a few current development projects which are described in more detail in next chapters. According to the NAP, the most important actions that give consideration to the effect of the health care system on social inclusion are the Health 2015 programme, the National Health Project, a programme to reduce health inequalities that is currently being prepared, the Current Care clinical practice guidelines and generic substitution to curtail medicine costs (for details of actions see section 1.2.2). Additionally, there are some programmes and planned or enforced legislation that has relevance to social inclusion through the health care sector, such as defining maximal waiting times in public health care and the dental care reform.

1.2.2 National health programmes associated with the NAP

The Health 2015 programme

The overall health promotion policy in Finland is based on the Health 2015 public health cooperation programme, which was approved by the Government in 2001 (MSAH 2001). The programme outlines the targets for Finland's national health policy up to 2015. The foundation for the strategy is provided by the Health for All (HfA) programme of the WHO, which was revised in 1998. The strategy is a continuation of the Finnish national HfA 2000 programme.

The Health 2015 programme provides a broad framework for health promotion in various sectors of society. It reaches across different sectors of administration, since public health is largely determined by factors outside health care. Correspondingly, the main focus is not in the health care sector or its development. The concepts 'settings for everyday life' and 'life course' play a key role in the programme.

The strategy presents eight objectives for public health, focusing on problems in different phases of the life course, requiring concerted action by various bodies,

some of which are relevant to the current paper. These include targets to increase average healthy life expectancy by two years, to improve functional capacity among people aged over 75, to maintain the satisfaction of Finnish residents with health service availability and functioning, to keep subjective healthiness and experience of environment impacts on personal health at least at present levels, and finally, to reduce inequality and increase the welfare and relative status of population groups in the weakest position when implementing all targets of Health 2015 programme.

In addition, there are 36 lines of action underlined by the programme, incorporating challenges and guidelines related to citizens' everyday environments and various actors in society in different phases of the life course. Among the working-age population the programme states that 'every effort must be made to prevent social exclusion, ensuring that the unemployed and people in atypical jobs and workplaces have the same opportunities as others to get health services and health promotion'. Among the ageing population the programme emphasises that local service and transport environments must be developed to be suitable for ageing population groups. Additionally, according to the programme, municipalities should work out a service programme for care services needed in daily life and long-term care.

The programme emphasises that health services should be equal, sufficient and of high quality and that both health and social services should be developed to guarantee health literacy in terms of citizens' rights and responsibilities in health care, general information about health and health promotion, and citizens' voice in decision-making about their own health regardless of socioeconomic status or origin.

The programme was prepared by the Advisory Board for Public Health set up by the Government. The process involved consultation with specialists, analyses, seminars and group work. The stakeholders include the Government, MSAH, municipalities, health services, NGOs, researchers and research institutes.

To our knowledge, the Health 2015 programme has not been evaluated from the point of view of any population subgroups or in terms of its effect on access of health care services in general or among population subgroups. An evaluation of health promotion activities in Finland (WHO 2002) was performed only one year after the start of the Health 2015 programme, thus not providing a meaningful follow-up period for conclusions regarding the programme.

In relation to the Health 2015 programme, a National Action Plan to Reduce Health Inequalities is currently being prepared by the MSAH. The action plan aims to identify the policy areas and measures required to achieve the national target for reducing socioeconomic differences in health as stated in the Health 2015 programme. The action plan will be built around seven strands: (1) Reinforcing the theme Health in All Policies (HiAP) and integrating health inequalities into it; (2) Strengthening work to reduce health inequalities in municipalities; (3) Alcohol and tobacco policies; (4) Enhancing equity in the services; (5) Reducing health inequalities among children and young people and preventing social exclusion; (6) Reducing health inequalities among people at working age and (7) Developing monitoring systems for health inequalities between population groups. The preparation of the programme is the responsibility of the Advisory Board for Public Health.

Furthermore, to support intersectoral implementation of health promotion, the Finnish government has decided to initiate a cross-cutting policy programme for health promotion for the ongoing four-year parliamentary period. The programme is based on economic arguments and stresses the productivity gains that can be reached by health promotion. The programme is based on "Health in All Policies"-thinking, it puts an emphasis on reducing health inequalities, and it covers all sectors and all levels. The programme was launched in dialogue with regional and local stakeholders. The policy programme for health promotion has three strategic aims: 1) to reinforce structures for health promotion activities in the municipalities, government and working life; 2) to collect, disseminate and implement best practices in health promotion; and 3) to build health promotion capacity.

Strategies for Social Protection 2015

Launched in 2006 by the Government, the strategy assesses and anticipates the increasing demands posed by the changing policy environment for both preventing social problems and solving them (MSAH 2006c). It presents the long-term objectives for welfare policy that are important in developing social services and action to be taken in future development work. The Ministry sums up the social protection strategy for the next decade under four strands. These are:

- 1) promoting health and functional capacity
- 2) making work more attractive
- 3) reducing poverty and social exclusion
- 4) providing efficient services and reasonable income security.

Two lines of action especially relevant to the current report are encouraging the social inclusion of migrants and ethnic groups and guaranteeing availability and quality of services for the elderly.

The Welfare 2015 programme

The national development project for social services started in 2003 and is composed of twenty projects that are aimed at different stages of the life course⁴. As a part of the project, the Welfare 2015 programme for social services was developed (MSAH 2007b).

Relevant subprojects of the national development project for social services are organisation of 24-hour emergency social services in the whole country to ensure immediate access to social services in crises, a project aiming at seamless social services, use of vouchers in social care, developing caring of close relatives, a project for developing institutional care for the elderly, developing home services and home care and preparation of legislation concerning the population right for an evaluation of the need for social services. Additionally, the programme works together with the Health 2015 programme in

⁴ More information on the national project to develop social services is available at <http://www.sosiaalihanke.fi/Resource.phx/sosiaalihanke/english/index.htm>

developing seamless services between health and social care. Major stakeholders of the development project include the Government, Ministries of Education, Social Affairs and Health, Finance, and Trade and Industry, agencies of social welfare, the Association of Finnish Local and Regional Authorities, and municipalities. The preparation of the programme was supported by a STAKES project examining the limits of the Finnish welfare state (Teperi et al. 2006).

An evaluation of the Welfare 2015 programme by an independent evaluator is planned by the end of 2007, with each of the projects making a self-evaluation and a follow-up of the implementation of legislation.

The National Development Programme for Social and Health Care 2008-2011

The first National Development Programme for Social and Health Care will be initiated in 2008. The responsibility for preparing, implementing and following up the plan has been given to the new Advisory Board of Social and Health Care. The Programme has been prepared in co-operation with municipalities in five regional consultation meetings. It will consist of four strands: health promotion and early intervention, reform of service structures, social inclusion, and strengthening of knowledge base. The detailed preparation of the programme is underway. It seems clear, that in the future government funding of local development programs in social and health sector will be closely tied to the goals of the national development program.

1.2.3 Other relevant programmes

In addition to public health and welfare programmes there are some programmes and changes in the legislation that have an impact on access to health services for different population groups. These include legislation ensuring access to public health care, a programme for production and dissemination of clinical practice guidelines, extension of publicly funded dental care to the whole population, generic substitution of prescription medicines and use of vouchers for private health and social care.

Ensuring access to public health care

The Government decision on securing the future of health care stated that the principle of access to treatment within a reasonable period would be embodied in legislation by the year 2005 (MSAH 2002). These provisions were added to the Primary Health Care Act and the Act on Specialized Health Care and came into force in March 2005. According to the new legislation, patients with non-urgent health problems must be assured of an immediate contact with their health centre, and their need for care must be assessed by a health care professional within a maximum of three weekdays after contacting the health centre. In non-emergency specialised medical care, the hospital district is responsible for assessing the patient's need for care within a maximum of three weeks after receiving a referral, and any necessary medical care must be provided within three months, or at the very latest, six months. If the treatment cannot be provided within the time specified, treatment must be procured from another service provider at no extra charge to the patient. (MSAH 2004)

During 2004 the MSAH put together national guidelines defining the limits of access to non-emergency specialized care procedures based on expert proposals. Harmonised guidelines were made for 193 diseases or treatment groups comprising 80% of non-emergent hospital care. The guidelines define which patients should receive the treatment in question. Systems for scoring need of care are used in some of these guidelines, which are to be updated in 2007.

Programme for clinical practice guidelines

Evidence-based "Current Care" clinical practice guidelines have been produced since 1994⁵. Up to June 2007, guidelines had been published for 76 diseases or conditions. The guidelines are developed by a group of relevant clinical experts, always including a general practitioner, and allied health professionals when appropriate. The guideline development process follows the principles of evidence-based health care, and recommendations are graded according to level of evidence. The draft guidelines are widely circulated to identified

⁵ For more information on the Current Care guidelines, see www.kaypahoito.fi

stakeholders for comments and are then reviewed. The work is organised and managed by the Finnish Medical Society Duodecim and currently funded by the Finnish Slot Machine Association (RAY) under the auspices of the MSAH. The Current Care guidelines are freely accessible via the Internet and constitute the basis of local and regional treatment path descriptions.

A research project⁶ is currently evaluating the implementation of guidelines for hypertension and cardio-pulmonary resuscitation and developing a generic model for evaluation of guideline implementation. Additionally, the EUROASPIRE group has evaluated the implementation of international guidelines for coronary heart disease management in 15 countries, including Finland (EUROASPIRE II Study Group 2001). The group found that there is still a gap between evidence based guidelines and the secondary prevention of coronary heart disease. To our knowledge, the effect of clinical guidelines on access to and quality of services has not been evaluated in relation to the subgroups of interest for the present study.

Extension of publicly funded dental care to all

In Finland, there is public and private dental care. Traditionally, the duties of the two sectors have been clearly defined as only children, young adults up to certain age limits, and groups with special needs were entitled to public services. To improve adults' access to dental care and to lower cost barriers to the use of dental services, the age limits restricting access for adults to public dental services were removed in 2001–2002 and subsidies for private dental care were expanded to cover all age groups.

Services were to be offered based on medical or dental indications of treatment need and no longer on age or belonging to a special needs group, as had been the case previously. Thus public dental services were to offer dental care according to the same principles as the general public health care system. The rationale behind the reform was improvement in young people's oral health and in the demand and need for dental care by the increasingly dentate middle-aged and elderly.

⁶ <http://www.uta.fi/laitokset/tsph/terttu/projects/roine.html>

The municipalities are obliged to provide basic public dental services for their inhabitants either by producing them themselves or by contracting them out to other municipalities or to private providers. Persons using private dental services are eligible to be reimbursed for part of the spending by the NHI. (Prosthetic and orthodontic treatments are not refunded at all).

Opening the public dental services and reimbursements for private care to all age groups, increased adults' demand for dental services greatly in both sectors and waiting times for the public dental services became long, especially in a number of bigger cities that previously had restricted adult dental care. The public dental services continued catering for children and adolescents even after the reform (very few children go to private dentists in Finland). In 2005, about 20% of the public dental service units had not yet implemented the reform. This was particularly true for the largest conurbations (e.g. Helsinki, Turku, Tampere). However, improvements were seen in the supply of emergency dental services in the public dental services across the country. Access to care, however, did not improve as much as expected and especially in the private sector, the numbers of patients remained low. The implementation of the reform was pushed forward by legislation in 2005 ensuring access to public health care (see above), defining a maximum waiting time of 6 months for non-urgent dental care (MSAH 2004).

The reform had strong support from the Government mediated through the MSAH. Major stakeholders include MSAH, the municipalities, the National Social Insurance Institution, and public and private dentists.

A survey evaluating the effects of the reform reported that self-reported oral health improved and the perceived need for dental care decreased between spring 2001 and spring 2004 (Kiiskinen et al. 2005). At the same time, the proportion of persons using dental care during the past 12 months increased from 57% to 61%. The utilization of the public dental services increased slightly, but the total number of private patients remained at the same level as before the reform. The increase in the use of services was especially clear in persons having middle level education. An increase was also seen in those having a low level of education but their use of services still remained at a lower level

compared with that of persons having middle or high level of education. Thus, the dental care reform contributed to the goal of achieving greater equity in access to dental care.

To sum up, the equity and fairness of the oral health care provision system improved and access to services improved slightly.

Generic substitution

Generic substitution was introduced in Finland in 2003 (Vuorenkoski 2005). Pharmacies are obliged to substitute a prescribed medicine which costs more than the maximum price limit—defined by the SII—with a product costing less and containing the same substance. The prescribing doctor may decline generic substitution for medical or therapeutic reasons. The patient can decline substitution and is refunded by the NHI according to the actual costs of the prescription (there is no reference pricing system for medicines in Finland). Doctors decline substitution very seldom and patients in about 10% from the potentially substitutable prescriptions. Annual savings from generic substitution have been about 5% of the outpatient drug expenses. The major stakeholders are pharmaceutical companies, private pharmacies, the National Agency for Medicines, the SII and the Government.

eHealth Strategy

Finland's eHealth Roadmap (MSAH 2007d) is a continuation of the work with national strategies started in the middle of the 1990s. A starting point was the strategy for utilisation of ICT in welfare and health (MSAH 1996). A central objective of the strategy was to guarantee equity for all citizens, including children, the elderly, unemployed, disabled, migrants and other disadvantaged groups by adhering to the standard rules of design for all. It was stated that the needs of these groups should be taken into consideration when implementing eHealth, and specifically stated that costs should not form a barrier to access.

In 2002, as part of the National Program for Securing the Future of Health Care, the government decided that a national electronic patient record should be introduced by the end of 2007. The strategy for the national Electronic Health

Record (EHR) was published in January 2004. In addition, the national project to develop the use of ICT in social services started in 2003. The relevant legislation (Act on Electronic Records in Health and Social Care and Act on Electronic Prescriptions) came into force in 2007.

Finland's national objective is to secure access to information for those involved in care regardless of time or place. The means used to achieve that objective have included a comprehensive digitalisation of patient data, development of the semantic and technical compatibility of the electronic patient record systems in regard to the entire content of a record, development of the national health care infrastructure and information network solutions, identification and verification solutions and electronic signature, and also the maintaining of information that supports decision-making on the net. Another major objective is to enable the involvement of citizens and patients, to increase citizen access to information and to ensure a high quality of health information. The national EHR archive, providing residents access to their own patient/health records and log information, is to be established and maintained by the SII. The measures have also included development of a health information portal for citizens.(Hämäläinen et al. 2007.)

It is characteristic of the Finnish approach to emphasise data security and data protection and to develop the systems in a way that is sustainable from an ethical and juridical point of view. According to Finnish policy definitions, the storing and use of health information is based on networked corporate data with high data security. So far issues of equity in access to the new health portal have not been considered in depth, and one might fear that the new eHealth structure may constitute a new barrier to access for the disadvantaged.

Vouchers in social and health services

Since 2004, a new law has provided a legal framework for the use of service vouchers in social and health services. The main aim of the legislation was to increase clients' freedom of choice, to support elderly people to live at home longer, to increase the cost-efficiency of services and to increase the supply

and range of services available, as well as to encourage small firms to enter home care markets to improve employment.

A voucher is a tax-free fixed sum granted by the municipality to a customer eligible to receive municipal services. A customer's need for services is defined by a municipal officer (e.g. a case manager). A service voucher is an alternative for municipal provision of services and a customer has no right to require a service voucher, but may always choose a municipal provider. The municipalities are responsible for maintaining a list of acknowledged private providers allowed to offer voucher-purchased services and for monitoring the quality of the services. The customers may choose and change the provider of the services freely. The customer's deductible limit of the value of a voucher is not allowed to exceed a municipality's user charge from similar services. Particularly, the new legislation encourages use of vouchers in purchasing home care services. (Mikkola 2004).

According to a recent evaluation of the service voucher system, vouchers were mostly used for purchasing home care services. (MSAH 2007c.) When more municipalities start to issue vouchers, it will lead to a shift of resources from public services to private service providers. The use of vouchers has not been evaluated from the equity viewpoint, but it can be assumed that vulnerable groups, such as migrants, frail elderly and people with mental disorders, will find it difficult to use the service vouchers, because they require a high level of user health literacy and awareness.

Integration of social and health services

Often social and health services are organized by separate organisations of municipalities. To improve the coordination of social and health services, the traditionally separate health boards and social welfare and services boards have been merged into a single board in most municipalities that maintain a health centre of their own.

There has also been some regional reforms to integrate social and health services, e.g. in the Kainuu region (85 000 inh.) where provision of health and social care in 2005 were provisionally transferred from nine individual

municipalities to the region. The experiment created a new regional self-regulating mid-level administrative body with its own regional council elected for a four-year term at the same time with the general municipal councillors' election. The new administrative body has no right to levy taxes but it gets funding from state subsidies and from municipalities. It is responsible for several welfare services which were previously run by the municipalities: upper secondary schools and vocational education, primary health services, specialized health care, and a large part of social services. In this experiment, provision of primary health care and specialized health care (municipal health centres and Kainuu central hospital) were merged to the same organization. (Keskimäki 2003b)

Most recently, the health and social care provision has been integrated in the Itä-Savo and Päijät-Häme regions, from the beginning of 2007. In the Itä-Savo health district all nine member municipalities purchase secondary care services from the new organisation, seven of the municipalities purchase primary health care services and three of the municipalities (comprising 62% of the population of the district) also some social services such as elderly care and services for alcohol and drug abusers. In the Päijät-Häme district the new organization is responsible for providing secondary care services for all fifteen member municipalities, and primary health care and social welfare services for eight member municipalities.

