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Memorandum of the National Project on
Safeguarding the Future of Health Care Services

MINISTRY OF SOCIAL AFFAIRS AND HEALTH

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Summary

Proposals for safeguarding the future of health care services:

The Government set up on 13 September 2001 a project to safeguard the future of Finnish health care. The steering group of the project appointed five rapporteurs ad int. and support groups for them to carry out the background work for the project. The groups have heard a wide range of experts in health care.

The steering group of the project has formulated upon the presentation of the chief rapporteur a proposal for the measures that should be undertaken to safeguard the future of health care services. The steering group suggests that access to treatment within prescribed periods of time should be guaranteed by 2005. By that year all such care and treatment that is deemed necessary must be provided within six months; an estimate of out-patient treatment within specialised medical care within three weeks; and a first estimate of treament and need for treatment at a health centre within three days from the date the client has contacted the centre. If the municipality or joint municipal board is not itself able to provide the necessary treatment within the prescribed time, it must acquire it from elsewhere and this must not involve increased costs to the patient.

The volume of education for health care personnel will be increased. The number of openings for medical students is proposed to be increased from 550 in 2002 to 600. Workplaces will be developed by providing management training. Employers will provide health care staffs with systematic further training.

Functions and structures are proposed to be reformed so that primary health care is organised as functional entireties according to sub-region. Regional differences and geographical distances are taken into account. The division of labour within specialised medical care will be developed and enhanced. Regional hospitals form together with the primary health care within their area health care regions or are linked more closely to central hospitals.

The need for additional funding for health care will be € 0.7 billion by 2007. By this financing share it will be possible to achieve the level required by care recommendations, as well as to ensure the increased demand for care on account of population ageing and access to treatment within the prescribed periods. The state and local authorities are together responsible for additional financing. Separate project funding will enable functional changes and the introduction of electronic patient records, as well as the implementation of the so called Valid treatment and ROHTO projects. The grant for the evaluation unit for health care methods will be increased.

The steering group is responsible for the execution of the project. The Ministry of Social Affairs and Health co-ordinates the carrying out of the programme.

Key words

Care, care recommendation, health care, health care personnel, public services, specialised medical care

Other information

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Julkaisun osat

Tiivistelmä

Ehdotukset terveydenhuollon tulevaisuuden turvaamiseksi

Valtioneuvosto asetti 13.9.2001 projektin terveydenhuollon tulevaisuuden turvaamiseksi. Projektille nimettiin johtoryhmä ja johtoryhmä nimesi hankkeen taustatyöhön viisi selvityshenkilöä ja heille tukiryhmät. Ryhmät ovat kuulleet laajaa joukkoa terveydenhuollon asiantuntijoita.
Hankkeen johtoryhmä on selvitysmiehen esityksestä muovannut esityksen niiksi toimenpiteiksi, joihin tulisi ryhtyä terveydenhuollon tulevaisuuden turvaamiseksi. Johtoryhmä esittää, että hoitoon pääsy määräajoissa turvataan vuoteen 2005 mennessä. Kaikki tarpeelliseksi todettu hoito on tähän mennessä järjestettävä kuuden kuukauden kuluessa, poliklininen hoidon arvio erikoissairaanhoidossa kolmen viikon kuluessa sekä terveyskeskuksen ensiarvio hoidosta ja hoidon tarpeesta kolmessa päivässä yhteydenotosta. Jos kunta tai kuntayhtymä ei itse voi järjestää hoitoa määräajassa, on se velvollinen hankkimaan sen muualta potilaan omavastuuosuuden muuttumatta.
Terveydenhuoltohenkilöstön koulutusta lisättään. Lääkärikoulutuksen aloituspaikkojen määrää esitetään lisättäväksi vuodesta 2002 alkaen 550:stä 600:aan. Työyhteisöjä kehitään järjestämällä johtamiskoulutusta. Terveydenhuoltohenkilöstölle järjestetään työnantajan toimesta systemaattinen täydennyskoulutus.
Toimintoja ja rakenteita esitetään uudistettavaksi niin, että perusterveydenhuolto järjestetään seutukuntakohtaisina toiminnallisina kokonaisuuksina. Ratkaisuissa huomioidaan alueelliset erot ja etäisyydet. Erikoissairaanhoidon työnjakoa kehitetään ja lisätään. Aluesairaalat muodostavat alueensa perusterveydenhuollon kanssa terveydenhuoltoalueita tai toimivat nykyistä kiinteämmin keskussairaaloiden yhteydessä.
Terveydenhuollon lisärahoitustarve vuoteen 2007 mennessä on 0,7 miljardia €. Tällä rahoitusosuudella voidaan päästä hoitosuositusten edellyttämään tasoon sekä turvata väestön ikääntymisestä aiheutuva palvelujen kysyntä ja hoidon saamisen enimmäisajat. Lisärahoituksesta vastaavat valtiot ja kunnat yhdessä. Erillisellä hankerahoituksella tuetaan toiminnallisia muutoksia sekä elektronisen sairauskertomuksen käyttöönottoa, Käypä Hoito- ja Rohto- projekteja. Terveydenhuollon menetelmien arviointiyksikön rahoitusta nostetaan.

Hankkeen toimeenpanosta vastaa johtoryhmä. Sosiaali- ja terveysministeriö koordinoi ohjelman toteuttamista.

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Förslag till tryggande av hälso- och sjukvården i framtiden

Statsrådet tillsatte 13.9.2001 ett projekt för att trygga hälso- och sjukvården i framtiden. För projektet utsågs en ledningsgrupp och ledningsgruppen utsåg för det grundläggande arbetet fem utredningspersoner samt stödgrupper för dem. Grupperna har hört ett stort antal sakkunniga inom hälso- och sjukvården.

Projektets ledningsgrupp har på förslag av utredningsmannen utformat ett förslag till åtgärder som skall vidtas för att trygga hälso- och sjukvården i framtiden. Ledningsgruppen föreslår att vård garanteras inom utsatt tid före ingången av år 2005. Nödvändig vård skall då ordnas inom sex månader, poliklinisk vårdbedömning inom den specialiserade sjukvården inom tre veckor och en första konsultation angående vård och vårdbehovet vid hälsovårdscentral inom tre dygn från den första kontakten. Om kommunen eller samkommunen inte kan ordna vård inom utsatt tid, är de skyldiga att köpa den av andra serviceproducenter utan att klientens självriskandel påverkas.

Hälsovårdspersonalens utbildning utökas. Enligt förslaget skall antalet studieplatser inom läkarutbildningen utökas från år 2002 från 550 till 600. Arbetsgemenskaperna utvecklas med hjälp av ledarutbildning. Arbetsgivaren skall ordna systematisk fortbildning för hälsovårdspersonalen.

Arbetsgruppen föreslår att funktionerna och strukturerna reformeras så att primärhälsovården ordnas i form av funktionella helheter inom de ekonomiska regionerna. I samband med detta skall de regionala skillnaderna och avstånden beaktas. Arbetsfördelningen inom den specialiserade sjukvården utvecklas och utökas. Kretssjukhusen bildar hälso- och sjukvårdsområden tillsammans med primärhälsovårdenheterna på området eller verkar i samband med centralsjukhusen i större utsträckning än för närvarande.

Hälso- och sjukvården är i behov av en tilläggsfinansiering på 0,7 miljarder euro före ingången av år 2007. Med denna finansieringsandel kan man uppnå den nivå som vårdrekommendationerna förutsätter och trygga den efterfrågan på service som befolkningens åldrande föranleder samt garantera att vård fås inom utsatt tid. Staten och kommunerna svarar tillsammans för tilläggsfinansieringen. De funktionella förändringarna, ibruktagandet av elektroniska sjukjournaler, projektet Gångbar vård och Rohto-projektet stöds med särskild projektfinansiering. Finansieringen för enheten för utvärdering av medicinsk metodik höjs.

För verkställigheten av projektet svarar en ledningsgrupp. Social- och hälsovårdsministeriet samordnar genomförandet av projektet.

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FOREWORD

On 13 September 2001 the Council of State appointed a national project to secure the future of health care. The task of the project was to prepare, by 31 March 2002, a plan and implementation programme to ensure health care functions and the availability and quality of health care services. The project had to allow for international experiences of health care reform, target and action plan for social welfare and health care 2000 – 2003, the Decision-in-Principle of the Council of State on the Health 2015 public health programme, the experiences of the Healthcare into the 2000s programme, and other available reports. The work of the project had to establish a foundation for preparing the programme of the next government.

The work had to involve hearings for representatives from various quarters, including various ministries, the parliamentary Social Affairs and Health Commitee, local authorities and joint municipal boards, labour market organisations, organisations of patients and of the social welfare and health care sector, the Social Insurance Institution, universities and polytechnics, research institutes and private health care enterprises.

Markku Lehto, Permanent Secretary at the Ministry of Social Affairs and Health was appointed to chair the project management group. The other members appointed to the group were Permanent Secretary of State Raimo Sailas of the Ministry of Finance, Managing Director Risto Parjanne of the Association of Finnish Local and Regional Authorities, Chief Executive Officer of Nursing Pirkko Valkonen of the Central Finland Hospital District and Special Investigator and Director General Jussi Huttunen of the National Public Health Institute of FinlandMinisterial Councellor, Health/Medical Affairs Jouko Isolauri of the Ministry of Social Affairs and Health served as secretary to the management group.

The function of the project administrator was to prepare an assessment of the overall situation and a plan of action for the following five subjects falling within the terms of reference of the project:

- Reform of the operational and administrative structures of the service system and improvement in efficiency and productivity.
- The need for labour in various staff groups and the division of duties between them. Strengthening of management, improvement of working conditions and enhanced incentives to join the sector. Arrangement of in-service training.
- Health care finance. Level and stability of financing, channels of finance and allocation of resources, the statutory State subsidy system, local authority invoicing, client charges policy. Improvement of the State guidance system.
- Development of the division of labour and co-operation between service providers in the public health care, private and third sectors.

- Implementation of health care practices, national recommendations and regional health care programmes. Development, assessment and introduction of new methods of diagnosis and treatment.

The project administrators appointed to prepare reports on these five subjects were Hospital District Director Rauno Ihalainen of Pirkanmaa Hospital District, Professor Mats Brommels of the University of Helsinki, Matti Uusitupa, Dean of the University of Kuopio, Chief Health Care Officer Riitta Simoila of the City of Helsinki, Director-General Jussi Huttunen of the Social Insurance Institution, Hospital District Director Pentti Silvola of the Northern Ostrobothnian Hospital District, Executive Director Hannele Kalske of the Rheumatism Foundation Hospital, Professor Marjukka Mäkelä of the National Research and Development Centre for Welfare and Health – Stakes, and Chief Physician Leena Niinistö of St. Catherine's Hospital, Vantaa. The Ministry of Social Affairs and Health appointed expert task forces to assist the project administrators responsible for the various subjects. Nearly 400 experts and actors in the sector were consulted in the course of the work.

