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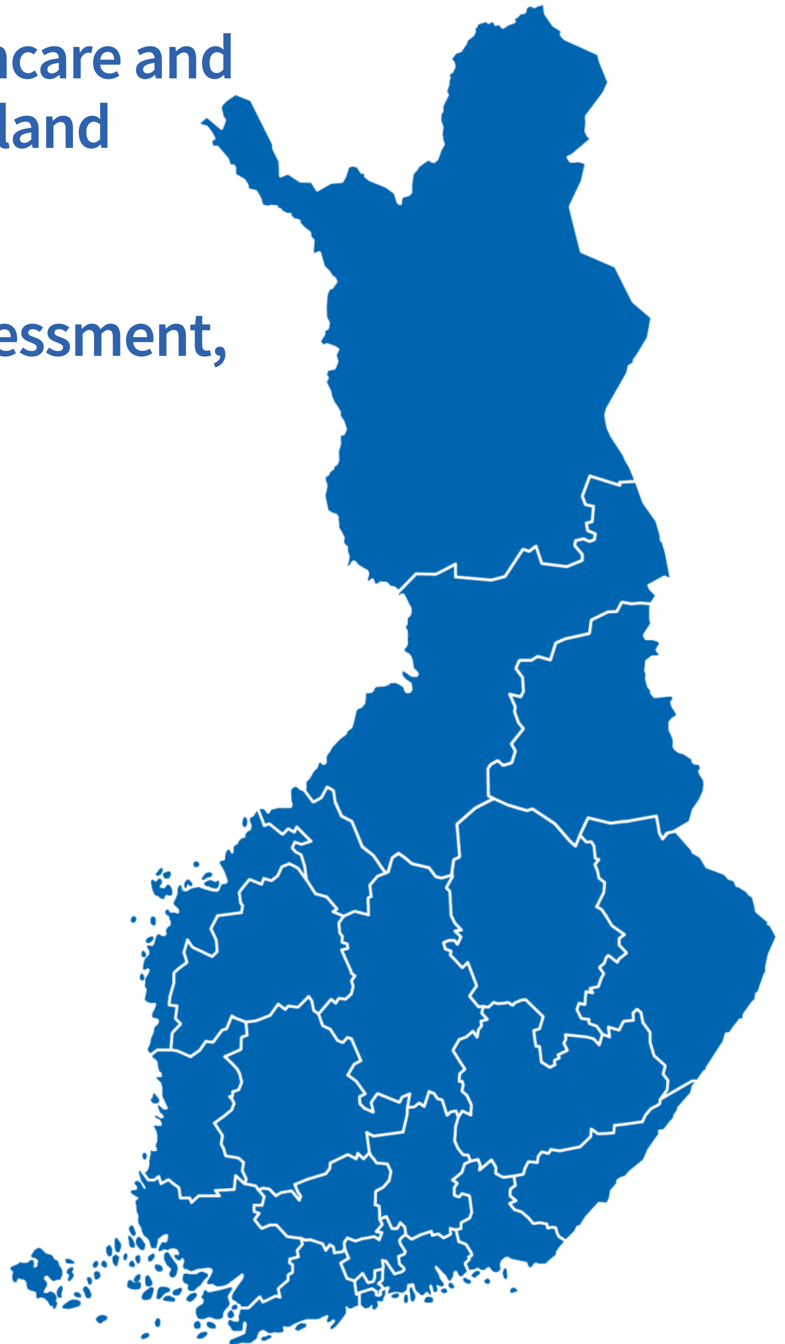
Organising of healthcare and social welfare in Finland



National Expert Assessment, spring 2023

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To the reader

On 1 January 2023, the responsibility for organising healthcare, social welfare and rescue services was transferred to 21 wellbeing services counties. The City of Helsinki is responsible for organising healthcare, social welfare and rescue services as a municipality, and the HUS Group for organising specialised healthcare in Uusimaa.

THL's statutory duty is to draw up annual expert assessments on the organisation of healthcare and social welfare in each wellbeing services county, collaborative area and nationally. This National Expert Assessment provides a fresh situation picture of the initial situation of the wellbeing services counties, which started their operations at the beginning of 2023. The expert assessment looks at the service need of the population, the formation of the administrative and operational structure of the wellbeing services counties, and the availability and sufficiency of competent personnel. In addition, the assessment focuses on the current state and development measures taken in the integration of services, the availability and accessibility of equitable provision of services, and the development and funding of the costs of healthcare and social welfare. The current state of healthcare and social welfare is also assessed in relation to the strategic objectives confirmed by the Government for national healthcare and social welfare for the period 2023–2026, as appropriate.

The national assessment produced by THL on the current state of organising healthcare and social welfare has been formed by utilising the county-specific situation pictures drawn up during autumn 2022 and other topical county-specific and national reports and studies. A considerable part of the available national knowledge base focused on services the organisation and costs of which were the responsibility of municipalities. The up-to-dateness of the national situation picture in organising healthcare and social welfare has been ensured by also utilising documents and reports drawn up at the preparation stage of the wellbeing services counties.

The National Expert Assessment of the organisation of healthcare and social welfare has been aimed at supporting national decision-makers, officeholders and specialists and those in the counties. The assessments produced by THL on the organisation of healthcare and social welfare lay the basis for the national report drawn up annually by the Ministry of Social Affairs and Health. The Ministry's report includes propositions for the measures required for drawing up the General Government Fiscal Plan, the Budget and the national objectives for healthcare and social welfare, and for other national guidance. The expert assessment drawn up by THL also supports the implementation of the work in the wellbeing services counties by providing fresh observations of the key points of view concerning the organisation of services nationally and in different parts of the country.

In Helsinki, 21 March 2023

Nina Knape

Director of Assessment

Summary of the expert assessment

Wellbeing services counties began their operations in the middle of a deepening personnel shortage

The wellbeing services counties began their operations challenged by the treatment and service backlog that developed during the COVID-19 pandemic, a deepening personnel shortage and the growing service needs of the ageing population. The birth rate is at a record low level, while mortality is record high. The population growth in the country is based on positive net migration and the demographic development in the wellbeing services counties continues to differentiate. The proportion of older people is largest in counties where the population will decline most according to population forecasts. In addition to differences between the counties, socio-economic and gender differences in matters such as the potential years of life lost have remained considerable. The group with the largest number of potential years of life lost is men in lower income groups.

Formation of the administrative and operational structure continues in wellbeing services counties

The transfer of the responsibility for organising health, social and rescue services from municipalities to the wellbeing services counties on 1 January 2023 went mainly as planned. In the transition phase, the counties focused on the tasks that were necessary. Counties with regional organisers took advantage of the previously formed decision-making and management structures. Some of the wellbeing services counties organised service provision into smaller, geographical areas. The most commonly selected policy-making structure has been the county committee model. Some of the counties have identified a need to further develop the administrative structures. The agreements on collaborative areas are under preparation; the agreement for Northern Finland has already been approved.

National goals encourage wellbeing services counties to collaborate in reforming their client and patient information systems

In the transition phase, the wellbeing services counties focused on ensuring the functioning of the information systems. In counties that have had little collaboration between organisers, several client and patient information systems are in use. However, progress has been made in their harmonisation, and the development of e-services for different client groups has continued. When reforming client and patient information systems, wellbeing services counties can gain synergy benefits from procurement cooperation at the level of collaborative areas in accordance with national objectives.

Reform of service network supports equitable access to services and management of finances

The service selection, the service criteria and the client fees have been harmonised. Harmonisation has started from statutory fees and from services used by a large number of clients. The current state of the service network has been surveyed in most of the country, but the actual reform work will take place in the coming years. The reform is guided by the strategic goals of the wellbeing services counties and their finances. In counties with regional organisers, the service networks and channels have already been developed for a longer time.

Backlog in care and services and shortage of personnel challenge timely availability of services

In many places, personnel shortages and the backlog in care and services incurred during the COVID-19 pandemic are hampering the timely availability of services in both primary and specialised healthcare. Older people's access to home care and housing services has become more difficult. The gradually tightening staffing ratios in 24-hour care of older people have led to a reduction of care places in some cases. The maximum waiting time guarantee in outpatient care in primary healthcare is gradually tightening at the same time as the shortage of physicians in health centres is becoming worse. Problems at the level of primary healthcare have led to an increasing workload at emergency clinics in many counties. The waiting times for non-urgent treatment in specialised healthcare have become longer and the number of surgeries performed has had to be reduced in some places. Over the past two years, there has been a fivefold increase in the number of children and young people who have waited for psychiatric treatment for more than three months. The wellbeing of children and young people has declined and the number of child welfare notifications has increased. The statutory maximum number of clients in child welfare has been exceeded in many counties. It has not been possible to fully comply with the statutory deadlines in social welfare services.

National development projects strengthen availability and integration of services

The implementation of new digital services and multidisciplinary and multiprofessional operating models has been promoted in the national development projects currently under way. In line with the Government's objectives, the county-level development projects of the Future Health and Social Services Centres programme have reinforced services at the level of primary healthcare and shifted the focus to preventative work. Services with a low threshold have been developed with the aim of responding to the needs of clients in a vulnerable position. The availability and cost-effectiveness of healthcare and social welfare services is improved in the development projects of the Sustainable Growth Programme for Finland by reducing the backlog in care, rehabilitation and services.