1.3 Quality in and equity of access to health care: summary and main findings

Equity in health and health care is a major goal of Finnish health policy – a principle also enshrined in the Constitution and in the Act on the Status and Rights of Patients. In general, the country's health care system supports equity targets. The financing of services is based mainly on taxes and user fees for most of the services in municipal health care are rather small or non-existent. Moreover, the services operate on universal coverage, the municipal health services cover the whole country, and universal, mandatory health insurance

partly refunds for loss of earnings during illness and for spending on medicines and private health services.

Research especially on socioeconomic equity in access to and quality and outcomes of services has, however, pointed out some structural features of the system that do not support equity. According to a recent OECD report, occupational health care functions well in Finland and it responds to the need for health services, especially to the challenge posed by an ageing working population. People with access to occupational health service doctors seem to have higher rates of consultations than those who rely on municipal health centres, after allowing for income and need. (OECD 2005)

Additionally there is inequity inside of occupational health care as about 15% of employees do not have even compulsory occupational health services (mainly small enterprises) and the scope of the voluntary services provided varies a great deal between employers.

Municipal health centres were considered by the OECD as not functioning as well. This is partly due to the fact that occupational health services are provided free of charge to the users and are usually readily available, whereas municipal services include user-fees and their supply is not sufficient in relation to need. To conclude, selective access to private health care and to occupational health care contributes to the pro-rich distribution of use of outpatient services in Finland.

Regarding in-patient care, lower-income groups generally use hospital care more than the better-off, but there are socio-economic differences in the content, quality and outcomes of care (Keskimäki 2003a). Groups in higher socioeconomic position have been reported to receive more elective surgery than those in lower socioeconomic position. Socio-economic inequity in quality of care has been rather clear in some disease groups including coronary heart disease care (Hetemaa et al. 2004, 2006). Large increases in elective surgery in the late 1990s and in early 2000s seem to have levelled the differences in relation to need, though not fully. One structural feature behind the socio-economic differences in access to some elective surgery (e.g. cataract

operations) is likely to be private referrals to hospital treatment. Private doctors are more often specialists, and there has been a relative lack of specialist outpatient services in the public sector. MSAH has recognised the need for more effective measures and is preparing a national action plan to reduce health inequalities in 2007.

Direct national level steering mechanisms were gradually weakened in the 1980s and 1990s, and currently the municipalities are able to organise health care services rather independently. Legislation, especially the Primary Health Care Act and the Act on Specialized Medical Care, provides a rather loose framework for municipal health service provision. During the last fifteen years the main national level steering mechanism has been steering by information.

The main responsibility of the national level supervision of health care providers is currently with the five provincial state offices. The only sanction for municipal health care providers is conditional imposition of a fine but in practice this sanction has never been used. Citizens can appeal to an administrative court if they do not receive appropriate health services from the municipalities. These appeals have increased somewhat during last few years.

However, since the principle decision by the Government in 2002 to secure the future of health care (MSAH 2002), there has been a trend towards increased national level steering of health care. Four recent reforms have contributed to this trend change. First, in 2005 the Parliament enacted maximum waiting times for public sector health services and the MSAH put together national level guidelines defining the limits of access to non-urgent specialized care procedures. Before the reform there were significant variations in waiting times between municipalities. The reform has significantly improved the access to public sector health services and decreased the geographical differences in long waiting times.

Second, in 2006, national level supervision was reinforced by expanding the functions of the National Authority for Medicolegal Affairs from handling complaints against individual professionals to also supporting and co-ordinate the supervision activity of provincial state offices over public organisations,

health centres, hospitals and other institutions providing health services. It is anticipated that the reform increases patient safety and decreases differences between municipalities in service production.

Third, to strengthen national level steering, the Parliament amended legislation in January 2007 to replace the four-year Target and Action Plan for Social Welfare and Health Care with a new "National Development Programme for Social and Welfare", which the government issues for a four-year time period based on the Government Programme. The main reason for the reform was that the impact of the Target and Action Plan was found to be rather modest. The first National Development Programme for Social and Welfare will be produced in 2007. The new development programme will be more implementation oriented than the previous target and action plans. In the future, government funding of local development programs in social and health sector will be closely tied to the development program. The responsibility for preparing, implementing and following up the plan is given to the new Advisory Board of Social and Health Care, as defined in the new legislation.

Fourth, a reform to restructure municipalities and their services by mergers and mutual co-operation has been initiated (for details, see section 2.9). The driving force behind the recent re-centralisation trend has been the financial difficulties of municipalities to provide high quality health and social care to their residents. Especially small municipalities in rural areas suffering from depopulation are facing major financial constraints due to decreased tax income. In order to support depopulated and poor municipalities, there has been an increase in the central government transfers to the municipalities during the latest years. In spite of this, it has been perceived that municipalities in some cases have provided sub-standard services, leading to a plea for more centralised steering of health care to ensure provision of high quality care all over the country. The enactment of maximum waiting times and the extension of the supervising functions of the National Authority for Medicolegal Affairs should be interpreted as government efforts to reduce geographical inequalities and to ensure that all municipalities provide high quality health services. Also the purpose of the restructure of municipalities is to create a firm structural and financial basis so

that the organisation and provision of services would be secured in the future. The project concerns not only health care but all services organised by the municipalities, and is expected to restructure both municipalities and services. In 2007, the Act on Restructuring Municipalities was introduced, stating that primary health care and social services closely related to health services should have a catchment area of at least 20 000 inhabitants. Currently only about one in four health centres has a population base of 20 000 or more.

2 Major barriers of access

2.1 Introduction

Finnish health care is based on universal access to services for all permanent residents in Finland, irrespective of citizenship. Access for everyone to adequate social, health and medical services is enshrined in the Constitution. The scope of the health basket includes all services (including dental care and mental health care), provided that a physician or dentist has made an evaluation of the need, though some co-payment is the rule in most services. Notable exceptions to the co-payment principle are occupational health care and public out-patient mental health services.

In general, no restrictions have been made in the scope of the basket, but it should be noted that Finnish legislation does not endorse a subjective right to health care. The definition of what constitutes adequate care is in the end left to the individual practitioners.

In terms of distribution of benefits there are two major challenges in the Finnish health care system: geographical inequities and inequities between socio-economic groups. Some statistical data on inequities between population groups, such as geographical distribution of health care use, are collected routinely but much less information is available regarding socio-economic differences (see e.g., Häkkinen & Alha 2006, Teperi et al. 2006).

Some features of the Finnish health care system have been considered to affect equal access to health services. These include the multi-channel outpatient care system and cost-sharing in part of the health services. As described previously, the Finnish health care system consists of three main channels; i.e. 1) public primary care provided by the municipal health centres, 2) primary and specialist care offered by the private sector, which is only partly reimbursed by the NHI, and 3) free occupational health care, which is co-funded by the SII and the employers. Each of these three channels feed patients into the municipal specialist services, which are provided by the hospital districts owned by the municipalities. Some cost-sharing requirements exist in the health centres, and

even more in the private services, but cost-sharing does not exist in occupational health care, leading to inequity.

There are significant socio-economic differences in the use of health care services. Among OECD countries, pro-rich inequity in doctor visits in Finland was found to be one of the highest (along with the United States and Portugal) in 2000 despite the fact that inequality of distribution of physician visits between socio-economic groups has decreased somewhat in Finland between 1987 and 2000 (van Doorslaer et al. 2006). The distribution has been especially pro-rich in the use of private outpatient services, and, if the whole population is considered, in occupational health services (Häkkinen & Alha 2006). There are also significant pro-rich differences in screenings, in some preventive services (Koponen 2006), dental care (Manderbacka et al. 2006a), coronary revascularisations in relation to need (Hetemaa et al. 2004, 2006) and in some elective specialized care operations (for example hysterectomy, prostatectomy, and lumbar disc operation) (Keskimäki 2003a, Manderbacka et al. 2006b). A large increase in coronary revascularisations, primary knee operations and cataract operations in the 1990s and early 2000s has diminished the differences, but not levelled them if need is taken into account (Manderbacka et al. 2006b).

Important reasons for the socio-economic differences in the use of health services are shorter waiting times and provision of a fuller spectrum of services in private health care and occupational health care than in the public health services, despite the fact that legislation requires municipalities to provide all necessary health services. Major problems in the provision of municipal services are among others in the supply of dental services and psychotherapy. In general, private health services and occupational health are more commonly used by the better-off. Main reasons to use private services instead of municipal services are shorter waiting times and possibility to choose provider.

A pro-rich distribution of private health services leads to pro-rich distribution also in specialised municipal services, as private out-patient services are an important pathway to specialised level municipal health services. The threshold for remittance to specialised treatment may be lower for doctors in private

practice than for doctors in municipal health centres, maybe because the latter lack financial responsibility within the municipal health care budget.

Geographical inequity in access to care is mainly due to a concentration of private health care supply in large cities in combination with a shortage of skilled staff in public health care in rural areas. Most visits to private doctors are made in southern Finland, and the least visits to private doctors are made in eastern and northern Finland (Kauppinen and Niskanen 2005). During recent years geographical inequity in municipal health services has been somewhat decreased by enacting maximum waiting times and by extending dental care to all population groups.

2.2 Population coverage for health care under public programmes

The municipal health care covers all residents of the municipality. For non-residents, only emergency medical care is provided. Groups not covered are asylum seekers without a residence permit, illegal immigrants and foreign temporary work force. EU non-residents are entitled to same services than Finnish residents (with some restrictions), but their care is paid by their home country.

Similarly, the NHI universally covers all residents. The meaning of residency is defined by the Health Insurance Act. In order to be acknowledged as living in Finland, a person must have primary home and residence in Finland and must continually spend most of his or her time in Finland. A person can also be considered to be living in Finland and eligible for benefits during a temporary (one year or less) stay abroad. An migrant can be considered to be living in Finland immediately from the day moving to Finland if the migrant intends to live in Finland on a permanent basis and has a residence permit for one year (if required). Whether residence is considered to be permanent or not is determined by reference to the purpose of entry to Finland. The move is considered to be permanent if the migrant is a refugee or a full time student, or if the migrant comes to Finland for family reasons or has either a permanent

work contract or a work contract for at least two years. Quota refugees are considered to be living in Finland starting immediately from the time they actually move to Finland. Persons seeking asylum in Finland are not considered to have a residence in Finland while their case is under consideration. If, however, they have been issued a residence permit valid for at least a year, they are considered as living in Finland from the date the permit was issued. Asylum seekers can receive necessary health care at municipal health centres, and urgent medical treatment in hospitals.

To conclude, asylum seekers without a residence permit, illegal immigrants and temporary alien workers are not covered by the public health care system.

2.3 The scope of the health basket

2.3.1 Public health care

According to the Constitution, adequate health and medical care is guaranteed by the public authorities. The scope of the health basket of the public health care includes all services (including dental care and mental health care), provided that a physician or dentist has made an evaluation of the need. Cosmetic surgery is not defined as health care and is performed within the public health service only on medical grounds. Also alternative therapies without a sound evidence base (e.g. homeopathic treatment) are not available in the public health services.

The Primary Health Care Act defines types of services which must be provided by the health centres responsible for the public primary health care. The Act on Specialized Medical Care states simply that necessary services should be provided to everyone. Under the Primary Health Care Act the main functions of the health centre are:

- to provide preventive services and offer health promotion, education and support;
- to organize medical examinations and screenings for local people;

- to run maternity and child health clinics;
- to arrange school, student and occupational health care services;
- to organize the provision of dental health care;
- to organize the provision of medical treatment for local residents and first aid in cases of emergency for anybody even temporarily staying in the area;
- to organize home nursing services;
- to provide rehabilitation services;
- to arrange provision of those mental health services which can appropriately be provided in health centres;
- to provide a local ambulance service.

Municipalities are obliged by decree of the MSAH to provide breast cancer screening for all women between the ages of 50 and 69 two-year intervals and cervical cancer screening for women aged 30–60 years at 5-year intervals. The vast majority of Finnish women participate in the screening programmes. In addition, some municipalities are offering breast cancer and cervical cancer screening to other age cohorts and also other screening services such as osteoporosis or bowel cancer screening (Mäkelä et al. 2006).

Municipalities have significant autonomy in defining and shaping the services they provide. The basic profiles and scopes of services are similar due to the legacy of earlier decades. However, due to cost savings or, more recently, shortages of GPs and dentists, the actual services given differ to a great extent across municipal lines. There is growing concern about geographical inequity in the country.

Policy case #1: Public dental care for all

To improve adults' access to dental care and to lower cost barriers to the use of dental services, the age limits restricting access for adults to public dental services were removed in 2001–2002 and NHI reimbursement for private dental care were expanded to cover all age groups. The implementation of the reform was pushed forward by legislation ensuring access to public health care in 2005

(see above), defining a maximum waiting time of 6 months for non-urgent dental care (MSAH 2004a).

According to national statistics the use of public dental services increased and the number of persons receiving reimbursement for the cost of private care doubled. Due to the reforms, improvements were seen in the supply of emergency dental services in the public dental services across the country. In 2000, 22% of adults used public dental services and in 2004 the user rate was 24%. The percentage of those aged 0–17 years who visited the public dental services remained on the same level (76%) throughout the period. In 2000–2004, the proportion of adults receiving reimbursements for private oral health care increased from 12% to 25%. At the same time, the total running costs of dental care in Finland increased by 19%. (Widström 2006)

The personnel of the public dental services increased some 10% and the number of full-time private dentists fell slightly. Delegation of tasks from dentists to dental hygienists has been an important tool in the implementation of the reform. (Widström 2006)

A survey evaluating the effects of the reform reported that self-reported oral health improved and perceived need for dental care decreased from spring 2001 to spring 2004 (Kiiskinen et al. 2005). Simultaneously, the proportion of persons visiting dental care during the previous 12 months increased from 57% to 61%. The utilization of the public dental services increased slightly, but the total number of private patients remained at the same level as before the reform. The increase in the use of services was especially clear in persons having a middle level education. An increase was also seen in those having a low level of education but their use of services still remained at a lower level compared with that of persons having a middle or high level of education. Thus, the dental care reform contributed to the goal of achieving greater equity in access to dental care.

In the public dental services, the cost share between patients (20%) and municipalities (80%) did not change. In the private sector the NHI financed a

greater part of the costs (in 2000, 15%; in 2004, 26%) and the patients' out-of-pocket costs decreased from 85% to 74%.

The utilisation of the public dental services increased most in big cities and other urban municipalities where the use previously had been lowest. The use of subsidised private services increased also most in densely populated municipalities, where it was already highest in 2000.

To sum up, the equity and fairness of the oral health care provision system improved and access to services improved slightly due to the legislative reform.

2.3.2 National Health Insurance

The NHI reimburses part of expenses for private health care services related to disease, pregnancy or childbirth. Thus, expenses for preventive services (e.g. birth control and vaccinations) are not covered by the NHI. Dental treatment in general is covered, but orthodontic or prosthodontic services are not covered. In addition, the NHI covers examinations and treatments, that a physician has seen as necessary for treating a disease, pregnancy or childbirth. Thereby visits to other health care professionals (such as physiotherapists or psychologists) are covered only if prescribed by a physician.

2.4 *Cost-sharing as barriers to access*

In Finland, informal payments ("under-the-counter") do not exist, but during the last 15 years, there has been an increase in user fees for public health care services, creating a barrier to access for disadvantaged and low-income households. There are plans by the current government to further increase the user fees in public health care. In the 1990s, the funding of Finnish health care was progressive (i.e. high income households contributed to health care costs with a greater share of their income than low income households), but in the beginning of the 2000s total financing became regressive, mainly due to an

increase in out-of-pocket payments, and the fact that they fell more heavily on low income households (Kapiainen & Klavus 2007).

Out-of-pocket payments have become a more important source of income for public health services, and the burden of these fees is disproportionately affecting low income households. Fees for public health care expenses would have been even more regressive in nature if annual payment ceilings had not been introduced. Three independently calculated payment ceilings have been introduced: 1) for accumulated customer fees in public health care, 2) for expenses for prescribed drugs and 3) for travel expenses due to use of health services. Long-term inpatient care user fees are not covered by the payment ceilings.