In accordance with its assigned terms of reference, the project focused on issues pertaining to development of the health care service system. Social welfare was examined in respect of co-operation and the division of labour within the social welfare and health care sector. After the Council of State issued its 2001 decision-in-principle on the Health 2015 public health programme, this project mainly focused on health promotion functions to be implemented within the health service system. No special examination of health care priorities was conducted for the project. Assignment of priorities as an aspect of health care development work was examined in the concluding work for the Health Forum 2000 seminar arranged in the year 2000 and led by Archiatre Risto Pelkonen. It was not possible in the course of the project work to prepare proposals for developing individual special sectors or functions.

Markku Lehto
Chairman

Raimo Sailas

Risto Parjanne

Pirkko Valkonen

Jussi Huttunen

Jouko Isolauri
Secretary

CONTENTS

1. INTRODUCTION

The basis of Finnish health care provision is the constitutional right of the public to adequate social welfare and health care services. The principles of the system are funding from tax revenues and the obligations of the State to guide the system and of local authorities to arrange services. The functions of the State are to define health care policy and to integrate this into other social policies, to guide and supervise the health care system, and to ensure the equitable provision and quality objectives of health care services. The obligation of local authorities to organise these services is based not only on legislation, but also on a long tradition. Democracy based on local policy-making strengthens the general acceptability of the system.

To date the system has functioned well. Basic health care provision and specialised treatment services arranged by the local authorities cover the whole of Finland. The staff are highly trained and committed to their work. Available indicators show that the quality of services is good and their availability is at least reasonable. Preventive health care policies have also been successful, and the health of both children and the adult population has progressively improved.

The service system is subject to a great many pressures. Even though senior citizens grow healthier every year, the changing age structure is reflected in the need for care and treatment. Rapid internal population migration will require part of the service system to be reconstructed. New technology can help to improve the standard and efficiency of care and treatment services. However, some of this new technology is costly, and so it is increasingly important that it is used in a controlled manner. Other challenges include dealing with the problems arising from unemployment and social exclusion, and the increasing use of alcohol and other intoxicants.

The character of specialised health care services is changing. Some of these services demand the highest expertise in narrow specialisms, and are focused on the five university hospitals, a few general hospitals and certain individual centres of expertise. Co-operation between basic and specialised health care and the entire health care and social welfare area is becoming an increasingly important objective.

The system is threatened by a labour shortage. A shortage of medical and nursing staff is hampering basic and specialised health care throughout the country. As the largest age bands of the population reach retiring age there will be shortages in all staff groups. The labour shortage may be alleviated by modifying the content of work and working methods, by correctly dimensioning training volumes and by supporting staff retention by improving working conditions and terms of service.

Overall health care costs and public health expenditure in Finland are currently among the lowest in the western industrialised countries. The productivity of health care services improved considerably during the 1990s and is now at a high average standard. This improvement in efficiency of operations was based on a high standard of vocational skills, the voluntary principle and a very highly motivated staff. Since the savings implemented during the recession years there has been only a slight increase in resources allocated to the health care system despite the fact that the number of people aged 65 years or over has increased by nearly 100,000 during this period. Some of the staff are currently working at the limits of their performance capacity.

2. AIMS OF DEVELOPMENT WORK

The objective of the development work described in this plan is to ensure the availability of health care services corresponding to their needs to all members of the public in the manner prescribed in the constitution. Patients are also guaranteed adequate information and participation in the making of decisions that affect them individually. The reform will also help to ensure continuity of services that are provided promptly, safely and to a high standard, will promote co-operation between various actors and will encourage cost-effectiveness. Development work will be implemented so that financing continues to be based on taxation revenues, inequity between municipalities is reduced, the system becomes more transparent and the effectiveness of operations improves.

Urgent treatment will be provided without delay. In all non-emergency cases the patient must receive a first assessment from a basic health care professional, usually a physician, within three days of the first contact, and a first assessment from a specialised health care physician within three weeks of issue of a referral. Access to any medically justified or otherwise necessary treatment measures must be secured within the period stipulated in the national treatment recommendations or otherwise within a reasonable time based on the evidence in the case, and normally within a period of three months but not exceeding six months. This objective will be achieved by the year 2005.

Service provision will be evaluated in the following functional areas: preventive health care, treatment of acute illnesses, treatment of chronic illnesses, treatment to be planned in advance and rehabilitation. Availability and quality objectives will be defined for each functional area. Operations will stress the principles of local and continuous care, prevention of illnesses and promotion of health. As the service system develops all measures shall be taken to support the conditions for good health and choices that promote this.

Responsibility for arranging health care services shall continue to be vested in local authorities. However, service provision may be diversified. In addition to local authority health care service units, statutory access to services may also be arranged from other providers such as NGOs and the private sector. Municipal commercial institutions may prove to be a viable solution, particularly for laboratory and imaging services, and for operations under certain pre-planned conditions.

The duties of the State shall include guidance and supervision of the service system and assurance of the equity and quality objectives of health care services. The system may be guided by norms, resource allocation, information and advance or retrospective supervision. State guidance will be developed with a view to ensuring the availability and quality of health care services in an equitable manner for all members of the public. This programme shall stress the importance of information-based guidance in service system development work.

Health care will succeed in its function if the staff are highly trained and motivated, committed to their work and fairly paid. The best way to achieve these objectives is to develop the skills of staff, to improve working conditions and to dimension staffing levels correctly.

3. DEVELOPMENT MEASURES

3.1 HEALTH PROMOTION

A person's state of health may improve or deteriorate according to individual circumstances, interactions, lifestyle and choices. Health is influenced by everyday surroundings and activities, as well as by knowledge, skills, mutual support and care. The choices and activities of individuals, families and communities are often more important to human health than any service system. A sedentary lifestyle, unhealthy eating habits, obesity, tobacco smoking and the use of intoxicants greatly increase the propensity to illness and the need for services.

Governments can influence public health through actions taken in many administrative sectors. Decisions that have important consequences for health are taken in relation to the living environment, welfare services, education, working life, social security and gender equality. Co-operation between various actors and branches of public administration promotes a favourable health impact.

Welfare policy programme work provides local authorities with an opportunity to make a broad examination of services and overall support in relation to human needs and local conditions. It covers the entire field of operations, various service needs and the preventive point of view. The welfare policy programme also supports the development of regional solutions and co-

operation between various divisions and sectors of the service system. NGOs have an important role to play in promoting health and providing information on human welfare.

In 2001 the Council of State issued a decision-in-principle on the Health 2015 public health programme. The programme serves as a health promotion framework to be implemented in various areas of society. The strategy presents eight objectives. These objectives focus on problems that require co-ordinated measures from various parties. The programme also incorporates 36 position statements seeking to guide operations and including recommendations for action with respect to everyday surroundings and various actors in society. This programme supplements the Health 2015 programme and includes proposals for measures to improve the health service system.

The abuse of alcohol remains the worst single current and future health problem in Finland. Alcohol consumption is growing and alcohol-related illnesses and fatalities are becoming increasingly common. The health problems caused by alcohol are in direct proportion to total consumption. The removal of special limits on importation by travellers and tax cuts bringing about a general fall in the prices of alcoholic beverages to approach the levels of other European Union Member States as of the beginning of 2004 have been estimated to increase overall alcohol consumption by some 10 to 20 per cent. As a result the health problems caused by alcohol and the consequent need for services will rise sharply.

The only swiftly effective means of reducing overall alcohol consumption is to reduce the maximum alcohol content of the beer and other fermented alcoholic beverages sold at retail outlets other than those of the State alcohol monopoly. This measure could significantly reduce the health problems arising from alcohol and the costs that these occasion to the service system. The relative impact on alcohol consumption by children and young adults would be greater than on consumption by older generations.

When Estonia joins the European Union it may also be necessary to cut tobacco taxes. This matter should be considered in the course of accession negotiations with a view to finding ways of preventing the health and economic problems arising from a reduction in tobacco prices.

Recommendation 1

Local authorities should assess the need and organisation of social welfare and health services as part of their work under welfare policy programmes. This work should stress health promotion, the prevention of illnesses, the development of regional solutions and co-operation between various divisions of the service system and various local authority sectors.

Local authorities and other actors should promote public health in line with the Health 2015 public health programme.

The maximum alcohol content of the beer and other fermented alcoholic beverages sold at retail outlets other than those of the State alcohol monopoly Alko Oy should be reduced from the current 4.7 per cent with a view to cutting overall alcohol consumption and reducing the health problems arising from alcohol and the consequent costs to the service system.

3.2 ENSURING ACCESS TO TREATMENT AND QUALITY CONTROL

The availability and quality of health care services must meet nationally imposed requirements regardless of the place of residence of the patient and of the manner in which services are arranged. The quality and information system will help to ensure that the services provided are equitably available, effective and cost-effective.

The patient shall always be able, with sufficient swiftness, to contact a health care professional who is capable of assessing any need for treatment and taking charge of further measures. Efficient electronic communications and an available, comprehensive and clear patient record will improve the conditions for securing an accurate and sufficiently swift evaluation. Harmonisation of grounds for treatment practices and waiting lists, and development of a unified electronic system of patient records will also enable waiting lists for medical examinations and operations to be controlled.

Good treatment can be effected where measures are based on the best available information. This improves the effectiveness, timeliness and cost-effectiveness of care, enhances safety and promotes gender equality. When correctly transformed the same information also improves the opportunities for people to promote their own health and to take part in making the decisions that affect their lives.

The aim of quality control is for the treatment process to be implemented in the most efficient manner possible, for patients to be well cared for and for them to receive at all times the information that they need concerning the aims of the treatment, its implementation and all other aspects of care.

3.2.1 Ensuring access to treatment

The availability of treatment varies in Finland both by type of illness and by geographical region. This is partly due to a lack of resources. Availability is also affected by varying treatment practices, skills shortages and old fashioned methods used in communications and information exchange. There are problems in communications both between health care service units and between these units and their clients.

When members of the public contact basic health care service units due to problems other than those requiring urgent treatment, they must receive a preliminary assessment from a health care professional (either a physician or a nurse) within three days. This assessment may either be a solution to the problem or details of an appointment to investigate the complaint. When patients receive prompt advice on how to proceed the need to bring medically non-urgent complaints to emergency centres is reduced.

Delays may be reduced by issuing the preliminary assessment more frequently through electronic communications without the need for an individual medical appointment. According to international estimates, as much as one-fifth of all health problems can be treated in this manner. Monitoring of chronic conditions and the questions of familiar patients concerning self-treatment are typical situations that can often be managed by telephone or e-mail.

When patients need assessments from health care specialists, they must receive details of their appointments and preliminary examinations within three weeks. If the patient's condition demands more urgent treatment, then the patient must be given an expedited appointment.

