Reports and Memorandums of the Ministry of Social Affairs and Health 2016:66

Agnes Couffinhal, Jonathan Cylus, Riku Elovainio, Josep Figueras, Patrick Jeurissen, Martin McKee, Peter Smith, Sarah Thomson and Ulrika Winblad

International expert panel pre- review of health and social care reform in Finland

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Title of report

International expert panel pre- review of health and social care reform in Finland

Summary

■ The Ministry of Social Affairs and Health invited the European Observatory on Health Systems and Policies to organize a panel of international experts to provide an evidence-informed pre-review of proposed comprehensive health and social care reform measures in Finland. The panel consists of high level experts from the Observatory, WHO Regional Office for Europe, OECD and academic institutions. The review has four broad aims:

- To review the objectives of the reform proposals
- To assess the expected impact of reform proposals by analyzing the strategies for reform and drawing on experience with similar reforms elsewhere in relevant countries
- To identify prerequisites to enable effective reform implementation
- To provide possible recommendations to adjust reform proposals in light of the results of the analysis.

The international panel carried out two workshops in July and September 2016 to meet with over 50 experts and stakeholders in Finland, and also reviewed a range of technical documents. The panel presented its preliminary observations in October 2016 to the Ministry and key stakeholders. During the work of the panel the draft legislation for health and social care reform was sent for public consultation and the legislation for freedom of choice was under preparation. The panel's observations on the expected impact of the reforms and prerequisites for success are based on evidence-based expert opinions derived from the panel's professional experiences, analysis of international evidence and understanding of the Finnish proposals.

Key words

health and social care reform, pre-review, Finland

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KUVAILULEHTI

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Muistion nimi

Kansainvälisen arviointipaneelin ennakkoarviointi Suomen sote-uudistuksesta

Tiivistelmä

■ Sosiaali- ja terveysministeriö antoi tehtäväksi European Observatory on Health Systems and Policies -organisaatiolle Suomen sosiaali- ja terveydenhuoltouudistuksen näyttöpohjaisen ennakkoarvioinnin. Tätä varten asetettiin kansainvälinen asiantuntijapaneeli, joka koostui korkean tason asiantuntijoista Observatorysta, WHO:n Euroopan toimistosta, OECD:sta ja alan tutkimuslaitoksista.

Arvioinnilla on neljä laajaa tavoitetta:

- Arvioida ehdotetun uudistuksen tavoitteita
- Arvioida uudistuksen odotettuja vaikutuksia analysoimalla uudistuksen strategisia valintoja sekä kokemuksia muiden vastaavien maiden uudistuksista.
- Identifioda uudistuksen tehokkaan toimeenpanon edellytyksiä
- Analyysin tulosten perusteella antaa mahdollisia suosituksia ehdotuksen tarkistamisesta.

Kansainvälinen paneeli haastatteli yli 50 suomalaista asiantuntijaa kahdessa työpajassa kesäkuussa ja syyskuussa 2016 sekä analysoi asiakirjoja. Lokakuussa 2016 paneeli esitteli ministeriölle ja keskeisille toimijoille alustavat havaintonsa, joista keskusteltiin. Paneelin työskentely ajoittui ajankohtaan, jolloin lakiluonnokset sosiaali- ja terveydenhuollon uudistuksesta ja maakuntauudistuksesta julkaistiin ja lausuntokierros alkoi, ja sosiaali- ja terveydenhuollon valinnanvapauslainsäädäntö oli valmisteilla. Paneelin huomiot odotettavissa olevista vaikutuksista perustuvat paneelin asiantuntijanäkemykseen, kansainväliseen tutkimuskirjallisuuteen sekä ehdotetun uudistuksen ymmärrykseen.

Asiasanat

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PRESENTATIONSBLAD

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Författare	**Uppdragsgivare**
Agnes Couffinhal, Jonathan Cylus, Riku Elovainio, Josep Figueras, Patrick Jeurissen, Martin McKee, Peter Smith, Sarah Thomson och Ulrika Winblad.	Social- och hälsovårdsministeriet
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Rapportens titel

En internationell expertpanels förhandsbedömning av social- och hälsovårdsreformen i Finland

Referat

■ Social- och hälsovårdsministeriet har gett organisationen European Observatory on Health Systems and Policies i uppgift att göra en evidensbaserad förhandsbedömning av social- och hälsovårdsreformen i Finland. För detta syfte tillsattes en internationell expertpanel som bestod av en högnivågrupp med deltagare från Observatory, Världshälsoorganisationens europakontor, OECD och forskningsinstitut inom branschen.

Bedömningen har fyra omfattande mål:

- Att bedöma målen för den föreslagna reformen
- Att bedöma de förväntade konsekvenserna av reformen genom att analysera de strategiska valen i reformen och erfarenheter av motsvarande reformer i andra länder
- Att identifiera förutsättningarna för att genomföra reformen effektivt
- Att utifrån analysen ge eventuella rekommendationer kring en revidering av förslaget.

En internationell panel intervjuade över 50 finländska experter i två workshoppar i juni och september 2016, och panelen analyserade även handlingar. I oktober 2016 presenterade panelen sina preliminära iakttagelser för ministeriet och de centrala aktörerna, och dessa diskuterades. Panelens arbete inföll vid den tidpunkt då lagutkasten i anslutning till social- och hälsovårdsreformen och landskapsreformen offentliggjordes, remissförfarandet inleddes och lagstiftningen om valfrihet inom social- och hälsovården var under beredning. Panelens anmärkningar om de förväntade konsekvenserna baserar sig på panelens expertåsikter, internationell forskningslitteratur och förståelsen för den föreslagna reformen.

Nyckelord

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SOCIAL- OCH HÄLSOVÅRDSMINISTERIET

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EXECUTIVE SUMMARY

The Ministry of Social Affairs and Health invited the European Observatory on Health Systems and Policies to organize a panel of international experts to provide an evidence-informed pre-review of health and social care reform proposals in Finland. The international panel was composed of experts from the Observatory, World Health Organization Regional Office for Europe, Organization for Economic Cooperation and Development and key academic institutions.

The review is based on expert consensus opinions derived from the panel's international experience and the assessment of the reform proposals. The panelists carried out two country visits in July and September 2016, met with a range of experts and stakeholders and reviewed selected documentation on the reforms. The report considers reform proposals up to 10th October 2016. This preliminary review constitutes the first phase of a more comprehensive reform monitoring and evaluation exercise that is scheduled to take place over the next years following the implementation program.

Reform Challenges, Objectives and Proposals

The Finnish health and social care system performs well in many respects; however, there is clear scope for improvements and there is a broad consensus about the need for reform. The system relies on municipalities, sometimes with very small populations, to provide health and social care services. While it has yielded many positive results, there are inequities and problems with access to and effectiveness of services. Unmet needs are higher than in other Nordic countries with 3.1% (2014) of the population reporting problems accessing services due to high waiting times particularly for specialist and primary care and social services. Those with access to occupational health services can access GP services comparatively more quickly than the general population. Out-of-pocket spending is also quite high for the Nordic region, at 19.1% (2015) of total expenditure. There is also evidence of inefficiencies particularly with the provision of health and social care for patients with chronic needs. These problems are caused in part by the limited managerial capacity and expertise in many, particularly small, municipalities. Moreover, municipalities vary in their revenue raising potential and have considerable discretion in terms of the services they cover. In addition, in many instances public sector providers do not have adequate incentives to be responsive and innovate.

One other major challenge that has triggered reforms in Finland is concerns about high health expenditure and the fiscal sustainability of the health systems, even though the current level of expenditure at 9.6% of GDP (2015) is only slightly above the EU average. While, as elsewhere, this concern stems from ageing and technology pressures, it is also due to broad fiscal constraints together with deficit reduction targets that go beyond the health and social care sectors.

The health and social care reform proposals aim, therefore, to improve equity, access and effectiveness of health and social care services while ensuring efficiency gains and containing costs. An overarching goal of the reforms is to curb expenditure growth through cost savings. More specifically, the government has established a target of 3 billion savings by 2029 to eliminate the so-called public sector sustainability gap. A number of the proposed reform strategies have been under debate for several years and command broad consensus among key stakeholders while

other more recent ones are deemed to be more controversial. However, there is general agreement that a system-wide health reform has been long overdue in Finland.

The review focuses on the five most relevant reform areas identified by the panelists; the first four constitute the central pillars of the new reform program, and the fifth while also key to the reform success is more horizontal or cross sectional in nature as it functions primarily to support and enable the implementation of the others. These five areas are:

i. Counties as organizers and purchasers of health and social care;
ii. Introduction of provider competition and freedom of choice;
iii. Integration of health and social care services within counties;
iv. Strengthening public health at the county level; and
v. Reinforcing governance, regulation and information systems.

On the whole, this review finds that the proposals have great potential to reduce inequalities, improve efficiency and curb expenditure growth in the long run; however, if the reforms are to be successful policy makers will need to address a series of issues and meet a number of prerequisites for implementation.

Key reform issues and prerequisites

1. The role of the county as organizer and purchaser

Under the reform proposals 18 newly formed counties will take responsibility from the municipalities for organizing and purchasing health and social services on behalf of their populations. Funds will flow primarily from central government to counties based on a needs-based resource allocation formula. Among all the proposed reforms this one has the highest potential for impact, commands broad consensus and has top implementation priority.