Further need to strengthen integration of services

The ability of the wellbeing services counties to ensure that they will reach the strategic integration goals varies greatly. The implementation of horizontal and vertical integration at the level of primary and specialised healthcare is still fragmented and sporadic in most counties. In healthcare, the continuity of care has declined, which makes the identification of the need for integrated services and their realisation more difficult. However, the multiprofessional approach is the most advanced in healthcare, in services for children, young people and families, and in services for older people. The number of family centres has increased in wellbeing services counties, which improves the availability of multidisciplinary services. Integrated services for other age groups have also increased at interfaces.

The integration of services is still hampered by sectoral thinking, different organisational cultures and differences between the views of different professions. In Uusimaa, the integration is challenging because of the number of organisers, which is larger than in the rest of the country, and because of the client and patient information systems. An organisational culture that makes integration possible is a precondition for reaching the national goal.

Wellbeing services counties began their operations with budgets in deficit and by working on adaptation plans

In the past few years, the growth of the net operating costs of the healthcare and social welfare that municipalities have been responsible for have been curbed by the discretionary government grants awarded for dealing with problems caused by COVID-19. Without these COVID-19 grants, the costs would have increased by 14 per cent in real terms between 2017 and 2021.

The budgets of the wellbeing services counties, which began their operations at the beginning of 2023, were mainly drawn up as budgets in deficit. The counties have prepared for the economic outlook of the forthcoming years by starting adaptation measures in their activities and finances. The harmonisation of the personnel's salaries has been carried out in some of the counties, but especially in counties built on decentralised responsibility for organising services, the work is only just beginning.

The wellbeing services counties will continue the investments started by hospital districts and municipalities, meaning that hospital construction will continue actively also in the coming years. Investments related to the harmonisation of the client and patient information systems create preconditions for clients' smooth use of services and for impact-based management.

Population and service need

Birth rate record low – mortality and net migration record high

According to preliminary information from Statistics Finland, Finland had 5,565,519 inhabitants at the end of 2022.[1] The slight growth of the population continued. The number of births declined significantly from the previous year and remained at the lowest level since Finland's independence. Mortality on the other hand increased to the highest level since the Second World War. Mortality has been higher than the birth rate since 2016 and the number of deaths exceeded the number of births by almost 18,000. There were more births than deaths only in Helsinki and in the wellbeing services counties of Vantaa and Kerava and West Uusimaa. The population of these counties was also increased by net migration, which reached a record level at the level of the whole country. Thanks to net migration, the population also increased in Central Uusimaa, Southwest Finland, Pirkanmaa, Ostrobothnia and North Ostrobothnia. Finland’s population growth is based only on positive net migration.[2] The size of the foreign language-speaking population and its proportion in the population are growing while the Finnish and Swedish-speaking population is declining. The proportion of the population speaking a language other than Finnish, Swedish or Sámi is largest in the Vantaa and Kerava wellbeing services county and in Helsinki.

The significant increase in the death rate in 2022 reversed the rising life expectancy of newborns. The last time there was an equal decline in the life expectancy of boys’ was 60 years ago and of girls, 65 years ago. Life expectancy has also begun to decline in most of the other EU countries during the years of the COVID-19 pandemic.[3]

Demographic development leads to increasing segregation of counties

According to the population forecast of Statistics Finland, the population of the whole country will grow slightly until 2030, but will start to decline in 2034. Especially in the wellbeing services counties of South Savo, Kymenlaakso and Kainuu, the population will decline sharply. These counties already have the oldest populations in the country today, and the proportion of those aged over 75 years in these counties will continue to grow more than in the rest of the country by 2030. On the other hand, in counties with a younger population, especially in the wellbeing services counties of Uusimaa and in Helsinki, the proportion of the older population will grow less than the average, even though the increase in numbers is considerable.

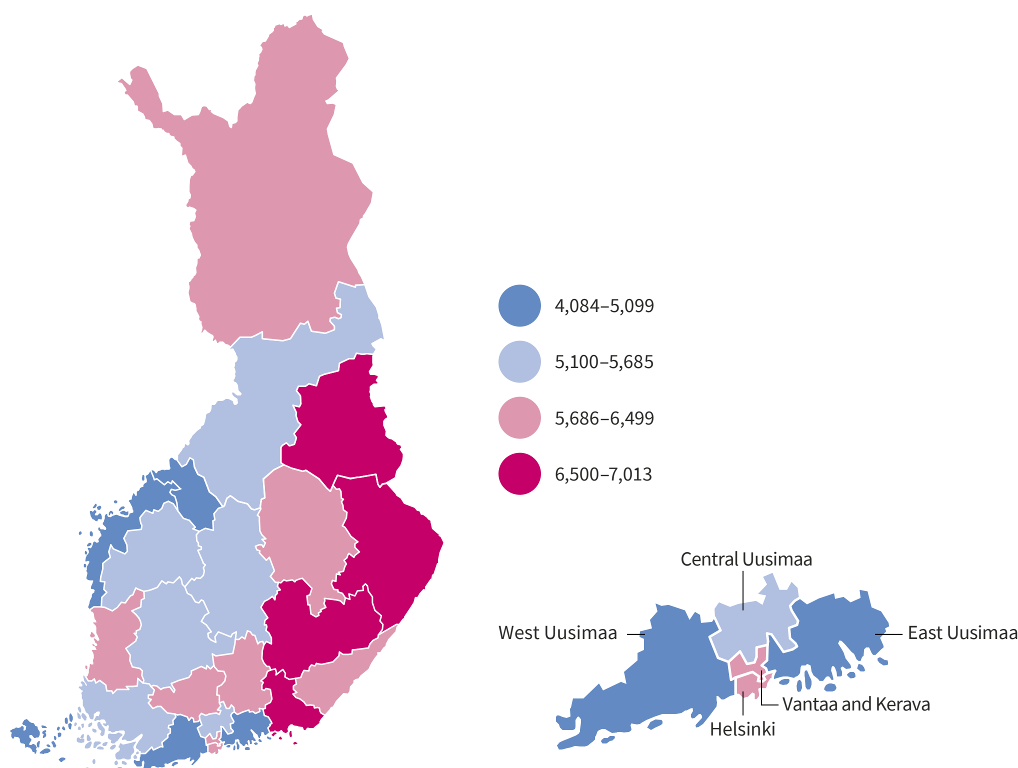
Wellbeing of young people declined during the COVID-19 pandemic

The wellbeing of young people has declined during the COVID-19 pandemic. Moderate or severe anxiety experienced by young people increased by about 50 per cent between 2019 and 2021. Approximately one fifth of the pupils in secondary school and general upper secondary education experienced anxiety in 2021. Girls experienced anxiety significantly more often than boys. Mental health disorders of young people also increased in the other EU countries during the pandemic.[3] There was a considerable increase in the unemployment rate in 2020, but it began to decline in 2021 and continued to do so in 2022. The proportion of unemployed people in the workforce fell to the same level as before the pandemic. On the other hand, youth unemployment and long-term unemployment were still higher at the end of 2022 than before the pandemic.[4]

Considerable differences in avoidable mortality between counties and socio-economic groups

In an examination extending to the year 2021, premature mortality in the population has been declining throughout the 21st century. There are considerable differences between the counties, however. (Figure 1) Premature mortality is the highest in the counties in Eastern Finland, where morbidity is also the highest. On the other hand, in Helsinki and in the Vantaa and Kerava wellbeing services county in Uusimaa, the lower morbidity of the population than in the rest of Finland is combined with higher than average premature mortality. This indicates the accumulation of both wealth and deprivation especially in the Helsinki Metropolitan Area. In addition to the differences between the counties, socio-economic and gender differences in the potential years of life lost are also considerable. The group with clearly the largest number of years of life lost is men in lower income groups.[5]

Figure 1. Potential years of life lost (PYLL) at ages 0–80 / 100,000 inhabitant



▲ The map presents the PYLL index by wellbeing services county. The PYLL index shows the number of potential years of life lost in the population due to deaths before the age of 80 per 100,000 inhabitants. In particular, the index reveals the health and welfare problems that increase the risk of death in younger age groups. The higher the county's PYLL index, the more and the younger people die. The calculation of the index is based on the number of deaths between 2019 and 2021.

Formation of the administrative and operational structure of the wellbeing services counties

Wellbeing services counties had very different starting points

On 1 January 2023, the responsibility for organising health, social and rescue services was transferred from municipalities to twenty-one wellbeing services counties.[6] In Uusimaa, the responsibility for organising services was divided between four wellbeing services counties, the City of Helsinki and the HUS Group.[7] The HUS Group, the joint authority for Helsinki and Uusimaa, was established to organise specialised healthcare. HUS's agreement on organising services, in which the division of work, collaboration and integration of the activities in organising are agreed, is due to be completed during spring 2023. Nationally, the only municipal actor that retained the responsibility for organising services was the City of Helsinki, which also organises and provides some of the specialised healthcare services.[7]

The key objective of the health and social services reform is to promote and maintain the population's wellbeing and health and to ensure equitable, compatible and cost-effective healthcare and social welfare services in the whole country.[6] The implementation of the reform progressed mainly as planned, but there was considerable variation between counties in the starting points of the reform and the extent of the structural change. Regional organisers (8) contributed to the transition into a wellbeing services county. The preparations for the transfer of responsibility for organising services were the most extensive in counties where organising was previously municipality-based. Because of the situation with the timetable and the resources, the wellbeing services counties focused on tasks that were necessary for the transition during the implementation, such as fulfilling the employer's obligations and the continuity of service provision.