Patients must normally have access to medically justified treatment within three and no more than six months of the decision that such treatment is necessary. The need for treatment will be assessed by the attending physician and the patient together. If treatment cannot be provided at the local health care unit within the time limit, then the local authority or municipal federation must arrange for treatment elsewhere (at another local authority health care unit, in the private sector or in the third sector), and must ensure that there is no change in the patient charges involved. Care must be taken in such cases to ensure respect for the right of patients to be treated in their own language, i.e. in either Finnish or Swedish.

The principle that access to treatment must occur within a reasonable time of verifying the need for such treatment, and that in order to promote the more equitable availability of health care services, provisions may be issued

by a Decree of the Council of State concerning the maximum periods for access to a medical examination and treatment is to be included in legislation on specialised health care, public health and mental health services by the year 2005. Without provisions, instructions and recommendations that are well prepared and based on the best available information, a situation will arise in which health care practices are fashioned on the basis of judgements by the courts.

Most patients secure sufficiently rapid access to treatment. Of those patients on waiting lists, about 2 – 5 per cent suffer from conditions in which the waiting period is considered to be too long. Waiting lists for operations mainly apply to a few patient groups. In certain groups the length of the waiting list varies considerably and without justification. One reason for this is variation in waiting list placement. The problems of access to treatment may be eliminated only if there is a common conception of the need for examination and treatment and on methods of treatment, and if waiting list data are monitored in real time using an electronic waiting list.

Further provisions on the maximum waiting times for access to treatment may be issued after national recommendations have been prepared on the principles for placement on waiting lists, after health care units have introduced proper waiting list management procedures, and after adequate resources have been allocated to the service system to clear waiting lists. To achieve the objectives active waiting list management will be developed and access to treatment will be improved by defining national criteria for waiting list inclusion. When work on these criteria is done a reasonable waiting period will be defined under various circumstances. The indicators and criteria will be applied initially to 2 – 4 general health problems that lead to waiting lists. These illness types will be used to test and develop means of managing waiting lists.

Implementation of medically justified treatment within the foregoing maximum periods will save public funds. According to a recent report, the costs of delayed treatment (sickness benefits, costs of medicines, social welfare expenses) for both the working population and pensioners exceed the costs of treatment, often very substantially. Delayed treatment has been shown in many investigations to greatly increase the risk of remaining on a disability pension.

The availability and quality of health care services will be monitored both nationally and regionally. Public and private service providers will be obliged by law to provide regular reports to an information system created for the purpose of national monitoring. Information on the effectiveness, quality, costs and productivity of treatment from publicly subsidised service providers must be public. This information will guide the local authorities and joint municipal boards that are responsible for arranging services in selecting service providers of the highest standard and greatest efficiency, and will also help members of the public to make their choices.

Recommendation 2

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

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

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

The National Research and Development Centre for Welfare and Health – Stakes and the Association of Finnish Local and Regional Authorities should begin to establish a monitoring system on the national availability of services, the effectiveness of treatment, quality, costs and productivity, and the use and costs of municipal resident health services.

3.2.2 Quality control

There have been several examples of serious shortcomings in the quality of health care. Care practices and the availability of treatment vary considerably in various parts of Finland. Treatment feedback is often not provided or is not sent quickly enough, with a consequent negative impact on the effectiveness of care. The annual cost of duplicated and otherwise unnecessary laboratory and imaging examinations has been estimated at more than EUR 200 million. These problems can be eliminated by improving management and information flow, by developing quality systems and by increasing co-operation.

National recommendations and a system of guidance and monitoring will help to promote a high standard of service provision regardless of the patient's place of residence. Nationally imposed objectives will harmonise practices. Public access to information will encourage service providers to improve their operations.

Regional care programmes will be based on national recommendations for prevention, treatment and function. Several quality recommendations are being prepared as part of a programme of objectives and action for the social welfare and health care. The continuity of these projects will be ensured by allocating adequate resources to them. The recommendations will also include measures to influence lifestyles and non-pharmaceutical care.

Hospital district authorities and basic health care units will co-operate to prepare, for the principal classes of illness, regional health care programmes and suitable specialised health care, basic health care and social welfare services from smoothly combined service chains. The regional care programmes will be based on national care recommendations and will include procedures for implementing care that are suited to the service structure in the region concerned. Quality control procedures will be used to ensure compliance with national care and quality recommendations and regional care programmes.

A quality control system ensuring that all parties involved in care comply with the principles of good care practice will be required of both public and private sector service providers. The systems will focus on promoting the effectiveness of care and the content of good care. National guidelines will be prepared to ensure that such systems are introduced. The hospital districts provide training to co-ordinate and support the development of quality control systems. Health care service units will identify the principal quality problems and will agree on how these are to be measured and on the steps to be taken to eliminate them. Operations will be assessed using a supervisor-subordinate procedure, by means of comparability evaluations and through auditing.

Recommendation 3

The preparation of national recommendations on preventive care and treatment, the provision and updating of versions suited to various users, and the production of centralised training materials on these recommendations should be financed through a grant (EUR 1.4 million per year) from Finnish Slot machine Association revenues as of 2003.

Hospital district authorities and basic health care units should co-operate to prepare regional preventive health care and treatment programmes for the principal classes of illness. These regional care programmes should be based on national care recommendations. Preparation of regional programmes for preventive care and treatment should be supported through a State subsidy allocated to development of the service system.

3.2.3 Ensuring expertise

Health care operations are based on continual revision and maintenance of professional expertise. This cannot be achieved without planned and systematic in-service training. The statutory obligation to arrange in-service training was repealed in the social welfare and health care sectors in the early 1990s. With respect to in-service training the training agreement annexed to the collective agreement on the terms of service of local government officers and employees is merely a recommendation.

Deficiencies in in-service training undermine the quality of services and cause problems both for employees and employers in the social welfare and health care sector. Training is arranged in a varying manner in different service units. Arrangements for locum cover hamper participation in training by physicians, particularly in health centres that are responsible for a specific catchment population. There are also problems in the supply of training services and in training methods.

Provisions specifying the obligations of employers and employees in respect of in-service training will be included in public health and specialised health care legislation. The professional development of staff will be linked to operational development and quality control. Employees will be required to participate in in-service training for individuals and working communities according to the development plan for the service unit concerned. Employers will be required to ensure that staff in-service training occurs and to monitor its implementation as one aspect of service unit quality control.

The Ministry of Social Affairs and Health will co-operate with the Ministry of Education, the Association of Finnish Local and Regional Authorities and labour market organisations to prepare minimum recommendations for in-service training and recommendations on its implementation. The minimum duration of in-service training will be determined in a graduated manner, having regard to the scope of basic training and qualifications and to duties, so as to comprise no less than 3 – 10 full days annually. An annual minimum of ten full days of in-service training will be agreed for employees working with challenging and rapidly developing information and technology. The needs of the service unit will be considered when specifying the length, content and implementation of in-service training.

In-service training of all vocational groups must include training in developing the working community and public health education. In-service training of care staff will be arranged partly in their own service units and partly elsewhere (new technology, duties requiring special expertise). In-service training of physicians will largely have to be implemented elsewhere than in their own service units. Health centre physicians will be guaranteed by region the opportunity for adequate in-service training in periods of 3 – 6 months and regular in-service clinical training through hospital work in periods of 1 – 4 weeks. This will promote the procurement of specialised expertise in health centres.

The basic funding for in-service training will be included in the staff budget for the health care service unit. Additional annual costs have been estimated at EUR 40 million. For this purpose an increase of EUR 10 million will be made in the State maintenance grant to local authority social welfare and health care services. The costs of developing in-service training will be met from the development budget of the Ministry of Social Affairs and Health.

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

Recommendation 4

Provisions on in-service training should be included in public health and specialised health care legislation by the end of 2003. Employers should be required to ensure that staff in-service training occurs and to monitor its implementation as one aspect of service unit quality control. Employees will be required to participate in in-service training according to the development plan for the service unit concerned.

The Ministry of Social Affairs and Health, the Ministry of Education, the Association of Finnish Local and Regional Authorities, the Comission of Local Authority Employers and trade unions should prepare recommendations for the content and implementation of in-service training by the end of 2003. The minimum duration of in-service training will be determined in a graduated manner, having regard to the scope of basic training and qualifications and to duties.

An increase of EUR 10 million for arranging in-service training should be made in the State maintenance grant to local authority social welfare and health care services as of 2004.

3.2.4 Introduction of new methods

Hundreds of new methods of treating illnesses, conducting medical research, rehabilitation and preventive care are developed every year. These methods are often introduced on the flimsiest of grounds. Many methods introduced without proper evaluation have proved to be less effective than the methods that they displaced. Comparisons of pharmaceutical products, non-pharmaceutical treatment and other methods are seldom performed. There are deficiencies in the development and assessment of methods suitable for basic health care. With the exception of research into vaccines, the evaluation of preventive health care methods remains in its infancy.

The controlled introduction of new methods requires close co-operation between the Ministry of Social Affairs and Health, clinical experts and the health care sector. Methods that are costly or require major investments must be tested in projects involving a proper comparison with the best available existing methods. Any methods intended for basic health care must be piloted in basic health care.

The controlled evaluation and introduction of new technology may be arranged as follows. Through its Finnish and international expert network the

health care methods evaluation unit of the Finnish Office for Health Care Technology Assessment – FinOHTA will identify new methods for evaluation, co-ordinate the selection of subjects and provide methodical support for the evaluation process. Piloting sites will be agreed with hospital district health authorities and health centres. Evaluation will be financed by allocating EVO research funds to effectiveness research. The Ministry of Social Affairs and Health will issue recommendations on the introduction of new technologies. The Social Insurance Institution will pay compensation only for examinations and treatment that has been assessed as effective.

A unit of about twenty staff will be needed for evaluation operations. This unit will be supported by an average of three rotating content specialists. The work may be divided between regions by establishing one or two branch units attached to the university hospitals. Institutes subordinate to the Ministry of Social Affairs and Health must participate in the work within their own specialist fields.

Pharmaceutical costs have risen rapidly in recent years and it would appear that this increase will continue throughout the current decade. The best way to slow this growth is to train the medical profession and to promote the rational use of medicines through a programme of national treatment recommendations. To achieve this objective the Rohto project seeking to promote the rational use of pharmaceutical products will be placed on a permanent footing.

Recommendation 5

The Finnish Office for Health Care Technology Assessment – FinOHTA should be developed into a medium-sized European evaluation unit to disseminate and, where necessary, produce information on the effectiveness of health care methods in a rapid and reliable manner. Increased resources should be allocated to the unit so as to achieve an annual budget of EUR 2.5 million by 2006.

The Rohto project promoting the rational use of pharmaceuticals should be placed on a permanent footing with an annual budget of EUR 1.3 million as of the year 2004.