- ***Centralizing the organization and financing of health and social care at county level should help to improve efficiency and equity through strategic purchasing, economies of scale and increased leverage over allocation of resources and care delivery.*** Counties will have the ability to allocate resources between geographic areas and among services according to health and social care needs. In the same way, they will be able to exercise leverage over providers and improve coordination between sectors and levels of care through prospective contracts and payment incentives. To realize this potential, it will be essential for counties to move from passive forms of purchasing – the mere reimbursement of providers – to more proactive and strategic forms of purchasing that consider which interventions should be purchased, how they should be purchased and (within the freedom of choice scheme) from whom.

- ***To strengthen strategic purchasing capacity, counties will need to build technical skills and infrastructure, with a particular focus on information systems.*** Purchasing requires a great deal of technical skills and capacity. Additionally, high quality data in particular are required to assess the health needs of populations, cost the current patterns of service provision and measure the quality of services. Data are also necessary to set up appropri-

ate contracting and payment systems. Finland still faces a dearth of information when it comes to measuring the performance of individual providers including the quality and costs of service provision. This represents a true barrier to the development of contracting, monitoring and performance evaluation.

- ***Conducting health and social needs assessment at county level is of high priority.*** Needs assessment is a key prerequisite for strategic purchasing to ensure appropriate allocation of resources between geographical areas, client groups and services. However, needs assessment is a complex process, requiring a wide range of disciplinary inputs, as well as detailed technical knowledge of the conditions and interventions being considered. Moreover, needs assessment may be especially difficult in a competitive environment, where the relationships between the purchasers and providers are subject to competition law.

- ***Designing new contracts and payment systems will be very complex; they will need to be adapted to the Finnish context and implemented incrementally in light of the progress in information systems, availability of purchasing capacity and closely aligned to the other reform measures such as freedom of choice and provider competition.*** The lack of appropriate information also has important implications for the types of contracts and payment systems to be implemented at the outset. In the presence of considerable uncertainty, cooperative solutions rather than formal detailed contracts would be better advised with all parties committing to strategically improve data collection over time.

- ***Harmonization of provider payments within and across counties is required to support individual counties and allow for cross-county purchasing and performance comparisons.*** Payment systems are complex to design and implement; as a result, most countries have uniform payment systems that are centrally designed. While variability in purchasing and payment systems across counties is inevitable in the short-run due to differences in technical capacity, in the long run, there should be a harmonization of payment systems and prices across counties (allowing for variations in costs due to geography in addition to some incentives). This will be administratively simpler for counties and providers, as well as facilitate patients seeking care from other counties, as compared to a scenario where counties determine their purchasing and payment strategies independently.

- ***Ensuring appropriate levels of autonomy for public providers is key if providers are to respond effectively to the new purchasing incentives and compete with other service providers.*** Autonomy is particularly important among publicly-owned providers within the freedom of choice scheme so that they can respond to incentives. Public service law utilities who are not subject to any competition should still have a great degree of managerial autonomy. In the case of the latter, public service law utilities will need the ability to manage themselves and re-organize so that they may respond quickly to changes in purchasing incentives.

- ***Due to some of the challenges associated with purchasing, giving more responsibility to collaborative catchment areas may offer an opportunity for further gains in economies of scale.*** The role and responsibility of the five collaborative catchment areas will likely need to be strengthened in future as these form a more appropriate level for purchasing and organizing more specialized services. It would be advisable to consider some form of regulation or provisions which would oblige the counties to (re)pool funding at the collaborative area level for more specialized services. Otherwise, from a purely purchasing and organizational perspective it would be more effective to have fewer than 18 counties. Fewer and larger counties would benefit from larger population bases particularly for high cost or specialized services and from critical purchasing capacity and skills, which are key to success. The collaborative areas approach offers the next best alternative in Finland but the governance arrangements for these areas currently in place may not be sufficient.

- ***National level guidance setting strategic and operational directions for information systems, contracting and purchasing will be essential to support counties.*** The national level should provide clear guidance on purchasing, such as setting the benefit package, national standard framework contracts or purchasing guidelines to support county capacity to purchase services within and across its borders. In that regard the Ministry's current initiative to support change in collaboration with counties is deemed to be very much in the right direction. In addition, given the overall population size of Finland, the purchasing of highly specialized and high technology services should be carried out at central level or under strict central regulation.

2. Choice and competition

While the details have yet to be finalized as of 10th October, freedom of choice and competition are important developments in the Finnish system; however, choice is not an entirely new concept. Some choice already exists within the municipal system (e.g. choice of health center), though this has not been seen as a strategic priority in most municipalities historically. The extension of freedom of choice is likewise not considered to be the core of the reform according to many key stakeholders.

- ***If well designed, there is clear potential for choice and competition to incentivize providers, increase access and responsiveness, and improve quality.*** However there is also potential for unintended, adverse consequences. Therefore it is recommended that implementation of choice and competition is undertaken cautiously, in a stepwise fashion, starting with services in which some degree of choice already exists (such as social services and some aspects of ambulatory care) and only progressing to more complex services (or bundles of care) once early experience has been assessed.

- ***Given the many potential models of freedom of choice, it is important that the reforms clearly identify the circumstances in which choice will be available.*** Freedom of choice can be valuable for imposing discipline on providers, and helping align packages of care with user preferences. However, there are countless ways in which choice can be introduced into a care pathway. It will be important for clarity on the objectives of freedom of choice, and the services or providers that are to be included in the scheme.

- ***Allowing private providers to compete to provide publicly funded services requires a level playing field between providers, with particular efforts to prevent cream-skimming.*** Providers should be treated the same in terms of the way they are monitored, contracted and paid and in the complexity of patients that they care for. This may be challenging. Given the current linkages between county-owned providers that compete under the freedom of choice scheme and the county itself, as some counties may take anti-competitive steps to ensure that their own providers remain financially solvent. Alternatively, private providers may choose to primarily treat simpler, low cost patients if public providers are obliged to serve as the provider of last resort. Independent surveillance capacity at the national level is needed as a watchdog on such practices.

- ***There are significant information needs to enable choice and workable competition, including public reporting of provider quality data so that clients can make informed choices and so that purchasers can decide who to allow into the market and monitor performance.*** Information is a fundamental requirement for choice and competition, to ensure that providers are delivering high quality care, and to act as a signal of quality for strategic purchasers, voters, and importantly, service users. Reports of provider quality are also vital to strategic purchasing, and audit of purchaser and provider performance.

3. Coordination and integration of health and social services

One of the primary aims of the reform is to 'integrate health and social services into a client-oriented package', which is expected to reduce institutional care, strengthen preventive work, and minimize the service needs of the elderly. Under the reforms, counties will be tasked with funding and provision of health and social services.

- ***Coordination and integration of health and social services can lead to patient-centered care, increase quality and improve efficiency.*** Insufficient coordination and integration of health and care social services is a well-known problem in many countries, especially for frail elderly, people with multiple chronic conditions, and people with substance abuse issues. With 10% of patients responsible for around 80% of costs in Finland there is clearly great scope for improvement regarding integration and coordination.

- ***There are many preconditions to establishing service chains that integrate care*** Country experiences demonstrate that coordinated activities do not necessarily take place even when health care and social services financing are integrated in the same regions – coordination will only occur with strong incentives (financial and otherwise) that encourage providers to cooperate.

- ***Finland should focus on both horizontal and vertical integrated care models, building on its considerable existing experience and pilots.*** Finland has a considerable range and depth of experience with pilots. Given the context-specific nature of health and social care integration, Finnish regions that have had successful pilots should build on and scale up these programmes and be given the autonomy to do so. In this way a 'toolbox' of well-functioning strategies could be advanced.

- ***Information systems must be carefully developed to facilitate providers to manage patients in integrated care models.*** The decentralized nature of the Finnish system allowed the development of parallel information systems that were largely not interoperable. The implementation of a new information structure creates an opportunity to address some key obstacles in information sharing across the system – for personnel, for evaluation and research purposes, as well as for citizens and patients. In terms of integrating care services, the use and sharing of electronic health records has been emphasized as a main function to increase efficiency and lessen the administrative burden for health care personnel.

- ***Care should be taken to ensure that integration of services is not disrupted by freedom of choice.*** There is a risk that the aims of choice and competition can undermine that of integration and coordination if applied in the same areas. By allowing patients to choose providers, it may be difficult to direct patients into cost-effective care pathways and to ensure coordination across providers who may be competing for business. An alternative could be to remove high-risk patients from the choice scheme in order to create more efficient service chains. A second alternative is to allocate the budget to the case-manager to organize services and allocate resources between the providers that the patient chooses.

4. Public health at the county level

The proposed health care reforms involve a number of changes that will impact on roles and responsibilities in relation to public health. Many public health functions currently residing at the level of the municipality will move to the new counties, including preventive care services, environmental health, and screening, as will at least some aspects of health reporting.

- **Finland is recognized as a leader in public health in Europe, with a strong record of achievement, and is looked to as an exemplar of what can be achieved.** Finland has often been considered to be a leader in public health, with the North Karelia project a widely cited example. The reforms offer considerable potential to consolidate and con-

centrate expertise at the level of the counties, developing a critical mass of skilled professionals, supported by appropriate infrastructure, including information systems, although this will also require a considerable strengthening of the public health function.

