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Decision in Principle by

the Council of State on securing the future of health care

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Decision in Principle by the Council of State on securing the future of health care

According to the Constitution, the state must, according to what is prescribed in greater detail by law, ensure sufficient social welfare and health care services for all and promote the health of the population. According to legislation, the responsibility for arranging services lies mainly with the municipalities.

Arranging health care services is one of the main tasks of municipalities. The state is responsible for the direction of health policy and the general operational framework.

In recent years, there have been growing problems in the operational framework for and availability of services, and this is something which must be addressed. For this reason, the Council of State initiated a national project to ensure the future of health care on 13 September 2001. Based on the health-related needs of the population, the aim of the project is to ensure the availability, quality and sufficiency of care in the various parts of the country, irrespective of the residents' ability to pay.

The service system is being developed in cooperation between the municipalities and the state, taking into consideration the operations of the private and third sector. In order to ensure the practicality of the service systems, the Council of State has decided upon the following measures:

1. Viable primary health care and preventive work

Sufficiently resourced and viable primary health care is the foundation of the entire health care system. Preventive work is one of the paramount duties of primary health care, which together with the responsibility of the public for their own health and

healthy habits, inhibits the rise in demand for services and redirects the need for services towards less demanding, more outpatient-orientated forms of treatment. The government has previously issued a statement concerning measures to promote health in the Health 2015 programme. The Council of State implements and promotes action by which it is possible to reduce substance abuse and the overload on the service system caused by such abuse as well as the existence of the most widespread illnesses and the need for treatment arising from these.

2. Ensuring access to treatment

In order to decrease differences in the criteria for access to treatment, the Ministry of Social Affairs and Health, together with the Association of Finnish Local and Regional Authorities, is preparing nationwide guidelines for non-urgent treatment and queue management to be implemented by the end of 2003. The preparation work is based on the following considerations:

- Access to an initial assessment by a primary health care professional, normally a physician, within three days of contacting the service.
- Access to an assessment by an outpatient department of a specialised health care unit must be arranged within three weeks of the issue of a referral.
- Access to medically justified treatment within a reasonable period specified in the nationwide treatment recommendations or otherwise warranted by the available evidence, which should normally be within three and no later than in six months.
- If treatment cannot be provided at a facility maintained by the local authority or federation of municipalities within the time specified, treatment must be procured from another service provider at no extra charge to the patient.

The principle of access to treatment within a reasonable period will be embodied in legislation by the

year 2005. The Ministry of Social Affairs and Health will more specifically guide access to non-urgent treatment through decrees and directives that will come into force on 1 January 2005.

3. Ensuring the availability and expertise of personnel

As of the beginning of 2002, the number of new places for students of medicine will be boosted from 550 to 600. Training for other health care personnel will be increased according to the guidelines of the Committee on Estimation of Labour Demand in Social Welfare and Health Care (Committee Report 2001:7, Ministry of Social Affairs and Health), and taking specific regional needs into consideration.

The Ministry of Education will revise the decrees concerning the further education in primary health care and specialised education of physicians as well as similar decrees applying to dentists, so that the education following each primary physician's or dentist's first degree would include a period of at least nine months' practical work as a physician or dentist at a health centre. At least half of the specialised education should be carried out somewhere other than a university hospital. During 2003–2005, pursuant to sections 47 and 47 b of the Act on Specialised Medical Care, EUR 8 million will be transferred from the government indemnity on research activity to the government indemnity on medical and dentistry education. Present practices will be restored in 2006.

In-service training for personnel will be arranged which, depending on the length of the basic education, on how demanding the work is and on changes to the job description, will average 3–10 days a year. The management of health care will be enhanced by arranging a multi-professional management education programme for the health care sector, no later than 2005, at universities providing medical and health education. Together with the Ministry

of Social Affairs and Health and the Association of Finnish Local and Regional Authorities, the universities will be responsible for the contents of the education. The employer will be responsible for the costs of in-service training. Health centres and hospitals must ensure that the training subsidy for health care professionals allocated by the pharmaceutical industry and other corporations is channelled to units that decide how the support is to be allocated rather than to individuals.

The state will promote discussions between organisations of trade unions and employers on the development of bonuses for results with the aim of factoring productive work inputs into wage-related solutions in the health care sector.

The system of special payment categories is being abolished by degrees. Section 9 of the Act on Client Fees for Social Welfare and Health Care will be annulled and the state will promote the development of an incentive system to replace it in connection with the abolition of the special payment category. If a hospital meets the criteria for access to treatment referred to in paragraph 2 above, the hospital district may buy in such outpatient and day-surgery services as additional work from its own personnel after the actual working hours, which will be paid for by other parties than the home municipality of the patient, e.g., employers, insurance companies and the patients themselves.

