Devolved Healthcare in Finland

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Healthcare system structure

Finland's population of 5.4 million[1] is similar to that of Denmark (however it should be remembered that both are considerably smaller than that of England). Finland's healthcare system is highly decentralised, with the main responsibility for the provision of both health and social care borne by local authorities where it can be organised independently according to locality, or via partnerships with one or several neighbouring authorities, with the sourcing of provision thereby shared.[2] Finnish local authorities can vary greatly in size, and be responsible for a few thousand citizens to over 600,000.[3] The goal setting and framing legislation for health and social care in Finland is provided by the Ministry of Social Affairs and Health (who also give guidance for social welfare). Central governmental agencies support the health service as a whole by commissioning research and collecting statistics.[4] Local government in Finland is currently administered by 320 separate authorities.[5] Each must provide the services as decreed by central government, however, local authorities enjoy relative flexibility as to how they supply services within this framing legislation; for example, as regards the scale of provision for each prescribed service.[6] These local authorities are, in addition to healthcare, responsible for nursing homes, social assistance within the community and for basic education.[7] They also address environmental and social health determinants such as food safety and rates of tobacco use.[8]

Most of the primary healthcare that Finnish local authorities oversee is given in local health centres, of which there are 160. These centres are also required to facilitate occupational healthcare for local employers who wish to purchase it.[9] The provision of secondary and specialist health services is also overseen by local authorities, who, forming 21 'hospital regions', co-operate to ensure primary healthcare is integrated with more specialist services.[10] The amount of people living in these hospital region catchment zones varies from between 65,000 to 1.4 million.[11] Accessing specialist care in the hospital regions requires referral from a physician. The 21 hospital regions have, in total, 34 hospitals of varying size, all offering both inpatient and outpatient care.[12] The hospital region districts also provide laboratory services including medical imaging, rehabilitation services, and oversee medical staff training.[13] As elsewhere in Europe, an increasing amount of healthcare and welfare services in Finland are now being provided by the private sector (currently at around 25 per cent), and by other non-governmental organisations.[14] Emergency departments are integral to hospitals within the hospital districts, but the equivalent of minor injuries unit services are often

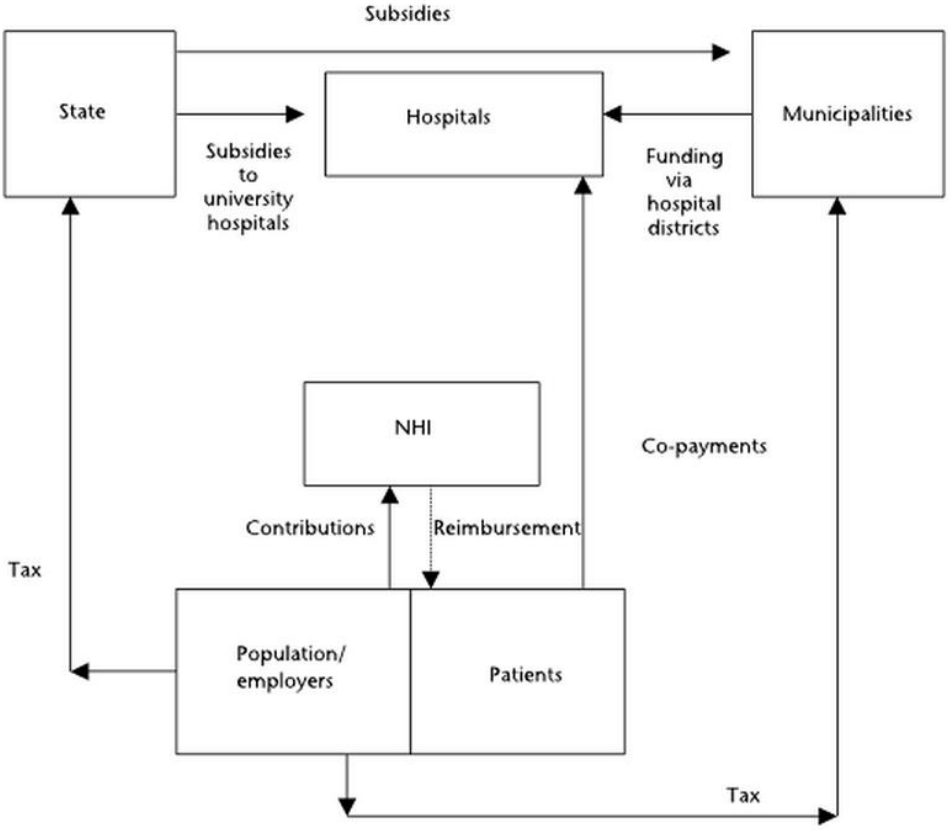
available at health centres run by local authorities; however, local minor injury services are often not available at weekends or at night.[15]

Patients appear to enjoy a good choice of services in Finland, being able to access their treatment anywhere in the country at both primary and more specialised levels. Local authorities also have the power to issue service vouchers which permit patients to use social welfare or health services from private providers.[16]