- ***There are risks during any major organizational reform, including the loss of critical expertise, institutional memory, and networks.*** Services will be transferred to the counties as complete packages, simply relocating the administrative structures. It is, important to recognize that structural reforms typically lead to a temporary, but at times severe disruption of existing activities, often lasting 2-3 years. Given Finland's high level of achievement in public health, it will be essential to guard against any deterioration, for example due to loss of key staff and institutional memory. This will require a carefully designed transition strategy.

- ***While recognizing the autonomy of the county authorities, there is a strong argument for developing national guidance on the range of essential public health functions, drawing on Finnish and international good practice.*** There is a strong argument for using the reforms to establish a national function that is capable of keeping up to date with emerging evidence on areas such as screening, synthesizing that information, and disseminating it in the form of guidance to the counties. Such a function can also make a valuable contribution to monitoring and evaluation, thereby maintaining Finland's excellent performance in this area.

- ***Counties need a clearly defined public health mandate and capacity.*** Much of the reform preparation is focused on services, however it is important that counties are provided sufficient resources and the authority to carry out public health functions.

5. Reinforcing governance, regulation and information systems

There are many challenges for governance raised by the reforms, particularly regarding the role and capacity of counties, as well as surveillance of the reformed system and regulation of the competitive markets. In addition to these challenges, high-quality data is an urgent priority for almost all aspects of the reforms.

- ***Care must be taken to ensure the reforms are in line with constitutional requirements.*** Constitutional issues derailed a previous iteration of the reforms in 2015. While we are unable to comment on the constitutionality of the reforms, undoubtedly efforts are needed to ensure the reforms are constitutional.

- ***Although counties are expected to have significant autonomy, for many functions – including information systems, monitoring, and some aspects of purchasing –a strong governance role for authorities at a centralized level will be important.*** Some of roles (such as clinical and service delivery guidelines) are already successfully undertaken at a

national level in Finland and it is important that these resources are maintained and strengthened further. Some national functions are necessary to maximize the benefits of decentralization by producing useful comparative information, some to avoid unnecessary duplication, and some to compensate for the limited managerial capacity that will be available in some counties. Moreover, particularly as freedom of choice and market competition play a role in the reforms, the capacity to supervise and regulate provider markets will be essential at a national level.

- ***The benefits of commercialization should be balanced against the benefits of trust in the current system.*** Compared to other developed countries, Finland has not historically relied extensively on formal governance arrangements to control and enhance its health system performance. It is vitally important that the reformed system retains the beneficial elements of trust and autonomy that it has enjoyed hitherto. In particular, many formal aspects of governance impose significant running costs on the system that may be avoided if actors can be trusted.

- ***A monitoring & evaluation strategy with pre-specified goals should be set up at an early stage.*** Setting priorities and standards is a key function in all health and social care systems. Many criteria are set at the national level, first because it promotes equity of standards (such as access and quality) across the country, and second because it economizes on the need for local bodies to have to set their own standards. The need for adequate performance reporting at all levels of the system is crucial. The specification and mandating of reporting requirements is usually a national governmental function (often delegated to an independent regulator) in many countries, to assure standardization and economy of effort. Importantly, monitoring must be fully integrated into a governance framework if it is to be of value for improving the system.

- ***Information systems will need to be in line with all aspects of the reform, supporting purchasing, choice, competition, integration and payment.*** There is a general consensus that the information system needs still further development before it is fully in-line with what is needed from it in the reform context. Building the information system to support all aspects of the reform is crucial, as it will in many ways be the basis on which the reform will stand or fall.

- ***Interoperability of the IT system at the county level will be essential.*** To secure effective integration, it will often be necessary to share patient records between providers, and with the purchaser. Interoperability of the IT system will be fundamental at the county level in order for the counties to fulfill their role of coordinators of health and social services. Certainly the county level is where the reality of the current situation of disparate and incompatible IT solutions will be mostly felt.

6. Achieving the reform objectives

The primary objectives of the reform are, broadly, to reduce inequalities and improve fiscal sustainability, primarily through of a mix of changes to public administration, some elements of market competition, and a renewed focus on care integration.

- ***Overall, the reforms are an ambitious effort to address concerns about inequalities in access to health and social care, effectiveness and sustainability of the public system.*** The panel finds that the consolidation of responsibility for health and social care at a higher level of public administration than the municipality, in particular, is a positive move. Nevertheless, this is not a 'magic bullet'. Counties will still need national level support and significant resources for the reforms to deliver.

- ***Consolidating responsibility for purchasing and organizing at county level and focusing on integration and coordination of health and social care services have great potential for improving system performance, however investments in strategic purchasing are needed.*** Municipalities have historically varied substantially in their capacity to organize services, given variation in their population size, demographics, and other factors. By consolidating responsibility for health and social care to a county level, resources can be more equitably distributed, counties can better align the availability of services with need, and use their financial leverage to steer the efficient delivery of services. Attention to strategic purchasing is a key pre-requisite for success; payment incentives must be in place that motivate providers and support care coordination.

- ***Introducing some choice and competition could also spur innovation, although proper incentives and regulations must be in place to prevent unintended consequences such as cream-skimming.*** Freedom-of-choice for patients and clients is intended to better balance supplies and demands, more specifically to give care-users the formal option to vote-with-their-feet. Experience elsewhere suggests that private providers are only likely to bid for contracts where there are few sunk costs and where the workload is as predictable as possible, in terms of both numbers and severity. Incentives must be in place to attract providers to undesirable areas and to encourage them to treat relatively complex patients.

- ***Care must be taken to ensure that past achievements in public health are not compromised due to organizational changes.*** As has been noted, Finland is recognized as a leader in public health in Europe. As the reforms proceed, it will be important that organizational change as responsibility is shifted to the counties does not lead to a loss of effectiveness.

- ***Information on population needs, care pathways, costs, and provider quality are essential pre-requisites to enable all aspects of the reform, and the importance of information cannot be understated. That said, information technology is unlikely to lead to cost containment in the near term.*** As highlighted throughout this report, good information is essential to support all aspects of the reform. Nevertheless, although information systems are often expected to deliver efficiency gains, it is important to note that at least in the short-term they are unlikely to deliver savings. In addition to fixed start-up costs, information systems may lead to increases in demand for services, which will lead to increases in expenditures.

- ***The degree of cost containment sought by the reform may jeopardize the reform's success and damage access and quality of care.*** The resource allocation formula will impose a strict reduction in the rate of overall expenditure growth in an effort to achieve 3 billion euros in savings by 2029. Current forecasts indicate that this will substantially reduce the level of resources in some counties. The panel finds that the plans to slow the rate of expenditure not only risk underfunding the system but also risk de-railing the reforms, creating new inefficiencies and damaging access.

7. Reform implementation

The approach and process of managing change is central to the success (or lack thereof) of any reform program.

- ***Many aspects of the reform have the potential to reduce inequalities and improve efficiency, however the pace of implementation may be too optimistic and there is potential for misalignment in some areas (e.g. between integration and competition).*** The reform plans include a helpful implementation timetable with approval of various legislations and implementation phases. The suggested timings, however, may be too optimistic in light of the complexity of some of the reform strategies suggested, the potential for misalignment and the challenges inherent to devolved decision making in Finland.

- ***Top priorities include establishing counties and building up their capacity to conduct strategic purchasing.*** Finnish policy makers may need to start the reform process by giving the highest priority and devote the main share of the resources to the establishment of the new county organization structures for which there is significant consensus among stakeholders as well as a large degree of technical certainty. Moreover, these new county functions form the basis to enable the introduction of the further reforms including strategic purchasing, contracting, provider competition, freedom of choice, new payment systems, integration of care and public health. Therefore the main priority should be putting in place a series of prerequisites for the new county financing, purchasing and organization functions to work.

- ***Use of framework legislation that sets general obligations and principles but leaves governing authorities some degree of flexibility in the future is advisable.*** Finland should consider adopting framework legislation, which sets out the main reform direction but allows bottom up innovation developments as well as more implementation flexibility.

- ***It will be essential to demonstrate early gains to maintain public support.*** For a reform plan to build momentum and gain broader stakeholder support there is need to demonstrate early successes. One very important condition for a successful reform that is complex and far stretching is the need to show 'early gains' and capitalize on the 'low hanging fruit'.

Study limitations

The methodological approach used for this review has a number of inherent limitations that need to be kept in mind when assessing the findings. First, the report focuses on a subset of reform areas deemed of key priority by the panelists; these areas were subsequently studied for a limited time period that included meetings with a selection of key stakeholders over two country visits, and assessments of selected key documentation. Second, the assessment is based on predicted impacts, drawing on expert opinions, prior experiences in other countries, as well as academic research. Third, at the time of writing this report many details of the reforms remain undecided – these could have important, unanticipated spillover effects throughout the system. Lastly, although every effort has been made to identify unintended effects of the reforms, with such comprehensive plans in place, it is not possible to ascertain how all aspects of the reform will impact on each other, as many – if not all – aspects of the reforms are intertwined and depend on each other for success.

CONTENTS

1 INTRODUCTION

In Spring 2016, the Ministry of Social Affairs and Health invited the European Observatory on Health Systems and Policies to organize a panel of international experts to provide an evidence-informed review of proposed comprehensive health and social care reform measures in Finland, commonly referred to as the SOTE (social services and health) reform. The panel consists of experts from the Observatory, World Health Organization Regional Office for Europe, Organization for Economic Cooperation and Development, and key academic institutions.