According to a study on the effects of payment ceilings, it plays a significant role in avoiding catastrophic health care spending. The level of catastrophic health care spending, defined as 40% or more of household capacity to pay, was exceeded by approximately 0.10-0.70% of Finnish households (about 2400–16700 households depending on the definition of capacity to pay) in spite of payment ceilings. Catastrophic health care spending is more common among the elderly and in lower income groups, and is typically due to expensive pharmaceuticals or frequent or long-term inpatient care. Without payment ceilings, the proportion of households encountering catastrophic health care spending would have been considerably higher. (Kapiainen & Klavus 2007)

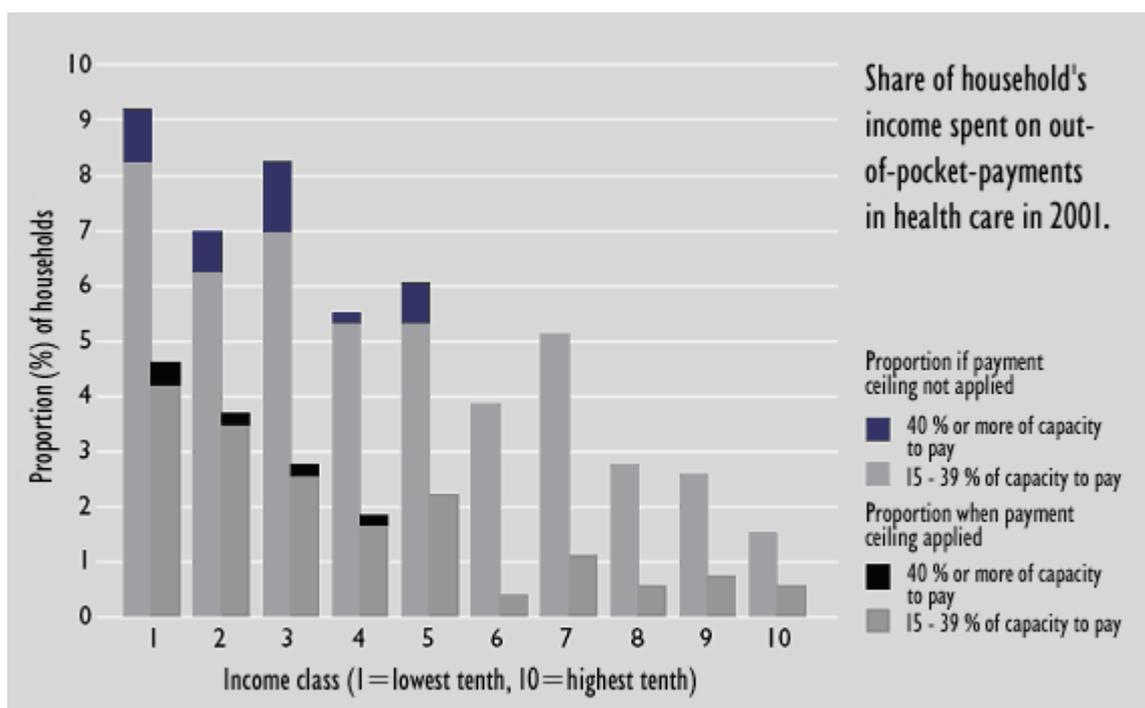


Figure 1. Impact of payment ceilings on share of households' income spent on out-of-pocket payments for health care (Kapiainen & Klavus 2007).

2.4.1 Public health care

Legislation (Act on Social and Health Care Services Customers Payments) and governmental statute define the maximum fees which health centres can charge, and also defines the services which must be free of charge.

Preventive health care, such as the services of maternity and child health clinics, are free of charge. Outpatient mental health care is free of charge. Laboratory and radiological examinations are free of charge at a health centre, as are immunization, examination and treatment of some communicable diseases specified by law (sexually transmitted diseases, tuberculosis, hepatitis and some others), medical aids such as wheelchairs and other mobility aids, prostheses and transport from a health care unit to another. Drugs administered during inpatient care are included in the daily fee of the hospital. Persons under 18 years of age do not have to pay for health centre ambulatory services, such as an appointment with a doctor or dentist, but may be required to pay a daily charge for up to 7 days for treatment on a health centre or hospital ward.

Fees are collected from adults for doctors' appointments at health care centres, for visits to hospital out-patient departments and there is a daily charge for in-hospital treatment (see Appendix 1 for a detailed description). The adverse effect of the out-of-pocket fees on access to health care has been acknowledged, and an annual ceiling for out-of-pocket fees within public health care has been introduced to at least partly offset the negative effect on equity in access to care.

Within public sector health care, user co-payment charges have an annual ceiling of €590, after which clients receive public outpatient services free of charge and the daily charge for short-term institutional care is reduced. The payment ceiling for parents includes the user fees for their under-18-year old children. The payment ceiling applies to health centre outpatient doctor's appointments, physiotherapy fees, hospital outpatient department fees, day surgery fees and user fees for short-term institutional care in both social welfare and health care institutions. However, user fees for long-term inpatient care (in health or social care) are not covered by the payment ceiling. User fees in long term care are 80% of the client's income.

The user is responsible for monitoring the cumulative fees and for checking whether they fulfil the payment ceiling, and have to apply for a certificate of having met the annual ceiling. The task of collecting user fee payment receipts and monitoring the cumulative spending is demanding, and many people with socio-economic disadvantage and chronic difficulties may have problems fulfilling the task.

Social assistance is a last resort form of economic assistance available when an individual's or a family's income is not enough to cover normal living costs. The payment of the benefit is stipulated by the Act on Social Assistance and is handled by the municipalities. Social assistance includes a basic sum of money and expenses that are taken into account separately (supplementary benefit). Major health care expenses are paid under the category of supplementary benefit. This scheme is intended as a last resort, and can be used by low income households who do not have sufficient money to pay the out-of-pocket expenses of public health care. The municipalities should decide on social

assistance payments without delay, within one week. However, the function of social assistance as a last resort is hampered by severe delays in the handling of applications in some municipalities, creating a geographical inequity in access to timely social assistance.

2.4.2 National Health Insurance

Private health care providers, such as doctors and dentists in private practice, are free to charge any price they like. In private health care patients pay all fees themselves, but may claim partial reimbursement from the universal NHI. In practice, the NHI reimbursement is often deducted from the fee already by the service provider, who can claim the NHI reimbursement on behalf of the service user. The NHI reimbursement is in general 60% of a fixed scheme of charges. The fees in the fixed scheme have not been changed during the last 20 years and thus are much lower than the real fees, meaning that in reality the reimbursement of doctors' fees are only 27.5% of the actual fee (2006). Treatment and examination, such as laboratory tests and X-ray examinations, ordered by a private doctor are reimbursed at 75% of an established fixed tariff.

Clearly, the low level of reimbursement for private health services restricts access to private health services for people in the lower economic segments (Figure 2) (Häkkinen & Alha 2006). The Finnish Medical association has demanded a rise in the actual reimbursement level, arguing that a raised reimbursement level would increase equity in access to health care. Opponents have argued that increasing the reimbursement level would inflate doctors' fees, and thus would not benefit the users of private health services.

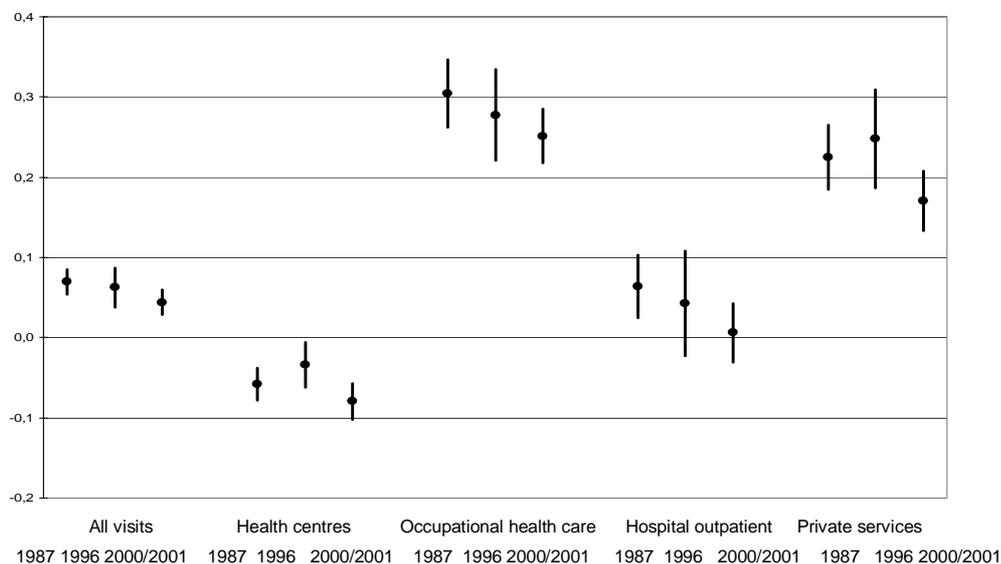


Figure 2. Inequity indices (95% confidence intervals) for visits to a doctor by sector in Finland in 1987, 1996 and 2000/2001 (Häkkinen and Alha 2006). Age, gender, long-term morbidity and self-rated health used as indicators of need.

To reduce the economic burden of high medication costs, there is a maximum limit for the co-payment for medicines, clinical nutrients and emollients paid by patients per year. The patients' out-of-pocket medicine expenses are tracked by the SII, and patients are entitled to an additional 100% reimbursement from the NHI scheme if the total co-payment for medicines exceeds €617 per calendar year (2006).

2.4.3 Occupational health care

Users are not charged for using compulsory or voluntary occupational health services. Services are funded by employers, who partly get reimbursed by the SII for their expenses. Employers are obliged to offer compulsory occupational

health services, i.e. services to prevent occupational health hazards, for example physical examinations. Many employers also offer voluntary services include wide variety of health services (usually curative generalist level services).

Because public health centres are entitled to collect customer fees, and occupational health services are free of charge, inequity in access to health care exists between adult persons with access to occupational health care and those without such access (Figure 2).

Within occupational health care, coverage of services varies between socioeconomic groups and some groups, such as people working with short-term contracts or in very small (less than 10 employees) companies, while those with a low level of education have been reported to have poorer access to services (Pirainen et al. 2003).

2.5 Geographical barriers to access

Research indicates that regional equity in health has not been achieved in Finland (Gissler et al. 2000). The issue of accessibility to health care will become more pressing in Finland due to depopulation of the north-east following internal migration to the south-west, centralisation of the health care system and ageing of the population. A general threat is that there will be difficulties in access to care due to long distances, especially in the north-east where the population age distribution is skewed towards old age. This threat has been identified, and one of the aims of the on-going project to restructure municipalities and services is to ensure localised access for everybody to basic services.

Problems in geographical equity mainly stem from regional differences in health service provision. Private health services can mainly be found in larger cities, meaning that rural areas are mainly served by public health centres. Health centres and public hospitals in remote rural areas do not attract enough physicians and other skilled staff. The lack of private health services and

adequate staff in public health services in remote areas affect the health services provided, creating geographical inequity in access to health care. Regional differences in the use of hospital services exist (Arinen et al. 1998).

2.5.1 Transport

Research on equity issues in transport related to the use of health care is lacking but transportation is considered to be an issue mostly in remote rural areas. There is growing awareness of transport problems becoming more of an issue along with ageing of the population and the geographical centralisation of health care.

To enable visits to health care facilities, the NHI reimburses expenses for transport in connection with treatment and examination of a disease or accident if expenses exceed €9.25. There is also an annual ceiling: if the cost of transport paid by patients due to disease or accident exceeds €157.25 per year (2007). The NHI reimburses all transport costs in excess of this limit. If public transport is not available or cannot be used, the NHI will reimburse the use of a taxi.

2.5.2 Regional differences

There are significant differences between municipalities in service provision (for example GP visits, dental care, mental health care, in population groups covered in screening tests, and in elective surgery in specialized care) and waiting times in municipal health services (Mikkola et al. 2005). Several factors can partly explain these differences. The Finnish health care system is decentralised and the national steering is rather weak. Significant differences exist between municipalities on resources invested, structure and supply of health care services. Shortage of physicians is a more severe problem in rural municipalities. In addition, access to private health care services and use of occupational health care services is more common in towns when compared to rural municipalities.

There are striking variations between municipalities in terms of per capita health care expenditure. Expenditure varied from €940 to €2 310 per inhabitant in

2004 (including long-term elderly care) and need-adjusted expenditure was 2.5 times more in the "most expensive" municipality when compared to the "cheapest" municipality (Hujanen et al. 2006.) These differences have existed for a long time, although during the last ten years they have appeared to narrow. Local differences in the structure of the health care system, shaped during previous decades, is one major factor explaining the differences in expenditure. It is clear, however, that some of the variation leads to differences in supply, quality and scope of municipal services.

To tackle geographical inequities, maximum waiting times were defined in the legislation in 2005 and the MSAH put together national guidelines defining the limits of access to non-urgent specialized care procedures. In addition to this, there are national treatment guidelines and quality guidelines for services so as to standardise practices and operations across the health care system (see chapter 1.2.3).

2.6 Organisational barriers

Each health centre organises an emergency service, either independently, jointly with other health centres, or in collaboration with the hospital district. The number of walk-in emergency services has been decreasing due to centralising, in order to achieve cost containment and to improve doctors' working conditions. Although the geographical distance to the nearest emergency service may have increased, everyone still has access to a walk-in public emergency service at the primary care level, and, if needed, at specialised care level. The issue of access to emergency services has not been discussed widely in Finland compared to other countries.

Research on the effects of organisational barriers on access to care in Finland is lacking. It is generally thought that the considerable co-payment for private health services and the barrier formed by user fees in public health care are more important factors in access to care than other organisational barriers. Additionally, free of charge occupational health care is a major factor effecting differential access to services. In addition, the coverage and quality of

occupational health services offered also varies between occupational groups. The inequity in access to these primary care level services leads to selective referral to secondary level services, i.e. those better off have higher rates of referral.

2.6.1 Waiting lists

The Primary Health Care Act guarantees every resident immediate access to health centres during working hours by phone or personal visit. Patients must be able to contact their health centre immediately by phone during normal opening hours. If the assessment requires a visit to the health centre, an appointment must be arranged within three days. The MSAH regularly monitors health centres for waiting times of phone help lines and for access to care. In February 2006, 80% of the population lived in municipalities without difficulties in getting immediate contact to primary health care whereas prior to the reform nearly four out of five health centres reported having constant or occasional problems with contact.

The new legislative limits for assessments of specialist treatment needs (within three weeks) and for initiation of specialist care (within six months) have considerably shortened the waiting lists (Vuorenkoski 2006). The time limit is even stricter for psychiatric treatment for children and young people, which must be given within three months.

The waiting lists vary between regions and between medical specialities. Most people waiting for more than six months are queuing for orthopaedic operations, hand surgery or plastic surgery. Some hospital districts have problems in providing psychiatric care to children and adolescents within the legislative limit. In spite of the best intent, the hospital districts have considerable difficulties to supply treatment within the time limits in these specialities due to the lack of a qualified work force.

During the era of long waiting lists, high income households in many cases used private health services to shorten the waiting time. It can be assumed that the successful reduction of waiting times has increased equity in access to non-emergency health care.

Policy case #2: Reducing waiting times for access to public health care

On the general level, defining maximum waiting times for access to public primary care and to public non-acute specialist health care can be considered to have increased equity in access to and quality of health care. One major challenge in the Finnish health care system has been the gap between available resources and the increasing need for health care services. This discrepancy has generated long waiting times for certain health services. There were also considerable differences in waiting times between municipalities. The Decision in Principle by the Council of State on Securing the Future of Health Care (MSAH2002) stated that the principle of access to treatment within a reasonable period would be embodied in legislation by 2005. The relevant Acts came into force in March 2005.

The new legislation and the national guidelines defining the limits of access to non-emergency care (see part 1.2.3) have had significant impact on reducing waiting times. In January 2005, 37% of the population lived in municipalities where they did not have difficulties getting an immediate contact to primary health care. After introduction of the legislation, in February 2006, the same proportion was 80%. In January 2005, 49% of the population lived in municipalities where the assessment of the need for care by a professional was provided by public primary care within a maximum of three weekdays, and after the introduction of the new legislation the proportion was 96%, in February 2006. (Vuorenkoski 2006)

The reform has decreased the number of patients waiting for non-urgent care significantly. In October 2002, ca. 66 000 people were on the waiting lists for specialised care. In anticipation of the new legislation, the number was reduced to 40 000 people in 2005. The new legislation took effect in March 2005. In May 2006 the number was 12 000 and in January 2007 the number of those who had waited more than 6 months for a specialised health care operation was

7332 (MSAH 2007a). In June 2007 the number was reported to have been further reduced to 5520.

The policy of guaranteeing every resident access to primary health care within a timeline, and of guaranteeing every resident access to secondary specialist care based on needs assessment, has been successful in reducing inequity in access to physical health care. However, it seems not to have improved access to psychiatric care.

2.7 Supply-side responsiveness

Research information concerning how the patients' voice is heard in the health care system is scarce and focused on specific patient groups like coronary heart disease patients (Haarni & Alanko 2005, Manderbacka 2005).

2.7.1 Gender

It is well-known that there are gender-related differences in the use of health services (Hemminki et al. 2006). Women visit doctors more often, and the difference between genders has been increasing. In 2004, Finnish women visited a doctor on average 5 times a year. This is partly explained by the age distribution differences between men and women, but age-adjusted statistics indicate that working-age women visit doctors more often than men. The same pattern is seen regarding visits to a dentist. The difference is remarkable, as many risk factors (e.g. smoking and alcohol use) are much more common among the male population.

The gender difference in the use of health services is partly explained by reproductive health issues, and by the fact that many prevention programmes (e.g. breast cancer screening, cervical cancer screening) are aiming at the female population only. However, it cannot be excluded that there is lack of health service sensitivity for the needs of the male population. Whether this has

any connection to the fact that the majority of health care staff are female remains speculative.

Gender issues and access to health care are multi-faceted. Research indicates that even if the health care demand is less in the male population, once they are treated they may be treated more actively, at least when it comes to coronary disease (Kattainen et al. 2003).

To conclude, it remains unclear whether the observed difference in use of health care services reflects differences in need, or whether it reflects problems in health care responsiveness.