A wide range of actors participated in working on county strategies

Administrative regulations governed the preparation of the organisational structures and management systems. In the course of the year, updates were made to the administrative regulations. In some of the areas, the structures are still being processed further after the county has started its operations.

The strategies for the wellbeing services counties were approved by nearly all of the counties. Their preparation was based on analyses of the operating environments and wide-ranging engagement of different stakeholders. In most of the counties, the service strategy was included in the county strategy as a whole. In the other counties, the separately drawn up service strategies and the indicators related to the strategies will be completed in 2023. Programs supporting the implementation of the strategies were under preparation.

The preparation of the collaboration agreements of the five collaborative areas formed by the counties is at different stages. The Northern Finland collaborative area had got furthest in the preparation work.

The decision-making and management structures were set up at varying paces and using different solutions

The organisation and decision-making were launched at different paces in different counties. In addition, the counties decided to implement different organisational solutions. The decision-making and management structures of regional organisers were utilised to varying degrees. Municipality-specific thinking and decisions along the lines of the structures of the previous organisers could still partly be seen. However, a desire to strengthen the integration of the services was generally visible. The perspective of organising varied in the organisation structures. The most commonly selected policy-making structure was the county committee model. Different participatory and influencing bodies, wellbeing and health promotion, cooperation at interfaces, safety and the future were strongly visible in the institutional structures. Some of the counties further reinforced the decision-making structures by setting up different divisions and advisory committees. A joint structure for rescue services has been established between the wellbeing services counties of Vantaa and Kerava and Central Uusimaa.

The personnel organisations were built at different paces, and work was still under way in some of the wellbeing services counties at the transition stage. The work of the management teams started at different intensities within the framework of the resources. The number of sectors providing services varied from two (South Karelia) to eight (Ostrobothnia). In most cases, operative provision had been divided on the basis of life cycles and services. The sectors most commonly organised as entities of their own were family and social services, services for older people and health or hospital services.

Some of the wellbeing services counties had included cross-cutting process and integration management responsibilities in the management system. Organisation of service provision into smaller, geographical areas was also visible, for example in South Ostrobothnia. Heads of profession in medicine, nursing science and social work had been appointed in some of the counties.

Harmonisation of client fees and service criteria progressed in counties

The harmonisation of the available services, the service criteria and the client fees support the national objective of equitable realisation of healthcare and social welfare confirmed by the Government.[8] Wider harmonisation of the service criteria started from services used by a large number of clients. The wellbeing services counties have promoted equity by harmonising the criteria for granting services and by organising certain services in a centralised manner. Although the service criteria and the service selection had been harmonised to a large extent, for example North Ostrobothnia had not yet decided on the grounds for granting all of the housing services. The harmonisation was furthest in counties based on regional organisers, such as in North Karelia.

The wellbeing services counties harmonised client fees. Apart from a few exceptions, client fees are charged according to the maximum amounts determined in the Decree on Client Charges in Healthcare and Social Welfare. The City of Helsinki does not charge any client fees for appointments at health centres and an assessment visit for home care is free of charge in the Satakunta wellbeing services county. Harmonisation progressed especially in statutory client fees. Work on discretionary fees was still partly under way.

Operation started with existing services networks

The situational picture of the development of the service network varied considerably by wellbeing services counties. In some of the counties, the service network and channels had already been developed for a long time, which meant that the need for changes were fairly small at the transition stage. On the other hand, there were counties in which the planning of the service network had not yet been initiated. To ensure a safe transition, a majority of the counties started their operations with the existing service network.

The current state of the service network was surveyed in different parts of the country, and its development was largely being outlined for 2023. The examination was closely linked with the strategies and resources of the wellbeing services counties. A link to the planning of healthcare and social welfare service points offering a range of services of different levels was also visible. In some counties, the reform was strongly defined by efforts to safeguard local services.

The variety of client and patient information systems reflects county-level collaboration of organisers

During the transfer of the responsibility for organising services, the counties focused on ensuring the functioning of the information systems and the correctness of critical information. Preparations were made for different kinds of risks, such as problems with financial transactions and the payment of salaries.

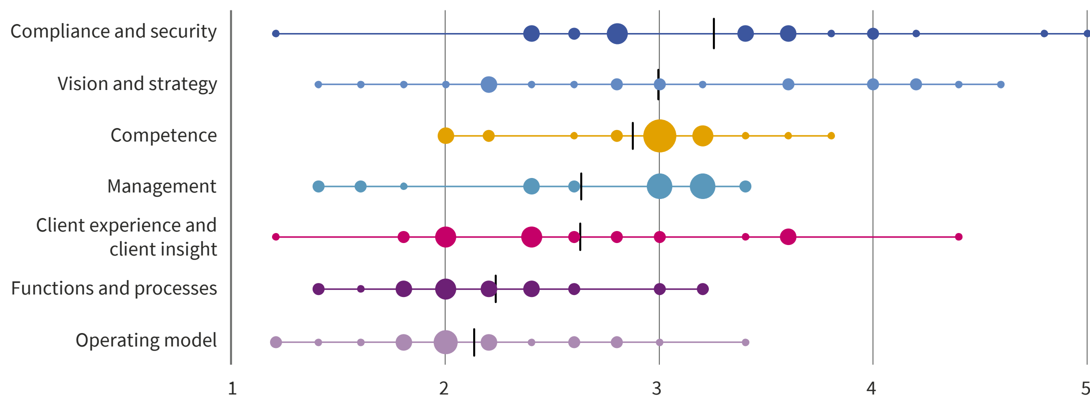
ICT preparations mainly progressed further in counties where the services were based on previous regional organisers. With regard to sector-specific systems, the West Uusimaa wellbeing services county had to do the largest amount of preparation and with regard to the ICT infrastructure, Ostrobothnia and Central Ostrobothnia.[9]

Information systems were harmonised and replaced, but the information management environment of the wellbeing services counties still mainly consisted of the information systems of the municipalities or joint municipal authorities. Southwest Finland had the largest number of e-service applications (405) and Eastern Uusimaa the smallest (33).[10] Remote service use is discussed in the chapter “Availability and accessibility of equitable services”. In counties with little collaboration between organisers, several client and patient information systems were still in use. Social welfare information systems were harmonised in South Ostrobothnia and Kanta-Häme.

A situation picture of the maturity of the digital health and social services of the counties was formed with regard to their capability to produce digital services. The compliance and security of the digital services were the aspects developed furthest by the counties. Nationally, there was most room for development in the operating models for providing digital services and in their functions and processes. There was great variation between the counties in the sub-areas describing the maturity level of digital services.[10] (Figure 2)

In ICT investments, the most important projects are related to the development of e-services, information systems and knowledge management. The national long-term objective is to implement important information systems at the level of the collaborative areas.[8] ICT investments were emphasised in the investment plans of the counties.

Figure 2. Counties' own assessment of the maturity level of digital services in autumn 2022



▲ The figure presents own assessments of the 21 wellbeing services counties and the City of Helsinki of the maturity level of digital services on a scale of 1 to 5. The vertical lines describe the average level in the country. The smaller the value, the more the sub-area requires development. The circles describe individual wellbeing services counties. The higher the number of counties that have received the same value, the larger the circle. The smallest circle corresponds to one county and the largest one to seven counties. The information has been received from the counties in September/October 2022. It has been retrieved from the performance reports submitted in the report tool maintained by THL (Hyvinvointialueiden digitaaliset sosiaali- ja terveyspalvelut).