The review has four broad aims[1]:

- To review the objectives of the reform proposals
- To assess the expected impact of reform proposals by analyzing the strategies for reform and drawing on experience with similar reforms elsewhere in relevant countries
- To identify prerequisites to enable effective reform implementation
- To provide recommendations (if and whenever required) to adjust reform proposals in light of the results of the analysis.

To arrive at their findings, the international panel carried out country two-day missions in July and September 2016 to meet with a range of experts and stakeholders[2] in Finland as well as reviewed a range of technical documents. The panel's observations on the expected impact of the reforms and prerequisites for success are based on evidence-based expert opinions derived from the panel's professional experiences, analysis of international evidence and understanding of the Finnish proposals.

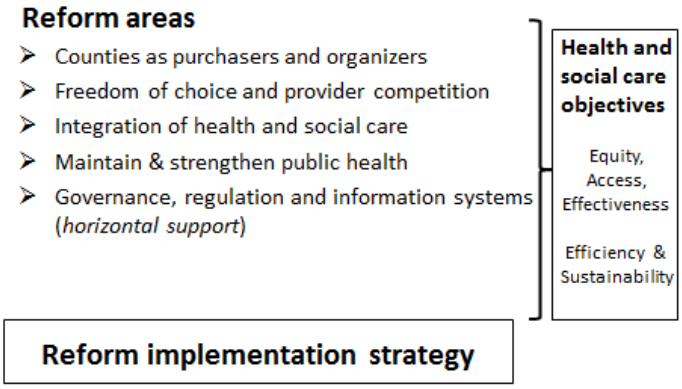
There are important limitations of such an approach. First, as mentioned, the international panel's assessment comes after only two country visits and a short period of deliberation. The scope of the analysis is restricted to providing an overview of selected key areas of the reform package given the time constraints, with some prominence given to issues related to health care rather than social care due to greater availability of information. Additionally, while the panel reports on its expectations of the proposals' impacts based on a variety of factors, including international experiences, the actual impacts of the reform will be context-specific; as there is no historical precedent in Finland for many aspects of the reform, it is difficult to determine with certainty how the reforms will develop or how stakeholders will respond to structural changes in the health and social care sectors. Moreover, many aspects of the reforms are intertwined and will have spillover effects on each other, which could lead to additional unforeseen consequences beyond those covered by the panel's analysis. Complicating matters further, the proposals continue to be developed as this report is being written. As a result, where relevant the assessment considers multiple reform options in a particular area; the report considers all developments up until 10 October 2016.

[1] See detailed TORs in Appendix 1
[2] See list of experts in Appendix 2

Framework for analysis

In writing this report we follow a framework that is specific to, and informed by the reform proposals themselves (Box 1). We frame the analysis by first focusing on the main objectives of the reforms, primarily to improve equity, access, and effectiveness of health and social care services and to improve efficiency and fiscal sustainability. These are not the only aims of the reform, however much of the rationale for the reforms is geared towards these objectives.

Box 1. Framework for analysis



We then focus on a selection of the main areas of the reforms: the role of counties as purchasers and organizers, freedom of choice and provider competition, integration of health and social care, public health, and governance, regulation and information systems. The first 4 areas are clearly central areas of the reform proposals. The last area, governance, regulation and information systems, is of equal importance. However it is more horizontal or cross-sectional in nature, functioning primarily to support various aspects of the reforms. Across all areas, we identify international experiences and pre-requisites for success, as well as key observations by the expert panel. We then re-visit the extent to which the reforms are likely to achieve the main objectives of improving equity, access and effectiveness, as well as efficiency and fiscal sustainability. Lastly, we consider the reform implementation strategy timeline and general approach, which encompasses all areas of the reform.

Despite the challenges and complexities of the task at hand, we believe the assessment of the reform proposals is of value and can assist both in the reform design, as well as implementation phases, by highlighting areas that may require additional consideration. The review constitutes the first phase of a more comprehensive reform monitoring and evaluation program that will take place over the next years and along the implementation of the health and social services reforms.

2 REFORM OBJECTIVES AND PROPOSALS

The health and social care reform package aims to improve equity, access and effectiveness of health and social care services while achieving efficiency gains and containing costs through a number of intertwined measures. In this section we briefly describe, first, the objectives of the reform proposals; and, second, the panel's interpretation of the reform plans which will provide context for the remainder of the report.

Reform objectives

Equity, access and effectiveness

The Finnish health system has relied on municipalities, sometimes with very small populations, to coordinate health and social care services. This has yielded many positive outcomes in line with other advanced OECD countries. However, inequalities are relatively high, in part because some municipalities – particularly smaller ones – have limited managerial capacity and clinical expertise (Vuorenkoski, Mladovsky and Mossialos, 2008). There are also wide variations in revenue raising potential between the municipalities, which are not fully compensated for by state grants.

While the Constitution guarantees access to high quality care for all residents of Finland, there is evidence of gaps in terms of access to care. According to data from EU-SILC, the most common reason for unmet needs for medical examination is waiting lists. Overall, in 2014, 3.1% of respondents reported unmet need due to waiting lists; among those over 65 years of age, 4.7% reported unmet needs due to waiting lists. These percentages are the highest of all Nordic countries and well above the EU-28 average, as shown in Figure 1.

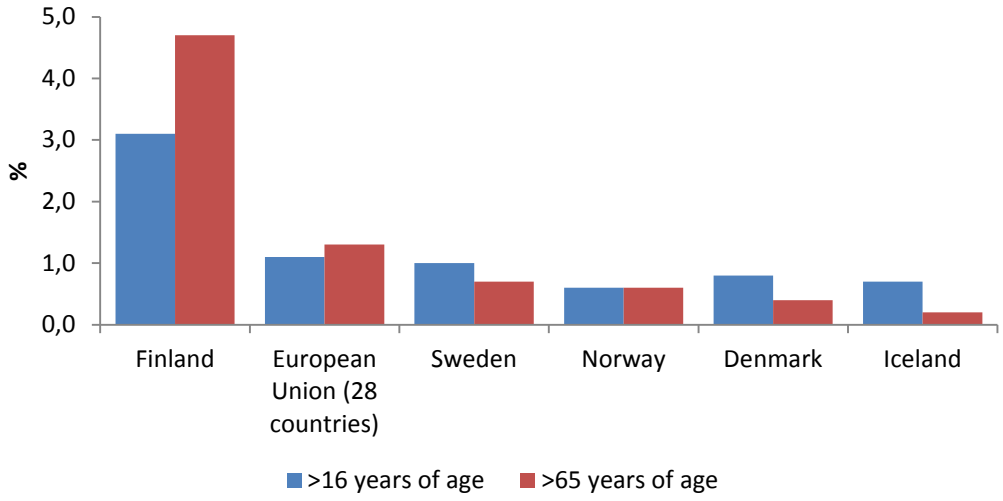


Figure 1. Percentage unmet need due to waiting lists, by age, 2014. Source: EU-SILC.

Research suggests that Finland has experienced significant declines in waiting times for some elective services, though waiting times often remain long relative to other countries as of 2011/12 (Siciliani, et al 2014). Waiting times were generally stable or increasing up to 2002 or 2003 and then fell sharply by about 43–48% for hip and knee replacement, 30–51% for prostatectomy, hysterectomy, cholecystectomy and hernia, 55% for cataract and 24% for bypass. Some of this reduction is attributed to maximum waiting time guarantees However, while more than half of patients in the UK, Portugal and New Zealand received hip replacements within 3 months, this was not the case in Finland, where only 40% received treatment in that time period; 18% of patients waited more than 6 months.

Other evidence also indicates that the Finnish population has concerns over access to health services. Although nearly a decade old, the Special Eurobarometer (283) report on health and long-term care (2007) finds that 26% of Finnish respondents feel that it is difficult to access a family doctor. This represents the 4th largest population share in the EU, between Romania (23%) and Latvia (27%). This is likely due in part to the considerable variability in capacity across municipalities.

Municipalities also have considerable discretion in terms of the services they cover. What this means in practice is that despite constitutionally guaranteed access to high quality services, access to care can depend on where one lives. Unmet need data from EU-SILC shows that although 2.4% of city dwellers report unmet needs in 2014, 3.8% of those living in towns and suburbs report unmet needs; 3.0% of those living in rural areas report unmet needs.

There are also important disparities in health care access and outcomes as a result of occupational health care services existing in parallel to the public health care system. Those who are eligible for occupational health services are able to obtain access to GP services much more quickly than people who rely on public provision. Since occupational health services are typically available to relatively healthy, working-age people, they can exacerbate inequalities.

Lastly, user charges are a potential barrier to access and source of inequality. Out-of-pocket (OOP) spending as a share of total health expenditure is quite high for the Nordic region, at 19.1% in 2015 according to data from the OECD. This is the highest OOP share of total spending among the Nordic countries. OOP spending mostly went towards medical goods (43.0%), ambulatory care (30.7%), and residential long-term care facilities (12.2%).