2.7.2 Socioeconomic position

The MSAH has recognised the special need for occupational health care type of services among the unemployed (MSAH 2004b) and in some municipalities, development projects for organisation of occupational health care for the unemployed have been introduced. Few of these development projects have been formally evaluated, but the evaluations indicate that interventions improving the workability and ability to become employed have had a positive and activating effect. (Karjalainen & Melametsä 2001). The MSAH has granted funds for the development of health services for the unemployed, and some municipalities have introduced health checks for the unemployed.

Labour force service centres (LAFOS) are a new one-stop concept for providing employment, social and health services for disadvantaged adults. Long-term unemployed clients are referred to the service offices from the employment offices or from the municipal health and social services. The aim is to reduce structural unemployment, to reduce public spending on social assistance and labour market subsidies, and to support the functional ability, work and social inclusion of clients. An intermediate evaluation of the labour force service centres has been published (Arnkil et al. 2007).

Policy case #3: Labour force service centres (LAFOS)

Labour force service centres (LAFOS) are a new one-stop concept for providing employment, social and health services for disadvantaged adults. In 2004–2007, 38 offices were established nationally as a cross-sectorial collaboration between municipalities (social services and health care), the state (employment offices), and the SII. The municipalities and the state fund the offices according to a fifty/fifty rule. The aim is to reduce structural unemployment, to reduce public spending on social assistance and labour market subsidies, and to support work and functional ability and social inclusion of clients.

Long-term unemployed clients are referred to the service offices from the employment offices or from the municipal health and social services. Most labour force service centres provide services by public health nurses and doctors, offering clinical assessment of health status and health needs. If further investigations or treatment is needed, the client is referred to the ordinary health care services.

An intermediate evaluation of the labour force service centres has been published (Arnkil et al. 2007). The LAFOS have been well received by the clients, and also the initial difficulties of combining the different work cultures of the participating organisations have been successfully overcome. Challenges remain in the double steering of the LAFOS, since they are based only on agreements between the local employment office and the municipalities. Final evaluations of the reform are to be delivered by Helsinki School of Economics and jointly by STAKES and the University of Tampere in 2008 (personal information by Vappu Karjalainen)

The interim evaluation indicates that the LAFOS have offered a successful case management for disadvantaged long-term unemployed people, offering improved access to health care services by the LAFOS in-house nurses and doctors, or by referral to other public health care.

2.7.3 Migrants

Health care services have historically been provided by the public system with a mono-cultural background. Knowledge and encounters of different cultures, health conception, beliefs and religious differences form a challenge for Finnish health care. However, there is an increasing amount of migrant health care staff (especially from the neighbouring countries of Estonia and Russia). Some NGOs have a program to support positive discrimination in order to emphasize migrants in their work force.

Integration of migrants in mainstream Finnish health care is an essential part of an efficient migration policy. In addition to the mainstreaming efforts, some special arrangements and services have been established to care for the special health needs of migrant groups. Asylum seekers can receive necessary health care at municipal health centres and urgent medical treatment in hospitals by arrangement with the public health nurse employed by the reception centres for asylum seekers. Special Rehabilitation Centres for Torture Victims have been established in Helsinki, Turku and Oulu, and in Helsinki the NGO Finnish Association for Mental Health maintains the SOS centre⁷, a crisis prevention centre for foreigners. The MSAH has produced a guide to boost support in health and social services for violence victims among migrant women (Kyllönen-Saarno & Nurmi 2005).

2.7.4 Linguistic and ethnic minorities

There is a need to sensitise health service responsiveness for the needs of minorities. In southwest Finland there is a considerable Swedish speaking minority (6% of the total Finnish population) and in the north a small Sámi minority (8 000 people, i.e. 0.15%). The Romani minority is spread over the country. There are about 5000 people in Finland belonging to the Finnish signed language speaking minority, and around 100-200 persons use the

⁷ More info on the SOS centre for foreigners: http://www.mielenterveysseura.fi/sos-keskus/sos_en.asp

Swedish signed language. The right to interpretation services includes clients with a sensory or speech defect.

[<http://pre20031103.stm.fi/suomi/tao/julkaisut/omakieli/kuulo.htm>]

According to the Act on the Status and Rights of Patients the mother tongue and culture of the patient have to be taken into account as far as possible in his/her care and other treatment. Several studies have indicated that Swedish-speaking people experience a need for health services in Swedish, but also that they have difficulties in accessing health services in their own language even in bilingual municipalities (Helsinki and Uusimaa...2004, Herberts 2004).

The task of the Advisory Board on Romani Affairs is to enhance the equal participation of the Romani population in Finnish society, to improve their living conditions and socio-economic position and to promote their culture. The Advisory Board functions in conjunction with the MSAH.

The studies note that it is difficult in Finland to get social and health care services in one's own language despite the fact that the constitution and language laws clearly secure the patient's rights to have services in his/her own language. Social and health care services are usually produced in the majority language of the municipality and on the personnel's terms. Administration, superiors and political management often have too optimistic a picture of the actual language skills of the personnel. Language requirements, rules and bonuses vary from municipality to municipality. Both patient and personnel may lack in knowledge of the patient's rights to receive services in his/her own language. Often, the importance of language in social and health care is not quite understood. (Lukkarinen 2001)

According to researches, clients often starts a conversation in the major language of the municipality, assuming that the staff either does not want to speak the patient's language or does not know how to. Also, the client may have bad experiences of using his/her own language. To produce services in two or more languages always causes extra costs for the municipality. State subsidies are too small to cover the costs. The situation is worst in the Sami municipalities. (Lukkarinen 2001)

One successful method of providing bilingual services in the municipality is to produce parallel monolingual ones. Some bilingual municipalities have introduced special health services for the Swedish speaking minority, e.g. City of Helsinki has provided Swedish speaking residents the opportunity to register with primary care units offering services in Swedish. Special units offering Swedish services exist within elderly care, care for people with learning disabilities and psychiatric care. The Helsinki University Central Hospital has a unit for signed language psychiatric services.

Often the production of native-language services depends on other factors than financial issues. Therefore it is especially important to try to influence attitudes. It should be automatic and natural to serve a patient in his/her own language. This requires that the staff is aware of the patient's mother tongue, that the language of the patient has been registered and that the patient always knows when it is safe to use his/her own language. (Lukkarinen 2001)

2.7.5 Other groups

A recent report on well-being and living conditions among disabled persons in Finland mentions problems with contacts with the health care system both in terms of attitudes toward disabled people among the health care personnel and in terms of the need for information in a suitable form about the services and the health care system among disabled persons and their families (Haarni 2006, MSAH 2006a).

2.8 Health literacy, voice and health beliefs

Health literacy and voice have received relatively little attention in Finland compared to other European countries. Four aspects of health literacy are discussed below: (1) the association of general literacy and health, (2) ability to manage in the health care system, (3) learning health literacy as part of compulsory education, and (4) health literacy as cognitive and social skills. Research in Finland is mainly found in the field of the third meaning of health literacy among children and young people.

Finland has a highly ranked compulsory education system, and in general, the literacy of the population is good. In PISA investigation 2003, Finnish adolescents ranked at the top in most of the abilities measured and especially in general literacy. Differences between boys and girls were reported to be small, but some differences were reported between socioeconomic groups (University of Jyväskylä 2004).

Health literacy as the ability to manage one's health and the health care system has not been a strong focus of research in Finland. Poor health literacy is related to poor knowledge of one's personal health, poor management of diseases, poor health and less use of preventive services. In Finland, lower socioeconomic groups are reported to use preventive services and screenings for common diseases as well as health promoting group activity less actively than the better-off groups (Koponen 2006). Among migrants and ethnic and cultural minorities, this can also be a case of a lack of culturally sensitive services, services in one's own language, or a lack of accessible information provided by the health care sector.

In Finland, development of health literacy is considered to be an integrated part of the compulsory comprehensive education. Health education in the comprehensive schools aims at developing skills and knowledge about health, life-style, health behaviours and risk factors, and abilities to take responsibility for promoting one's own health and that of others (National Board of Education 2004). It should include basic information of common diseases, commonest infectious diseases, recognition of the symptoms, self-care as well as cover the most important health and social services. The realization of these aims has not been widely studied, but single reports suggest that pupils have structured information and positive attitudes towards health and health promotion. The results further suggest that some pupils have less comprehensive knowledge and skills (e.g., Jakonen 2005).

According to the Finnish Local Government Act (17 March 1995), the municipal councils shall ensure that local residents and service users have opportunities to participate in and influence their local authority's operations, for example by electing representatives of service users to municipal organs.

2.9 Interlinkages and overarching policy initiatives

Interlinkages of different barriers in access to care

A major organisational barrier in access to services is the triple channel organisation of outpatient health services, i.e. accessible occupational health services offered free of charge to the economically active part of the population, requirement of out-of-pocket payments to less accessible municipal health centres for those unemployed and those outside the labour market, and private (often specialist level) services with relatively large cost for individual patients easily available in urban areas. Additionally, the relative lack of supply of specialist outpatient services in the public sector and differences in gate-keeping practices between the public and the private sector provide a differential access to non-emergency specialist care.

Additionally, there are significant differences between municipalities in health services provision and waiting times, partly due to significant differences in resources invested, but also due to different structures of health care services. Shortage of physicians and other qualified health care staff is a more severe problem in rural municipalities. In addition, access to private health care services and use of occupational health care services is more common in cities when compared to rural municipalities. Taken together, these differences are likely to create geographical differences in access to and quality of services.

Although three different payment ceilings have been introduced to health services for 1) accumulated user fees in public health care, 2) expenses for prescribed drugs and 3) travel expenses due to use of health services, they are calculated independently from each other, and co-payments may still have an impact on service use among the worse-off. Furthermore, the function of social assistance as a last resort is hampered by severe delays in handling of applications in some municipalities, creating a geographical inequality in access to timely social assistance.

Policy initiatives

Legislation ensuring access to public health care with the introduction of maximum waiting times for primary care health centres and for specialised non-emergency care, as well as the implementation of national guidelines defining limits to access to non-emergency specialised care and Current Care practice guidelines are likely to increase equity in access to health care for different population groups. Also the removal of age limits from public dental care will contribute to this goal.

The government has had two large programmes to reform its social and health services during 2001-2007. In 2001, the government initiated the *National Project to Securing the Future of Health Care*. The project aimed to solve a variety of deficiencies identified in the Finnish health care system, and the project was divided to five working groups:

- The reform of the operational and administrative structures of the service system and improvement in efficiency and productivity
- The need for division of labour duties and the improvement of working conditions and continuous medical education
- The level and stability of health care financing as well as sources of finance and the improvement of the steering system
- The development of the division of labour and cooperation in the public health care, private and NGO sectors
- The consolidation of treatment practices and improvement of access to treatment

The conclusions of the work groups were translated into political action by the Decision in Principle by the Council of State on Securing the Future of Health Care (MSAH 2002). The decision focused on strengthening primary health care and preventive work, ensuring access to treatment, ensuring the availability and expertise of personnel, reforming of functions and structures and augmenting the finances of health care. The project has continued following the path set by the decision in principle. The main outcomes of the project have been the

increase of state funding for health care and the introduction of maximum waiting times. It has also distributed funding for local and regional health care development projects.

The Project to Secure the Future of Health Care is supplemented by the *National Development Project for Social Services in Finland*⁸, aiming at improving the availability and quality of social services (MSAH 2004c).

In addition to health and welfare programmes, the Programme to restructure municipalities and their services is likely to have an effect on access to health services in the future. The project to restructure municipalities and services first came up in February 2005 as a possible solution to securing services organised by municipalities. The background was concerns about the increasing financial difficulties faced by municipalities and the growing need for health and social services because of the ageing of the population. Ageing of the population would reduce the availability of the workforce, as a large number of social and health care personnel would retire in the next decade. Simultaneously, ageing of the population would increase the need for the workforce in these sectors. (Järvelin & Pekurinen 2006).

The purpose of the public sector reform is to create within municipal services a firm structural and financial basis so that the organisation and provision of services would be secured in the future. Quality, effectiveness, availability, efficiency and technological change of services are also taken into account. The project concerns not only health care but all services organised by the municipalities, and is expected to restructure both municipalities and services. (Järvelin & Pekurinen 2006.)

In January 2007 the Parliament passed framework legislation on how to continue the process. According to that act the government will support mergers of municipalities financially. The act also states that primary health care and social services closely related to health services should have a catchment area of at least 20 000 inhabitants. Currently only about one in four health centres

⁸ For more information, see <http://www.sosiaalihanke.fi/Resource.phx/sosiaalihanke/english/index.htm>

has a population base of 20 000 or more. The legislation does not necessarily imply mergers of small municipalities, because they can create the necessary health centre catchment area by for example forming municipal joint federations. Municipalities must make a plan in 2007 on how these goals will be achieved. Additionally, according to the act, funding of forensic examinations and examinations related to sexual abuse of children will be transferred from the municipalities to the state no later than 2009.

Major stakeholders are the Government, Ministry of the Interior, the Association of Finnish Local and Regional Authorities, and the municipalities. The expected outcome is improvement in access to services and better control of total health care costs.

Since the legislation does not define the way services should be organised there is a possibility that a diversified development in the organisation of services will emerge in different municipalities. The effect on the ability of the central authorities to steer the development in municipalities remains to be seen.

2.10 Conclusions

It is possible to identify several policy level practices with a positive impact on access to health care that may contribute to the exchange of best practices on a European level. Such practices include introducing criteria and maximum waiting times for public non-emergency care (see 1.2.3), public dental care for the general population (see 1.2.3), service needs assessment for every resident over 80 years of age (see 3.2.1), support for informal carers (see 3.2.2), and the establishment of inter-service labour force service centres (see 2.7.2). Other successful policies that could contribute to the European exchange of best practices include the use of payment ceilings for user fees in public health care, medication spending and transportation in connection with health care (see 2.4), establishment of monolingual health services for linguistic minorities (see 2.7.4) and free interpreting services (see 3.1).

However, in spite of the many recent and ongoing reforms, many challenges remain in securing access to health care for people at risk of social exclusion and already marginalised people. Access to health care on a national level has considerably improved due to the legislative measures on maximum waiting times and extension of public dental care to cover every resident, but there are still some municipalities with major problems to fulfil the new requirements in provision of health care. The outreach of health care to socially marginalised groups through labour force service centres and occupational health services for unemployed people are promising initiatives, but still in the development phase and they will need to be fully evaluated before uptake into routine service provision can be secured. The payment ceilings have reduced the financial burden caused by health care expenses of many poor households, but challenges remain as there are still a number of Finnish households with catastrophic health care spending. The alarming financial situation of many municipalities will in the years to come lead to further increases of user fees in public health care. It will be a challenge to safeguard equity in health care access in spite of rising public health care user fees.

3 Improving quality of and access to health care for people at risk of poverty or social exclusion

3.1 Migrants, asylum seekers and ethnic minorities

Migrants are very broad group with different backgrounds and countries of origin, and therefore major cultural, religious and belief differences exist between and within migrant groups.

In this report the term migrant is taken to mean a foreigner who has been living or is planning to live in Finland for at least one year and who has a residence permit, if required. The intention to stay for at least one year is essential as this allows migrants to the same social protection as the original population. The term refugee is used to describe a status granted to an alien acknowledged as a refugee. Asylum seekers seek asylum in a foreign country due to being persecuted in their country of origin. The persecution may be based on religion, race, nationality, political views or belonging to a certain social class. Ethnic minorities refer to both ethnic groups and indigenous people. Ethnic group is a group of people with a common origin, common cultural and linguistic features (e.g. religion, norms, and language), some kind of social organisation or a sense of belonging together (ethnic identity). There may be several ethnic groups living in the same geographic area, all having the same nationality. The term indigenous people share a historical relationship with their lands and are generally descendants of the original inhabitants of such lands. Sámi are the only indigenous people in Finland.

3.1.1 Background of migrants and ethnic minorities in Finland

Finland has a relatively short modern history of migration and multiculturalism. The total number of migrants in 2005 in Finland was almost 114 000; thus migrants comprise only 2.2% of the whole population (Saarto 2006). By country of origin, the largest groups are people from Russia, Estonia, Sweden and Somalia (Statistics Finland, Demographic statistics). During the last decade immigration to Finland has increased steadily, but the top three immigrating

nationalities have remained the same. Russians, Estonians and Swedes constitute approximately 40% of the yearly foreign inflow to Finland. It should be noted that the top three immigrating groups are from neighbouring countries and include a considerable number of persons of former Finnish nationality (among those coming from Sweden) or other Finnish descent (Russia, Estonia) (Vilkama et al 2005).

The ethnic minorities of Swedish-speaking Finns, Sámi, Tatar, Roma, and Jews have been living in Finland for many centuries and are a part of the core population of Finland. However cultural differences distinguish them in several ways from the majority and, even though they have been part of the Finnish society for quite a long time, they can still experience difficulties, e.g. when dealing with the health care system (Voutilainen 2003). There are almost 300 000 Swedish-speaking Finns in Finland. The Romani minority numbers around 10 000 (MSAH 2004d). Moreover, there are about 8 000 Sámi, of whom more than half live outside the Sámi Homeland, and 800 Tatars. The Finnish Jewish Community consists of about 1500 members, mostly resident in Helsinki, although the town of Turku has been a traditional centre of Jewish life in Finland too. Swedish-speaking Finns have special status in that sense that the Constitution states that Finnish and Swedish are the national languages of Finland. According to the Language Act of 2004, public authorities are obliged to provide services in Finnish and Swedish, and there should be social welfare and health services in both languages. All persons in public service have to take officially legislated tests for Swedish language ability. The Sámi Language Act, in force since 2004, defines Sámi languages as regional minority languages in the Sámi Homeland and provides the right to use these languages before courts of law and other authorities as well as the access to services in Sámi.