Availability and sufficiency of competent personnel

Wellbeing services counties began their operations in the middle of a deepening personnel shortage

Almost 200,000 employees from municipalities and joint municipal authorities were transferred to the wellbeing services counties as from the beginning of 2023. This was also the largest transfer of a business in the history of Finland. In autumn 2022, the main tasks of the wellbeing services counties, which had just begun their operations, was to ensure that the services and the personnel were safely transferred to the counties. According to the counties' assessments, the transfer of the personnel was successful in the initial stage, and no major problems were observed in the payment of salaries, for example.[11]

One of the main challenges the wellbeing services counties faced at the very beginning of their operation was the poor availability of health and social services professionals. The problems with availability deepened further during 2022. According to the Occupational Barometer, all counties have a shortage of most health and social services professionals.[12] The availability of psychiatrists and psychologists is particularly challenging. The difficulties in the availability of social workers have also continued. In the next few years, recruitment challenges will be increased by the wastage of personnel, as one in five of the healthcare and social welfare personnel working in the public sector, or some 44,000 people, will retire on old-age pension by 2030. In some counties, the proportion of those retiring in the workforce in health and social services will reach approximately one third when persons granted disability pension and partial disability pension are included. Of the large professional groups, the retirement of practical nurses in particular is strong.[13]

The shortage of physicians in health centres deepened

According to the Finnish Medical Association's report in autumn 2022, the shortage of physicians in health centres had increased slightly from the previous year. Approximately eight per cent of the vacancies had not been filled. There were considerable differences between the counties. The most difficult situation was observed in North Karelia, where approximately one third of physician's tasks has not been taken care of.[14] The shortage of physicians complicates the possibilities of the counties to comply with the maximum waiting time guarantee in primary healthcare, which will be reduced to two weeks in September 2023. According to the Finnish Dental Association's report, the shortage of dentists in health centres has increased clearly. Almost one in ten dentist's positions had not been filled in 2022, and the shortage has rapidly almost doubled from 2020.[15]

Increasing challenges in the sufficiency of home care personnel

With the gradual increase in the staffing ratio determined in the Act on Care Services for Older Persons, the number of staff in 24-hour care for older people has increased. In autumn 2022, approximately one-third of the units met the personnel ratio of 0.7 employees per client, which will enter into force in December 2023. A considerable proportion of the recruitments in services for older people were therefore made in 24-hour care. On the other hand, the number of recruitments in home care declined and, according to

preliminary information, the number of visits to clients in home care started to fall, which indicates an increase in the personnel shortage in home care.[16]

The number of health and social services personnel working in services for older people increased in the professional group of care assistants, but the number of practical and registered nurses remained unchanged. In addition to the amendments in the Act on Care Services for Older Persons, the amendments in the Child Welfare Act require the wellbeing services counties to take measures. The number of clients of social workers in child welfare will be limited to a maximum of 30 clients as from the beginning of 2024, which will increase the challenges in the recruitment of social workers.

Recruitment of foreign workforce expands

Increasing the recruitment of foreign workforce has been proposed as one way of solving the declining availability of health and social services personnel. In the professional groups of general practitioners, dentists and practical nurses, approximately one in ten employees are of foreign background. On the other hand, of the other large professional groups, only approximately three per cent of registered nurses and approximately one per cent of social workers are of foreign background. In many counties, projects have been launched or are being launched to recruit foreign workforce especially to ease the personnel shortage in services for older people. The recruited persons most often work as practical nurses or care assistants. According to a report by the Ministry of Economic Affairs and Employment, recruitment from abroad can solve the shortage in availability only partly.[17] Cooperation with educational institutions is essential in promoting recruitment in Finland.

Wellbeing of personnel as a priority in strategies

In their strategies, wellbeing services counties have highlighted strengthening the retention and attraction of personnel as one strategic cornerstone. Counties intend to invest it their personnel's wellbeing at work and competence development and increase the flexibility of work. The salary systems will also be developed and made more rewarding, and the harmonisation of salaries increases the lowest salaries in each professional group.

Current state of service integration and the development measures

The Act on Organising Healthcare and Social Welfare Services and the national objectives require integration

The wellbeing services counties are responsible for coordinating clients' healthcare and social welfare services into integrated packages. They also have to identify the client groups requiring integrated services and define the service chains and packages. Services must also be integrated with municipalities, central government and other actors.[18] The government's objectives for organising healthcare and social welfare services ensure strategy-level support for increased integration.[19]

Structures and strategic policies enable integration

The structural integration of the wellbeing services counties has been implemented as from 1 January 2023. County councils and county executives are responsible for the integration of services in accordance with the Act on Organising Healthcare and Social Welfare Services. The organisations of the counties are partly based traditionally on the professions in healthcare and social welfare, but some also have operating and service areas that promote integration.

The responsibility for integration has also been defined in the administrative regulations of the counties. The majority has divided the responsibility not only with the county executive but also with other bodies and supervisors. However, there are significant differences between counties in how many levels of administration responsibility has been divided to. Some of the counties have established a post or a unit responsible for integration.

As a rule, all county strategies include the idea of integration of the services on the basis of the client's needs. For example, it may have been set as a goal or defined as a success factor in the strategy. The strategies clearly emphasise the theme of doing things together within the organisation and on interfaces. A few counties have also set follow-up indicators for multidisciplinary cooperation. Some of the 2023 financial and operational plans already include integrative measures at the practical level, targeted for example at clients requiring a lot of services. In a few counties, training programmes for supervisors and personnel have been launched in which integrative management is developed or a multiprofessional working culture is promoted. The realisation of integration requires strong support from the management and also interaction and seamless collaboration between different professional groups.

Target level of integration not achieved yet – healthcare services have progressed the most

The level of service integration still varied a lot in the wellbeing services counties. Wellbeing services counties in which the preparation had been the responsibility of regional organisers benefited from the previous long-term development of integration and the fact that many integration practices had already become established and refined in the service system. However, in spite of their better starting point, inadequacies were still revealed in integration in these counties, and especially the care chains between

primary services and specialised services need further development. Other wellbeing services counties promoted integration by drawing up harmonising plans and by organising projects in which models were piloted.

In all counties, integration had developed furthest in healthcare services.[20] Integration was often ensured by creating care chains between primary and specialised healthcare on the basis of the plans on organising services. The number, quality and use of the care chains still varied a lot, and their updating was occasional. Different consultation models and electronic systems supporting the implementation of integration were introduced into use in the counties.

Achieving service integration in accordance with the objectives will still take a long time in a large part of the wellbeing services counties and this is visible as variation in the equity of the clients and the quality of the services. It is crucial to ensuring integration that good practices are established and monitored. The effectiveness of service integration should be assessed and also updated to correspond to future service needs.

Multidisciplinarity increased in services – the potential of interfaces still partly unused

The integration of services for older people and of services for children, young people and families was already partly multidisciplinary in the wellbeing service counties.[20] The I&O key project contributed to the development of services for older people through the development of integration that had begun in the project and continued in the counties. The integration of services for children, young people and families was supported by linking the LAPE programme addressing child and family services to the Future Health and Social Services Centres programme. New family centres were established in the counties, which increased multiprofessional and multidisciplinary services. Joint appointment and consultation activities in healthcare and social welfare, client assistance and collaboration between social welfare services were also developed in the Future health and social services centres programme. Collaboration with employment management services and education services also increased.[21] The project strengthened the operation of health and social centres and at the same time challenged other parties to improve their preparedness for service integration.

In autumn 2021, only a few wellbeing services counties were using a shared operating model for assessing the need for support for work ability and functional capacity, and a few more counties were in the process of developing a model.[21] Cooperation with Kela strengthened in counties and the premise for cooperation with environmental health was good.[20, 22] In spite of the intensive development of the multiprofessional and multidisciplinary operating models in the counties, the majority of the models had still not been completed or introduced into use.[20]

The building of the interfaces of different client segments is likely to continue in the counties for a long time to come. Counties make progress at different paces in the identification of service packages and the building and implementation of service chains.

Continuity of care declined

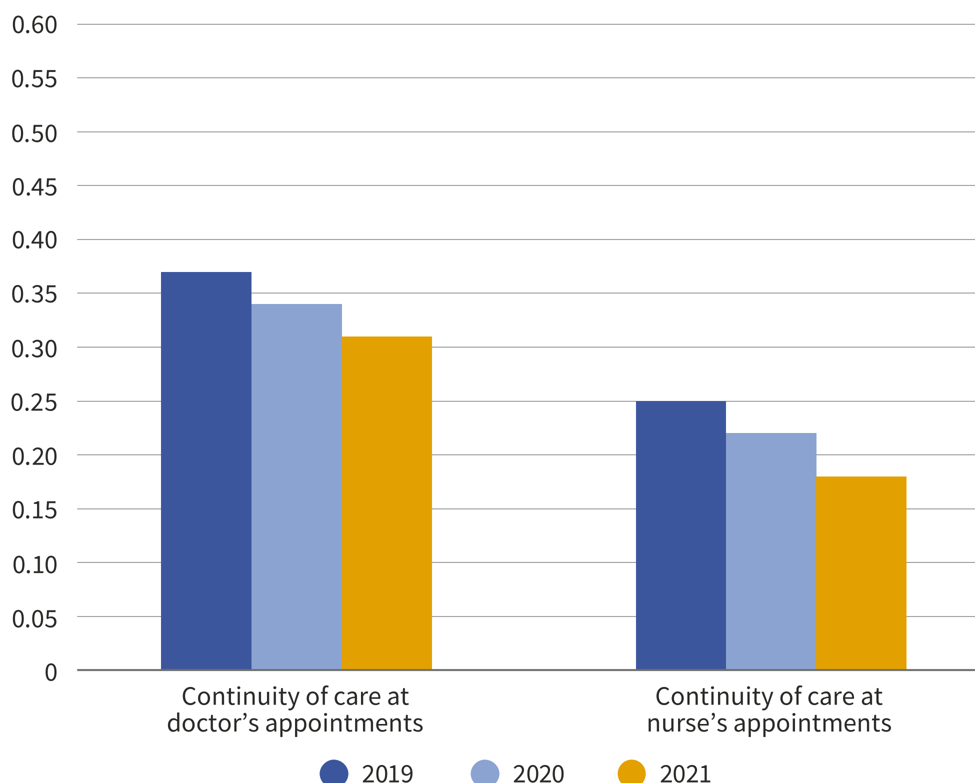
The continuity of the client's care promotes the integration of health and social services at the primary level. Especially those requiring a lot of services and treatment benefit from a long-term care relationship, such as a personal nurse-doctor work pair or multiprofessional team. Nationally, the continuity of care (Figure 3) has clearly declined over the past few years, and a patient with multiple diseases increasingly sees several different professionals.