Financing Finnish healthcare

An important feature of the Finnish healthcare system is that the majority of healthcare spending is devolved to local authorities.[17] Although most health provision is funded through local taxation (for example a municipal income tax raises around 40 per cent of local income)[18], the remaining is allocated from central government (see Figure 2). The amount allocated depends on demographic factors such as the age profile of the local population, local morbidity from specific diseases and the ability of a local authority's inhabitants to pay tax.[19] If the tax revenue per capita in any local authority amounts to less than 92 per cent of the national average, the difference is made up by the state. Those authorities able to collect more than the national average have their state allocation of funding reduced by 37 per cent of that local tax revenue which has exceeded the national average.[20] Equity of access to adequate health and medical services is a provision of the Finnish constitution. The balancing of taxation-based revenue between localities is a way of avoiding regional disparities in provision and thus remaining constitutional.[21] Hospital districts are financed by their constituent member local authorities in relation to the amount of services accessed by their citizens.[22]

Figure 2: Overview of Finnish funding[23]



In addition to tax funded healthcare, Finland maintains a statutory health insurance for its citizens called The National Health Insurance Scheme. This scheme's responsibility is for providing income related benefits (sick pay, maternity leave and special care allowances[24]) and for medical care insurance.[25] The scheme provides a fund which is drawn upon when local authorities reimburse patients for user fees incurred when accessing services from approved private providers.[26] The scheme is often categorised as a 'secondary public financing scheme', in that around half of each citizen's premium for belonging to it is state subsidised.[27]

In essence, Finnish local authority administered healthcare is financed through a combination of local authority taxes, state subsidies and user charges.[28] Central government has set national limits for individual user charges at €32.50 a day as an inpatient, €27.40 for accessing outpatient services and €89.90 for receiving day surgery. There is also an annual limit of €633 per user.[29]

When hospital districts go over their allocated budget it is unusual for there to be any repercussions. This is partly because estimated annual user volumes and

associated costs are often lower than those experienced in reality, and thus these have to be revised throughout the year. Hospitals enjoy considerable freedom in handling their budgets and cost accounting[30]. NordDRGs (versions of Diagnosis Related Groups as utilised around the world) are employed in Finland, as in other Nordic countries. The operations of these are slightly adjusted in relation to local factors in each Nordic country, and encompass formulae to calculate adequate reimbursement for specified episodes of care.[31] Local governments in Finland are only required to balance their budgets over a four year period, and when this is not achieved, rebalancing can take many years to accomplish and is usually free from sanctions. It is likely however that central government will soon become more rigorous in enforcing its budgetary regulations as fiscal pressure mounts in Finland as elsewhere.[32]

Although central government is benefitting from a degree of economic recovery since the financial crisis of 2008, and is consequently beginning to reduce its overall deficit, local authorities, with ageing populations and increased levels of chronic disease are increasingly forced to borrow money and raise local tax rates to meet their legal responsibility to provide services. Finnish local government debt has therefore increased from three per cent of GDP in 2000 to seven per cent in 2013.[33] Even the proportion of its income that each local authority receives from corporate income tax is unreliable, as taxes raised against profits can be subject to wide variation.[34]

Decentralised healthcare in Finland

The Finnish government is different from those of other Nordic countries in that it only has two main tiers of administration, local and central. Other Nordic States have an additional intermediate regional tier. The absence of this intermediate tier in Finland may be one reason for its high levels of administrative decentralisation including that for healthcare.[35]

Concerns have been expressed with regard to the ability of some Finnish local authorities to provide health and social care efficiently and to a sufficiently high standard. To be able to provide effective services, each local authority needs an adequate population base not only from which to raise funds, but also to make it worthwhile to establish particular service infrastructures. They also require an adequate pool of competent staff to effectively organise and deliver such services.[36] As stated earlier, Finnish local authorities have a high level of fiscal autonomy and may set their own income and property taxes within a range set by

central government, however, many new healthcare procedures are proving to be so expensive as to exhaust local resources. For example, local authorities also have a duty to run screening programmes (e.g. for breast cancer) in accordance with a national programme.[37] Since 2000,[38] the cost of this and other such initiatives has led, with encouragement from central government, to an increasing number of local authorities merging to provide cost-efficient health and social care.[39] This amalgamation decreases the risk that unwise managerial decisions or sudden major eventualities affecting the tax funding base might threaten the viability of any given locality's healthcare. Currently in remote areas it is feared that some smaller local authorities' resources are inadequate to ensure adequate provision of all required services to their populations.[40] It is believed the administrative model that the Finnish government would like to establish would consist of around 40 to 60 health and social care regions formed from federations of existing local authorities. These would deliver primary and some specialist care services as well as social care. Recently, even hospital districts are reporting that it is inefficient to attempt to offer every service at each hospital. Thus, specialist services are increasingly being offered at fewer more concentrated, specialised centres at quasi-national level.[41]

The decentralised administration of healthcare in Finland may have contributed to that country's recognised inequality of healthcare accessibility. In some local authorities there are continual shortages of healthcare personnel. This may imply that those citizens whose employers offer occupational healthcare, or who can personally afford private consultations, utilise these services more freely than others in the same local area.[42] Indeed by OECD standards Finland has slightly higher levels of wealth related inequality, especially as regards obtaining GP consultations and accessing specialist treatment.[43]