In respect of refugees, Finland is one of the countries accepting quota refugees. Finland accepts for resettlement persons defined as refugees by the UNHCR (Office of the United Nations High Commissioner for Refugees) and other aliens who are in need of international protection. The refugee quota is verified in the State budget for each year. In co-operation with the Ministry for Foreign Affairs and the Ministry of the Interior, the Ministry of Labour annually presents a

proposal to the Government concerning the regional allocation of the refugee quota. Finland has received about 25 000 refugees since 1973. Some are quota refugees, being asylum seekers who have received a positive residence decision, and some are refugees who have arrived in Finland through family reunion. The refugees have also included persons for whom it has been impossible to return to their home country or country of departure because of the circumstances prevailing there. The major refugee groups have arrived from Somalia, the former Yugoslavia, Iran, Iraq and Vietnam.

In last decades, the number of people seeking political asylum in Finland has varied between 700 and 4000 persons per year. More than half of the asylum seekers tend to be so-called Dublin cases who have already sought asylum in another EU country. In the year 2006 people seeking asylum declined by more than one third on the previous year. According to figures, 2324 people applied for asylum in Finland in 2006, which is 35% fewer than in 2005. Asylum was granted to 38 of them; 20 of those granted asylum were Russian citizens - mainly Chechens, and 12 were Iraqis. In 2006, the greatest numbers of applicants were from Bulgaria, Iraq, Serbia, Montenegro, Russia, and Belarus.

Finland has a small number of illegal immigrants. The National Bureau of Investigation has estimated that currently there are approximately 3 000 illegal immigrants in Finland.

3.1.2 Policies on the national level that are directed especially at social inclusion and/or access to health services for migrants

In regard to migrants' health care services, the main stakeholder is the MSAH. Because of principle of universality the MSAH does not distinguish as separate migrants, ethnic minorities, people with disabilities or other minority groups. The principle of universality also influences health care service policy planning. MSAH policy planning does not include separate policies for migrants or minority patients, because the aim is to mainstream migrant health care.

The Finnish Government adopted the Migration Policy Programme in October 2006. Its main emphasis is on promoting labour migration. Other central themes include creating a guidance system for all migrants, increasing the efficiency of

the integration measures, promoting good ethnic relations, as well as the policy on refugees and asylum. The general objective of the Programme is to promote the development of a pluralistic, multi-cultural and non-discriminatory society and thus to create preconditions for increasing immigration.

The new four-year government programme, adopted in 2007, will modify immigration administration. It remains to be seen how health care services for migrants and ethnic minorities will be brought up during the period of the new government.

Altogether 13 acts and several decrees govern immigration policy in Finland. Most important acts regarding access to services are the Aliens Act, the Integration Act, and the Non-Discrimination Act.

Aliens Act (301/2004) together with the Aliens decree covers entry to Finland, visas, residence permits, work documents and travel documents. The purpose of this Act is to implement and promote good governance and legal protection in matters concerning aliens. In addition, the purpose of the Act is to promote managed immigration and provision of international protection with regard to human rights and basic rights and in consideration of international agreements binding on Finland. An amendment to the Aliens Act regarding human trafficking entered into force in July 2006.

Act on the Integration of Immigrants and Reception of Asylum Seekers (493/1999) aims at enabling migrants to participate in Finnish society in a similar manner to those already living here. In addition to migrants themselves, key actors in integration include municipalities, employment offices and non-governmental organisations (NGOs), which together have the responsibility to make an integration plan. The concept of migrant integration became established in Finland when the Integration Act entered into force. After the initial implementation the Integration Act has been discussed and amended many times. In 2006 an amendment came into force, aiming to make integration more efficient and flexible for migrants. E.g. the division of labour and sharing of responsibility between the authorities were made more clear-cut at all levels of administration. The amended Act also includes the possibility to extend the

integration plan period from three up to five years in the case of special circumstances. The extension can be provided to allow for literacy or the syllabus of basic education to be acquired. In addition, such factors as the migrant's age, disability, illness, child protection measures, maternity or paternity leave can justify the extension.

The **Non-Discrimination Act** (21/2004) came into force in 2004 and states that "Nobody may be discriminated against on the bases of age, ethnic or national origin, nationality, language, religion, belief, opinion, health, disability, sexual orientation or other personal characteristics." The Act defines and prohibits forms of direct and indirect discrimination, harassment and instruction to discriminate. The word "ethnic" here refers to both migrants and Finland's old minorities such as Roma, Sámi, Tatars, Jews and representatives from the Old Russian community. Positive discrimination is acceptable if a person is deemed to be in need of special protection on the basis of ethnic origin, age or social status. The Act covers pursuits of profession, recruitment of employees, working conditions, education, memberships, social and health services, benefits, military service, housing and other services.

The Act assigns and distributes responsibility as follows 1) the occupational safety and health authorities monitor the implementation of the principles of non-discrimination laid down in relation to employment and public services, 2) the Ombudsman for Minorities issues guidelines, advice and recommendations and assists in conciliation and complaint procedure, and 3) the Discrimination Board handles complaints of discriminations and violations.

The **Transition Period Act** concerned migrants from the eight new EU member states, the Czech Republic, Estonia, Latvia, Lithuania, Hungary, Poland, Slovenia and Slovakia. The Act expired in April 2006. The purpose of the Act was to retain labour policy discretion on entry into the Finnish labour market of new member state citizens. Citizens of these eight countries are now free of working restrictions and need no work permit in Finland. Persons arriving in Finland from these countries should report information on their employment to the Employment Office for registration purposes to make monitoring possible.

The Government has adopted an action plan against human trafficking, which specifies the measures against human trafficking to be implemented in the various sectors of administration. In order to help victims of human trafficking it is essential that victims be allowed to request a residence permit. The measures includes arranging reception of trafficking victims and the necessary emergency help, housing, social and health care services, advisory and legal services as well as support for integration or safe return.

Methods

The overview on access to health care for migrants is based on a literature review and on consultation with the Finnish Refugee Council, which is a representative and independent NGO. The databases Medline, Cinahl, Caredata and the CSA databases (AgeLine / ASSIA / Social Services Abstracts / Sociological Abstracts) were searched by using search terms for migrants, refugees or asylum seekers or minorities or foreigners and search terms for health and equity or access. A draft of this report was sent to the social and health care providers of the Finnish Refugee Council for comments with a few additional questions:

1. Which current practices in Finnish social and health care are working well for migrants?
2. What kind of obstacles have you noticed in access to health care / quality of the care in respect of migrants?
3. What recommendation / good practices do you have for health care in order to guarantee equal access or to enhance the quality of the service provided to migrants?

3.1.3 Access to health care services

Migrants residing permanently in Finland are entitled to the same services and social security as Finnish citizens. They are also expected to pay the same user fees in public health care (for details see Appendix 1). For asylum seekers,

health services are provided in their assigned reception centre or in the health centre of the municipality their assigned reception centre is located in (Malin & Gissler 2006, Lukkaroinen 2005). All asylum seekers undergo a basic health screening by a nurse. They also have access to municipal healthcare if they require urgent medical treatment or essential dental treatment. These services are free for asylum seekers.

Lukkaroinen (2005) suggested developing preventive psychosocial support for asylum seekers. Asylum seekers have a remarkable number of psychosocial symptoms and from the viewpoint of quality of services, the greatest need for development was seen in the arrangement of counselling services and opportunities to work and study (Lukkaroinen 2005). The special rehabilitation Centre for Migrants in Helsinki and Turku is provided, where asylum seekers can receive assistance regarding social or psychological problems.

The biggest gap in access to health care is among illegal immigrants, who have neither organised public health care services in Finland nor health services by non-governmental organizations.

Immigration is a relatively new phenomenon in modern Finland, and this is reflected in the small number of health-related research focusing on migrants. However, there are a few studies on migrants' health care services and access to social and health services. One study (Clarke 2004) deals with access to social and health services in Finland for migrant people living with HIV/AIDS. It argues that access to social and health care is limited by the lack of recognition of people's needs. A lack of cultural competence can lead to indirect discrimination in services (Clarke 2004).

Gissler et al. (2006) explored migrants' use of social and health care services, the latter including primary and specialist care. Migrants use health services less than the Finnish core population. The exception was migrant women aged 15–29 years, who have more hospitalizations and hospital outpatient visits, in particular in connection with pregnancy and childbirth. The migrants originating from refugee countries (Yugoslavia, Somalia, Iraq and Iran) use health care services the most. The study did not identify reasons why migrants on the whole

use health care services more seldom than those of Finnish origin. It could be because migrants are relatively new in Finland, or that only young and healthy refugees are able to leave their country of origin, or a lack of health literacy or barriers due to lack of interpreting services. The study included only public health care and private hospital inpatient care. Migrants coming from the OECD countries are likely to have a number of outpatient visits to private health service providers, whereas visits to private providers are likely to be few among other migrant groups. Additionally, the study did not include health service use in the country of origin, which may constitute an important part especially among migrants from neighbourhood countries (Estonia, Russia) and from some OECD countries (other Nordic countries, especially Sweden). Available data did not enable the evaluation of the contribution of these services to total health service use. (Gissler 2006)

A few studies have investigated the quality of health care received by migrants. A survey (Pohjanpää et al. 2003) investigated living conditions of Russians, Estonians, Somalians and Vietnamese in Finland. Majority of the migrants considered health care services in Finland to be relatively good. Most critical were Russians, of which one fifth was dissatisfied with the provided services. Degni (2004) studied the use of contraception among Somali women. The study clarified the interaction between Somali women and public health nurses during consultation visits. Social interaction was reported to be degraded by the lack of common language, which led to misunderstanding in both ethical and cultural matters.

There are no studies about access to health care services for the Sámi. The Sámi is a small minority which contributes to the lack of health services in their own language. Distances to health care service in the Sámi area in Northern Finland are long and the number of health centres has decreased in northern Finland. This affects especially access to health care services among elderly Sámi. (Näkkäljärvi & Ristenreuna 2006). No research is available on access to health care services by Romani people, and no research regarding discrimination. It should be noted that the Romani people are a stigmatised ethnic minority, and discrimination of Roma in health care services is probable.

Romani people are not always aware of how to find information regarding health care services or what kinds of services are available. (MSAH 1999)

According to the Finnish Refugee Council, most difficulties to access health care services occur to those migrants, who would need the services most, especially elderly and already sick migrants. One of the main barriers of access is lack of information on health care service organization and how its functions, as well as limited linguistic capabilities. On a practical level, migrants are not aware when they should call to health care service centres to seek for consultation times, to which number to call and how different health care services are distributed among providers. Apart from language problems, cultural differences, like different body languages, taboos and cultural restrictions, may create barriers of access to health care. Prejudices and taboos can also be related to gender of the health care personnel. A husband may specially request a woman doctor for his wife, whereas another might have an opinion that a woman cannot be a doctor. A third patient might put lot of attention to professional status: he/she might believe what doctor says regardless of gender but might not trust the ability of nurses.

Mental health services

Within mental health services the competence and capacity to diagnose and treat migrants with mental health problems is scarce. There is hardly any university-level multicultural education for health care professionals. At present some bodies outside the public sector – namely the Helsinki Diaconess Institute, its Centre for Torture Survivors, and the Finnish Association for Mental Health and its SOS Centre for foreigners – have the deepest experience of providing mental health services for migrants. There are only a few psychiatrists in Finland who are working with migrants, and since this work is in the hands of a few specialists it is particularly vulnerable. (Rauta 2005)

3.1.4 Interpreting services

According to the Act on the Status and Rights of Patients, if a health care service professional does not speak the language of the patient, interpreting services are arranged if reasonably possible. These kinds of services qualify

access and the quality of services among migrants and some other groups, e.g. disabled people.

There are seven regional Interpretation Centres maintained by municipalities around Finland. Their services are intended to support public authorities dealing with migrants. Community interpreting is usually consecutive interpreting. It takes place either face to face or as remote interpreting (telephone or video interpreting). In addition to municipal interpretation centres, there are several private companies and freelance interpreters who offer interpreting and translating services in various languages. The Act on Administrative Procedure stipulates that the authority shall solicit and pay for interpreting services if the procedures are initiated by an authority or when it is necessary in order to resolve the matter and to secure the rights of the person concerned. For municipalities who have pledged to receive refugees, the state compensates interpreting costs arising from visits to public social and health services by persons who qualify as refugees. There is no dead-line for the compensation of interpreting and translating services. However, there are only a few interpreters capable of interpreting in the context of psychotherapeutic work (Rauta 2005). A recent report suggests that interpreter training should be increased urgently, and particular attention should be paid to improving their qualifications, further education, job supervision and well-being at work (Rauta 2005).

According to the on-going "Equality in Health" study (Kuusio & Kuivalainen, personal communication) the main concern of migrants in the provision of health services are interpreting services, which need to be better resourced to meet the need. Also the quality of interpreting services was a concern. From the point of view of health care, plain translation does not suffice in many cases, but interpreters more skilled in cultural interpretation are needed. This problem is especially highlighted in mental health problems, where diagnosis is culture-sensitive and it needs to be decided whether a professional with the same or a different cultural background is needed to ensure successful therapy.

The Finnish refugee Council reported that interpretation services are deficient. In many occasions the children of migrants take the role as interpreters. It is highly advisable that a family member should not interpret when other family

members use health care services. It is not known how often this occurs, but official interpreters are not always available in emergency cases.

Also the ethnic minorities, e.g. Sami people (Näkkäljärvi & Magga 2006) and Swedish-speaking Finns have difficulties in receiving services with their own language (Kalland & Suominen 2006, Swedish Assembly of Finland 2006).

3.1.5 Cost sharing

In terms of the cost of health services, the situation of migrants does not, generally, differ from that of the population of Finnish origin, with the exception of asylum seekers and illegal migrants. Although no studies are available concerning the effect on migrants of cost-sharing practices, similar differences are likely to exist in different groups of migrants as exist between different population groups in Finland in general due to the multi-channel organisation of outpatient services. A study has been made on costs incurred by the health service system in providing health care services to migrants (Gissler et al. 2006). The researchers pointed out that migrants' health care costs were lower than those for the population of Finnish origin. This is due to the fact that the migrants on the whole use health care services less than population of Finnish origin.

3.1.6 Health literacy and voice

In Finland, the migrant's voice in regard to improving the health services system can be said to operate through NGOs and other organisations both in terms of policy planning and in terms of gaps in services. This is also the case for other population groups since NGOs and other kinds of organisations play an important role in policy planning and other official working groups.

In health centres most of the general information is translated into the most frequently encountered languages (for example, instructions for coming into laboratory tests). On the other hand, there is recognition that all migrants may not be capable of reading these information letters (Kuusio & Kuivalainen, personal communication), e.g. Somali culture is based on oral tradition.

The Finnish Refugee Council provided the following suggestions to improve migrants' access to health care services and in Finland:

- Health care centres and hospitals should have more variable personnel in respect of cultures and spoken languages.
- Health care management commitment to equal treatment for all clients regardless of their cultural background.
- Education in cultural competence should be offered to whole spectrum of health care personnel from cleaners to management.
- In the individual integration plan (required by the Integration Law), each migrant's strengths should be acknowledged already in the beginning, to enable migrants to find a meaningful role and to become active citizen.
- The integration plan should concentrate more to the integration of the whole family instead of individual centric approach

3.2 Older people with functional limitations

In Finland the policy on ageing has at present six main lines: safeguarding a reasonable income; improving health and functional capacity; supporting living and coping at home, improving the quality of services; reinforcing and clarifying clients' rights: and ensuring sufficient funding for services and income security (MSAH 2006d). In Finland, about 90% of services for older people are provided by the public sector, which supports equity in access to health services.

In social and health policy, sizeable investments have been made in innovations that improve social adaptability in Finland. People who receive no earnings-related pension at all or a very small earnings-related pension receive the full amount of national pension. The pension scheme is supplemented by pensioners' housing allowance and pensioners' care allowance for supporting living at home and independent coping. Furthermore, pensioners with a small income are supported by special tax treatment of pensions. Public social and health care services also supplement the fulfilment of social objectives. In 2006, the full amount of the national pension was € 432–510 per month, depending on the place of residence and living conditions. The average total monthly old age

pension in 2004 was € 1372 among men and among women € 1026, and of the women 9% received solely the national pension (Official Statistics of Finland, 2004). Despite the equality of the Finnish pension system, it is a challenge to ensure sufficient pensions for women. In particular, those women who live alone and receive a mere national pension or a combination of the national pension and a small employment pension are at risk of poverty. In 2004, the poverty risk for women was 16% of women aged more than 65 years and 8% of men aged more than 65 years. (MSAH 2006d)

The availability and quality of services for the older people is ensured by increasing the resources available for the services as the number of elderly people grows. In Finland the service system has been directed from inpatient to outpatient services, while efforts have been made to improve the availability and efficiency of services for the elderly as well as health services. The target of Finland's policy on ageing is to maintain the functional capacity of older people for as long as possible. The services are dimensioned according to the individual's functional capacity. Outpatient services are provided for people with only slightly reduced functional capacity and long-term care is given to people whose functional capacity is impaired in the long term or permanently. This safeguards the right of the elderly to live independently at home in their familiar living and social surroundings for as long as possible, while ensuring the provision of necessary services and allocating resources in an appropriate way. (MSAH 2006d)

Another target is to increase the versatility and timeliness of preventive and rehabilitating activities in order to improve and maintain the functional capacity of older people. This includes independent exercise, rehabilitation with an emphasis on exercise, guidance on healthy eating, and reinforcement of social networks. The target is to improve the functional capacity of the elderly. A barrier free, functional, and safe neighbourhood and home environment as well as the use of assistive devices and new technology enable independence. (MSAH 2006d)

The focus is on services provided at home or in the neighbourhood. The target is to provide sufficient, timely, and appropriate care and rehabilitation services.