Outpatient care of persons with chronic diseases (asthma, diabetes, chronic obstructive pulmonary disease and heart failure) has improved and there has been a decline in inpatient care over the past few years. There are considerable differences between the wellbeing counties, however. South Karelia has the highest number of inpatient care episodes because of heart failure, almost double the number in the whole country. Outpatient treatment of asthma was the most successful in the Päijät-Häme wellbeing services county.

Those suffering from severe mental health problems returned to hospital less often after their discharge. However, there are still counties in which the situation has been the opposite. The proportion of those returning to the ward within a month increased especially in Kainuu and Lapland. The development trend reflects the need to strengthen service integration in these counties.

The weak level of integration is also reflected in the prolonged hospitalisations of home care clients. Severe shortage of personnel in services for older people has further complicated the situation. At the level of the whole country, this is also visible as an increase in visits to emergency care services in primary healthcare by persons aged over 75 years.

Figure 3. Continuity of care (COCI) of persons with multiple diseases in outpatient care in primary healthcare



▲ The Continuity of Care Index (COCI) indicates the average continuity of the care relationship and interaction between the patient and the professional for clients with multiple diseases. Clients for whom at least two chronic diseases falling into different disease groups have been registered are considered patients with multiple diseases. The index reveals whether the client usually meets the same professional or professionals or whether the person they see is a different one in most cases.

HUS Group supports the realisation of integration

In the HUS Group established by the City of Helsinki and the wellbeing services counties of Uusimaa, the responsibilities and collaboration in organising specialised healthcare services are agreed on in an agreement on the provision of specialised healthcare. The HUS Group is also responsible for university hospital services in the Southern Finland collaborative area.

The organisation and the strategy of the HUS Group strongly support integration. The HUS Group executive is responsible for the harmonisation of the services and the committee for locally accessible services and integration for the objectives of service integration. The HUS Group has several interfaces, the operation of which the Group ensures through a client relationship management unit.[23] The strategy emphasises the integration of services and their coordination into client-oriented packages.[24] HUS has already funded regional integration projects for years, which is visible in an increase in electronic services, mobile services and care chains in the county. Care chains vary by wellbeing services county, which weakens the equity of clients. In both Uusimaa and the collaboration area, the realisation of integration is challenged by the large number of organisers and the fragmentation of the client and patient information systems. With strong county structures, the HUS Group makes it possible to monitor the services and anticipate the service needs also for the development of the integration.

Availability and accessibility of equitable services

National projects have promoted availability and accessibility of services

A wellbeing services county must plan and implement healthcare and social welfare services with a content, extent and quality that meets the needs of clients.[25] The objectives for availability and accessibility are set in the service strategy that is part of the county strategy.[25]

In accordance with the Government's objectives, the county-level development projects of the Future Health and Social Services Centres programme (2020–2023) have strengthened services at the primary level and shifted the focus to preventative work.[26] One of the objectives of the Sustainable Growth Programme for Finland is to reduce the care, rehabilitation and service backlog caused by the COVID-19 pandemic by improving the availability and cost-effectiveness of the services.[27] The programmes have promoted the implementation of new digital services and multidisciplinary and multiprofessional operating models. Efforts have been made to speed up access to care and treatment, especially in primary healthcare. Furthermore, low-threshold services have been aimed at responding to the needs of people in a vulnerable position.

When the wellbeing services counties started their operations, the care and service backlog caused by the COVID-19 pandemic and the shortage of personnel continued to weaken the availability of the services. The wellbeing services counties launched their operations mainly using the old facilities, so there were no significant changes in the availability of site-specific services. In terms of travel time, the best accessibility of services was found in the large wellbeing services counties of Southern Finland.[28] The harmonisation of the services and their award criteria and the centralisation of the services increased the equity of clients.

In the past few years, the availability of services has been improved by increasing the use of outsourced workforce and service vouchers throughout the country. Individual services, service packages and service points have also been outsourced. In addition, the availability and accessibility of services have been improved by increasing mobile and electronic services. Matters related to personnel are discussed in the chapter "Availability and sufficiency of competent personnel".

Services in Swedish and Sámi have been guaranteed by law

To safeguard the linguistic rights of Swedish-speakers, bilingual wellbeing services counties must conclude a collaboration agreement in healthcare and social welfare. The drafting of the agreement is coordinated by the Southwest Finland wellbeing services county. The West Uusimaa wellbeing services county supports the development of Swedish-language health and social services and the Lapland wellbeing services county the development of Sámi-language health and social services in the whole country.[25]

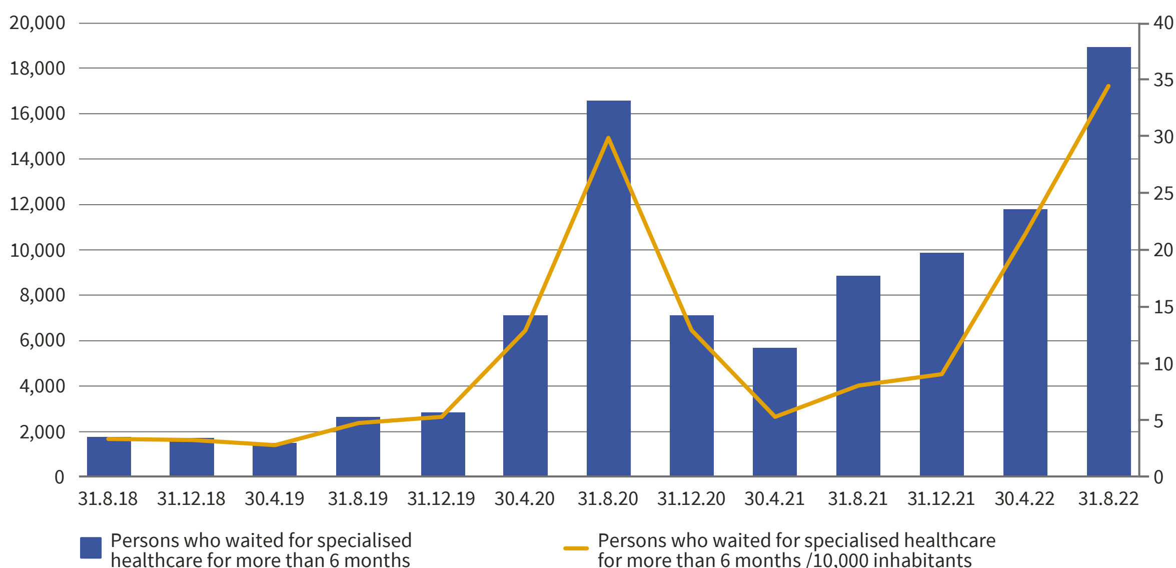
The right to use the Sámi language applies to the health and social services provided in the municipalities located in the Sámi homeland, to services that Lapland wellbeing services county provides only in service units located outside the homeland municipalities, and to services that the county has designated for the residents of the homeland municipalities to use on the basis of accessibility of the services.[25] There were still deficiencies in the availability of Sámi-language services and services in accordance with the Sámi culture.[29]

Waiting times for specialised healthcare have become longer

At the end of August 2022, more than 152,000 patients were waiting for non-urgent specialised healthcare provided in healthcare units of primary healthcare or in the hospitals of hospital districts.[30] Of these people, nearly 19,000 had waited for the latter for more than six months, whereas their number had been under half of this the previous year (Figure 4). Their number was largest in surgery (10,422), ophthalmology (3,768) and psychiatry (1,831). Proportionally the largest number of people who had waited for longer than a year was found in the hospital districts of North Savo and North Karelia, and the lowest in the hospital district of South Karelia.[30]

The median of waiting time (50-% point) increased in almost all hospital districts from 2019 to 2020 and further to 2021. In addition to the accumulated backlog in care, the situation was made more difficult by the labour market situation in 2022, as prolonged industrial action weakened the availability of care staff. The fact that moving from specialised healthcare to further treatment in primary services has slowed down, has partly congested emergency clinics and inpatient wards.

Figure 4. Persons who waited for specialised healthcare for more than six months in the period 2018–2022



▲ The figure presents the number of persons who waited for specialised healthcare for more than six months and their number in proportion to 10,000 inhabitants 31 August 2018–31 August 2022. The information is based on the THL's data on access to specialised healthcare (Erikoissairaanhoidon hoitoonpääsy). The figures do not contain persons who waited for access to specialised healthcare units of primary healthcare.