3.3 STRUCTURAL REFORM OF THE SERVICE SYSTEM

The current service system suffers from structural problems that increase costs, undermine the quality of services and hamper staff recruitment. Some

of these problems concern co-operation between specialised health care, basic health care and social welfare and the division of duties between them, some pertain to the organisation of specialised health care and basic health care, while some derive from the operating methods of various parties.

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

Local health care services will be arranged as a functional regional package for a sufficiently large population base. Services will comprise basic health care functions and a basic standard of special health care services in areas where this is expedient. Operations will stress the principles of local treatment and continuity, prevention of illness and promotion of health.

Arrangements for specialised health care will ensure the functions of demanding specialised health care and equitable access to services for the entire population. Demanding specialised health care operations will be planned in larger regional packages.

The private sector, occupational health care and organisations provide a great deal of health care service, particularly for the residents of growth centres and their environs. Although these functions supplement the local authority service system, they overlap in certain respects. Clarification of the division of duties will improve healthy competition between the public and private sectors.

The conditions for competition and the ability of local authorities and joint municipal boards to procure services from the private sector will be improved. Uniform commercialisation of services, cost accounting and price comparability will require national guidelines.

Information management will be improved in order to promote information flow between various parties, smooth operation of service chains and monitoring of quality. A national information system supporting health care guidance will help to ensure the equitable availability, effectiveness and cost-effectiveness of services to the public.

Due to local conditions, services cannot be arranged in a similar manner throughout the country. In spite of this, it must be possible to provide services on an equitable basis to the entire population of Finland. State guidance will therefore be reinforced. The State must urge local authorities to improve the availability, safety, effectiveness and cost-effectiveness of services, and to implement structural reforms that promote these objectives.

3.3.1 Local services

Local health care services are provided at a location near to municipal residents. These local services are preventive health care, arrangements for care of acute cases of illness, outpatient reception services, most care of the chronically ill, some rehabilitation services, dental treatment, geriatric care, outpatient psychiatric care services and occupational health care.

Depending on the size of the municipality, local services are arranged by individual municipality or through regional co-operation. Regional co-operation is particularly important in municipalities that must adapt their service provision to a declining population and tax base. Co-operation is an aide to finding solutions that transcend municipal boundaries. These solutions may also involve service providers in the private or third sectors.

The conditions for effective basic health care include responsibility for a catchment population, health centres that are capable of a high standard of diagnosis and care, and a two-way chain of care including social welfare services, in which the basic health care unit co-ordinates and maintains a plan of care prepared with the patient and monitors its implementation. Regional care programmes are one means of improving co-operation between basic health care and specialised health care.

A functional unit serving a catchment population of about 20,000 to 30,000 residents and providing operating conditions for some 12 to 18 physicians is often also an administratively expedient minimum size for the provider of local health care services. In regions where the level of substitute private sector services is low or the work of basic health care physicians is broadly based, there will be a need for one health centre physician for every 1500 – 1800 residents. Health care service operating points must be dispersed so that travel constitutes no impediment to the use of health care services.

From the point of view of both individual care and cost-effectiveness it is justified for examinations and treatment to be performed as far as possible in health centres. Basic health care services require special expertise in preventive health care work and in the care of certain general patient groups. Preventive health care work must be systematic and comprehensive. Special attention must be paid to maternity and child welfare clinics and school health care. The members of a multidisciplinary team must work in the same unit in order for daily co-operation to occur.

Geriatric care is a common field for health care and social welfare services, and must be implemented in a manner ensuring that administrative boundaries lead neither to overlapping functions nor to gaps in service provision. The limits of health care services and social work currently prevent the realisation of objectives and responsibility for overall costs is dispersed in municipalities where these functions are separately organised. To ensure a harmonious and functional service package from the point of view of the client, it is necessary to develop common instruments for social welfare and

health care provision thereby guaranteeing that the chain of service is not broken when a client transfers from one part of the service system to another.

There have been many encouraging experiences of combining decentralised functions in home health care and home social service provision. Co-operation and/or functional combination of home social services, home health care services and institutional care will be promoted. Full-time institutional care in old people's homes and health centre wards and full-time care of dementia patients may be provided through regional co-operation.

The challenges of mental health and intoxicant abuser services and of family psychosocial services include prevention and treatment of the mental health problems of the elderly, children, young adults and families, the care of narcotics and intoxicant abusers, and arrangements for associated first aid services. One problem of the current service system is that it is decentralised, with operating units that are too small. Services are divided between day-care centres, child welfare clinics, school health care, family counselling centres, educational counselling, mental health services and alcoholism clinics. This decentralised character will be rectified, the size of operating centres will be increased and the service provision model will become more client-centred.

The new Occupational Health Care Act stresses the requirements imposed on the qualifications of staff and on the content and quality of operations. The structure of a local authority occupational health care system consisting of small independent operating units does not support the achievement of these objectives. Overlaps between occupational health care and basic health care will be eliminated.

Regional hospitals and the basic health care services of the surrounding municipalities form a natural basis for a functional package to be known as a health care area. Besides local services this package will include the basic level of specialised health care services that can be provided in a cost-effective manner and to a high standard while complying with the principle of local health care provision. Co-operation may also be effected in the form of a health service district, meaning the package made up of the present hospital district and the local services provided in its area.

There are no legislative impediments to regional co-operation between local authorities. The Local Government Act enables the functions referred to in the Act to be provided either in the municipality itself or in association with other municipalities. The natural forms of co-operation are the joint municipal board and the regional agreement.

Recommendation 6

Local health care services should be arranged as a functional package at regional level. Health care service operating points must be dispersed so that travel constitutes no impediment to the use of health care services.

Services should be provided in a client-centred manner in association with social services on the principle of responsibility for a catchment population. If the organisation of social welfare and health care services requires a larger population base, then these services should be provided through regional co-operation. Geriatric care should be based on a local authority geriatric policy strategy.

Mental health outpatient services, psychosocial services, services for intoxicant abusers and associated emergency services should be organised as a functional regional unit in association with the private and third sectors.

Health promotion and the prevention of illness are an essential aspect of local services. To ensure that these functions are performed local authorities should develop structures for health promotion management and co-operation between administrative areas.

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

3.3.2 Specialised health care

The aim of the reform is to establish a system that provides a high standard of specialised health care services in a cost-effective manner. This requires a more thorough division of duties, reduction in overlapping functions, centralisation of services and research requiring specialised expertise and the effective allocation and use of investment.

The increase in the number of specialisms and the need for emergency functions require special health care organisations to operate over a larger catchment population or to work more closely together. Co-operation and the vision of duties must be based on a mutually agreed operating strategy. The division of duties will be agreed in a field of specialist responsibility in a manner that also enables general hospitals other than university hospitals

or their detached operating units to provide services throughout the said field. The special standard specialised health care services to be centralised nationally will be stipulated by Decree.

The objective is for the current small general hospitals to focus on the basic standard of specialised health care and for the large hospitals to provide both this standard and separately agreed more demanding specialised health care services. The university hospitals will be responsible for the functions of general hospitals and for separately agreed more demanding special standard functions in their fields of special responsibility. The specialised health care of regional hospitals that is not integrated into a regionally determined health service district will be combined as part of the general hospital. Functional and administrative reduplication in specialised health care implemented within the same district will be eliminated by transferring more demanding specialised health care services so that they become subordinate to the same administration.

To improve co-operation and the division of duties the hospital districts in a special field of responsibility must together prepare plans concerning more demanding treatment that can be planned in advance, operating teams for small patient numbers, treatment services and support services. These plans will allow for the services provided by the private sector and the third sector, and will also examine co-operation between hospital districts operating in various fields of special responsibility. The local authorities of the area will participate in preparing these plans.

The plans of co-operation and division of duties will be filed with the Ministry of Social Affairs and Health by 31 May 2003. The necessary development measures will be implemented either by combining hospital districts or by expanding functional co-operation and the division of duties between hospital districts. If the plans lead to no expedient solutions for operations, then the State will take its own steps to implement the necessary changes.

The municipal commercial institution model is particularly well suited to the organisation of laboratory and imaging services, medication and occupational health care through municipal co-operation. A municipal limited company may be used in situations in which broader partnership models than the joint municipal board are sought, either within the public sector or together with the private sector. Both the municipal commercial institution model and the limited company model require the services to be sufficiently well commercialised and for their cost accounting and pricing to meet the requirements of commercial operation and competition regulations.

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

The development of demanding special standard of services will require established research and development co-operation with the universities. In

view of their current broad range of duties, the university hospitals are not ideally placed in all respects to do this. Separate centres of expertise will be established for functions at this special standard, at which co-operation between the hospitals and universities may become closer and provide the greatest possible benefit.

Recommendation 7

Demanding specialised health care should be planned in packages by special responsibility field. By 31 May 2003 the hospital districts in special responsibility fields should prepare a plan of co-operation and division of duties for the Ministry of Social Affairs and Health concerning more demanding treatment that can be planned in advance, operating teams for small patient numbers, treatment services and support services. The specialised health care of regional hospitals that is not integrated into a regionally determined health service district should be combined as part of the general hospital. Laboratory and imaging services and medication should be arranged in the form of comprehensive co-operation in one or several hospital districts with the participation of both basic and specialised health care.

The necessary development measures should be implemented either by combining hospital districts or by expanding functional co-operation and the division of duties between hospital districts. The practical measures involved in developing functional co-operation between hospital districts and in combining administrations should be supported by separate project financing.

3.3.3 Information systems

Effective information management is the basis for health service provision, documentation, management and monitoring of functions, development of service functions and evaluation of health policy and its various subdivisions. Regional co-operation is not possible without fundamentally compatible national solutions.

Even though most patient records are already in electronic form, a needless amount of time at work continues to be spent in searching for information, copying records, rewriting materials, sending them and saving them again. When a patient transfers from one place of treatment to another it is necessary to use extraordinary resources in transferring information. If this infor-

mation is not available, then the outcome is a repeat of an examination already performed, a delay in treatment and sometimes even erroneous measures.

Compatibility of information systems is a fundamental condition of rapid data transfer and effective information management. To ensure this the Ministry of Social Affairs and Health, the National Research and Development Centre for Welfare and Health – Stakes, the Association of Finnish Local and Regional Authorities and other participants will work together to define a common coding method for the basic data in patient records, administrative services that ensure compatibility of health care systems and open interfaces for the smooth exchange of information between systems.

National services and the interfaces of health care systems will be made mandatory for all health care participants by a Decree of the Ministry of Social Affairs and Health. Model applications will be made for implementing the most important functions. The nationally approved interfaces and model applications will be made public, after which data systems suppliers can implement the service and system interfaces in their own products.

The patient records contained in the basic health care system will form regional data systems in which patient data are securely and accurately available in a nationally uniform manner. By feeding uniformly coded cost data into the regional data system together with patient, examination and treatment data it will become possible to produce national comparability data on the costs and effectiveness of treatment methods to support health system guidance.