Providing social welfare services sufficiently early is ensured by enforcing time limits for signing up for key services. A preventive and rehabilitating approach is systematically adopted in the services, and care practices are improved such that they are more client-oriented, activating, and multi professional. Health centres offer physician visits, home nursing and other kind of out-patient primary care. (MSAH 2006d: Official Statistics of Finland, 2007). The Finnish Pensioners' Federation (FPF) points out that even if health centres offer a variety of services they tend to lack services aimed at health promotion and disease and illness prevention. Prevention of osteoporosis and depression as well as rehabilitation resources are scarce. Such services are particularly relevant to maintaining people's good health in later years.

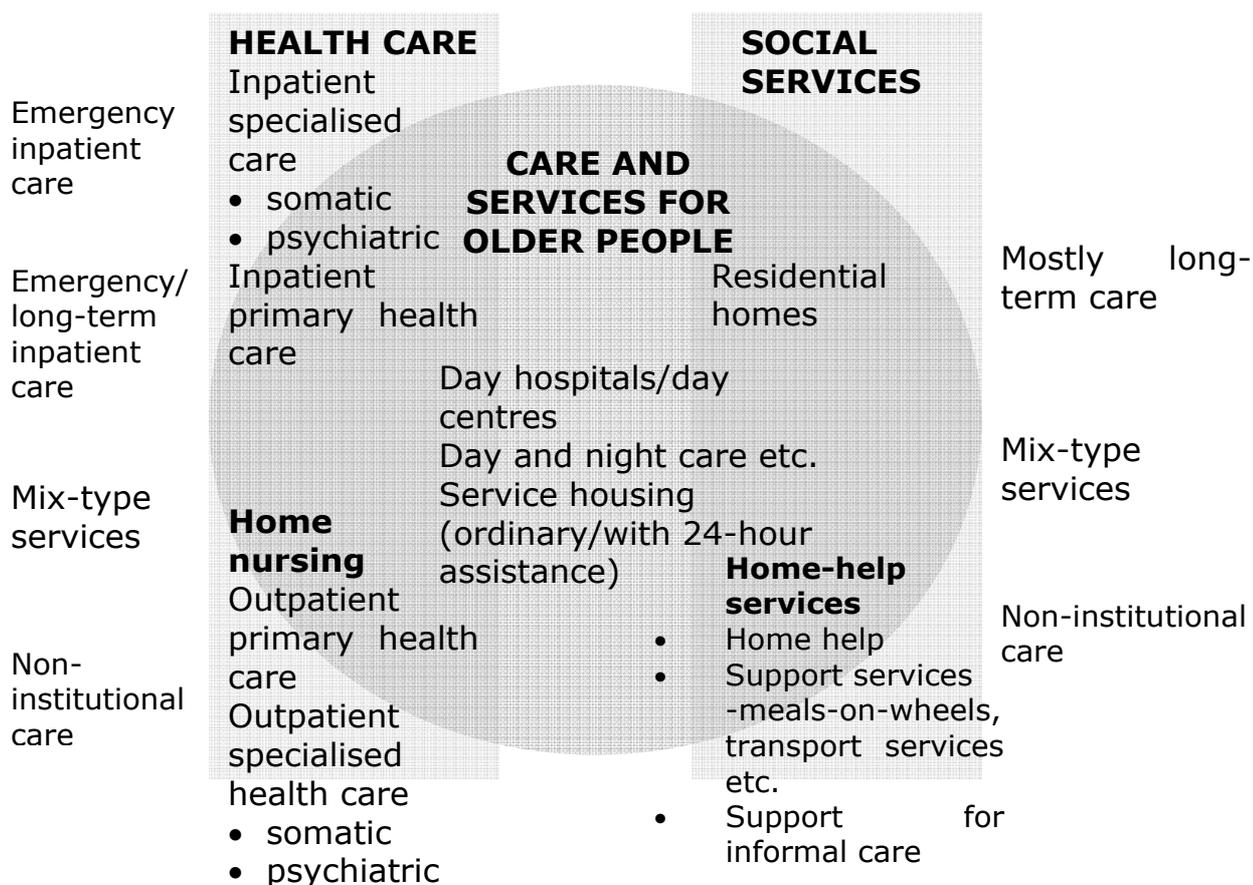
The services are based on the older person's own resources, functional capacity, and network of family and friends. The local authorities in concert with the third-sector service providers support the input and capabilities of the relatives (MSAH 2006d). Many of the services that previously were part of home help are now delivered as support services such as shopping, cleaning and meals on wheels.

These lines of policy are implemented via various projects for promoting the independent initiative of the elderly and postponing the need for institutional care. The social welfare and health care sector, together with the housing authorities and private enterprises, support independent living and accessible environments. The funding of the services shall support elderly people receiving the treatment corresponding to their functional capacity. Another target is to ensure high-standard services in close co-operation with the local authorities, organisations in the third sector, volunteer workers, and companies in the field. The target of the policy is to safeguard the necessary services for all residents of the municipality, regardless of their financial or social status. Their equality is ensured with specialist services, such as personal help and individual housing solutions. A particular challenge lies in the development of safe and high quality home care and service housing for older people suffering from dementia. (MSAH 2006d) According to FPF, dementia is underdiagnosed and therefore many old people do not get the services they need.

In Finland, there is no separate legislation or organisation for care of the elderly or long-term care, but long term care is part of the general health care and social welfare system (Figure 3). Services for older people are provided in both social and health care. In- and outpatient care in specialised health care and primary health care are service forms invariably provided in the area of health care. Emergency medical care is provided mainly in university hospitals and central hospitals and, to some extent, in health centres.

Institutional care and non-institutional services for older people are provided in both social and health care and in many municipalities, jointly by social and health care. Institutional care is provided in health-centre inpatient wards and in residential homes for older people. Day-hospital services are provided by health centres and hospitals. Day centre activities, in turn, are usually provided by social welfare authorities, as well as sheltered housing and support services. Services provided in the person's home are provided by home-help service units (social care) or home-nursing units (health care) either jointly or separately. The share of social and health services provided by private enterprises and non profit organisations has been increasing and in 2004 represented one quarter of all social and health care services (MSAH 2006d: Official Statistics of Finland, 2007).

Figure 3. Care and services for older people in Finland



Methods

The overview on access to health care for older people with functional limitations is based on a literature review and on consultation with The Finnish Pensioners' Federation (FPF). The databases CSA illumina / Ageline, ASSIA, Social Services Abstracts, Sociological Abstracts, Academic Search Elite, Psycinfo, Socindex, and the national databases Nelli, Linda, Arto, Fennica and publications of MSAH and the Finnish government. Databases were searched by using the search terms elderly, older adult, 65+ stigma barrier or discrimination, stereotype, exclusion, health, medical, equity, access and in Finnish, iäkäs, palvelut, esteet, ikääntyneet, 65+.

The NGO Finnish Pensioners' Federation (FPF), that represents 120 000 members, have contributed to the section on older people with functional

limitations. FPF has about 50 full time employers and approximately 10 000 voluntary workers. FPF is mainly funded by the Finnish Slot Machine Association (RAY).

3.2.1 Home care

Home care, consisting of home-help services, home nursing, and other support services, is an important area in integrated care, provided by health care and social services. In the past few years, the provision of long-term institutional care has diminished, and the social services have clearly organised more long-term institutional care than have the health care services. The home care service providers offer a variety of outpatient services so that the elderly can live at home for as long as possible. These integrated services include home-help services, home nursing, day hospitals and other day-care centres, as well as part-time in-patient care. The regular intermittent in-patient care, defined as at least 8 periods of during a year, is an important support service, especially for clients with informal care support. (Official Statistics of Finland, 2007)

The main reason for the increase in out-patient care for the elderly is the upturn in the percentage of service housing and family care arising from the decline in the number of older people receiving home services. In 2004, 18% of people aged 75 and over received home services. In the Target and Action Programme for Social Welfare, the Government set as the national target the provision of home services on an annual basis for 25% of people aged 75+ by year 2007. In service housing, people live in their own flats, but they have various services at their disposal, such as meals, medical treatment, and other help needed in everyday life. Outpatient and inpatient units for the elderly have also developed interval care, which supports living at home. A considerable proportion of service housing for the elderly has been built with funding from the Finnish Slot Machine Association RAY. (MSAH 2006d)

Municipalities may organise home help and home nursing services either separately or jointly. Efforts are made to boost the guidance of home help and home nursing services at the national level as part of the social sector

development project. The main target of the project is to achieve permanent improvement in the availability, quality, and financial and functional efficiency of home help and home nursing services. Increasing co-operation between social services and health care is an important aspect of this project. Deficiencies in co-operation can have a key impact on the client's view of the municipal services. Home help and home nursing services and institutional care should be closely linked and form a well-functioning entity.

3.2.2 Long-term inpatient care

Municipalities provide long-term care in the inpatient wards of health centres and non-medical long-term care in institutions for the older persons. A maximum of 80% of a patient's monthly income is charged for long-term hospital or institutional care, ensuring that at least € 80 remains available for the patient's personal use.

The average age of older people in long-term inpatient care in health centres at the end of 2005 was 83 years. Over 80% of clients in institutional care were dependent or in need of nearly constant care and the placement of clients at different levels of care seems to have taken place appropriately in the country as a whole. (Official Statistics of Finland, 2007)

3.2.3 Problems in access to health services

In Finland, care and services for older people are arranged within health care and social services. The provision of social and health services is the responsibility of the municipalities. The service provision for older people vary from one municipality to another, depending on local circumstances and the needs of the population. Most services which old people use belong to the social services. A good integration of social and health services is essential for the provision of high quality services. The Finnish Pensioners' Federation (FPF) highlighted that use of services is complicated for many old people because of fragmentation of services. Municipalities do competitive bidding for private service providers, creating fragmentation of social and health services which often makes the use of service difficult and create a need for consultation or

advice. According to the FPF, reforms to integrate health care and social services is crucial

Guaranteed access to health care, which came into effect in March 2005 (see section 1.2.3), also applies to services for older people. In addition, provisions on the obligations of municipalities to arrange a service needs assessment were added to the Social Welfare Act in March 2006 (Act on Amendments to the Social Welfare Act 125/2006.) (see section 3.2.10). This legislative amendment does not alter the municipalities' obligation to arrange social care services, but it specifies the procedures for accessing these services.

Elderly people experience difficulties in accessing health care. 88% of home care clients with physical rehabilitation potential did not receive physiotherapy, occupational therapy or exercise therapy. There are also problems in recognition and treatment of pain: a quarter of home care clients suffer from severe pain on a daily basis, with a fifth being subject to an inadequate pain control regimen. Also dementia processes or other types of cognitive impairment often remain unrecognised (Finne-Soveri et al. 2006).

Problems exist in meeting the needs of older people in terms of the allocation of care and services, especially concerning the treatment of sleep disorders, depression, pain, fall prevention, and dementia. Geriatric care recommendations should be prepared, and the "Current Care" practice guidelines should include specific recommendations regarding the care of older people. (Kivelä 2006)

The Finnish Pensioners' Federation (FPF) reports that utilisation of health care is more difficult for older people with deficient health literacy, who may not understand what services they are entitled to or how to access them or to whom to ask. This is associated with problems concerning information transfer: e.g. poorly designed printed material utilising small fonts (such as labels on medications) and forms that are too complicated to older people. Such perceptual failures may result from assessing the needs of older people exclusively within a health and welfare framework. Also the language health care personnel use may be difficult to understand for many old persons.

According to the FPF, relevant information is in many cases presented exclusively on the Internet, utilising websites that are difficult for older people to access and use. Therefore the need for personal advice is increasing.

Furthermore, the FPF highlighted ageism in the attitudes of health care professionals and the policies of relevant institutions. According to FPF, in health services assumptions are made about investigation, intervention, treatment and rehabilitation that would not be applied to a younger person presenting with exactly the same symptoms or illness.

3.2.4 Multiple risks: low pensions, social isolation and care needs vs. cost of services

Despite the equality of the Finnish pension system, it is a challenge to ensure sufficient pensions for women. In particular, women in older age groups may be at a risk of poverty if they receive no earnings-related pension and have to rely solely on the national pension or on a combination of the national pension or a small employment pension, due to divorce or the death of the breadwinner. In 2004, 54% of women and 24% of men aged 60+ lived alone. The percentage living alone increases with increasing age: 65% of 75–79 years old women lived alone, and 88% of women aged 85+ lived alone. Elderly women living alone have the lowest incomes (Vaarama et al. 2006). In 2004 the poverty risk for women was 16% of women aged 65+ and 8% of men aged 65+ (MSAH 2003). In 2002 the mean monthly net incomes of women aged 60+ were €1170 and the lowest incomes were among women aged 85+ (€899) (Vaarama et al. 2006). To conclude, especially older women living alone are at risk of poverty and social isolation as well as economical barriers of access to health care.

Within public health care, user fees have an annual ceiling of €590, after which clients principally receive outpatient services free of charge. However when comparing this sum to the net income means of old women there is a risk of a barrier to access health services due to poverty. (Voutilainen & Vaarama 2005.) In the consultation process of this report, the Finnish Pensioners' Federation (FPF) pointed out that customer fees for older people with low income pensions

are often too high and that there is a need to protect purchasing power of older people.

3.2.5 Problems of access: geographical barriers

The poorer mobility of certain sub-groups of the elderly may be due to health status, a lack of a driver's license and to inequalities in transport infrastructure. The findings of one study (Siren & Hakamies-Blomqvist 2004) showed that those elderly making few trips and most willing to do more trips were women, the oldest old, those without a driver's license, those with a lower educational level, and rural residents i.e. those who have longest distances to health services. Women who do not drive seem to be more affected by age-related mobility barriers, such as the physical decline associated with increasing age, than men. For those older women who do not drive and live in areas with insufficient public transportation, or who do not have the physical health needed for walking, other persons' support in transportation becomes crucially important. For disabled elderly, the car's importance might lie in its compensatory qualities: the car is used as a tool and an aide in maintaining independent mobility in old age. However, women give up driving earlier than men. (Hakamies-Blomqvist & Siren 2003)

The FPF points out that mobility problems concern the old people not only in rural-areas but also in cities and suburbs and towns. Old people may be especially struck by geographical barriers of access to health care because of difficulties in the use of transportation. Old people especially with functional limitations may experience difficulties travelling and they may not receive assistance.

3.2.6 Ethnic minority older people

It has been recognised that ethnic minority older people do have specific needs, problems and access barriers in their usage of health and social services. The most important reasons relate to language problems, closely followed by a client's cultural norms and values. The most common reasons are that their numbers are still small, the staff do not have the language skills and culture-specific competence and that the organisations are not active in promoting

services for this particular clientele (Quality of Social and Health Care Services for the Minority Ethnic Older Persons the Service Providers' Perspective in Finland, 2003). Minority ethnic older people experienced racial harassment in social and health care services, both from the professionals and from other clients. Vietnamese had experienced racial harassment from care professionals clearly more often than the Russians and Samis. Some 28% of the Vietnamese respondents had often experienced harassment, whereas the same figure was 5% for the Russians and 2% for the Samis. (Quality of Social and Health Care Services from the Minority Ethnic Older Persons: Perspective in Finland, 2003)

3.2.7 Age discrimination in access to mental health services

Research indicates that in Finland older persons suffer frequently from depressed mood (Heikkinen & Kauppinen 2004). More than one third of women at age 85 years and nearly one-third of men are reported to suffer from depressive symptoms. A statistically significant increase in the prevalence of depressiveness for women particularly from the age of 80 to 85 years has been found.

Sixteen per cent of home care clients have a psychiatric disease. Depression is the most prevalent psychiatric disorder among the elderly. It has been estimated 15% suffer from depression (13% among men and 17% among women). As many as one in four home care clients is characterised by suspected depression and /or receives antidepressants (Finne-Soveri et al. 2006).

However, among those over 65, outpatient visits in specialised health care psychiatry totalled only 42 500 in 2005, representing about 1% of the total population over 65 and among those over 75 and over 85 the number of visits was even less. Correspondingly, one in three people over 85 received care in primary care, more than one in three in the somatic specialities but only 0.5% in psychiatry (Official Statistics of Finland 2005). With a view to the prevention and treatment of depression in old age a national development project has been proposed (Kivelä 2006).

Until 2006, there has been no information or educational material concerning alcohol- and drug-related harm in the older population, and neither have there been national programs targeted at preventing and reducing alcohol- and drug-related harm in the older population.