Fewer than one half had to wait for an appointment with a health centre physician for more than a week

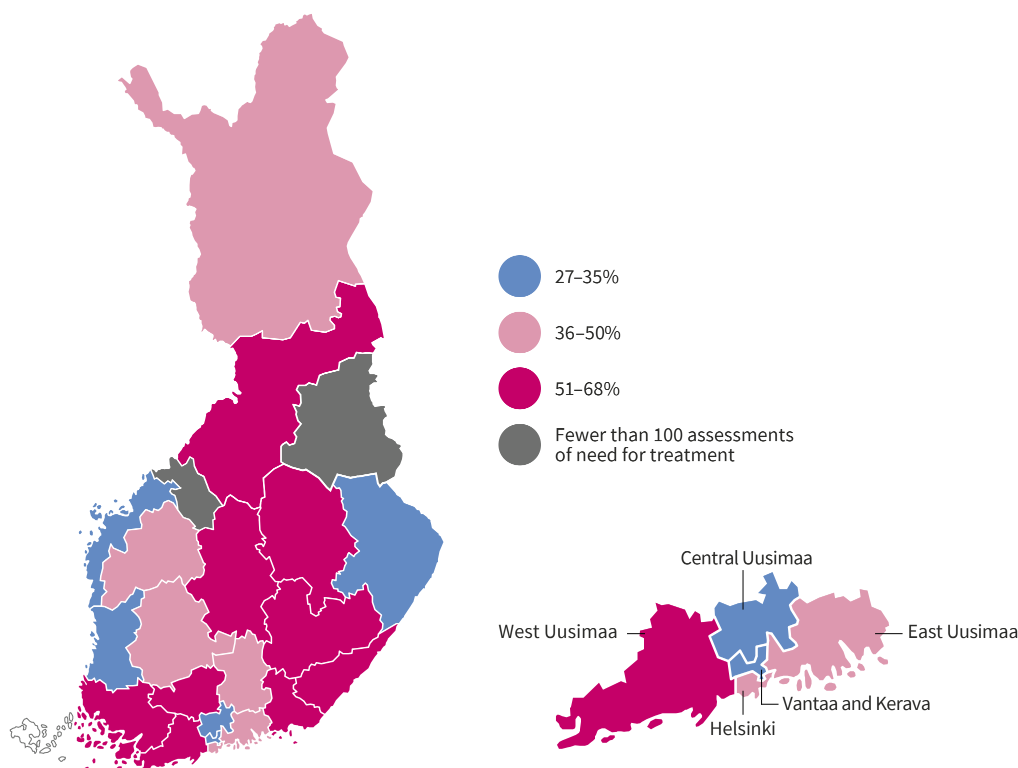
In October 2022, 42% of non-urgent doctor's appointments in outpatient care of primary healthcare took place more than a week after the need for treatment had been assessed. The proportion varied between wellbeing services counties (27%–68%) (Figure 5).

When the use of remote services is also taken into account, 44% of the appointments took place after more than a week and 33% after more than two weeks. Of appointments with a registered nurse or a public health nurse, only 10% took place after more than one week.[31] In October 2022, the maximum waiting time guarantee (3 months) was seldom exceeded in physician's appointments (0.6%). According to a population survey, in 2020, one in five people felt they received insufficient physician's services: the most satisfied respondents were in North Savo, South Ostrobothnia and Central Ostrobothnia.[32]

Almost one quarter of the respondents felt they had received insufficient dentist's services, and about one third of the respondents in Kainuu and Helsinki.[32] In October 2022, 84% of non-urgent dentist's appointments took place within three months from the assessment of the need for treatment. More people had to wait for longer than the maximum waiting time guarantee (6 months) in October (4%) than in March (3%).[31]

Because the operating practices developed in the Future Health and Social Services Centres programme to improve access to treatment had not yet been extended to apply to entire wellbeing services counties in spring 2022, their impact was still small.[33]

Figure 5. Realisation of appointments in outpatient care more than seven days after the assessment of the need for treatment in October 2022

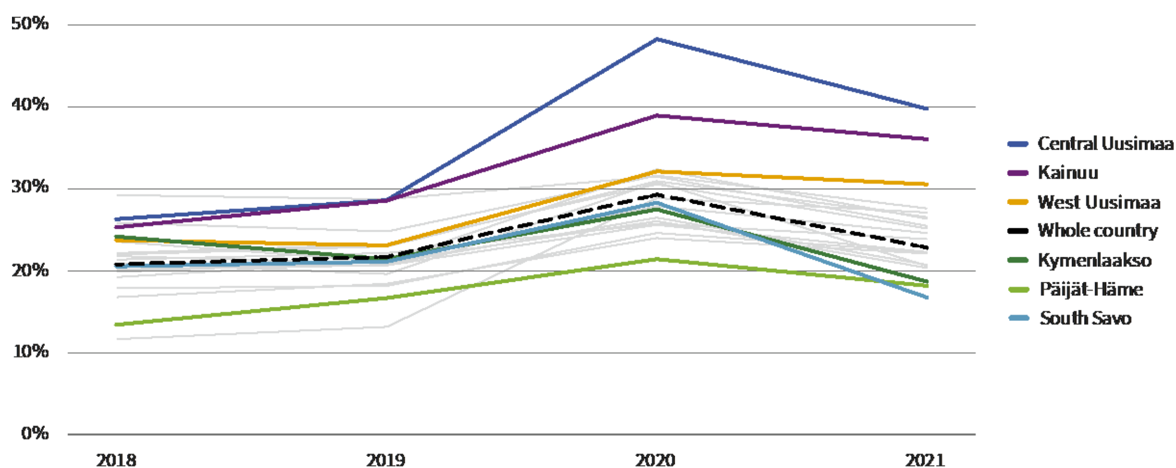


▲ The map presents the county-specific percentages of non-urgent outpatient appointments with a physician in primary healthcare that were realised more than seven days after the assessment of the need for treatment in October 2022. The information is not presented for counties in which fewer than one hundred assessments had been made. The information is based on the information in THL's Register of Primary Health Care Visits (Avohilmo).

Use of remote services has increased in recent years – still a long way to reaching the target

Remote services have developed, expanded and become significantly more common, but there is a lot of variation by wellbeing services county in the services offered.[34, 31] Different obstacles and clients' concerns continue to be associated with the use of e-services. [34, 35]The aim is that 35% of contacts will be made through remote services in 2025. The use of remote services increased from 8.4 million to 11.3 million transactions between 2018 and 2021, making their proportion in appointments in outpatient care 23%. Variation between counties was considerable (17%–40%). The proportion of remote service use was at its largest in 2020 (29%), when appointment activities had been reduced because of the COVID-19 pandemic. (Figure 6)

Figure 6. Proportion of remote service use in outpatient appointments in primary healthcare by wellbeing services county and in the whole country in the period 2018–2021.



▲ The information concerning the whole country and the wellbeing services counties with the largest or smallest proportions have been highlighted in the figure. The information is based on the information in THL's Register of Primary Health Care Visits (Avohilmo).
The figure does not include the information on the City of Helsinki or the Vantaa and Kerava wellbeing services county as there are deficiencies in the information on Vantaa (starting from 2019), Helsinki and Kerava (starting from 2021) because of the replacement of the patient information system.

Child welfare notifications more common and staffing ratio is becoming stricter

The number of child welfare notifications continued to increase in 2021, when notifications were made on 8.6% of children under the age of 18. The proportion varied by wellbeing services county, ranging between 6.2% and 12.1%. Almost all (97%) assessments of the need for child welfare services between 1 October 2021 and 31 March 2022 were initiated within the maximum time (7 working days), but a smaller proportion (92%) was completed within the maximum time (3 months). Both maximum times were exceeded most often in Vantaa and Kerava and Central Ostrobothnia wellbeing services counties.

There is a lack of social workers in child welfare in the whole country, but it is particularly severe in some of the wellbeing services counties, and compliance with maximum times has declined in them. Under the Child Welfare Act, the social worker responsible for the child's affairs was permitted to have responsibility for 35 children at the most as from 2022, and the figure will be 30 children at the most as from 2024.[36] In November 2022, about one half of the social workers in Ostrobothnia (54%) and Päijät-Häme (46%) wellbeing services counties had more than the maximum number of clients.[37] The maximum number of clients was exceeded in 15 wellbeing services counties. Because of the shortage of personnel, some counties have purchased child welfare social work from private service providers.

Significant part of clients considered the services they received insufficient

There have been problems with access to the school social worker and to the school nurse. In 2021, one in ten children did not get an appointment with the school social worker and about one in twenty with the school nurse, in spite of trying.[38] The situation varied somewhat by wellbeing services county.

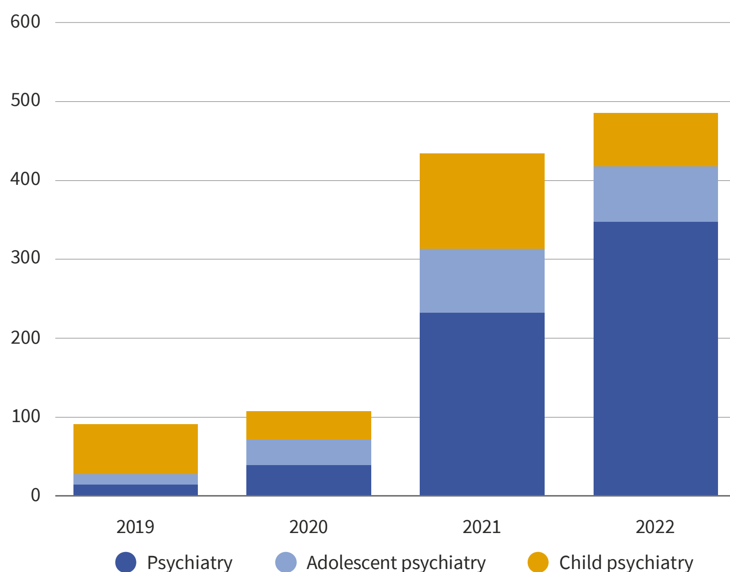
According to the 2020 population survey, more than one third of those needing services for families with children or home care services for older people felt that the services they had received were insufficient, and almost one half of those needing social work services or disability services felt the same.[32] The most critical feedback on insufficient services was received in Helsinki, Central Finland and Kanta-Häme.