The transfer and use of client and patient data across organisational boundaries must be based on the statutes governing data transfer and on national data protection policies. This data protection policy and the principles for transferring information will be specified through co-operation between the Ministry of Social Affairs and Health, the office of the Data Protection Ombudsman, the National Research and Development Centre for Welfare and Health – Stakes and the Association of Finnish Local and Regional Authorities. Preparation of legislation will begin on the initiative of the Ministry of Social Affairs and Health with the necessary partners in 2003.

Service providers in the social welfare and health care fields will be the parties procuring and using information systems. Enterprises will implement and maintain the data systems. The stipulations on co-operation and data protection will be imposed as minimum requirements for the new data system. Current data systems will have to meet these minimum requirements within a five-year transition period.

Recommendation 8

The Ministry of Social Affairs and Health, the National Research and Development Centre for Welfare and Health – Stakes, the Association of Finnish Local and Regional Authorities and other concerned parties should specify the common administrative services and open interfaces ensuring compatibility of health care systems for smooth information exchange between regional and basic information systems. A budget of EUR 0.8 million should be allocated for specification work and the creation of model applications in 2003.

National services and the interfaces of health care systems should be made mandatory for all health care participants by a Decree of the Ministry of Social Affairs and Health issued no later than in 2007.

The data protection policy and the principles for transferring information should be specified through co-operation between the Ministry of Social Affairs and Health, the office of the Data Protection Ombudsman, the National Research and Development Centre for Welfare and Health – Stakes and the Association of Finnish Local and Regional Authorities. Preparation of legislation should begin on the initiative of the Ministry of Social Affairs and Health with the necessary partners in 2003.

The university hospital districts should co-ordinate regional information management development work in their special fields of responsibility. A total budget of EUR 30 million over the years 2004 – 2007 (see recommendation 9) should be allocated to development of information management in five special fields of responsibility from the budget for service system development projects.

A total of EUR 1.6 million for the years 2004 and 2005 should be allocated for modernisation of the national statistical and information service system (National Research and Development Centre for Welfare and Health – Stakes) for the health care and social welfare sector.

3.3.4 Employment of local authority medical staff in the private sector

Work in the private sector by municipal sector physicians in their spare time can lead to conflicts of interest. The Finnish Medical Association, Health Care Sector Service Organisations and hospital district management have compiled recommendations to prevent such problems from arising. Health service operating units must supervise compliance with these recommendations.

The main principles of the recommendations are as follows:

- In respect of activities not forming part of official duties a physician must comply with public service regulations governing permission for secondary occupations and notification thereof.
- Physicians participating in policymaking or the preparation thereof pertaining to outsourced services may not serve as members of the board of directors, supervisory board or comparable organs, or as Managing Director of enterprises engaged in the provision of outsourced services for a hospital or health centre.
- Physicians in public service may not refer patients to their private clinics in a manner that conflicts with their official duties.
- Admission of a patient to a hospital or polyclinic must be arranged according to equitable principles based on the need for treatment. A physician may not participate in person in policymaking concerning the admission of a patient that the said physician has referred for treatment unless there are compelling reasons for so doing.

3.3.5 Implementation of structural reforms

Reforms in the service system will be planned locally and regionally though co-operation between local authorities and various actors in social welfare and health care. Implementation of the reforms will require national co-ordination, guidance and special funding to support the changes made.

Arrangements for local services will be planned within the territory of a hospital district by region. This work will be co-ordinated by management committees to which representatives will be appointed from hospital districts, local authorities, basic health care, specialised health care and social welfare functions. Work in special responsibility areas will be co-ordinated by the university hospital districts. The management committee will include appointees from all of the hospital districts in the special responsibility area and a representative of the provincial administrative board. These plans will be approved by the Ministry of Social Affairs and Health.

At the first stage of the programme work a plan will be prepared for arranging regional local services. At the second stage the plans drawn up at hospital district level will be harmonised at the level of special responsibility

area. Co-operation of specialised health care within a special responsibility area will be agreed in the manner set out at point 3.3.2. The work will allow for the development proposals presented in the implementation programme for the Health Care 2000 project and for the objectives and operating policies of the Health 2015 programme.

The implementation plans arising from regional programme work and requiring separate project finance will be submitted to the Ministry of Social Affairs and Health for consideration and approval of funding. The first project proposals of this programme work will be prepared by the end of spring 2003. Project funding will be continued on an annual basis with a view to completing the reforms by the year 2007. Project funding will be entered under a forthcoming social welfare and health care sector budget item intended for financing operational development projects.

The reforms are the objectives that they encompass will be supported by combining the health care legislation that is currently set out in several separate Acts of Parliament. This legislative work will seek to promote co-operation and the division of labour between concerned parties, and thereby to improve the availability, effectiveness and cost-effectiveness of services.

Recommendation 9

The service system should be developed through gradually progressing programme work for which separate project financing should be allocated in the State budget. This project financing should continue until the main objectives of the reform have been achieved in 2007. The project financing allocation should be EUR 8 million in 2003 and EUR 30 million over the period 2004 – 2007.

The Ministry of Social Affairs and Health should work with the Association of Finnish Local and Regional Authorities to prepare and specify the health policy objectives guiding programme work, the criteria for access to services and service quality, and the procedures for monitoring implementation of these criteria, and to co-ordinate development work.

The Ministry of Social Affairs and Health should initiate a statutory reform combining the Act on Primary Health Vare and the Act on Specialised Medical Care into a single Health Service Act.

3.4 STAFF DEVELOPMENT

The health service will succeed in its work if the staff are capable, motivated, committed to their work and fairly rewarded. These aims are best achieved by developing staff training, improving working conditions, dimensioning the staff to correspond to need, and implementing a flexible division of duties between various staff groups. Development work must support local co-operative reform of the health service and the development of working methods centred on the changing needs of the client.

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

The training of health service staff must support the operations and objectives of the service system. The planning of training will allow for both national and regional needs, which in turn requires quantitative and qualitative planning and close co-operation with the universities, polytechnics, institutes of vocational education and participants in the health service sector.

3.4.1 Functional working communities and good management

Management development is one of the most important ways to achieve the strategic objectives of health care. The health service is a labour-intensive sector based on a high standard of expertise. Good management improves the welfare of staff and the working community.

The training of health service managers is decentralised, narrow and unsystematic. People with inadequate managerial experience and training are often appointed to managerial positions. Managing physicians often spend too much of their working time engaged in clinical work at the expense of human resources leadership and operational development. The shortage of physicians in health centres also hampers the management and development of basic health care.

Regardless of individual training and education, improving the managerial skills of middle managers (managing physicians and head nurses in operating units and fields of responsibility) and local managers (ward physicians, specialist physicians and ward managers) requires multi-vocational training, most of which can be performed as in-service training. This training must

become a requirement for staff seeking local and middle managerial positions in the health service.

The length of training must be 40 study weeks for those who have qualified as specialised physicians and have completed a master's degree in health sciences, and 60 study weeks for those who have completed a health sector polytechnic qualification. 20 study weeks of this training may be performed as part of medical specialisation studies or a master's programme in health science. Studies in multi-vocational health care groups must encompass at least 20 study weeks. The training must be based on a national curriculum and a national co-operation network will be required for its implementation.

Working communities in the health care sector must be developed through common training for the entire working community, in which management and staff engage in dialogue both with one another and with their clients and health service policymakers. The subjects of development work will include managerial models, co-operation and the division of duties between various occupational groups, the content of work and reform of working methods. Development work may best be implemented through the budget allocated to the working life development programme co-ordinated by the Ministry of Labour.

Constructing effective co-operation between social welfare functions and the parties responsible for ensuring other forms of welfare will be essential in these development processes. This means the ability to work in and manage networks and multi-vocational teams. The development processes will require sufficient time and commitment.

Recommendation 10

The Ministry of Social Affairs and Health, the Ministry of Education and the Association of Finnish Local and Regional Authorities should work with the universities to plan and implement management training in preparation for multi-vocational duties in local and middle management, with prospects for enrolment irrespective of the individual applicant's training and education. This training should be required of everyone seeking appointment to local and middle-tier health service management.

A national programme should be launched to develop health care sector working communities. This programme should be financed by an annual budget of EUR 2 million to be included in the working life development programme for 2004 – 2006.

3.4.2 Expedient division of labour

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

Some duties pertaining to the prevention and monitoring of long-term illnesses and the examination of acute cases of infectious disease have been transferred from physicians to nurses. Experiences of such transfers have been favourable, for example, in the treatment of diabetes, asthma and rheumatism.

The division of duties between vocational groups must be systematically reviewed and any practices proving to be favourable must be made official. Job descriptions may be enlarged only if nurses receive the necessary additional training and adequate work experience, the opportunity to consult a physician, jointly prepared working instructions and pay that corresponds to the enlarged scope of duty.

Any change in the division of duties will require further training for nurses. This training must be planned to allow for the prior work experience of the employee concerned. Further training must include adequate theoretical studies, practical training in the necessary skills and some verification that these skills have been mastered. Responsibility for planning this further training will be vested in university faculties of general medicine and nursing science in association with polytechnic social affairs and health departments.

The working hours of health centre physicians is currently being spent in duties that could be discontinued or naturally assigned to other vocational groups. Physicians spend an unreasonable amount of time writing certificates. Some of these certificates should be discontinued entirely and some should be assigned to other vocational groups. At the same time the transition to certificates prepared in electronic form should be accelerated, the structure of certificates should be simplified and a study should be conducted of how certificates may be transmitted electronically.

Recommendation 11

The Ministry of Social Affairs and Health and the Ministry of Education should take measures to review the division of duties and authorisation of physicians and nursing staff.

Allowance should be made for changes when developing training programmes. The need for revising the division of duties between other health care vocational groups should also be investigated.

The Ministry of Social Affairs and Health should work with other stakeholders to assess the need for medical certificates. Statutes and practices should be amended in so far as such certificates are unnecessary. Certification of short sick leaves (3 – 7 days) should be transferred to health care professionals or to the employee concerned in the manner agreed between employer and employee organisations.

3.4.3 Correctly dimensioned training

A rapidly worsening shortage of physicians is hampering both basic and specialised health care. The causes of this shortage lie in the training cuts made in the 1990s, in the early and semi-retirement of physicians, in the recruitment of physicians for occupations other than traditional medical work (in research and industry), in the feminisation of the medical profession, in the transfer of physicians to full-time work in the private sector and in the rapid increase in the number of public service positions for physicians in local authority health care[1]. Rectification of this labour shortage will require both correctly dimensioned training and improvements in working conditions.

The training of specialised physicians has recently been reformed. The first experiences of this reform suggest that the new regulations are creating significant operational problems in certain sectors (including paediatrics, internal diseases and surgery). The impact of the reform will be assessed and training regulations will be revised in the necessary respects.