3.2.8 Reforms to support health care access

Assessment of service needs for people aged over 80

The equality of older people in access to services is being improved by developing a more extensive and harmonised assessment of service needs. Since March 2006, all people over 80 years of age may have an assessment of their non-emergency service needs if they so require by the seventh working day from the day of contact (MSAH 2006d). However, even though there is right to an assessment of service needs, residents do not have the right to demand specific services of their own choice. In urgent situations the need for services must be assessed immediately, regardless of the age (MSAH 2006d).

The assessment of functional capacity as a part of the assessment of service needs is a means of providing the client with well-coordinated, individualised services that ensure continuity of care. No such assessment method is yet widely used (Voutilainen and Vaarama 2005). In particular, the most widely used measures pay little attention to psychological and social functioning and environmental factors. This means that poor psychological functioning may remain unrecognised and therefore treated inadequately. This is cumbersome, because cognitive impairment afflicts many home care clients (Finne-Soveri et al. 2006).

Policy case #4: Service needs assessment for every resident over 80 years of age

<p>The equality of older people in access to health services is being improved by developing a more extensive and harmonised assessment of service needs. Since March 2006, all people over 80 years of age and those receiving a special care allowance from the SII should have an assessment of their non-</p>

emergency service needs by the seventh working day from the day of contact. In urgent situations, the need for all services must be assessed at once, regardless of age. The measure does not seek to upgrade the standards of services, but to clarify and standardise practices. Many municipalities already carried out service needs assessment prior to the new law. The aim of the new law is to ensure deadlines are in place and that assessments are available everywhere.

The assessments should be performed by a team of health and social care professionals, and it includes a rating of level of functioning. The implementation of the law has highlighted the problem that different municipalities use different instruments for measuring level of functioning.

After the assessment of service needs has been carried out, the client must be given a written decision on the acceptance or non acceptance for services if the client so requires. The client may appeal the decision. If the decision on the arrangement of services is positive, a care and service plan must be drawn up for the client. However, even if there is right to an assessment of service needs, the residents do not have the right to demand services of their own choice.

The reform has not yet been thoroughly evaluated.

Support for informal carers

Support for informal care consists of social and health care services provided for the person being cared. support for the carer and care fee paid to carer. The system has been in use since 1984, and it has been amended several times, the last time being at the beginning of 2006, when the Act of the Informal Care (937/2005) came into effect. The 2006 reform of the law on family care provision has sought to improve the situation of care-givers and their charges, updating what was an often informal system of arrangements with a more comprehensive kind of support, involving services, remuneration and leave. The main arguments to reform of the law on family care provision were to harmonise

the arrangements across the municipalities and ensure the support services to caregivers in addition to caregivers' allowance. (MSAH 2006b, 2006d).

Relatives – a spouse, partner children or even not a family member – looking after an older person are entitled to an allowance for this from the municipality. The municipality pays for the accident insurance of the informal carer and may also arrange various social and health services to further support this care. The most common services provided to informal caregivers are days off, service guidance, social work services and peer activities (Voutilainen 2007). The municipality and the person providing care draw up a care agreement that includes a plan on care and services.

In 2007 the minimum caregivers allowance is €310 a month. If the carer is unable to be gainfully employed during a transitional stage with the nature of care being heavy, the support for informal care is at least €600 per month. There is no upper limit on the allowance, which is taxable. A carer with an agreement with the municipality is covered by an earnings-related pension provision for his or her work, provided that he or she is not already retired. In the care and service plan, support services for the carer are also specified, in addition to the services provided for the patient. The person receiving support for informal care is entitled to have at least two days off in any month during which the nature of the care is extremely restraining. The municipality provides for the care during the statutory time off. During the caregivers' statutory days off the care for persons in informal care was mostly arranged in the form of short-term institutional care in an old people's home, a health centre ward, a special care district institution or rehabilitation institution (Voutilainen et al 2007). The municipality may also provide recreational time off without reducing the amount of support for informal care. When the informal carer exercises his or her right to have a day off, the patient will have to pay a maximum of nine euros per day for home help services arranged via a service voucher. Service vouchers were introduced in home services and as the joint coverage target for home services was defined 25% of the population over 75 years of age.

The implementation of the law is being monitored by follow-up research conducted by STAKES and the MSAH and involves 362 municipalities. This

follow-up research is conducted every fourth year. In 2006, municipalities budgeted €12 million for informal carer support and this year about half of them plan to increase the budget. The number of informal carers has been increasing since 1994 and from 2004 to 2006 it increased by 15%. There were some 29 500 caregivers working nationwide in 2006, caring for some 22 000 mainly older residents. The follow-up research indicates that without the new system of caregiver support some 11 600 more people would be being cared for in institutions. The average pay for a caregiver is €416, up from the average of €288 paid in 2002. A total of 75% of caregivers are women, 53% of them of working age and a fifth, or 22%, over 75 years old. The health and capacity of caregivers is mainly assessed by home visits conducted by local authorities.

According to recent evaluation (Voutilainen et al. 2007) of the support system for informal carers, more than half of the carers had retired from work life and about one fifth had fulltime employment. Three quarters of the caregivers were women. Compared to 2002, the situation changed so that the proportion of caregivers in receipt of a pension increased. In the municipalities that took part in the study the fees paid as support for informal care were most often between €300 and €599. The reform has not affected amount of the services given to the client. (Voutilainen et al. 2007)

The municipal officials estimated that more than half of the caregivers who are entitled to statutory days off used that right. For about one fifth of the clients care was arranged with the help of relatives, neighbours or volunteers or in short-term care in a service-housing unit. Types of care that were used to a minor extent included stand-in services at home, 'family care' holidays and respite care provided by means of home help service. Compared to 2002 the situation in regard to services for informal caregivers had changed only slightly (Voutilainen et al. 2007).

According to a recent report (Voutilainen et al. 2007) the major challenges for developing support for informal care are the following:

- 1) Promotion of the quality of life of the persons cared for and the caregivers by

- a. developing varied services, such as recreation and rehabilitation services, to maintain and promote the caregivers' physical, emotional and social functional capacity through an extensive cooperation between various actors such as municipal authorities, non-governmental organisations, parishes etc.,
 - b. developing appropriate options for organising respite care in the client's home during the caregiver's statutory days off;
- 2) A comprehensive evaluation of the functional capacity and resources in regard to both the person cared for and the caregiver so that the necessary help can be directed appropriately and purposefully, as guided by the care and service plan;
 - 3) Development of informal care as an integral part of the service structure on a long-time basis, including increased coverage of support.

Policy case #5: Support for informal carers

Informal carers may receive financial support from their municipality. The minimum amount of support for informal care is €300 per month. If the carer is unable to be gainfully employed during a transitional stage with the nature of care being heavy, the support for informal care is at least €600 per month. The support is classified as taxable income. A carer with an agreement with the municipality is covered by earnings related pension provision for his or her work, provided that he or she is not already retired.

In the care and service plan of the care recipient, support services for the carer are also specified, in addition to the services provided for the person in care. The person receiving support for informal care is entitled to have at least two days off in any month during which the nature of the care is extremely restraining. The municipality provides for the care during the statutory time off.

The implementation of the law is being monitored by follow-up research conducted by STAKES and the MSAH and involves 362 municipalities (Voutilainen et al. 2007). In 2006, municipalities budgeted 12 M€ for informal carer support and about half of them plan to increase the budget in 2007. The

number of informal carers has been increasing since 1994. From 2004 to 2006 it increased 15%. There were some 29 500 caregivers working nationwide in 2006, caring for some 22 000 mainly older residents. The evaluation indicates that without the new system of caregiver support some 11 600 more people would be being cared for in institutions. The average remuneration for a caregiver is €416, up from the average of €288 paid in 2002. 75% of caregivers are women, 53% of them of working age and a fifth are over 75 years of age. The health and capacity of caregivers is mainly assessed by home visits conducted by municipal authorities.

3.2.9 Training policies to improve responsiveness of services for older people with functional limitations

All medical schools offer geriatric studies. However, the proportion comprises only 0.4–1% of credits (ECTS). It is also possible to qualify in geriatrics as a medical specialty, but the percentage of specialists in geriatrics is only about 2% of all medical specialists. There is also a degree programme in Elderly Care. The graduates of this degree programme become Bachelors of Elderly Care. They are experts in elderly care whose aim is to promote the health, well-being, functional capacity and social participation of elderly citizens. The degree programme combines multi-disciplinary gerontological knowledge with practical elderly care qualifications and with the supervision and development of services for elderly people. The experts of elderly care work with individual clients, providing guidance and tailor-made services to support home-care, and as managers and developers of services in municipalities and institutions for elderly clients. They are also specialists in dementia work.

The MSAH recently commissioned a report (Kivelä 2006) on developing the quality of geriatric care and elderly care, taking account of the most recent research-based information. The task concerning education was to draw up proposals for measures to develop basic and continuing education by means by which to secure the skills of social and health care personnel. The rapporteur proposes that the basic degree programmes for all groups of social and health

care employees should be developed so as to include an adequate amount of studies in normal ageing, geriatric prevention, care and rehabilitation, and pharmacotherapy of older people. The studies in pharmacotherapy should also be increased in nursing degree programmes. Geriatric psychiatry should be made a medical specialty. The amount of training of specialists in geriatrics and geriatric psychiatry and of geronomes should be increased. An additional degree programme in geriatrics and elderly care should be started in particular for general practitioners, as well as a joint degree programme in elderly care for health and social sectors that will form a part of the studies for a higher polytechnic degree. Interest in the degree programme in elderly care for practical nurses in social and health care should be promoted among young people. All the hospital districts and primary health care in cities should have geriatric evaluation and rehabilitation departments and departments for geriatric psychiatry with outpatient services. More focus should be placed on theoretical extension studies in elderly care and multiprofessional development projects for elderly care. Separate continuing education degree programmes in pharmacology and pharmacotherapy should be started for physicians and nursing staff. (Kivelä 2006.)

3.3 People with mental disorders: the issues

On the policy level, the goal has been to include mental health policy in the general health policies, and no specific national policy document for mental health exists. This can be seen as advantageous from the point of view of inclusion policy, but this decision also includes the risk of neglecting mental health issues. In the current public health programme, Health 2015 (see section 1.2.2.), mental health issues are not prominent. The programme stresses the need to secure mental health services for children, but it does not touch upon the need to improve access to general healthcare for people with mental disorders.

On the programme level, national programmes to prevent suicides and to facilitate early interaction between mother and child have been implemented on

a large scale. Currently, pilot programmes to raise awareness (e.g. the depression campaign in the Ostrobothnia district) and to prevent social marginalisation (the Time Out! Programme) are being evaluated, and these programmes may also have a positive effect on access to health care.

On the health service level, people with mental disorders are expected to use the same services as the rest of the population. Very little attention has been paid to develop the responsiveness of services to this special group of patients. At some public health centres, home visiting services have built capacity to meet the needs of people with mental disorders, and singular examples of special services tailored for this group exist (e.g. weight control group sessions for people with mental disorders).

3.3.1 Access to general health care

Finnish research indicates that there is an excess of death from natural causes among people with mental disorders. A longitudinal cohort study indicated a 50% mortality increase for those with a diagnosed mental disorder, mainly due to respiratory and cardiovascular disorders (Joukamaa et al. 2001). The morbidity rate was especially high in people diagnosed with schizophrenia, who evidenced a two- to three-fold risk of death from natural causes (Joukamaa et al. 2006).

The Mental Health Act includes a section on treatment of physical illness. The Act states that a patient (in mental health care) is entitled to treatment for physical illness according to the general Act on the Status and Rights of Patients, i.e. general health care should be provided on equal grounds to people with mental disorders. Furthermore, the Mental Health Act states that an illness must be treated in mutual understanding with the patient, in accordance with the Act on the Status and Rights of Patients. If a patient that is not able to decide on his or her care objects to treatment of a physical illness, treatment may only be given if it is necessary to avert danger to the patient's life or health. The physician attending the patient decides on the treatment, and the same physician may also decide on other short-time limitation measures that are necessary to give treatment for physical illness. Such treatment can be given at

general hospitals or psychiatric hospitals. To conclude, the mental health legislation builds on the universal principle of mutual understanding between patient and doctor when treating physical disease, and the provisions for treatment of physical disease if the patient objects to treatment are strict.

In spite of the increased mortality among people with mental disorders, there have been no policy level initiatives to increase access to general health care for people with mental disorders. The need for improved physical healthcare is included in the evidence-based national practice guideline for the treatment of schizophrenia (Finnish Psychiatric Association 2001). There is no Finnish research addressing the issue of access to general health care for people with mental disorders.

Outpatient mental health services as a rule do not provide general health services. They tend to refer patients to their local health centre for physical care, thus creating fragmentation of the care, which can create a barrier to access especially for people with severe mental disorders.

Inpatient mental health services used to offer limited general health services, often provided by an in-house specialist in internal medicine or neurology. Since the administrative collation of general health care and mental health care (in 1991), this kind of medical service specifically tailored for psychiatric in-patients has been decreasing, because general hospitals are expected to provide these services to all in-patients in the hospital districts.

The issue of inadequate access to general health care has been raised by the user organisation the Finnish Central Association for Mental Health. Neither the general public nor even all policy makers are aware of the problems in access to healthcare for people with mental disorders.

3.4 Conclusions

In spite of available evidence of existing health inequities and avoidable excess mortality, awareness of this problem is low within health services. No policy initiatives or programmes to improve access to general health care for people

with mental disorders exist. The problem of general health needs of people with mental disorders is largely neglected. Awareness in Finland needs to be raised, e.g. by exchange of experiences and best practice in this field between EU countries.

4 Access to general health care for people with mental disorders

4.1.1 Legislation

Health and social services for people with mental disorders are based on the provisions in the Mental Health Act (1116/1990). The Act specifically mentions that the universal provisions in the Act on the Status and Rights of Patients are valid also for patients in mental health care. The Constitution of Finland and several other acts guarantee equality and prohibit discrimination. The special anti-discrimination legislation, by which Finland transposed the Race Equality and Employment Equality Directives, came into force in 2004. The Act does not specifically mention mental disorders, but it prohibits discrimination based on age, ethnic or national origin, nationality, language, religion, conviction, opinion, state of health, disability, sexual orientation and any other individual reason. It prohibits both direct and indirect discrimination. Concerning all grounds, it is to be applied to the fields of employment, working conditions, terms of employment, career advancement, education and training, as well as the preconditions for entrepreneurship and supporting business and industry. It also covers memberships and activities in, among others, employee and employer organisations. The Act also applies to cases of discrimination concerning social welfare and health.

The Mental Health Act includes a section on treatment of physical illness. The Act states that a patient (in mental health care) is entitled to treatment for physical illness according to the general Act on the Status and Rights of Patients, i.e. general health care should be provided on equal grounds to people with mental disorders. Furthermore, the Mental Health Act states that an illness must be treated in mutual understanding with the patient, in accordance with the Act on the Status and Rights of Patients. If a patient that is not able to decide on his or her care objects to treatment for physical illness, treatment may only be given if it is necessary to avert a danger to the patient's life or health. The physician attending the patient decides on the treatment, and the same physician may also decide on other short-time limitation measures that are

necessary to give treatment for physical illness. Such treatment can be given at general hospitals or psychiatric hospitals. To conclude, the mental health legislation builds on the universal principle of mutual understanding between patient and doctor when treating physical disease, and the provisions for the treatment of physical disease if the patient objects to treatment are strict.

4.1.2 Policies

On the policy level, the goal has been to include mental health policy in the general health policies, and no specific national policy document for mental health exists. This can be seen as advantageous from the point of view of inclusion policy, but this decision also includes the risk for neglect of mental health issues. In the current public health programme, Health 2015 (see section 1.2.2.), mental health issues are not prominent. The programme stresses the need to secure mental health services for children, but it does not touch upon the need to improve access to general healthcare for people with mental disorders.

In spite of the increased mortality among people with mental disorders, there have been no policy level initiatives to increase access to general health care for people with mental disorders. The need for improved physical healthcare is included in the evidence-based national practice guideline for treatment of schizophrenia (Finnish Psychiatric Association 2001).

4.1.3 Programmes

On the programme level, national programmes to prevent suicides and to facilitate early interaction between mother and child have been implemented on a large scale. Currently, pilot programmes to raise awareness (e.g. the regional depression campaign implemented by the Ostrobothnia project) and to prevent social marginalisation (the Time Out! Programme⁹ implemented by STAKES) are being evaluated, and these programmes may also have a positive effect on access to health care.

⁹ For more information on the Time Out! programme, see <http://info.stakes.fi/aikalisa/EN/index.htm>

The “Time Out” programme¹⁰, implemented by STAKES as a randomised trial, aims at preventing social exclusion of young men by offering case management in connection with the military conscription at age 18. The intervention includes a needs assessment, and referral to health services if deemed beneficial. According to a preliminary evaluation, the intervention group has evidenced a beneficial mental health effect and reduced alcohol consumption.

4.1.4 Research

Access to general health care for people with mental disorders has not been a research issue in Finland, and no quantitative data on the issue is available.