Efficiency and fiscal sustainability

The current health and social care system may be prone to inefficiencies in part due to its high degree of fragmentation. Although municipalities have already been responsible for both health and social services, some, in particular smaller municipalities, lack adequate steering instruments and the political mandate to influence care coordination. For example, some municipalities report difficulties influencing the behavior of hospitals, which leads to them losing the ability to govern the provision of care and the control over patient flows and health care processes at large[3]. This contributes to high spending for patients with chronic needs; around 10% of the population is said to account for 80% of costs (Leskelä et al 2013). Additionally, initiatives to provide integrated disease prevention, public health services, and primary health care services to needy citizens, have often emerged locally, but have proven hard to scale up to the regional or national level.

[3] Even if some of the hospital districts have developed specific care trajectories – so-called care paths – for selected patient groups, this work has been ad hoc and sanctioned from neither the national nor the regional level (Personal Communication, 2016).

Although there are no accurate estimations of expenditure on social services available, health expenditure as a share of GDP was 9.6% in 2015 in Finland. While not among the highest shares in the OECD, there are broader concerns in Finland regarding public finances and fiscal sustainability beyond the health and social care sectors. As shown in Figure 2, between 2000 and 2008 Finland had a surplus in every year. However Finland has run a deficit in every year since 2009, as revenue generation has remained flat while public expenditures have increased. As a result, public debt as a share of GDP has reached 63.1% as of 2015 according to Eurostat -- almost double the level in 2008.

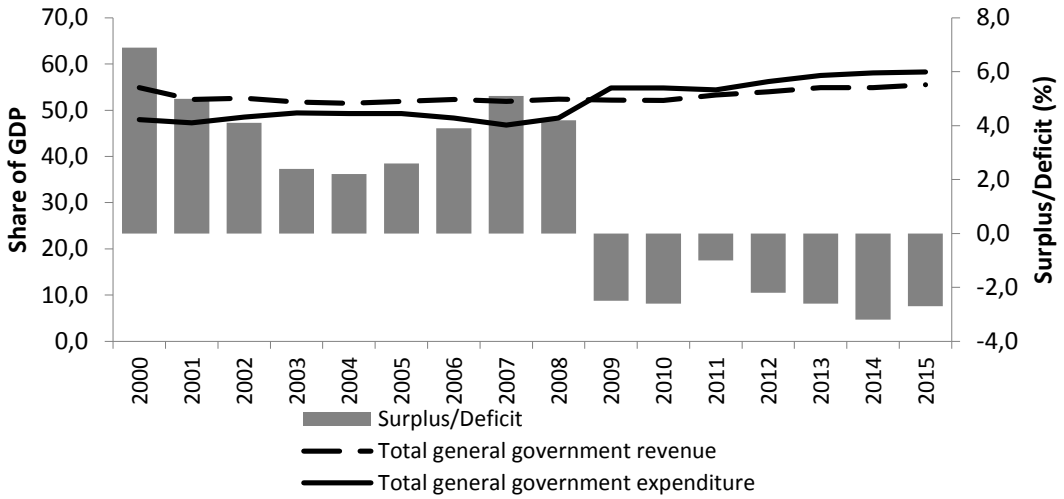


Figure 2. Fiscal situation in Finland, 2000-2015. Source: Eurostat.

Additionally, according to baseline reference scenario projections from the Ageing Working Group in 2015, health and long-term care will consume 2.8 additional percentage points of GDP in 2060 than in 2013 in Finland. This is of concern, as it is well above the EU average of 2.0 percentage points over the same time period.

Public finances are expected to remain weak in the long-term. Due to these concerns, a so-called public sector sustainability gap, calculated as the difference between the baseline projection of public expenditure and a preferred alternative target projection considered more sustainable, has been estimated (Bank of Finland, 2015). The difference between the two projections amounts to EUR 3 billion by 2029. It is hoped that the reforms will generate this level of savings by the end of the 2020s.

Reform proposals

The reforms are intended to address some of the challenges related to inequalities and fiscal sustainability described above. Here we briefly review the reform plans as they are understood by the panel.

Counties as organizers and purchasers of health and social care

One of the main features of the proposed reform is to introduce a new level of public administration – the county. Rather than leaving responsibility for health and social care to local municipalities, 18 counties will be in charge of organizing and purchasing health and social care on behalf of their populations, while 5 larger collaborative catchment areas will be responsible for more specialized services. The motivation for this reduction in the number of organizers (or purchasers) is, in part, to reduce fragmentation and to better share the burden of financing care between regions, which can improve efficiency and to reduce inequalities.

Funds will flow primarily from central government to counties based on a needs-based resource allocation formula. County funding will initially be based on historic expenditure of the municipalities that comprise each county, with a transitional period that eventually sees budget caps limit overall expenditure growth to 0.5% per year, well below historic trends, in an effort to close the EUR 3 billion sustainability gap. In principle, counties cannot bypass these fiscal constraints; they must balance their budgets and have no power to raise revenue on their own. The counties will also acquire ownership of public providers, mostly hospitals and will have the right to lease or rent premises currently owned by local municipalities. The details related to contracting and provider payments under the new system are not discussed in detail in the reform package at this point.

Introduction of provider competition and freedom of choice

Provider competition and freedom of choice aim to improve responsiveness, access and efficiency by encouraging innovation, increasing access by bringing new providers into the market, and ensuring that 'money follows the patient'. Under the reforms, for some pre-defined set (or 'package') of health and social care services, patients will have the freedom to choose their provider(s). The county will still be responsible for organizing provision for all other services that are not under the freedom of choice scheme; each county will create a county-level public law service utility that provides these services.

For the freedom of choice scheme, counties will be obliged to establish county-owned companies that are technically separate from the county itself. These publicly owned companies will be allowed to compete with private profit, and non-profit ("third sector") providers to offer some client services within the freedom of choice scheme. The precise services open to competition have yet to be decided.

Integration of health and social care services within counties

One of the primary aims of the reform is to 'integrate health and social services into a client-oriented package', which is expected to reduce institutional care, strengthen preventive work, and minimize the service needs of older people. Under the reforms, counties will be tasked with funding and provision of health and social services. The reform proposal defines and outlines how both vertical integration (i.e. linking different levels of care such as primary, secondary and tertiary care) and horizontal integration (i.e. linking similar levels of care like primary and social care between hospitals and primary care/social care) will be facilitated, with strong emphasis on the inter-organizational structure in the production of services. The county will be responsible and accountable for managing care for the patients, specifically through care planning, well-defined roles and responsibilities of the caregivers, and at the same time ensuring the patients' right to choose providers. However, little is mentioned about how coordination of services will be conducted in practice, for instance the use of case management.

Strengthening public health at the county level

Currently, responsibility for protecting and promoting wellbeing and health lies mainly with the municipalities and it is planned that many functions will be transferred to the new counties, as will a number of other functions that have important implications for public health. Some specified tasks will continue to be undertaken by THL, under legal mandate, such as infectious disease surveillance on the national level, availability of vaccines, and national registries. Preventive care services, environmental health, and screening will reside in counties, as will at least some aspects of health reporting, including the existing Structural Social Reporting which seeks to document and map social problems.

Reinforcing governance, regulation, and information systems

There is widespread agreement that - without good governance - the most enlightened reforms of health and social care systems can fail. Compared to other developed countries, Finland has not historically relied extensively on formal governance arrangements to control and enhance its health system performance. Instead, in common with other Nordic countries, it has relied to a large extent on 'trust' that providers, purchasers and patients will 'do the right thing' to ensure that - in general - the right services are delivered, with satisfactory levels of efficiency and a high level of clinical quality. However some aspects of the reform proposals – such as the amalgamation of responsibility for health and social care to the county level as well as the encouragement of choice and competition – require more formal governance mechanisms and lines of accountability in place to ensure reform success.

Information systems are also an important prerequisite to the reforms and have the added potential to deliver efficiency savings and improve care coordination. While Finland is well regarded for its use of data registers, information systems in Finland will need to respond to several data and information needs of the reform. These systems must be able to collect the considerable amount of data for assessing need and for monitoring and evaluation of the performance of the system at county and central level, including data on provider performance and cost that is necessary for purchasing, monitoring, and public reporting. This is likely to require substantial and sustained investment to create systems that are appropriate for the new, and in information terms, more demanding processes. These systems must also provide operational information for the counties to perform their tasks as organizers and purchasers of the health and social care services, including data and information for monitoring the care chains, especially for the integrated health and social services.

3 THE ROLE OF THE COUNTY AS ORGANIZER AND PURCHASER

Key Observations

- Centralizing the organization and financing of health and social care at county level should help to improve efficiency and equity through strategic purchasing, economies of scale and increased leverage over allocation of resources and care delivery.

- To strengthen strategic purchasing capacity, counties will need to build technical skills and infrastructure, with a particular focus on information systems

- Conducting health and social needs assessment at county level is of high priority.

- Designing new contracts and payment systems will be very complex, need to be adapted to the Finnish context, and implemented incrementally in light of the progress in information systems, availability of purchasing capacity and closely aligned to the other reform measures such as freedom of choice and provider competition.

- Harmonization of provider payments within and across counties is required to support individual counties and allow for cross county purchasing and performance comparisons.

- Ensuring appropriate levels of autonomy for public providers is key if they are to respond effectively to the new purchasing incentives and to compete with other service providers.

- Given some of the challenges associated with purchasing, giving more responsibility to collaborative catchment areas may offer an opportunity for further gains in economies of scale.