According to the social welfare and health care sector labour requirement forecasting commission, there will be a need for dental nurses/assistants in

[1] In 1990 there were 3,200 public service positions for physicians working in local authority basic health care and 5,400 in local authority specialised health care. The corresponding figures in 2000 were 3,700 and 7,000 public service positions.

the near future due to the extension of access to social insurance compensation for dental treatment costs. The report of the oral health care development task force indicates that some of the current duties of dental surgeons could be assigned to dental nurses/assistants, who already have the necessary training. The development of dental surgeon training will be evaluated by the end of 2003, having regard to transfers of duties and regional needs.

The number of nursing staff qualifying during the 1990s exceeded the needs of public health care. Large numbers of nurses work outside of the health service and abroad. As the largest nursing staff age groups approach retiring age, however, an impending labour shortage has arisen. Shortages will occur in particular in geriatric care and in the outpatient and institutional care of psychiatric patients. There will also be a need for nursing staff in preventive health care of children, adults and the elderly.

A great deal of feedback has come from health care service units suggesting that the content of polytechnic health care training and the skills of graduates from these courses often fall short of the practical needs of working life. This criticism is supported by several investigations conducted in recent years.

The Ministry of Education will assess the need to revise polytechnic curricula and will harmonise these curricula so that the nursing science element may be discerned in terms of study weeks. There will be a considerable increase in the proportion of medical science subjects and compulsory attendance training. Clinical skills will be verified through well-guided practical training. Curriculum development work will be implemented through cooperation between the Ministry of Education, representatives of working life, the polytechnics and university faculties of health science. Guided practical training in real employment situations will be developed in association with representatives of working life and the polytechnics.

Polytechnic degrees in the social welfare and health care sector are designed to provide a basis for specialisation studies, further qualifications and university studies. Specialisation studies and opportunities to complete further qualifications will be added to meet the needs of basic and special health care services.

About 2,500 senior nurses and ward managers will reach retiring age during the decade from 2001 to 2010. The situation will be particularly difficult in the Helsinki Metropolitan Area, where master's degree programmes in nursing science were discontinued in the early 1990s. The polytechnics provide neither the formal competence nor the skills required for ward management. Training of ward managers is primarily arranged either as part of a health science master's degree programme or through s a further qualification to be taken after completing a health care sector polytechnic degree.

The training programme for district nurses became a three-year programme in 1999 and its content was also adjusted to correspond to the needs for

change and development in practical health care work. It has been estimated that the need for district nurses will increase, especially in institutional care of the elderly. This need will be affected by the division of duties between district nurses and dental nurses, mental health care workers and hospital nurses.

Recommendation 12

Faculties of medicine should increase their annual medical student enrolment from the present figure of 550 to 600 new students in 2002. Training of other vocational groups in the social welfare and health care sector should be increased in line with the trends outlined by the social welfare and health care sector labour requirement forecasting commission, having regard to the estimates of training needs of the national and regional training advisory boards (see recommendation 14).

The Ministry of Education should assess the impact of the recently implemented specialised physician training reform and should revise the statutes on specialised physician training as necessary.

The Ministry of Education should assess the need for guidance of polytechnic instruction in the social welfare and health care sector, and the means of effecting this guidance. The polytechnics should continue to harmonise health care sector studies with working life so that the content of training and the skills of graduates meet the needs of working life. Specialisation studies should be expanded to ensure clinical expertise.

The training of ward managers should be arranged either as part of a health science master's degree programme or through specialisation studies pursued after completing a polytechnic degree. Master's degree programmes in health science should be expanded from the present annual enrolment figure of about 230 students to 280 – 330 students. This training should begin in the Helsinki Metropolitan Area in 2003.

3.4.4 Other measures to alleviate the drawbacks of a shortage of medical staff

In 2001 there was a shortage of more than 300 physicians in basic health care and some 600 specialised physicians in specialised health care. The employment situation varies by geographical region and by specialism. Problem sectors include psychiatry, eye diseases, radiology, anaesthesiology and certain surgical specialisms. The most difficult situation is currently in basic health care. There are several health centres in Eastern and Northern Finland with no physicians at all, or where operations depend on a rapid turnover of locum physicians. There are also unfilled public service positions for health centre physicians in population growth centres. The general hospitals have a particular shortage of specialised physicians.

In the medium term the shortage of physicians can be rectified by increasing training, improving working conditions and improving the prospects of physicians for managing their own work. Immediate measures must also be taken to ensure a minimum standard of services in basic and specialised health care in all regions and specialisms.

The Ministry of Education is reviewing the Decrees governing further training of physicians in basic health care and specialisation training with a view to extending from six months to nine months the health centre service that follows completion of the basic degree. Section 4 of the Decree on Further Training in Basic Health Care (no. 1435 of 1993) will be revised so that a physician must serve as a health centre physician for no less than six months. Section 6 of the Decree on Qualification as a Specialised Physician (no. 678 of 1998) will be revised so that no less than six months of the training period must be performed in physician duties at a health centre. No more than three months of this period may be replaced by service at a health centre of the kind referred to in section 4 of the Decree on Further Training in Basic Health Care. These amendments will not extend the overall time needed to complete the qualification as a specialised physician. The amendments are expected to increase the number of health centre physicians by 70 –100.

A point will be added to the Decree on Qualification as a Specialised Physician specifying that no less than half of the training period, including the health centre service, must be performed at a health service operating centre other than a university hospital. After hearing the Ministry of Social Affairs and Health, the Ministry of Education may determine the training programmes for which it is expedient to deviate from the said period.

The proposed amendments will also be expedient from the point of view of the objectives of physician specialisation training. Familiarisation with the work of a general practitioner and the work of health centres is an important element in specialised physician training, and it promotes smooth co-operation between the basic health care and specialised health care services.

Working in other general hospitals in addition to university hospitals during the specialisation period improves the abilities of a specialised physician and diversifies the training.

The State pays imputed compensation to local authorities and joint municipal boards maintaining health service operating units for the costs incurred in medical research of university standard. This budget employs some 200 – 400 physicians annually in research work. Due to the severe shortage of physicians, EUR 8 million of the State compensation used for research will be transferred over a three-year period to State compensation intended to cover the costs incurred in training physicians and dental surgeons. This amendment is expected to increase the number of physicians working in the health service system by some 50 – 100. The current practice will be restored in 2006.

The State compensation intended to cover the costs incurred in training will be used to support the working conditions and training of young physicians working in health centres.

Recommendation 13

Section 4 of the Decree on Further Training in Basic Health Care (no. 1435 of 1993) should be revised during 2002 so that a physician must serve as a health centre physician for no less than six months. Section 6 of the Decree on Qualification as a Specialised Physician (no. 678 of 1998) should be revised so that no less than six months of the training period must be performed in physician duties at a health centre. No more than three months of this period may be replaced by service at a health centre of the kind referred to in section 4 of the Decree on Further Training in Basic Health Care. These amendments will not extend the overall training time.

A point should be added to section 6 of the Decree on Qualification as a Specialised Physician (no. 678 of 1998) specifying that no less than half of the training period, including the health centre service, must be performed at a health service operating centre other than a university hospital. After hearing the Ministry of Social Affairs and Health, the Ministry of Education may determine the training programmes for which it is expedient to deviate from the said period.

Over the period 2003 – 2005 the sum of EUR 8 million should be transferred from the State compensation intended for research activities referred to in sections 47 and 47b of the Specialised Health Care Services Act to the State compensation intended for training of physicians and dental surgeons. The current practice should be restored in 2006.

3.4.5 Co-ordination of training

The best way to co-ordinate the dimensioning and content of training in the social welfare and health care sector is to appoint a permanent advisory board to develop this kind of training, promote co-operation between training units, evaluate and predict the need for training, and monitor the labour market situation. The advisory board should include representatives from the Ministry of Education, the Ministry of Social Affairs and Health, the Ministry of Labour, the Ministry of Finance, the universities, the polytechnics and the municipal employers, and should have a permanent secretariat.

A regional advisory board is also needed in each university hospital special responsibility area, with members from the provincial administrative board, the universities, the polytechnics, local authorities, hospital districts, basic

health care, employment and economic development centres, and the private and third sectors. The function of these advisory boards will be to assess the regional need for training in the social welfare and health care sector and to attend to regional development of basic, further and supplementary training.

The national and regional advisory boards will work in close co-operation. The national advisory board will harmonise the needs of the regional advisory boards and will prepare recommendations based on these needs on matters such as the distribution of enrolment places at polytechnics.

Recommendation 14

By the end of 2002 the Council of State should appoint an advisory board for training in the social welfare and health care sector, which will co-ordinate the development of training in the said sector, promote co-operation between training units, and assess the need for training and its content. The Ministry of Education should appoint a regional advisory board for training in the social welfare and health care sector in each university hospital special responsibility area for the purpose of evaluating the regional need for training and developing the said training

3.4.6 Pay systems providing incentive

The State auditors have proposed the discontinuation of the special charges item for hospitals as it treats patients according to inequitable principles financially and may constitute an impediment to fair performance of treatment. Although the special charges item is part of the pay system for physicians, it also treats physicians in various ways. Only a rather small proportion of physicians are eligible to use the system and only a small number actually exercise this right. The physicians' pay system currently includes too few incentive factors.

The special charges item system will be gradually phased out. All physicians working in hospitals will be compensated for this discontinuation through the public service collective agreement. Physicians who are eligible for the special charges item will retain this right for the rest of their careers. No new special charges item rights will be granted after the matter has been settled as part of the collective agreement. At the same time as the special charges item is discontinued the incentive element of hospital physician pay will be developed.

As part of developing the incentive element in pay a system will be introduced in which hospital physicians may perform additional work (primarily polyclinic and day surgery work) in the service of local authority employers outside of their working hours proper. The costs of this may be borne by the local authorities, insurance companies, employers or the clients concerned. It will be a condition of applying the additional work system that the work performed during working hours proper remains efficient and productive.

Recommendation 15

The special charges item system for hospitals should be gradually phased out as part of the collective agreement for physicians, and should be replaced by the development of a pay system providing incentives and promoting the implementation of efficiency and productivity objectives for operations. A system should be developed as part of this work whereby hospital physicians may perform additional work for local authority employers outside of working hours proper.

3.5 CLIENT CHARGES

Charges are payable for most public health services in Finland. Client charges account for some 9 per cent of the overall costs of public health services. These charges have two objectives: to finance the service and to guide their use. While the financial impact of service charge revenues is minor, they constitute a major burden on some households and place a disproportionate strain on low-income clients. Client charges in Finland are higher than those of most other European countries.

From the point of view of the guidance function it is essential to impose and dimension client charges so that they guide the patient in seeking expedient care but do not prevent the use of services. At their most effective client charges can influence the initial approach when the patient has genuine freedom of choice. At later stages of the service process the decisions of physicians are decisive with respect to the use of services.