4.1.5 Health services

On the health service level, people with mental disorders in need of general health services are expected to use the same health services as the rest of the population. Very little attention has been paid to develop the responsiveness of services to this special group of patients. At some public health centres, home visiting services have built capacity to meet the needs of people with mental disorders, and singular examples of special services tailored for this group exist (e.g. weight control group sessions for people with mental disorders).

The issue of inadequate access to general health care has been raised by the users’ organisation Finnish Central Association for Mental Health. The general public and not even all policy makers are aware of the problems in access to healthcare for people with mental disorders.

4.1.6 Civic society

The national NGO representing people with mental disorders is the Finnish Central Association for Mental Health¹¹, representation consisting of more than 150 local, regional and national mental health associations from all over the country. Generally, the members of these associations are people with personal experience of mental problems and various mental illnesses. The Association is

¹⁰ For more information, see <http://info.stakes.fi/aikalisa/EN/index.htm>

¹¹ For more information on the Association, see http://www.mtkl.fi/fin/in_english/

active in advocacy, maintains an information service, organises courses and peer support groups and publishes the magazine "Revanssi". It performs the yearly Mental Health Barometer Survey, which measures the attitudes and mental health literacy of the general population. A recent policy initiative by the Association asks for a pooling of the three different payment ceilings (see section 2.4-2.5) to reduce the burden of health care spending among people with long-standing health problems.

4.1.7 Public attitudes

Several surveys have measured public attitudes in mental health issues. The Mental Health Barometer Survey has been performed by the Finnish Central Association for Mental Health in 2005 and 2006: The survey is based on a sample consisting of general population, mental health service users and their families. In 2006, the survey samples also included psychiatrists and psychologists. The Barometer Surveys have highlighted discriminatory attitudes in the general population and stigma perceived by the users. On the other hand, there is widespread support among the population for investments and improvements in mental health services. (Finnish Central Association for Mental Health 2005, 2006). The Ostrobothnia Project performed a baseline general population survey in 2005 to map population attitudes prior to the project interventions (Herberts et al. 2006). The Ostrobothnia Survey indicated a widespread support for community-based mental health services, but also revealed several deficiencies in the mental health literacy of the population (Aromaa 2007, Aspvik 2007).

4.2 Methods

A literature search was performed focusing on studies, reports, and grey literature on access to general health care for people with mental disorders. Databases that were included in the portals of EBSCO, CSA and OVID were searched. The search was supplemented by a general Internet search. The national experts Juha Teperi and Timo Tuori (STAKES) and Eeva Ollila (MSAH) were consulted. Researcher Markku Salo from the NGO Finnish Central

Association for Mental Health contributed with valuable comments on a draft of this report.

4.3 Access to general health care for people with mental disorders

Finnish research indicates that there is an excess of death from diseases and medical conditions among people with mental disorders. A longitudinal cohort study, with a follow-up period of 17-years, indicates a 50% mortality increase for those with a diagnosed mental disorder, mainly due to respiratory and cardiovascular disorders (Joukamaa et al. 2001). An increased overall relative risk of death was verified in both sexes: in men the risk of death was 1.6 (95% confidence interval (CI) 1.3-1.8) and in women it was 1.4 (95% CI 1.2-1.6). In men and women with schizophrenia the relative risks of death during the follow-up period were especially high: 3.3 (95% CI 2.3-4.9) and 2.3 (95% CI 1.3-3.8) respectively.

The increased mortality is only partly explained by suicides or deaths to other external causes. The morbidity rate from natural causes, i.e. diseases and medical conditions, in people diagnosed with schizophrenia was three-fold risk compared with the rest of the cohort (Joukamaa et al. 2006). The morbidity rate remained two-fold even after adjusting for somatic diseases, blood pressure, cholesterol levels, body mass index, smoking, exercise, alcohol intake and education (Joukamaa et al. 2006). The excess mortality was confirmed in a nationwide register study of nearly 60 000 schizophrenia patients, who had an increased mortality from natural causes of death (RR 2.59, 95% CI 2.55-2.63) (Heilä et al. 2005). Taken together, these data from Finland indicate that people with schizophrenia die more frequently than other people with similar risk factors.

Further studies have identified subgroups with extremely high mortality. The study by Räsänen et al (2003) of long-stay psychiatric in-patients in northern Finland identified an excess mortality from natural causes. Diseases of the circulatory system were the most common single cause of death in both

genders and mortality due to that cause exceeded mortality in the general population nearly four-fold. Inadequately organised somatic care and the prevailing culture of "non-somatic" treatment in psychiatric wards were suggested to, at least in part, explain this phenomenon. The study by Sailas et al. (2006) demonstrated that within a nationwide cohort of prisoners, who evidenced a seven-fold increase in mortality compared to the general population matched for sex and age, the odds of death for prisoners with previous psychiatric treatment was 1.58 (CI 1.28-1.96) compared to prisoners without a psychiatric history. The study indicates that the health needs of this highly troubled group with multiple problems have not been met.

The general population health examination study "Health 2000" confirmed that people with schizophrenia or other non-affective psychoses, when adjusted for sex and age, evidence excess type 2 diabetes and metabolic syndrome and poorer visual acuity than the general population (Suvisaari et al. 2007a, Suvisaari et al. 2007b, Viertiö et al. 2007).

The study designs do not allow any conclusions regarding causality, but the risk of premature death may either be due to some unknown factor related to the mental disorder or its treatment, or it may reflect an excess of avoidable deaths due to deficiencies in access to health care. Although no data is available on how people with mental disorders access and use general health services, the findings from mortality studies indicate that considerable barriers to access exist. It seems plausible that multifactorial barriers are in function, and that these are related to the general stigmatisation and marginalisation of people with mental disorders.

4.4 Barriers in access to general health care for people with mental disorders

Outpatient mental health services as a rule do not provide general health services. They tend to refer patients to their local health centre for physical care, thus creating fragmentation of the care, which can create a barrier to access especially for people with severe mental disorders.

Inpatient mental health services used to offer limited general health services, often provided by an in-house specialist in internal medicine or neurology. Since the administrative collation of general health care and mental health care (in 1991), this kind of medical service tailored to psychiatric in-patients has been decreasing, because general hospitals are expected to provide these services to all in-patients in the hospital districts.

4.4.1 Gaps in coverage

In Finland, the NHI is universal. However, people in public hospital residential care, e.g. long-stay psychiatric patients, are not entitled to reimbursement for visits to private care providers such as doctors or dentists. This exclusion is based on the assumption that the institution will provide all the necessary medical services for in-patients. In reality, access to general health care is hampered by the fact that many institutions can provide neither in-house specialist services, nor have sufficient funds for purchasing services for their patients from external medical or dental service providers. It is alarming that such barriers in access to health care exist in the long-stay population with documented excess mortality (Räsänen et al. 2003).

Many people with mental disorders are not active in working life. Even within a cohort of young adults with schizophrenia, more than half of the people received disability pension or were on sick leave (Lauronen et al. 2007), excluding them from access to free occupational health care. In practice, the only available route of access to primary care for many people with mental disorders will be the public health centres, because financial constraints mostly precludes the use of private health services.

4.4.2 Scope of health basket

In principle, people with mental disorders are entitled to the same spectrum of health services as every resident of Finland. However, in reality the public health services have major problems in supplying psychiatric treatment. The availability of psychotherapy is severely hampered by shortfalls in staff resources and staff capacity. In urban areas private psychotherapists are available, and treatment is to some extent reimbursed by the SII, as

"discretionary rehabilitation services". Those rehabilitation services include psychotherapy or neuropsychological rehabilitation. The demand for psychotherapy rehabilitation is far in excess of available SII funds, and thus the SII applies strict limitations to reimbursement for psychotherapy. Long-term psychotherapy will be reimbursed for a maximum of 1-2 visits per week for a maximum of three years, and only if the therapy is deemed to restore the patient's ability to work or study. The restrictions imposed on duration and intensity of long-term psychotherapy are insufficient for the successful treatment of some psychiatric conditions, e.g. borderline personality disorders. Short-term psychotherapy is reimbursed for a maximum of 25 visits.

People with mental disorders encounter problems in accessing the same level of rehabilitation, social and handicap benefits as people with somatic illness. The SII administers "medical rehabilitation for persons with severe disabilities", which refers to intensive and individualized out- or inpatient rehabilitation services which go beyond curative treatment and form a necessary part of efforts aimed at maintaining or improving the client's work and functional capacity. The SII funds various group rehabilitation courses for people with severe mental disorders based on the rules for medical rehabilitation. People with mental disorders claim problems in accessing medical rehabilitation, partly because both application forms and the knowledge of the SII offices that make the benefit decisions are geared towards physical illness.

4.4.3 Cost sharing

Mental health problems are associated with low socio-economic status. Past and present economic difficulties are strongly associated with common mental disorders in the Finnish population (Lahelma 2006). A recent Finnish longitudinal register study has indicated that employees with low socio-economic position had increased risk for mental-health-related mortality, as indicated by suicides, deaths from alcohol-related causes, and all-cause mortality (Kivimäki et al 2007). Because of the lower socio-economic position, cost sharing constitutes a barrier of access to health care of special concern in the group of people with mental disorders.

The NGO Finnish Central Association for Mental Health has advocated for lower or no user fees in public services, and pointed out that user fees in some cases of long-standing mental illness are over € 1350 per year. A local study in the Pirkanmaa region has highlighted the high level of out-of pocket spending in mental health care, because of the accumulation of user fees from public primary care, home care, hospital in-patient care, and supported housing (Forma et al. 2003).

Pensioners care allowance, administrated by the SII, is intended to promote home care and to reimburse pension recipients for extra costs caused by illness or disability. People with mental disorders are eligible for pensioner's care allowance, depending on their level of functioning.

4.4.4 Geographical barriers

People with mental disorders may be especially struck by geographical barriers of access to health care because of difficulties in the use of transportation. People with mental disorders may experience difficulties travelling, and symptoms of the psychiatric disorder may preclude use of public transport.

Many municipalities purchase out-of-town residential services for people with mental disorders. This will incur problems for the patients to reach the health services of their own municipality. A recent study (Salo & Kallinen 2007) indicates that the location of residential services creates a real barrier of access. The study shows that 10% of residential service units for people with mental disorders are located with a distance of more than 10 km to other services, and 22% of residential service units have a distance of more than 5 km. The study reports that residential services provided by limited companies or private entrepreneurs more often have a remote and isolated location than residential services provided by municipalities or NGOs.

4.4.5 Organisational barriers

Most people in long-term care, e.g. in psychiatric hospitals, will not be eligible for NHI reimbursement for private health care spending. This effectively excludes this vulnerable group from private health care. One may speculate

whether there may be a connection between the low access to public and private health care and high mortality figures (Räsänen et al. 2003) in long-stay patients of psychiatric hospitals.

Although no specific efforts have been made in Finland to improve access to general health care for people with mental disorders, it is highly likely that the general policy measures, such as the introduction of maximum waiting times for non-emergency care, have improved access to general health care for this vulnerable group as well.

4.4.6 Supply side responsiveness

In spite of recent reports of excess mortality from natural causes in people with mental disorders (see section 4.3), insufficient awareness prevails on the special measures needed in response to the health needs of this group. Many clinical practice guidelines mention existing co-morbidity, but health service providers in general have not developed special programmes or services for people with mental disorders. This is partly due to ignorance, but it may also be due partly to a conscious effort to streamline and integrate health services of people with mental disorders into the ordinary health services.

There is some anecdotal evidence that in “difficult cases”, health centres have evidenced a negative responsiveness, by e.g. banning certain people with mental disorders from emergency rooms, usually due to disturbing or threatening behaviour of the person in question. Such decisions severely jeopardize the person’s constitutional right to health services.

There are no national efforts to improve health care staff’s attitudes towards people with mental disorders, neither any national programme to improve the responsiveness of general health services towards this group of people. However, the programme of occupational health care for the unemployed, which includes e.g. health checks, probably will target some people with mental disorders.

Foreign research has indicated that mental disorders are more common among migrants. The preparedness within health services to handle mental health

problems of migrants vary. Migrants' mental health problems are in many cases treated rigidly according to the same principles as those of the majority population. The situation is better in those municipalities that have a unit for foreigners or otherwise more centralised health care arrangements for migrants. Migrants' mental health problems are also identified better in municipalities which have multiprofessional teams in primary health care. In the best of cases, appropriate care chains are in place, and the dialogue between specialised medical care and primary health care functions well in connection with admission to and discharge from hospital and when planning continued treatment (Rauta 2005).

4.5 Policy initiatives and their impact on access to general health care for people with mental disorders

4.5.1 Impact of general health policy initiatives

Although many Finnish health policy initiatives may have specific impacts on people with mental disorders, no evaluations targeting this vulnerable group have been performed. It can be assumed that the introduction criteria and maximum waiting times for public non-emergency care (see 1.2.3) have improved access to general health care for people with mental disorders. Advocacy groups have aired the concern that the reduction of waiting times will shift resources from psychiatry to surgical procedures, because waiting lists exist for surgical procedures, but not for psychiatric treatments such as psychotherapy.

The horizontal policy of establishing inter-service labour force service centres (LAFOS) (see 2.7.2) may be of special importance for people with mental disorders. Among the long-term unemployed who get referred to those centres, a considerable proportion will have mental disorders. Also the municipal initiatives to provide occupational health care to the unemployed will probably support access to general health care for some people with disorders.

It is also plausible that other health policy initiatives, such as the introduction of public dental care for the general population (see 1.2.3), a service needs assessment for every resident over 80 years of age (see 3.2.1), and support for informal carers (see 3.2.2) may have had a positive impact on the access to general health services among people with mental disorders. The policy to use payment ceilings for user fees in public health care, medication spending and transportation in connection with health care (see 2.4) offers some support for access to health care, but the payment limits are probably insufficient for those worst off.

4.5.2 Impact of mental health policy initiatives

The Finnish mental health policy has supported deinstitutionalization and is aimed at strengthening community care. In a worst case scenario, this could have led to abandoning people with severe mental disorders to their own devices, leading to poverty, marginalization, and excess mortality. Studies however have indicated that there has been no increase in mortality among people with schizophrenia during the era of deinstitutionalization (Salokangas et al 2002, Pirkola et al 2007).

The results indicate that the Finnish mental health reform has not introduced new barriers of access to health care.

On the other hand, there is no evidence indicating improved access to health care for people with mental disorders. Data on excess mortality among long-stay patients indicates that barriers may still exist within psychiatric hospitals (Räsänen et al 2003). Existing data (Wahlbeck 2004) indicates that the deinstitutionalization process in fact partly has been a transinstitutionalization process, i.e. hospital patients have been moved to mostly private residential facilities, without really removing the barriers of full social inclusion. Stigma and social exclusion are still a part of everyday life of people with mental disorders.

4.6 Conclusions

Mortality figures indicate that there is excess avoidable mortality among people with mental disorders in Finland. No data is available on access to general health care for this vulnerable group, indicating that there is a lack of awareness of this problem among policy makers and researchers. The lack of awareness is also evidenced by the fact that no national policies addressing the issue of access to general health care for people with mental disorders were identified. A first measure to improve access to general health care for people with mental disorders must be advocating for actions by the government, the municipalities and the health system. Some good practice models are available in Europe, especially in UK, and these should be scrutinised and adapted for Finland if deemed effective. Continuing the efforts to mainstream mental health care and reducing psychiatric hospital care will probably result in better access also to general health care for people with mental disorders.

Many general health policy initiatives have most probably supported access to general health care for this group, as many barriers to access are shared with other groups. Of special interest are two Finnish initiatives: the labour force service centres and occupational health care for those who are unemployed. The interim evaluation of the labour force service centres is positive. Outreach actions will be needed to meet the physical health needs of the most vulnerable groups among people with a mental disorder.

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Appendix 1. Fees in public health care in Finland 2006.

According to the legislation (Act on Social and Health Care Services Customers Payments 734/1992), a health centre may charge a single or annual payment for doctor's appointments. The maximum single payment is €11, which can be charged for a maximum of three appointments, i.e. €33 per calendar year. The maximum annual payment is €22 per calendar year. Extra fees can be charged for visits to the health centre emergency clinic outside of office hours. Clients aged 15 and above may be required to pay a penalty charge of €27 for unattended appointments. The basic fee for dental care is a maximum of €7. On top of this, a fee can be charged for the treatment administered (€5–130).

Public hospitals charge for visits to outpatient departments (excluding outpatient psychiatric services) (maximum €22 per visit) and for outpatient surgery procedures (maximum €72). A daily hospital fee is charged for in-hospital care (generally €26 per day, but €12 per day in psychiatric wards. The daily in-hospital charge covers examinations, treatment, medicine and meals and stay. A maximum of 80% of a patient's monthly income is charged for long-term hospital or institutional care, ensuring that at least €80 monthly remains available for the patient's personal use.

With regard to a series of treatments, €6 is charged for each appointment up to 45 appointments a year. A series of treatments can be for example dialysis treatment, radiographic or cytostatic treatment and medical rehabilitation. A daily fee of €9 can be incurred by an establishment for the rehabilitation of a disabled or mentally handicapped person. A maximum fee of €27 can be charged for a medical certificate depending on the type of certificate.

The fees for home care provided at home depend on whether the care is occasional or continual. A maximum of €11 per visit is charged for occasional treatment by a physician or a dentist, while €7 is charged for a visit by some other health care professional. A monthly fee is incurred for continual treatment, which depends on the quality and extent of the service, as well as the patient's monthly income and family size.