- National level guidance setting strategic and operational directions for information systems, contracting and purchasing will be essential to support counties.

Introduction

In the current system, municipalities are responsible for organizing and purchasing health and social care on behalf of their populations and have considerable autonomy over how they pay for services, contributing to an extent to geographic variability and inequalities. Under the reforms 18 newly formed counties will be in charge of organizing and purchasing health and social services. Transferring this responsibility from municipalities to counties can reduce inequalities and improve efficiency.

To capitalize on this shift it will be essential for counties to move from organizing services or passive forms of purchasing – the mere reimbursement of providers – to more proactive and strategic forms of purchasing that consider *which* interventions should be purchased, *how* they should be purchased and (within the freedom of choice scheme) *from whom*. Strategic purchasing is important not only when but

purchasing from competing providers in a market situation, but also when commissioning services publicly owned providers (i.e. public service law-utility) who are not subject to competition.

International trends and developments

Consolidating responsibility for care at higher levels of government

The concentration of responsibility for organizing and purchasing care at a higher level of government is in line with what other OECD countries have done recently, including those with a strong tradition of local government. For example, the merger of municipalities and regions into larger geographical units has taken place in several of the Nordic countries. Denmark implemented a large regional reform in 2007 in which 13 counties were merged into five regions and 279 municipalities became 98. Sweden is now planning to make the same change, merging 21 county councils responsible for health care into six regions. The primary aim in both the Danish and the Swedish cases was to increase efficiency by lowering the number of administrative units, to simplify integration and make coordination easier, although there is still limited evidence as to the extent to which geographical mergers lead to better integration. In 2016, a number of Italian regions have also taken steps to merge local health authorities (LHAs) either through administrative measures (for instance Veneto which reduced the number from 22 to 8), or through deeper reforms that provide more autonomy to the merged entities in terms of commissioning, financing and planning (e.g. in the case of Lombardy, which moved from 15 LHAs to 8 new Agencies).

Benefiting from a purchaser-provider split

Introducing or strengthening a purchasing function may require disentangling and sometimes explicitly separating payer and provider(s). The idea of introducing a purchaser-provider split (PPS) while concurrently increasing the provision side's autonomy to respond to newly introduced incentives and accountability rules has been at the core of many public sector reforms since the 1990s, in line with the spreading of new public management theories, starting with the UK and Sweden (Sliverbo, 2004), but also New-Zealand (Ashton, 2005), the Catalan region of Spain, among others. The separation of purchasing and provision is expected to increase efficiency, transparency, flexibility, accountability and to empower citizens (Tynkkynen et al 2013, Takian et al 2015).

The model in Sweden is perhaps the closest to the envisaged model for Finland. Health care provision in Sweden is funded, purchased and accounted for by a county council that is elected every fourth year in public elections. Each of the 21 Swedish counties have somewhat different models but mainly, the county council has an executive board and in some counties also an elected hospital or primary care board, that decide on what to purchase from the providers. The providing organization and management is run by a county director and often different heads of administration for the different sectors.

There are of course many different approaches to purchasing, and, as for many other reforms, context specificity and path dependency will be key. It is worth highlighting that in England, through many waves of reform, the purchaser at the core of the model has been a provider or a provider-led organization in charge of purchasing many routine services on behalf of patients. However, it is important to note that many specialized services are still commissioned nationally, by NHS England, providing benefits of scale and overcoming the challenge of recruiting staff with the specialist skills necessary for purchasing (see discussion in Chapter 7 on the role of the central level).

As is often the case, the lessons emerging from the introduction of a purchasing provider split are not always conclusive (Bokje and Goddart 2010 for the UK, Takian et al 2015 for a brief and recent review). One criticism of implementing a PPS is that it can be costly and create a significant administrative burden, in particular in the process of contracting and competitive bidding. Purchasing is a complex process, which requires a lot of capacity and is very data intensive. For instance, in New Zealand, the initial costs of contracting were very high (but tended to decrease over time); the burden was especially high on small providers and when lengthy negotiations had to take place. In addition, the administrative costs increased when purchasers pursued a strategy of opening the "market" to all providers as opposed to negotiating with a selected set of preferred providers (Ashton et al 2004). In spite of the complexities, there seems a general trend across many countries towards introducing a purchaser-provider split.

Designing provider payment systems

Selecting provider payment levels and methods is an integral part of the design of a contractual mechanism. In doing so, it is important to recognize that provider payments are powerful policy levers and generate incentives, which affect the quality and quantity of services provided, as well as ultimately the structure of the markets and the degree of competition. Fee for service, payment per case, capitation and global budgets are the four main payment methods traditionally used in OECD countries (Table 1).

Table 1. Characteristics, advantages and disadvantages of traditional payment systems in OECD countries.

	FFS	Capitation	Global budget	DRG
Description	Retrospective activity-based payment: billing of individual services and patient contacts	Prospective lump-sum payment per enrolled patient covering a range of services	Prospective lump-sum payment covering a range of services independent of actual volume provided	Prospective activity-based payment per patient, patient classified into groups based on diagnoses and resource use
Main setting in OECD countries	Predominant mode of payment for GPs and for outpatient specialist services	Mode of payment for GPs in a number of countries	Payment for public hospitals in a number of countries	Payment for hospital inpatient cases in many countries
Reasons to implement	-better compliance to guidelines with required number of visits ·quicker uptake of innovative activities -less risk selection issues -improving access -transparency	·cost control -low transaction costs - higher focus on preventive activities	·cost control ·low transaction cost	- increasing activity when replacing global budget decreasing activity when replacing FFS -increased technical efficiency -reduction in average length of stay -equity -reduction in waiting times -transparency

Possible unintended consequences	·high clinical activity (number of visits and services per patients) ·associated with higher costs ·high transaction costs	·increase in number of patients ·possible skimping of care (less visits per patient and fewer activity per patient) -quicker referrals to other providers -possible risk selection	-rationing of services with increased waiting time ·possible skimping of care (less visits per patient and fewer activity per patient) -budget allocation may be less transparent	·hospitals trying to attract additional patients -focus on more profitable activities -associated with higher total costs -high transaction costs -early discharges -upcoding -possible risk-selection

Source: adapted from OECD (2016).

In attempts to strike a balance between incentives, payment systems are becoming more elaborate and increasingly combine different methods (for example, primary care providers receive blended payment in 25 out of 34 OECD countries). Overall, the traditional payment systems described in the table above do not adequately recognize, reward, or incentivize quality and value. Pay-for performance which gives more prominence to results (and thus require these are measured) are used in a growing number of countries.

Countries also now tend to favor broader payment systems, where groups of providers are jointly responsible for larger segments of care. Typically providers are put at financial risk but can retain surpluses (provided quality requirements are met). These payments take two main forms: (i) bundled payments for episodes of care or chronic diseases or (ii) population-based payments. This is seen as a way to incentivize efficiency by shifting some financial risk to providers, as well as improve coordination and quality (see Chapter 5 on care coordination).

Most countries have a centralized payment system. In Sweden the county councils are allowed to design their local payment systems. However, within primary care, the payment systems have become more homogenous over the course of several years, with capitation being the predominant choice over fee-for-service reimbursements, although many counties still have a 10–20% share of fee-for service payment. The capitation is, to varying degree, risk adjusted for age, diagnosis groups, and socioeconomic factors. Target based reimbursement methods for meeting quality standards or certain public health goals have also been a common policy to steer caregivers.

While the evidence on the impact these new payment methods is still emerging and the results mixed and context-dependent, there is enough evidence for countries to continue moving towards payment systems linked to activity and, to the extent possible, to outcomes.

Key reform issues and prerequisites

Contemporary health and social care analysis recognizes that whoever is paying for services cannot limit its role to passively financing transactions that take place between providers and patients. Public (or private) entities who pool and direct significant amounts of funding into service delivery must make good use of their leverage to ensure that, within the limited funds available, the right services are purchased from cost-effective providers of high quality in order to best meet patients' needs and expectations. In other words, counties can and must take on a role of strategic purchaser to improve performance; this is true even when purchasing services from their own public service providers.

This subsection outlines some key features of effective purchasing of particular relevance to the Finnish context and which may be of some help in developing purchasing guidance.

Meeting information and skill needs to support strategic purchasing

Municipalities in Finland have often been thought of more as 'organizers' rather than 'purchasers' of health and social services, perhaps since much of their role involves the direct allocation of funds towards public service production. However simply transferring this responsibility to county level is likely not by itself enough to deliver substantial efficiency or equity gains; to do this, it will be important for counties to exercise their increased leverage through strategic purchasing from both private as well as public providers, including public service law-utilities who are not subject to competition.

Purchasers need the information and skills to decide how different services should be paid for, and to develop the right incentive structures for providers. More broadly, to be effective active purchasers, purchasers require the skills to negotiate and create contracts with providers, as well as to be able to monitor care delivery. Purchasing can easily become an overly complex, lengthy, and administratively burdensome (not to mention costly) process. Key considerations include deciding in advance (i) whether and when to purchase individual services or packages and particularly within a competitive market-based atmosphere such as the freedom of choice scheme (ii) which providers (or groups of providers) to contract with.