4. The reform of functions and structures

Primary health care is organised as regional, operational entities. The recommended population base is 20,000 – 30,000 inhabitants and units structured in this way have 12–18 physicians. When configurations are formed it is, however, necessary to take regional differences into consideration and to ensure the operations of smaller but efficient units. When formulating the network of operational units, attention is paid to the fact that distances should not be a hindrance to using services.

Mental-health outpatient services, psychosocial services, services for substance abusers and associated emergency services should be arranged as an operational regional unit in association with the private and third sectors.

Operational cooperation and the division of work in specialised health care will be carried out according to specific spheres of responsibility. Methods for joint procurement of medicines and materials are still under development. Emergency services are being rationalised. During 2003, the Ministry of Social Affairs and Health will introduce a decree to be implemented nationwide on research and treatment and according to spheres of specific responsibility. The hospital districts will enter into agreements regarding cooperation, amalgamate or form health care districts. In order to develop cooperation and the distribution of work, by 31 May 2003 the hospital districts in specific spheres of responsibility should submit a plan the to Ministry of Social Affairs and Health in respect of demanding treatment that can be planned in advance, operating teams for small numbers of patients, treatment services and support services. The cooperation can be implemented either by combining hospital districts or within the framework of existing hospital districts. The Ministry of Social Affairs and Health will process the plans and allocate funds for projects where necessary. If the plans do not lead to appropriate solutions from the operational viewpoint, the hospital districts may be obliged to take action by legislative amendments. District hospitals will form health care districts together with the primary health care units in their areas or will operate as part of the central hospital in their area.

In laboratory and imaging operations, there will be a changeover to units formed out of one or more hospital districts, and municipal enterprises and state-of-the-art technology will be utilised. The principles for the determination of sickness insurance compensation for laboratory and imaging examinations in the private sector will be reduced to the level of the

production costs of the most efficient units by the end of 2002.

Nationwide 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, so that the increase in efficiency will achieve rationalisation-related benefits. Existing data on efficiency will also be put to use in rehabilitation work. The rationalisation of prescriptions and medicine use will be promoted by supporting the Rohto project which is being carried out for this purpose. The projects to reform the operations and structures mentioned above will be completed by the end of 2007 and it is estimated that, with their help, it will be possible to achieve savings of EUR 0.2 billion a year.

5. Augmenting the finances of health care

As of 2003, state subsidies for social welfare and health care allocated to the municipalities will be increased by EUR 104 million a year in accordance with decisions made in government framework negotiations. According to the project, the need for additional funding is a result of the increased demand for services caused by the change in the age structure of the population, the introduction of new technology, and the additional costs arising from attaining the standards required by in-service training and quality recommendations.

Providing that the reform of operations and structures has got under way as proposed, the state subsidies allocated for municipal social welfare and health care and their percentage value will be gradually increased to permit the attainment of the aforementioned aims. The stability and predictability of municipal financing will be improved. Regulations on client fees and the payment ceiling will be reformed.

The elimination of queues for examinations and treatment is being discussed by the state, the Association

of Finnish Local and Regional Authorities and the hospital districts. State grants will be disbursed for the abolition of queues on the basis of these negotiations. The necessary amount of additional grants will be decided on the basis of a separate study.

The service system is being developed as programme work advancing in stages, for which EUR 8 million will be allocated in next year's budget and from 2004 to 2007 a project allocation of EUR 30 million annually. The operational and structural reforms proposed in the projects will have been implemented by the end of 2007. Project funding will be allocated for the regional provision of services, the development of the division of work between hospital districts, and supporting the solutions following their operational and administrative amalgamation. Discussions concerning the division of work between hospital districts are being held according to the specific sphere of responsibility.

In addition to the project funding, the state supports the development and introduction of national electronic patient records with separate funding amounting to EUR 0.8 million and the Current Care (EBM) and Medicine projects with EUR 1.4 million and EUR 1.3 million annually in the period 2003–2007. Financing for a unit for the evaluation of health care methods will be boosted to EUR 2.5 million by 2007.

6. Implementation of the proposals for the project

A management group appointed by the Ministry of Social Affairs and Health will be formed to carry out the project. The Ministry of Social Affairs and Health will coordinate the implementation of the programme. For this purpose, a grant of EUR 0.3 million will be allocated for 2002 and an annual grant of EUR 0.8 million for the period 2003–2007.