The charges policy commission set out the general principles governing client charges in the early 1990s and these were then included in the Act and the Decree on Client Charges in Social Welfare and Health Care. Since that time several individual modifications have been made in these charges. A client charge ceiling was introduced in the year 2000. The resulting body of rules and regulations has now become unclear both to the clients and to other concerned parties.

There are several charge ceilings in health care services. Aside from the family-specific charge ceiling in local authority social welfare and health care services, there are interim ceilings in health centre charges, in charges for serial treatment, and in short-term institutional care for persons under 18 years of age. There is an annual ceiling on rehabilitation travel costs paid by the Social Insurance Institution and in travelling and medicine costs paid by the sickness insurance scheme. From the point of view of the client there is good reason to combine these charge ceilings.

There will be a thorough reassessment of the objectives of the charging policy. The relationship between the charging policy and other social security and taxation will be specified, provisions governing charges will be clarified and charges will be made more transparent. At the same time there will be an investigation of the excess arrangements in sickness insurance and of how these relate to local authority charges for social welfare and health care services. The separate charge ceilings for local authority health care services will be combined. At the second stage the prospects for combining the charge ceilings for municipal health care services and the sickness insurance scheme will be investigated.

Recommendation 16

By the end of 2003 the Ministry of Social Affairs and Health, in collaboration with the Association of Finnish Local and Regional Authorities and the Ministry of Finance, should assess how the charging policy for social welfare and health care services can be used to support the objectives of health policy and to specify the relationship between charging policy and other social security. The charging system should be reformed by the year 2005 so as to form a single coherent system.

The Ministry of Social Affairs and Health should initiate preparatory work to combine charge ceilings for local authority health care services and investigative work on combining the charge ceilings for local authority health care services and the sickness insurance scheme.

3.6 HEALTH INSURANCE AND REHABILITATION

The principal financiers of health care are local authorities, the State, employers, the Social Insurance Institution and private households. Finnish Slot Machine Association funds are also disbursed as grants to public health organisations for preventive and rehabilitation work. This multi-channelled funding system is comprehensive and diversified. However, it hampers the guidance and co-ordination of services and may lead to distortions in service

provision. Funding as a whole becomes obscure and the system tends to encourage participants to shift expenses onto others.

The multi-channelled funding system leads to partial optimisation: savings are made in one's own costs by declining responsibility for overall expenses. Local authorities and service providers fail to allow for the additional welfare benefit costs arising from delays in treatment. Surgical procedures are not performed because the costs arising in alternative medication-based treatment are covered by sickness insurance. Local authorities fail to arrange institutional and outpatient care in an expedient manner when seeking to transfer costs to the Social Insurance Institution. No single party is willing to take responsibility for rehabilitation as a whole.

Over the last ten years the proportion of financing borne by the sickness insurance scheme administered by the Social Insurance Institution has risen from just over 10 per cent to the current level of 15 per cent. Medication compensation payments are forecast to rise by nearly EUR 1 billion by the year 2006. The costs of occupational health care, sickness benefits and travelling compensation have also increased. There have been no changes in compensation for physician fees and for the costs of examinations and treatment, but compensation for dental surgeon fees have increased as new age groups have become eligible for compensation.

There are certain problems in sickness insurance compensation. The system fosters inequities by social grouping and place of residence. Not all areas can provide private medical, examination or treatment services, and so compensation for these services in unevenly divided between various parts of Finland. Sickness insurance compensation may have an indirect negative impact on local authority health care. Support for the private sector during a shortage of physicians may encourage physicians to transfer from the public to the private sector, thereby further exacerbating the shortage of local authority physicians.

Compensation for medical examinations and treatment may give rise to overlapping capacity and perpetuate an inexpedient service provision structure. One recent cost investigation (Juva and Linnakko 2001) suggests that the cost of some laboratory tests now exceeds the true expenses involved in providing these services. A reduction in compensation for laboratory and other tests would release funds enabling other compensation to be increased to match current expense levels more closely.

The total cost of rehabilitation services in 2000 was approximately FIM 7.2 billion (EUR 1.2 billion). Real growth in this area since 1997 was 9 per cent. Rehabilitation services and their finances are administered by several organisations and there are no clear arrangements for co-ordination and guidance. This tends to obscure responsibility for the outcome of measures taken, for correct allocation and for cost-effectiveness. There is inadequate internal guidance for health care, which increases the inefficiency of operations. Responsibility for implementing rehabilitation measures is shifted in

an inexpedient manner from one administrative sector and financier to another.

Recommendation 17

The Ministry of Social Affairs and Health and the Social Insurance Institution should assess the impact of sickness insurance compensation and rehabilitation benefits from the point of view of public and private sector service provision (including psychotherapy and ophthalmology services and physiotherapy) and should allow for these in development work on the system.

The sickness insurance compensation payable for laboratory and imaging tests should be reduced by the end of 2002 to a level corresponding to the costs of providing such services in efficient operating units.

The Ministry of Social Affairs and Health and the Social Insurance Institution should develop the sickness insurance system so that compensation continues for cost-effective treatment and the system does not unnecessarily increase the use of costly but less effective treatment and examinations. Minor expenses should no longer be compensated.

3.7 HEALTH CARE FINANCING

The overall cost of health care in Finland in 2000 was FIM 51.8 billion (EUR 8.71 billion). The net outlays of the public health service amounted to FIM 38.9 billion (EUR 6.54 billion), of which the cost of in-patient care was FIM 19 billion (EUR 3.20 billion) and that of outpatient care FIM 12.0 billion (EUR 2.02 billion), medicines accounted for FIM 4.0 billion (EUR 0.67 billion) and other costs FIM 3.9 billion (EUR 0.66 billion). State financing of the total costs of health care in 2000 stood at 17.6 per cent, while local authorities covered 42.2 per cent, the Social Insurance Institution 15.4 per cent and domestic households 20.6 per cent. Other private sources of finance defrayed 4.3 per cent of the total.

Several factors will influence the development of health service outlays in the near future. By the year 2010 the number of people over 65 years of age will rise by about 15 per cent and those over 80 years by 24 per cent. Internal population movements will require a restructuring of some parts of the service system and it will be difficult to reduce the overcapacity remaining in depopulated areas. New technology will enable illnesses to be prevented and treated, and will improve operational capacity. Some of this technology will be costly, however, and will increase health service outlays. A rise in

wage costs of 5 per cent means an increase of about 0.2 percentage points in the proportion of GNP taken up by the health service.

There are also several factors that will tend to reduce the costs of the health service. The general health and operational capacity of the population is improving. Improved living conditions will retard growth in the need for services. Alternatives to institutional care continue to be developed. Some new technology is cheaper to use than previous approaches.

Health care outlays will be affected more by factors bearing on the supply of services than on the demand for them. Physicians will be in a key position for cost control. Most of the decisions affecting the costs of health care are made when the physician and the patient meet. Rational treatment practices are key issues in the cost development of the health service.

An effective service system of a high standard may be maintained only by systematically reforming service structures and continually improving operational efficiency. While rapid economic growth enables further resources to be allocated to health care, a sustained economic downturn or recession will require new cuts to be made.

3.7.1 Total health care funding requirement 2003 – 2010

In the course of this project an assessment has been made of the immediate need for further funding of the service system and of changes in its funding requirement by the year 2010. This assessment also allows for the savings that can be realised by developing and rationalising the service system in the manner outlined in this programme.

There is an immediate need for further resources in mental health outpatient care, in the care of intoxicant abusers, in certain specialised health care fields (cancer, orthopaedics, cardiology and eye diseases) and in basic health care. This immediate additional requirement is about EUR 175 million. The immediate further requirement for geriatric care is estimated at some EUR 170 million. Resources are also needed for service system development projects and for renovations to hospital and health centre buildings. These problems can be eliminated only if both the State and local authorities allocate significant additional resources to the health care system.

Various calculations have been made of the impact of the changing age structure of the population on the overall cost of social welfare and health care provision. In the course of this project it has been estimated that the ageing of the population will create additional expenses of some EUR 95 million per year over the period from 2003 to 2010. This figure includes EUR 23 million for specialised health care, EUR 23 million for basic health care, EUR 26 million for geriatric care, EUR 14 million for sickness insurance, and EUR 10 million for other items. The calculations do not allow for changes in labour costs or productivity.

Development measures will enable savings of 2 – 4 per cent in public health care. These rationalisation benefits may be gradually achieved within 3 to 5 years. Growth in medication expenses may be retarded by promoting rational medicine management and the use of cheaper generic products, and by developing a regional medication service. Savings of about EUR 100 million may be effected in both laboratory and imaging costs by transferring these to regional service provision units. Regional care programmes based on national recommendations, developing the division of duties and co-operation between operating units, continual training, quality systems and electronic case records will all reduce costs.

The most sustainable way to prevent costs from increasing is to reduce the incidence of illness and the need for care. The importance of maintaining functional capacity will rapid increase as the number of older people rises. It is by no means clear that the present improvement in the overall health and functional capacity of the population will continue. Preventing lifestyle-related illnesses and maintaining functional capacity will require further investment if the need for care and treatment is to be controlled.

The shortfall between health care opportunities and available resources will grow in future. Using the new and at least initially expensive technologies that are currently being developed it will be possible to cure several general illnesses for which there is currently no effective treatment (including many forms of cancer). If the rate of taxation cannot be increased, then there will be only two alternatives open to public health care: to prioritise functions or to reform the financial structure or mode of funding in a radical manner.

The principles to be applied in prioritising functions must be agreed between the public, politicians and health care professionals. Only in this way will it be possible for the local authorities responsible for service provision and health care professionals to comply with similar and jointly accepted principles when making choices.

3.7.2 Impact of national health care development project proposals on State and municipal finances

Ensuring the adequacy and stable development of the local authority financing base is essential to the organisation of health care services. The state of local authority finances as a whole has been fairly good in recent years. However, increased costs and an uncertain revenue base mean that local authority finances are forecast to worsen over the next few years. Municipal financial progress will be affected by the shift away from statutory State subsidies towards local income taxation and the transfer of tax revenue growth to municipal taxes that divide corporation tax more evenly.

The purpose of the statutory State subsidy system is to ensure that local authorities are able to maintain a sufficient standard of local services in various parts of Finland at a reasonable local taxation rate. The statutory State subsidy for imputed combined operating costs of services is different for

educational functions (57 per cent) and social welfare and health care provision (25 per cent). The State subsidy paid to local authorities through the statutory scheme is a general and unspecified grant which the local authority may decide to use as it sees fit. The legal status of the statutory State subsidy for the local authority is thereby similar to local taxation revenues.

The legislation governing statutory State subsidies prescribes that the division of costs between the State and local authorities must be maintained at the percentages stipulated in the law. Maintenance of this division is examined for the entire country every four years. The examination is used to revise the statutory State subsidy so as to restore the statutory division to the prescribed level as of the beginning of the year following the year of the inspection. The next four-yearly examination will take place in 2005. Statutory State subsidies are also revised annually to keep pace with changing costs.