Strategic purchasing is dependent on the availability of high quality information on needs, but also on costs and quality of care, which are necessary to determine prices and to decide which providers to purchase from. In spite of recent major efforts, Finland still faces a dearth of information when it comes to measuring the performance of individual providers (volume, quality and cost) and to measure the costs of service provision in a detailed way. This represents a true barrier to the development of contracting, in addition to monitoring and performance evaluation (see Chapter 7 on governance). It has also important implications for the types of contracts and payment systems to be implemented at the outset. In the presence of a lot of uncertainty, it may be better to consider more informal agreements rather than formal detailed contracts, with all parties committing to strategically improve data collection over time (see Chapter 9 on reform implementation).

Payment systems will nevertheless likely have to be based on relatively crude provider cost data initially, the quality of which will probably vary across counties. Transparent and mandatory reporting should be a core condition of the contracts, to allow for quick adjustments to payment rates and to ensure that over time, payments can be properly adjusted to account for patient characteristics.

Conducting needs assessment in counties

To have adequate procurement skills and to allocate resources appropriately (both within counties and more broadly to the health sector overall), it will be necessary to conduct needs assessments. As one element of strategic purchasing, needs assessments can then form the basis for seeking providers through competition or other mechanisms.

Health needs assessment entered the lexicon of health policy in the early 1990s following the introduction of the purchaser provider split in the British National Health Service. It was envisaged as a means by which the purchasers of health care could systematically assess the health needs of the population for which they were responsible. There are a number of definitions but all identified a series of elements, beginning with the systematic review of the health issues facing a population, setting of priorities, and implementing packages of care, backed up by appropriate resources, to meet those health needs. It is proactive, explicitly

seeking to identify need that is not translated into demand. In this way it differs fundamentally from traditional health services that wait until individuals bring their needs to service providers. It is an approach that is underpinned by a commitment to reducing inequalities, recognizing that those who are disadvantaged are least likely to translate their need into demand.

Traditionally, health needs assessment involves a series of steps. The first is to define the target population. In the Finnish context, this could be the entire population of a county or it could be groups within the population, defined on the basis of geographical location, such as those living in remote or rural municipalities, of settings, such as schools or workplaces, of social characteristics, such as age, ethnicity, or sexuality, or of experience of a particular condition, such as mental illness or cardiovascular disease.

A second step is to select the topic for the needs assessment. Given finite resources, this involves an initial prioritization. Several factors should be taken into account. One is the impact of the condition on the population, although this is not absolute and on occasions it will be appropriate to undertake a needs assessment for a rare condition, but one that disproportionately affect certain groups or which has high resource consequences. Another is the scope to implement change. There is little point in undertaking a health needs assessment if there is no appropriate intervention. A third is acceptability, taking account of the ease with which change will be brought about. Finally, resource feasibility should be considered, lest expectations that cannot be met are raised.

The methods to be used will vary, but will likely include analysis of existing data, recognizing that information obtained from health providers only provides insights into those who have obtain care. Nonetheless, this can be helpful in identifying otherwise unexplained variation in utilization. In many cases, it will be necessary to use data from surveys, either from the area in question or from others where it can reasonably be assumed that the population is similar. Finally, it may be necessary to collect new data. It is then necessary to provide an overall assessment of need in the population, combining these data with evidence from the published and grey literature were appropriate.

There is a considerable literature and priority setting, including the use of techniques such as multicriteria decision analysis, although the most important principle is that decisions should be transparent and acceptable to those concerned, where possible. Similarly, the design of packages of care can draw on what is not a very extensive body of literature on both health technology assessment and service delivery and organizational research. In this respect, it is important to determine not just what works, but what works in which circumstances. This will involve a detailed understanding of the local context, drawing on the literature on, for example, soft systems analysis.

There are several implications for Finland. As will be apparent from this brief review, needs assessment is a complex process, requiring a wide range of disciplinary inputs, as well as detailed technical knowledge of the conditions and interventions being considered. Consequently, it will be necessary to establish mechanisms by which those responsible for health needs assessment in the county administrations, who are likely to be part of the public health function, are able to draw upon the skills of practicing clinicians, working in partnership with them.

Health needs assessment may be especially difficult in a competitive environment, where interactions between the purchasers and providers of care may be perceived as collusion in the market. This is especially problematic where the relationships are subject to competition law.

Designing appropriate contracts and payment systems

At the time of writing this report, Finland is considering several types of contracts and a range of reform options for paying health and social care provider institutions and individuals. Here we include four key observations to bear in mind when designing new contracts and payment systems in Finland.

First, we need to consider whether the payment will be retrospective, prospective or based on competitive bidding; each one comes with its own benefits and drawbacks:

- Paying retrospectively for each service delivered. This model generally requires that individual providers be paid for each unit of service provided (on a fee for service basis). The fee may either be freely set by providers or regulated; in the first case, to limit its financial exposure, the purchaser typically reimburses a fixed amount (this is current model for private services reimbursed by the social security), and the patients may incur high out-of-pocket payments.

- Paying prospectively on pre-agreed prices and/or volumes.

- Paying through competitive bidding process to provide either specific services or entire packages of care.

Second, as the section on international experience with payment systems shows, none of the traditional payment systems alone are ideally suited to pay for all primary and social care services. Where the service to be reimbursed is narrow and well defined the system may need to be based on fee-for-service schedules (with the risks described in the table in particular that volumes of services may increase). If the contracts are more bundled, then other payment methods would be feasible (for instance capitation, adjusted for the scope of services different categories of patients might require). We believe that in the context of Finland, broader packages and payments which are more conducive to cooperation among providers, system-wide efficiency and cost-containment should be privileged as part of the reform. They should also be designed to monitor and potentially reward good performance on key quality indicators.

Third, it is important to highlight the potentially high administrative burden contracting can put on counties, especially when competitive bidding takes place, which requires detailed and hard contracts. This experience, which is largely shared across OECD countries, has sometimes prompted them to revert to more cooperative joint planning approaches between preferred purchasers and providers. This model, which is based on trust, seems well suited both to the existing governance culture of Finland and the current shortcomings of information systems.

The reform recognizes that the effective management of population's health requires a comprehensive and strategic management of various segments of the population. It is very important that counties identify "packages" adapted to various segments of the population based on their needs and that these be embedded in the countries purchasing strategy. This is easier to achieve in models where (groups of) providers are jointly accountable and paid for delivering packages rather than contracted and paid for each service separately by the purchaser.

Finally, the use of more cooperative forms of provision is further reinforced when aiming to integration and coordination of services. Finland, like many other countries, faces a major challenge to put in place contracts and payment mechanisms that enable vertical integration between hospital, primary and community services; as well as horizontal integration between health and social services. Many methods of con-

tracting and paying providers that encourage competition and improve accountability often work against integration.

Coordination is very difficult to achieve if providers are competing among themselves and across levels, individually contracted and patients' are free to choose their pathways and providers. Population-based payments and bundled payments should therefore be privileged over payment per individual products or services – see Chapter 5 for a more detailed discussion on coordination and integration of services.

Harmonizing provider payments within and across counties

As responsibility for paying providers will be transferred from municipalities to the counties, they will have to invest time and effort in collecting information and hard data to understand both the scope and nature of services provided by the facilities in each municipality and the cost of provision of these services. Some degree of eventual harmonization will be required both in terms of "products" purchased and prices for these so the public resources pooled at the county level are used in a fair way.

In fact, most countries have uniform payment systems which are centrally designed, generally quite sophisticated to take advantage of and balance incentives, build on uniform reporting requirements by providers, and where prices are more transparent and harmonized across administrative boundaries and public and private sector. The complexity of designing and implementing payment systems for all types of providers at each county level should not be underestimated.

Although this may not seem an immediate priority in the reform agenda, consideration should be paid to centralizing some of the design effort that needs to go into these payment system reforms. Similarly data collection and costing methodologies should be prioritized and adopted early on in the reforms and coordinated at central level. While variability in purchasing and payment systems across counties is inevitable in the short-run due to differences in technical capacity, in the long run, there should be a harmonization of payment systems and prices across counties (allowing for variations in costs due to geography in addition to some incentives). This will be administratively simpler for counties and providers, as well as facilitate patients seeking care from other counties, as compared to a scenario where counties determine their purchasing and payment strategies independently.

Ensuring autonomy of all public sector providers

To create a legitimate purchaser provider split, publicly owned providers need to be granted sufficient autonomy to respond to incentives, bids, sub-contract themselves, etc. This is particularly important among publicly-owned providers under the freedom of choice scheme, but is also relevant among public service law utilities who are not subject to competition. In the case of the latter, public service law utilities will need the authority to manage themselves and re-organize so that they may respond quickly to changes in purchasing incentives; some degree of decentralization of responsibility for provision should be considered. In the case of publicly-owned providers under freedom of choice, these new companies will require the capacity to make a whole new set of devolved decision over areas such as staff conditions, service development or capital investments as well as the necessary (and often) scarce skills to do so (see Chapter 4 section on the need for a level playing field among providers).

Ensuring autonomy of county-owned providers could prove more difficult. If the expectation is that county-owned providers will compete with other service providers for services under freedom of choice, ensuring transparent and fair purchasing by the county may be a challenge, since in effect, counties will be both purchaser and provider. As such, they may be inclined to contract themselves which can give rise to

conflict of interests. A national level competition regulator may play an important role, as is the case in the Netherlands.