National project to secure the future of health care

Preamble

In September 2001, the Council of State declared a national project to secure the future of health care. The mission of the project was to evaluate the existing problems of the service system and those threatening it as well as to prepare a plan and programme of action to eliminate the problems.

A project **management group** was appointed, chaired by *Markku Lehto*, Permanent Secretary at the Ministry of Social Affairs and Health. 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 Hospital District of Central Finland and Special Investigator and Director General *Jussi Huttunen* of the National Public Health Institute of Finland. Ministerial Counsellor, Health/Medical Affairs *Jouko Isolauri* of the Ministry of Social Affairs and Health served as secretary to the management group.

Four pairs of administrators and one trustee were appointed for the project, all of whom were assisted by their own support groups.

The reform of the operational and administrative structures of the service system and improvements in efficiency and productivity were considered by Hospital District Director *Rauno Ihalainen* of Pirkanmaa Hospital District and Professor *Mats Brommels* of the University of Helsinki.

The need for labour and division of duties and the improvement of working conditions and in-service training were considered by *Matti Uusitupa*, Dean of the University of Kuopio, and Chief Health Care Officer *Riitta Simoila* of the City of Helsinki Health Department.

The level and stability of health care financing as well as sources of finance and the improvement of the guidance system were considered by Director-General *Jussi Huttunen* of the National Public Health Institute.

The development of the division of labour and cooperation in the public health care, private and third sectors were considered by Hospital District Director *Pentti Silvola* of the Northern Ostrobothnian Hospital District and Executive Director *Hannele Kalske* of the Rheumatism Foundation Hospital.

The consolidation of treatment practices and improvement of access to treatment were considered by Professor *Marjukka Mäkelä* of the National Research and Development Centre for Welfare and Health Stakes and Chief Physician *Leena Niinistö* of the Katariina Hospital.

The project administrators and their support groups handed in their interim report in January 2002. On the basis of this, the project management group submitted its final proposals to secure the future of health care in April 2002. The Council of State issued a decision in principle on the matter also in April 2002. The aim of the decision in principle is to develop health services as cooperation between the municipalities and the state so that the activities of NGOs and the private sector are also taken into consideration. In this way it is possible to ensure that the population receives the high-quality care that it needs in different parts of the country in such a way that the provision of treatment is not dependent on the recipient's ability to pay.

Health care reforms being implemented in cooperation

The implementation of the decision in principle is being continued with the aid of previously started projects and by launching new development projects in various

parts of the country. The attainment of results demands broad and varied collaboration, not only the management of the project by also in monitoring and in practical operations.

The key spheres of development are concerned with health promotion and preventive work, ensuring access to treatment, staff availability and the improvement of skills, reforming health care functions and structures, and reinforcing financing. This is a question of a national reform, to which all parties will be invited. The project will be carried out under the guidance of the manage-ment group in close collaboration with the Ministry of Social Affairs and Health, other ministries and the Association of Finnish Local and Regional Authorities.

The Ministry of Social Affairs and Health has appointed a management group and follow-up group for the project as well as a committee examining access to treatment and queue management. Many of the targets set in the decision in principle are being worked on by unofficial teams of experts.

The management group for the project to secure the future of health care

The management group approves the project's action plan to implement the decision in principle, and it monitors and assesses the implementation of the decision in principle of the Council of State. When required to do so, it also makes proposals on such continuing actions as are not included in the decision in principle of the Council of State but which are required to ensure health care for the population. Permanent Secretary *Markku Lehto* of the Ministry of Social Affairs and Health serves as the chairman of the management group.

The follow-up group for securing the future of health care

There is also a follow-up group for the project. The duty of this group is to promote a dialogue between health care and its stakeholders for the improvement of health services, to pass on information on the goals of the decision in principle made by the Council of State and on their implementation, to monitor and assess the progress of implementation, and when necessary to make proposals on changes and improvements in connection with implementation.

The follow-up group must take into consideration in its work, for example, the implementation of the action programme Health care for the 21st Century, the results of the Meaningful Life programme, the Council of State's decision in principle on the Health 2015 public health programme, and the objectives and action programme to be drawn up for social affairs and health care in the period 2004–2007. Deputy Director General *Marjatta Blanco Sequeiros* of the Ministry of Social Affairs and Health chairs the follow-up group.