The number of children and young people who waited for psychiatric treatment for more than three months fivefold

The number of under-23-year-olds who waited for treatment in psychiatric specialities for more than three months has increased fivefold compared to 2019 and 2020 (Figure 7).

The emphasis in mental health services for children and young people is on specialised healthcare although the number of clients is higher in primary healthcare, which reflects the current inappropriate assignment of treatment. In 2020, there were more patient visits in specialised healthcare (median of visits 8) than in primary healthcare (median of visits 2). There are considerable differences between counties in the services offered and used, for example, in whether 18–22-year-olds are referred to adolescent psychiatry or psychiatry for adults.[39]

Figure 7. Number of under-23-year-olds who waited for treatment in psychiatric specialities for more than three months in the period 2019–2022



▲ The information for the year 2022 is from the end of November, for the other years from the end of December. The information is based on the THL's data on access to specialised healthcare (Erikoissairaanhoidon hoitoonpääsy).

Access to home care and housing services has become more difficult

The growing service need among older people, the accumulated backlog in care and the shortage of personnel have weakened the availability of timely and necessary services. Places in 24-hour care have had to be closed and access to home care and housing services has become more difficult.[34] In September 2022, the statutory maximum waiting time was exceeded for some of those waiting for 24-hour housing services and for the first time, there were also fewer home care visits than the previous year.[40]

In September 2021, older people mainly got an appointment with a social worker or instructor in less than seven working days, in five wellbeing services counties in 9–14 working days.[33] In future, clients' equity will be promoted by the implementation of the RAI assessment system in all regular services for older people.

Healthcare and social welfare costs, investments and funding

Major differences between counties in social welfare and healthcare costs

In 2021, the net operating costs of the social welfare and healthcare under the responsibility of municipalities in Mainland Finland amounted to EUR 20.0 billion*, with an average of EUR 3,620 per inhabitant (Figure 8). The costs per inhabitant varied from EUR 2,970 in West Uusimaa to EUR 4,676 in South Savo. The increase from the previous year was approximately EUR 500 million.**

Net operating costs increased in real terms by a total of 7.6% between 2017 and 2021, according to the price level of 2021. The more moderate growth in recent years is explained, for example, by the discretionary government grants awarded for dealing with COVID-19. Without them, net operating costs would have increased by 14.4% in real terms (Figure 9). Because of these COVID-19 grants, the real net operating costs decreased especially in outpatient care in primary healthcare in 2021 and increased moderately in specialised healthcare between 2020 and 2021. The reductions made in operation affected particularly the operating income from oral healthcare and the operating costs of disability services in 2020. The strongest increase in the real net operating costs was seen in open services for children, young people and families in social welfare and in child welfare (24%), which is explained by an increase in the number of children placed outside the home.

The increase in the real net operating costs per inhabitant was the lowest in West Uusimaa (2.3%) and in Southwest Finland (3%) and largest in South Savo (13.5%).

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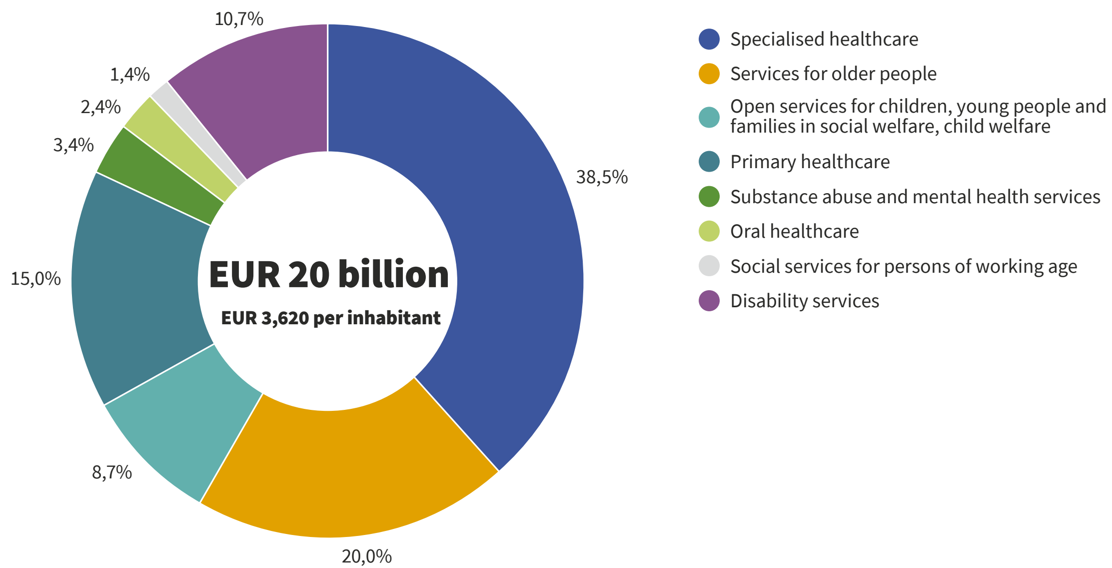
* The net operating costs of healthcare and social welfare do not include information on Åland. Environmental healthcare is not taken into account in the net operating costs of healthcare and social welfare.

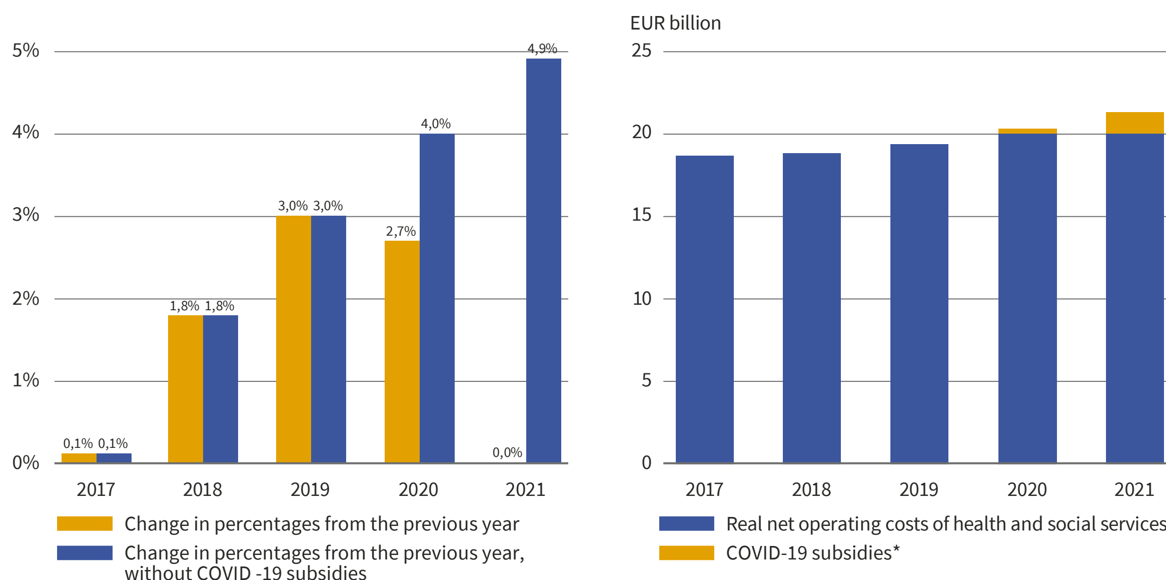
** The reform of the statistics on local government finances caused changes in the classification of healthcare and social welfare services. For the period 2017–2020, services supporting employment, excluding the municipal share of labour market support, have been taken into account in the net operating costs of social welfare and health care.

Figure 8. Distribution of the net operating costs of healthcare and social welfare in Mainland Finland by service package in 2021.



▲ The figure presents the task-specific percentages of the net operating costs of healthcare and social welfare in Mainland Finland in 2021. The information is based on the data municipalities have reported to the State Treasury.

Figure 9. Real net operating costs of healthcare and social welfare in Mainland Finland and the changes in percentages in the period 2017–2021



▲ The figure presents the real net operating costs of healthcare and social welfare in Mainland Finland between 2017 and 2021 and their changes from the previous year as percentages. The net operating costs are based on the information municipalities have reported to the State Treasury's financial information service.

* COVID-19 grants include the discretionary government grants awarded by the Ministry of Finance to hospital districts between 2020 and 2021, by the Ministry of Social Affairs and Health to healthcare and social welfare for costs caused by the COVID-19 epidemic in 2021 and the government grants awarded for health safety at the borders.