Net outlays on local authority health care services in 2000 were about EUR 5 billion, of which in-patient care accounted for some EUR 3.1 billion and the cost of outpatient care was approximately EUR 2.0 billion. The combined statutory State subsidies for social welfare and health care services in 2002 will be EUR 2.5 billion, including an extra EUR 34 million in statutory State subsidies for operating costs of social welfare and health care services in the preceding year. In framework negotiations the government has agreed to an increase of EUR 104 million in the statutory State subsidy for social welfare and health care services in the State budget for 2003.

The immediate need for further resources in local authority health care has been estimated at approximately EUR 0.35 billion. Such an investment would significantly reduce the waiting times for surgical and other operations and the delays in cancer treatment, implement quality recommendations in mental health and geriatric care and develop basic health care services. A further EUR 50 million will be required each year over the period 2003 – 2007 to cover additional costs arising from the changing age structure of the population and an additional annual sum of EUR 50 million will be needed for costs arising from the introduction of new technology (including cancer treatment). The costs of in-service training for health care service staff will be EUR 40 million per year as of 2004 (see point 2.2.3). At the end of the period covered by the implementation of this programme it will be possible to achieve annual rationalisation savings of some 0.2 billion. The total need for additional resources compared to the current situation will thus be EUR 0.7 billion by the end of the period under review.

It is the understanding of the steering group for this project that sufficient additional resources must be allocated to municipal health care services over the period 2003 – 2007 that the recommended need for services is satisfied. Statutory State subsidies for local authority social welfare and health care service operating costs will be gradually increased, having regard to the foregoing immediate need for further resources and to growth in the need for services. This change will be allowed for in the cost division between

the State and local authorities by increasing the percentage of statutory State subsidies. The size of the latter increase will be decided after an assessment has been made of the financial situation of the local authorities and of implementation of the measures proposed in this programme.

Table 1 summarises the impact of implementing the national health care services development project on the State budget. The budgets pertaining to project financing for structural and operational development of the service system and to development of the working community in health care services, national treatment recommendations, rational medication, assessment of technology, information systems and electronic patient records have been justified in the earlier sections of this plan.

Table 1 National project to ensure the future of health care. Impact on the State budget of implementing the proposals involved in the project (additions to the level of the framework for 2003)*

Budget (EUR million)	**Year**				
	2003	2004	2005	2006	2007
Structural and operational development of the service system** – including regional information systems, support for structural changes, preparation of regional care programmes	8	30	30	30	30
Development of the working community (Ministry of Labour)	-	2	2	2	-
National treatment recommendations (Finnish Slot Machine Association)	1.4	1.4	1.4	1.4	1.4
Rational medication (National Agency for Medicines)	1.3	1.3	1.3	1.3	1.3
Assessment of technology (Finnish Office for Health Care Technology Assessment – FinOHTA)	-	0.5	1.0	1.5	2.5
Development of information systems and electronic patient records (National Research and Development Centre for Welfare and Health – Stakes)	0.8	0.8	0.8	-	-
Programme implementation (Ministry of Social Affairs and Health)	0.8	0.8	0.8	0.8	0.8

* Excluding proposals on statutory State subsidies to local authorities for social welfare and health care functions
** State assistance will be paid from the State aid budget supporting structural and operational development of the service system

Recommendation 18

Sufficient additional resources should be allocated to municipal health care services over the period 2003 – 2007 that the recommended need for services is satisfied. Statutory State subsidies for local authority social welfare and health care service operating costs should be gradually increased, having regard to the immediate need for further resources and to growth in the need for services. The financial condition of local authorities should be considered when deciding on statutory State subsidies. It should be a requirement when making this decision that implementation of the measures set out in this programme has begun.

The sum of EUR 8 million in 2003 and EUR 30 million per year over the period 2004 – 2007 should be allocated to support strategic and temporary structural and operational service system development projects.

3.8 IMPLEMENTATION OF THE PROGRAMME

The Ministry of Social Affairs and Health will co-ordinate implementation of this programme. For this purpose the Ministry of Social Affairs and Health will appoint a steering group with representatives from the Ministry of Finance, the Ministry of Education and the Association of Finnish Local and Regional Authorities. A monitoring group with representatives from labour market and professional organisations, hospital districts, basic health care services, social welfare services, the universities and polytechnics, and health care service providers in the private and third sectors will be appointed to support the steering group. An annual budget of EUR 0.8 million will be allocated for co-ordinating the project over the period 2003 – 2007.

Implementation of the programme will be evaluated annually when deciding on additions to the statutory State subsidy to local authorities for social welfare and health care service operating costs.

4. SUMMARY

The basis of Finnish health care provision is the constitutional right of the public to adequate social welfare and health care services. The principles of the system are funding from tax revenues and the obligations of the State to guide the system and of local authorities to arrange services. To date the system has functioned well. Basic health care provision and specialised treatment services arranged by the local authorities cover the whole of Finland. The staff are highly trained and committed to their work. The quality of services has been good and their availability has been at least reasonable.

The productivity of health care services improved considerably during the 1990s and is now at a high average standard. This improvement in efficiency of operations was based on a high standard of vocational skills, the voluntary principle and a very highly motivated staff. Some of the staff are currently working at the limits of their performance capacity.

The service system is subject to a great many pressures. The rising average age of the population increases the need for care and treatment. Rapid internal population migration will require part of the service system to be reconstructed. As the largest age bands of the population reach retiring age there will be shortages in all staff groups. New technology can help to improve the standard and efficiency of care and treatment. Some of this technology is costly, however, and so it is even more important that new technology is used in a controlled manner.

The objective of the development work described in this plan is to ensure the availability to all members of the public of health care services corresponding to their needs. The service system will be developed through co-operation between local authorities and the State, having regard to the operations of the private and third sectors. Patients will be guaranteed adequate access to information and opportunities to participate in making decisions that affect their lives. The reform will help to ensure the continuity, timeliness, safety and quality of services, to promote co-operation between various actors and to encourage cost-effectiveness.

Urgent treatment will be provided without delay. In all non-emergency cases the patient must receive a first assessment from a basic health care professional, usually a physician, within three days of the first contact, and a first assessment from a specialised health care physician within three weeks of issue of a referral.

Access to any medically justified or otherwise necessary treatment measures must be secured within the period stipulated in the national treatment recommendations or otherwise within a reasonable time based on the evidence in the case, and normally within a period of three months but not exceeding

six months. If treatment cannot be provided within the time limit at a facility maintained by the local authority or joint municipal boards, then the treatment must be procured from another service provider at no extra charge to the patient.

The principle that access to treatment must occur within a reasonable time of verifying the need for such treatment, and that in order to promote the more equitable availability of health care services, provisions may be issued by a Decree of the Council of State concerning the maximum periods for access to a medical examination and treatment will be included in legislation on specialised health care, public health and mental health services.

Basic health care services will be arranged as regional functional units generally serving a catchment population of about 20,000 to 30,000 residents and providing operating conditions for some 12 to 18 physicians. The network of operating points will allow for local conditions, population density and distances. Mental health outpatient services, psychosocial services, services for intoxicant abusers and associated emergency services will be organised as a functional regional unit in association with the private and third sectors. Geriatric care services will be arranged together with social service functions mainly as a local residential service.

Functional co-operation and the division of duties in specialised health care will be implemented by special responsibility areas. Hospital districts will prepare plans by special responsibility area for developing co-operation and the division of duties for submission to the Ministry of Social Affairs and Health. Co-operation may be implemented either by combining hospital districts or within the framework of existing hospital districts. The Ministry of Social Affairs and Health will consider these plans and grant project funding for their implementation as necessary. Regional hospitals will form health service areas together with basic health care units in their areas or will serve as part of the general hospital in their area.

Laboratory and imaging functions will shift to a regional system, the use of municipal commercial institutions, and utilisation of the latest information technology. The sickness insurance compensation payable for laboratory and imaging tests will be adjusted to a level corresponding to the actual costs of providing such services. Sickness insurance compensation practices will also be revised so that they compensate on uniform grounds for well-founded patient examinations and treatment implemented on the same diagnosis as in local authority health care.

National electronic patient records will be introduced. The preparation of national treatment recommendations and regional treatment programmes will continue and their application in practice will be enhanced. Existing data on effectiveness will also be used in rehabilitation work.

Additional resources will be directed towards geriatric care, health care in the home and mental health work, basic health care services and certain

fields of specialised health care. The stability and predictability of local authority funding will be improved. The regulations on client charges and charge ceilings will be reformed.

The service system will be developed through programme work for which project funding will be allocated in the State budget. Reforms will be implemented by the end of 2007. Project funding will be allocated to regional organisation of local services, development of a division of duties between hospital districts, and support for solutions following their functional and administrative combination. The development and implementation of a national system of electronic patient records, the Käypä Hoito project to standardise treatment methods and the Rohto project seeking to promote the rational use of pharmaceutical products will be supported.

Faculties of medicine should increase their annual medical student enrolment from the present figure of 550 to 600 new students in 2002. Training of other vocational groups in the social welfare and health care sector should be increased in line with the trends outlined by the social welfare and health care sector labour requirement forecasting commission, having regard to the estimates of training needs of the national and regional training advisory boards

In-service training will be arranged for staff, taking an average of 3 – 10 days depending on the length of basic training. The employer will be responsible for the costs of such in-service training. For this purpose an increase of EUR 10 million will be made in the annual statutory State subsidy to local authority health care services. Health care service management will be improved by arranging a multi-vocational health care service management training programme.

The State will encourage the social partners to embark on negotiations to develop an incentive pay scheme with a view to allowing for productive work in pay arrangements for the health care sector. The special charges item system will be gradually phased out.

Several measures will be implemented to alleviate the problems caused by a shortage of physicians. The Ministry of Education will revise the Decrees governing further training of physicians in basic health care and specialisation training with a view to extending to nine months the health centre service that follows completion of the basic degree. The whole of further training in basic health care will have to be performed at a health centre. 3 months of this further training may be accepted as part of specialisation training. No less than half of the specialisation training period will have to be performed at a health service operating centre other than a university hospital. These changes will not extend the overall training period. Over the period 2003 – 2005 the sum of EUR 8 million will be transferred from the State compensation intended for research activities referred to in the Act on Specialised Medical Care to the State compensation intended for training of physicians and dental surgeons.

Statutory State subsidies for local authority social welfare and health care service operating costs will be gradually increased, having regard to the immediate need for further resources and to growth in the need for services. This change will be allowed for in the cost division between the State and local authorities by increasing the percentage of statutory State subsidies. The size of the latter increase will be decided after an assessment has been made of the financial situation of the local authorities and of implementation of the measures proposed in this programme.

The Ministry of Social Affairs and Health will co-ordinate implementation of the programme and will appoint a steering group to monitor the implementation of the project.