Three days – three weeks – three months

The ultimate goal for securing the future of health care is for the patient to have access to treatment as quickly as possible and to receive the best possible treatment, regardless of his or her financial position or where he or she lives. The decision in principle of the Council of State requires the Ministry of Social Affairs and Health to prepare, in collaboration with the Association of Finnish Local and Regional Authorities, guidelines for the implementation of nationwide non-urgent treatment and queue management by the end of 2003. The ministry has appointed a committee to examine

queue management and access to treatment. The mission of the committee is to draft proposals on general principles concerning access to treatment, the criteria of the system for assessing the need for treatment, the principles of queue management, and necessary proposals for amendments to legislation.

The basic premises of preparation are access to preliminary assessment of health within three days of contacting the service, access to outpatient assessment by a specialist within three weeks of referral, and access to medically justified treatment assured within the time specified by the nationwide treatment recommendation or within a reasonable time based on other evidence, usually within three months and in no more than six months. The chairman of the committee is Professor *Mats Brommels* of the University of Helsinki.

The financing of health care is being reinforced

The state grants for municipalities' social welfare and health care will be increased as of 2003. In health care, additional money is required because of, for example, the increased demand for services due to the ageing population, the adoption of new technology, in-service training, and the implementation of service quality recommendations. In 2003 state grants will be increased by a total of EUR 223 million. Of this, a total of EUR 57 million will be spent on the project to secure the future of health care.*

In addition, a number of appropriations are proposed for the project to secure the future of health care. These include allocations to developing the service system (EUR 8 million for municipalities), the Current care -project (EBM) (EUR 1.4 million), establishing a pharmaceutical treatment development centre (EUR 1.3 million), developing electronic patient records

(EUR 0.8 million), and for personnel resources associated with implementing the project (EUR 0.8 million).*

(* Government proposal for the state budget for 2003.)

State aid for eliminating queues for treatment

In July 2002, the Council of State granted 25 million euros in state aid for eliminating queues for examination and treatment. All hospital districts applied for the aid in the maximum amount, and it was granted to them all.

The state aid has to be used in its entirety on costs arising from hospital districts' elimination of queues for examination and treatment. It cannot be used to cover normal activities included in the hospital districts' financial and action plan. One fourth of the state aid received must be used for eliminating queues for outpatient examinations and for examinations and treatment, and three quarters must be devoted to eliminating queues for surgery and treatment. Part of the allocation to be used for eliminating outpatient queues must be used to support community care services for psychiatric patients and mental health care rehabilitation. The state aid must be used by the end of 2003.

Hospital districts must agree with their constituent municipalities that they will pay half, in respect of the services purchased or produced with the state aid, of what their share of payment would have been under the terms of payment normally applied by the hospital district.

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Facts about Finland

Area	338,145 km^2
Inhabitants	5.2 million
Life expectancy	78 years
Currency	euro/EUR (USD=0.8956, average rate)
Gross domestic product at current prices	EUR 26,033 /inhabitant
Wage-earners' average monthly pay	for regular hours of work EUR 2,142
President	elected every 6th year
Parliament	200 MPs, elected every 4th year
Government	13 ministries
Regional government	5 Provinces plus the autonomous Province of Åland Islands
Local government	448 municipalities (in 2002, largest 560,000 inhabitants, smallest 128 inhabitants)

A few words about the Finnish public health care system

Primary Health Care

The responsibility for organizing health care in Finland lies with the local authority municipalities across the country. These can either provide primary health care services independently or join with the neighbouring municipalities in joint municipal boards which set up joint health centre. They can also buy in health care services from other municipalities or the private sector. There are altogether about 270 health centres in Finland (2002 figure). Each health centre can have several units.

Health services are funded mainly from taxation revenue, partly from local taxation and partly from central governments grants. The central government contribution to municipal social welfare and health care expenditure is determined by the population, age structure and morbidity of the municipality plus a number of other computational factors. Around 10 per cent of public health care costs are covered by customer charges.

Specialist Medical Care

The local authorities are responsible for organizing specialist medical care for residents of the municipality. To this end, the country is divided into 20 hospital districts. Each hospital district has a central hospital, five of which are university hospitals. Each municipality must belong to one or other of the hospital districts. The hospital district organize and provide specialist medical services for the population of their area.

Private Health Care

Public health provision is supplemented by private health care services. They are concentrated primarily in the larger municipalities. Less than 10 per cent of physicians work exclusively in the private sector, but many public health service doctors hold private surgeries outside their regular working hours. There are also a few private hospitals in Finland.

Patients can reclaim part of the fees charged by private doctors from the national health insurance system; a similar system also applies to private dental charges.

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