Increase in healthcare and social welfare costs projected to be the largest in Uusimaa

Based on THL's forecast calculations on changes in the age structure of the population, the real growth in the healthcare and social welfare costs in the whole country is anticipated to be on average one per cent per year until 2031. The increase is forecast to be the largest in the City of Helsinki and in the wellbeing services counties of Uusimaa, and the slowest in Kainuu and South Savo, where the proportion of older people in the population is currently the largest in the country.

Local government finances were supported in many ways

As in the previous year, local government finances remained good in 2021 thanks to the positive tax revenue development and government subsidies for dealing with COVID-19. In a majority of the municipalities, the annual margin was sufficient to cover the depreciations. Only eight municipalities had a negative annual margin. The municipal tax revenue grew as a result of the increase of 10 percentage points in the share of corporation tax revenue as part of the COVID-19 subsidies allocated for the years 2020 and 2021.

According to the preliminary analysis of financial statements in local government finances, local government finances remained only just in balance in 2022. Expenditure in local government grew rapidly and the positive result was mainly reached thanks to exceptional non-recurring items, such as capital gains from the sale of healthcare and social welfare properties.[41]

The loan portfolios of hospital districts increased

The results of the hospital districts improved from the previous year; the result was in deficit only in the hospital districts of Central Finland, North Karelia and Vaasa in 2021. Because of extensive hospital investments, the loan portfolio of hospital districts grew by half a billion euros to EUR 3.9 billion, as in the previous year. The loan portfolios grew the most in the Helsinki and Uusimaa and the Northern Ostrobothnia hospital districts.

The poor availability of workforce and the industrial action in the spring were reflected in the provision of services in many hospital districts in 2022, which also caused problems in invoicing the municipalities. The hospital districts and other joint municipal authorities for healthcare and social welfare with their funds and debts were transferred to the wellbeing services counties at the beginning of 2023. Under the act implementing the reform, as the operation of the joint municipal authorities ended, the deficits accumulated in the balance sheet in many counties remained to be covered by the member municipalities. A decision to reduce the basic capital as part of covering the deficit accumulated in the balance sheet has been made in the Hospital District of Central Finland.[42] The Lapland wellbeing services county, on the other hand, has filed an appeal against the decision made by joint county authority council of the Länsi-Pohja Healthcare District to cover the deficit by reducing the basic capital.[43]

Hospital investments and client and patient information systems emphasised in investment plans

The investment projects implemented in own balance sheets of the wellbeing services counties, the City of Helsinki and the HUS Group total EUR 3.7 billion for the budget planning period 2023–2025.[44, 45] According to the investment plans of the counties, a majority of the investments (63%) are investments in construction, and a significant part of the investments in devices and equipment (21%) are also closely related to investments in construction. The wellbeing services counties continue the already planned and ongoing hospital investments as well as the construction and renovation projects in primary services.

In the investment plan period 2023–2027, ICT projects account for about 15% of the investments. They consist of sector-specific systems (54%), the infrastructure and infrastructure systems (17%), sector-dependent systems (12%) and other ICT investments (18%). Investments in the harmonisation of the client and patient information systems are made especially in counties in which a regional-level organiser did not operate previously. In addition, the investments also have an emphasis on systems for knowledge-based management and on data pools as well as on e-services and remote care systems.

On the basis of the investment plans, the authority for additional borrowing was granted to North Savo, Kanta-Häme, North Ostrobothnia and the HUS Group, which increased the authority to take out long-term loans by a total of EUR 1.3 billion. The Kainuu wellbeing services county does not have an authority for borrowing, so the investments must be implemented with cash funds. As a result of the investments, the loan portfolio of the wellbeing services counties is expected to rise to EUR 4.8 billion in 2023.[44]

Funding calculations of wellbeing services counties will be further specified

The funding of the wellbeing services counties is mainly based on universal funding from central government and partly on client and user fees. The final funding for 2023 is checked on the basis of the financial statements for 2022. Parliament approved the Government's proposal (HE 328/2022) that central government award compensation for the costs of two primary and specialised 24-hour services units in the wellbeing services counties of Lapland and South Savo.[46] Parliament also approved the Government proposal (HE 322/2022) in which one new determining factor, the university hospital supplement, is added to the universal funding model.[47]

According to the calculations published by the Ministry of Finance in November 2022, the funding for the healthcare, social welfare and rescue services of the wellbeing services counties and the City of Helsinki for the year 2023 totals EUR 22.5 billion, of which the share of funding for healthcare and social welfare is EUR 22.0 billion.[48] The funding for healthcare and social welfare is determined on the basis of the estimated service need of the counties' population (80%) and factors related to language and other circumstances. According to the calculations, the imputed funding would increase the most in the wellbeing services counties of North Karelia, Southwest Finland and Lapland, and would decline in many of the counties in Uusimaa. The changes in the funding will be staggered between 2023 and 2029 using a transitional equalisation method, which will give the counties time to adapt to the changing funding.

Budgets for the year 2023 in deficit

Except for North Savo, the 2023 budgets of the wellbeing services counties have been drawn up to be in deficit. The deficit of the counties is approximately EUR 860 million in total. However, according to the financial plans, a balance will mainly be reached between 2024 and 2025.[44] In the first supplementary budget proposal for 2023, the Government has proposed strengthening the funding for the counties by a total of EUR 500 million. Of this funding, EUR 150 million would be an advance payment for the adjustment item payable in 2024[49], which as a whole is likely to cover a considerable part of the estimated deficit.

Local Government and County Employers has estimated that the harmonisation of salaries will increase the labour costs by about 6 per cent.[50] In counties that were previously organised regionally, such as in South Karelia, the harmonisation of salaries has already been carried out, but some counties are still in the process of doing it. Correspondingly, the harmonisation of salaries is only just beginning in counties where the organisation of the services has previously been decentralised, such as in Pirkanmaa, Southwest Finland, West Uusimaa and North Ostrobothnia.

Methods and quality statement

Assessment knowledge base

The expert assessment drawn up by the Finnish Institute for Health and Welfare (THL) on organising of healthcare and social welfare is mainly based on a quantitative and qualitative knowledge base that is publicly and openly available. The quantitative knowledge base of the assessment is based on the national Cost-effectiveness Indicators in Social Welfare and Healthcare (KUVA). The situation picture laying the basis for the expert assessment has been extended by also taking advantage of other indicator data and county-specific and national document material. The observations made by the National Supervisory Authority for Welfare and Health Valvira and the regional state administrative agencies and other calculations and reports of national authorities have also been utilised in the assessment. In addition, an important source of information in the county-specific assessments are the assessment interviews conducted with the representatives of the wellbeing services counties.

The National Expert Assessment compiles the situation picture in the whole country mainly on the basis of the observations of the expert assessments of the counties. In addition, the achievement of the national objectives set by the Government are examined in the Expert Assessment. The regional levels of indicators utilised in the national assessment are the wellbeing services counties and the whole country. The indicator data for the whole country also include the corresponding data for Åland. In accordance with the Act on Organising Healthcare and Social Welfare Services, county-specific assessments in turn focus on the wellbeing services counties, the City of Helsinki and HUS. Where applicable, the indicator data for the whole country are also compared with international data.

Openness, availability and quality of the knowledge base

The KUVA indicators can be examined in the Sotekuva web service

The KUVA indicators are a set of 500 indicators produced by the Ministry of Social Affairs and Health and an extensive group of experts. The set of indicators is aimed at ensuring that the data used in the guidance, assessment and monitoring of the organisation of healthcare and social welfare in accordance with the act on organising (612/2021) is uniform, which is a prerequisite for forming a shared situation picture.

The KUVA indicator data used in the assessment is openly available in THL's Sotekuva web service at the level of the whole country (incl. Åland), by wellbeing services county and by municipality. The other indicator data used in addition to the set of indicators is available in the Statistics and Indicator Bank Sotkanet (all of THL's indicators). Other statistical data has been marked with separate references.

Information on the qualitative documentation used in the assessment is available in the source list. The observation reports of Valvira and the regional state administrative agencies have been openly available on the assessment website (only in Finnish). Unlike the rest of the knowledge base, the discussions with the county representatives are not public. The discussions with the representatives of the counties and THL's experts deepen and complement the interpretation of the situation picture of the counties.

Quality and up-to-dateness as objective in indicator production

The objective is that the indicator data used in the assessment will be reliable and up to date. However, not all the KUVA indicators are updated every year; most indicators based on data from surveys are

updated every two years. Delays in the annual update of indicators are often due to difficulties in providing information and deficiencies in its quality.

The assessment pays special attention to the quality of the indicator data used. Deficiencies in quality are monitored with indicator-specific additional information. Indicators with significant quality deficiencies have not been used in the assessment. Because of the serious quality deficiencies caused by the reform of reporting in the statistics on local government finances and because of changes in the schedule for publishing the information, the information on the net operating costs for 2021 was not completed in time before the wellbeing county-specific expert assessments that were published in autumn 2022 were written. However, this information is included in the National Expert Assessment.

Ongoing development work

Between 2021 and 2024, the KUVA indicator set will be developed to better meet the needs of impact-based guidance and assessment. The production, management and reporting of the indicators will be reformed at the same time.

More information on the assessment and the knowledge base: thl.fi/arviointi (in Finnish)

Indicator values in Sotekuva: sotekuva.fi

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