Interestingly while small local authorities in Finland might suffer from diseconomies of scale, particularly with regard to specialist or intensive services requiring high capital investment, very large authorities also seem to have become less efficient as they are extremely complex to administer, often without greater levels of management expertise than is found in smaller authorities. As a consequence, it is proposed that large cities might be best managed by a single authority, which is why the central government is encouraging the aforesaid administrative mergers.[44] Central government is also concerned by conflicts of interest within local authorities. For example, when these both commission and manage healthcare services, it has been discovered that many local authorities would agree to service

costs at 20 per cent above average rates in order to avoid, for example, closing a local hospital under their control.[45]

Social care in Finland

In Finland long-term care for elderly is the responsibility of local authority social services administration.[46] Two laws: the Primary Health Care Act and the Social Welfare Act designate local authorities as the bodies responsible for all public sector healthcare including social services. These local authorities enjoy a high level of autonomy, indeed, amongst the greatest of any country,[47] and, as in Denmark, they are required to provide a range of services from home care visits to maintaining residential care homes. Eligibility for care is determined by assessing the 'need profile' of each individual who applies for it; however, user fees are also sometimes demanded and these are determined by the ability of each applicant to pay them. [48] As local authorities administer both health and social care services, the distinction between long-term care and healthcare is often not clearly defined, however this fact may prove beneficial to users by enhancing effective integrated care.[49]

Finnish health system performance

As is the case in both England and in Denmark, Finland has an ageing population and is experiencing an increase of lifestyle related chronic disease.[50] In addition, Finland has the highest prevalence of child, type 1 diabetes in the world[51] with over 300,000 of its relatively small population being in some form diabetic.[52] This population ageing, combined with poor public health, is identified as the main causative factor for the increasing levels of spending and debt experienced by local authorities in recent years. Concern is expressed that smaller local authorities are struggling to meet national provision standards[53] and central government funding allocation has stayed relatively unchanged though local costs have steadily risen.[54] This is why the government has a policy of encouraging voluntary mergers. The central government favours a minimum size of health and social care administration of that of 20,000 inhabitants, but it believes that local authorities need populations of over 50,000 if they are to efficiently organise specialised care.[55] If, as is the case at present, local authorities are not voluntarily merging to the extent that central government would wish, is is likely to impose mandatory mergers on some local authorities (as was effected in Denmark) or simply abolish particular local authorities where economies of scale would prove beneficial.[56]

Table 2: Key health data UK and Finland

Indicator	UK	Finland
Hospital beds (per 1000 people)[57]	3.0	5.5
Physicians (per 1000 people)[58]	2.8	2.9
Nurses and midwives (per 1000 people)[59]	10.1	10.8
Maternal mortality ratio (per 100,000 births).[60]	8	4
Mortality rate, under 5's (per 1,000 live births)[61]	5	3
Life expectancy at birth (years)[62]	82	80.63
Government health expenditure as a percentage of total of government expenditure[63]	16.1	12.3
Out-of-pocket expenditure as a percentage of total health expenditure[64]	9.9	18.6
Government health expenditure per capita (PPP int.$)[65]	2,883.5	2673.3
Mortality amenable to healthcare (per 100,000)[66]	94	82.5
Mortality after surgery[67]	3.6%	2.0%
Hospital acquired C-difficile 30 day mortality[68]	30%	14%
Average* proportional 5 year cancer survival[69][70]	42.3%	49.3%
Absolute inequalities in all-cause mortality between lowest and highest levels of education (deaths/100,000 persons/year)[71]**	662	869

Inequality indices for specialist doctor visit probability between high and low income groups.[72]***	0.012	0.118
Postoperative pulmonary embolism or deep vein thrombosis. (per 100,000 discharges)[73]	812	680
Foreign body left in during procedure (per 100,000 discharges)[74]	5.7	3.4
Age-adjusted 30 day In-hospital case-fatality rate following Acute myocardial infarction (per 100 patients)[75]	5.2	4.8
Unplanned schizophrenia**** readmissions within 30 days to same hospital.[76]	8.1	19.3
Unplanned bipolar disorder**** re-admissions to the same hospital within 30 days.[77]	10.3	18.4
Mammography Screening, percentage of women aged 50-69 screened, 2000-2009.[78]	74%	84.4%
Percentage of participants 'fairly satisfied' or 'very satisfied' with their healthcare.[79]	85%	66%
Average length of stay for acute myocardial infarction (AMI) (days).[80]	7.7	8.8
Average length of stay for normal delivery (days).[81]	1.6	3.1
Unmet need for a medical examination, total for selected reasons***** for lowest income 5th of population.[82]	1.7%	4.6%
*Average cancer survival calculated from survival percentages for Lung, Breast and Ovarian cancer: the only three survival rates obtainable for all three countries.**Positive value pro higher educated, negative value pro lower ed ucated.***Positive value pro rich, negative value pro poor. ****Does not include patients with a secondary diagnosis of the mental health disorder.*****'could not afford to' 'waiting time' and 'too far to travel'.		

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