Giving more responsibility to collaborative catchment areas

The decision to organize the country into 18 county divisions has been controversial and responds to a number of administrative and political reasons that fall beyond the scope of this report. From a purely purchasing and organizational perspective, however, it would be more effective to have a fewer number of counties. Although having a large number of counties allows for decision making to be closer to population needs and gives an opportunity to conduct experiments and observe variations, the organization and purchasing of services benefits from larger population bases, particularly in the case of many high cost or specialized services. Larger counties will also benefit from a critical mass of purchasing capacity and skills, which as noted above, are key to success.

This has two sets of implications for consideration. First the role of the five collaborative catchment areas will likely need to be strengthened in the future, as these appear to be natural units of organization and purchasing. The current governance approach, based on 'collaborative agreements' between areas, may not be sufficient for this to occur seamlessly and most effectively, and should be carefully monitored. It would be advisable to consider some form of regulation or provisions which would oblige the counties to (re)pool funding at the collaborative area level for more specialized services.

National level guidance to support purchasing

National level authorities will need to play an important role in designing information systems and facilitating data collection to support not only strategic purchasing, but also competition, integration and other functions of the system. To ensure equity across counties as well as to support purchasing services across county borders, clear guidance on purchasing should come from the national level such as setting national standard framework contracts. Otherwise, while leaving purchasing decisions entirely up to the counties (e.g. organizing tenders to provide specific services versus negotiating with one or more provider; purchasing individual services or packages; they could purchase from individual or consortia of providers) could spawn innovation, it also may be overly burdensome in its entirety and counties may not have sufficient capacity to undertake all of the complexities of purchasing. The expert panel wants to highlight the importance of the Ministry's initiative to support change that is designed in cooperation with counties. As needed, this could usefully lead to the development of some guidelines for purchasing. It will be important to organize a platform for counties to share mutual experience – good and bad, similar to or as part of the Innovillage platform which is intended to support open, collaborative efforts within the health and welfare sectors in Finland. Counties should also be encouraged and enabled to form alliances to work on specific agendas, such as collaborative purchasing (for instance if they have similar profiles).

In the same way the purchasing of highly specialized and high technology services should be carried out at the central level to refer patients to specialized centers and to benefit, among others, from higher volume, specialization and better outcomes. In fact, there is increasing trend towards referring rare diseases and highly complex diseases to centers in member states across the EU i.e. EU's European Reference Network Initiative. At any rate, given the overall population size of Finland, some purchasing (e.g. for specialized care) would be better carried out at national level. In England, for example, £32bn out of £95bn purchasing finance is spent at national level by NHS England.

4 CHOICE AND COMPETITION

Key Observations

- If well designed, there is clear potential for choice and competition to incentivize providers, increase access and responsiveness, and improve quality
- Given the many potential models of freedom of choice, it is important that the reforms clearly identify the circumstances in which choice will be available
- Allowing private providers to compete to provide publicly funded services requires a level playing field between providers, with particular efforts to prevent cream-skimming
- There are significant information needs to enable choice and workable competition, including public reporting of provider quality data so that clients can make informed choices and so that purchasers can decide who to allow into the market and monitor performance

Introduction

Countries have different concepts of choice and competition, in different sectors, with different instruments and objectives, and different degrees of effectiveness making generalizations difficult. Freedom of choice combined with some competitive pressures has the potential to improve responsiveness, access and efficiency by spurring innovation and ensuring that 'money follows the patient'. Introducing some contestability, or even the mere threat of competition among public sector providers may also encourage more efficient practices. Moreover, for a number of countries allowing patients the right to choose and to involve private providers are endpoints in themselves. In the same way, economic and political interests in growing the private sector may offer sufficient justification to introduce choice and competition. While there appears to be some consensus to introduce freedom of choice, the precise model of choice in Finland remains undecided at this point in time. Nevertheless, evidence from other countries demonstrates that developing and implementing freedom of choice schemes as well as stimulating and regulating the market in a way that achieves its intended objectives have proven to be very complex undertakings. An adequate design that relates to the specific context of the country at hand is a key requisite for a successful implementation.

Freedom of choice is an important development in the Finnish system, however, it is not an entirely new concept (Tynkkynen L-K, Saloranta A, et al 2016). Some choice already exists within the municipal system (e.g. choice of health centre), though this has not been seen as a strategic priority in most municipalities. The extension of freedom of choice is likewise not considered to be the core of the reform according to many key stakeholders.

In this section we review the potential for choice and competition to benefit the Finnish health and social care sectors, although it is important to note that competition is not necessarily synonymous with patient choice. We focus in particular on the practicalities associated with private providers competing to provide publicly funded services.

International trends and developments

Freedom of choice

Freedom of provider choice has always been a feature of the traditional 'Bismarckian' systems of social health insurance, and is becoming increasingly widespread in tax-funded systems. It has a number of objectives, including directly improving the satisfaction of service users, prompting quality improvement amongst providers, and stimulating new entrants and innovative service delivery methods into the market.

Freedom of provider choice effectively devolves some aspects of system governance to the individual service user or their advisors. Whilst potentially offering benefits, especially in social care and for caring for individuals with chronic conditions, where personal preferences may be particularly important, it can also pose governance challenges for other aspects of the system. For example, procurement decisions of strategic purchasers (counties) may be undermined by the decision of some service users to use providers with which the purchaser does not hold a contract; in this case, the patient would likely be responsible for 100% of the costs. Strategic integration of services may also become more difficult to effect with uninhibited freedom of user choice.

Freedom of choice can be valuable for imposing discipline on providers, and helping align packages of care with user preferences. However, there are countless ways in which choice can be introduced into a care pathway. For example:

- choice of general practitioner;
- choice of specialist provider at first outpatient referral;
- choice of provider of acute intervention;
- choice of rehabilitation provider;
- choice of ongoing ambulatory care provider;
- choice of long term care setting and provider.

Patients (or their providers) may likewise have the freedom to choose their own care pathway, irrespective of clinical guidance. Furthermore, there may exist different freedoms as to how much choice is allowed, for what aspects of care, and at what stage changes to provider can be made. Most research evidence relates to very particular aspects of choice (such as first specialist referral), and it is difficult to generalize the lessons from research (Propper and Leckie, 2011). It will be important that the reforms specify clearly the circumstances in which choice is available.

Thus, whilst freedom of choice holds the potential for stimulating improvements in user satisfaction and provider performance, its introduction could lead to unintended complexities and paradoxes. Therefore it is strongly recommended that implementation is undertaken cautiously, in a stepwise fashion, starting with services in which some degree of choice already exists (such as social services and some aspects of ambulatory care) and only progressing to more complex services (or bundles of care) once early experience has been assessed.

Sweden introduced a mandatory primary choice system in 2010. The reform sets out that each individual is allowed to freely choose a health care center (or in some counties a GP) in the county. The reform also allows private providers to establish freely wherever they want in the counties. The payment is entirely connected to patients' choices, i.e. incomes are based on the health care center's ability to attract patients. The introduction of the 2010 choice reform has been followed by an excessive debate on equity and quality. Evaluations show that access of care has improved greatly due to the reform, predominantly due to the establishment of 270 new private providers after the reform. Patient satisfaction has improved slightly,

probably as an effect of the improved accessibility. A drawback is that new establishments have been more common in well-situated and densely populated areas. (Isaksson et al., 2016; Riksrevisionen, 2014). Another problem is that patients with simpler conditions use the services more often and patients with severe or complex condition tend to use health services less, triggering a debate on health care equity. So far, it has proven difficult to ascribe effects on medical outcomes of the reform. Since 2015, patients in Sweden have also been allowed to choose their primary care and ambulatory care providers across the entire country.

Private sector development and performance

For-profit hospital providers have taken up larger market shares in many – but not all - OECD countries over the past decades (Table 2). The results are even more robust for psychiatric and substance abuse services, ambulatory treatment centers and nursing homes, although comparable data for these segments are lacking. However, in the US 68% of all nursing homes are for-profit; in the UK 55% of all care home beds are operated for a profit; in Canada figures differ from 15% in Manitoba towards 52% in Ontario (Bos et al, 2016). Ambulatory treatment centers, outpatient centers, and community care need substantial less capital, which creates opportunities for entrepreneurial physicians that typically own such facilities. It is also in such areas where many innovations come across that rely on a fundamental redesign of the services at stake – driven by changes in patient needs and the ambition of professionals to improve care. Well-known international examples are the Aravind eye clinics in India or the Buurtzorg model for community care without any bureaucracy in the Netherlands. Still, other sources of for-profit growth stem from services that depend on private patients such as (luxury) substance abuse clinics and assisted living facilities for the better-off elderly.

There exist some remarkable growth stories in for-profit health and social care, for example the staggering growth of for-profit hospitals in the new German states after reunification (1990); and in the US after Medicare (1965) - which until the early eighties ‘guaranteed’ a return on equity for private investors. In the UK, the private sector prospers during periods where the NHS struggles with limited funding and/or depending on NHS commission practices (Jeurissen, 2010).

It is rather complicated to explain the growth of for-profit healthcare providers, though some evidence suggests a proliferation of private providers where there are high compensation business models and where there are a dearth of available public providers (Jeurissen, 2010).

Table 2. Development of hospital beds and number of for-profit providers.

		1995	2000	2005	2010	2013	1995-2013
Australia	# hospital beds	82 477	76 875	78 715	83 166	85 200 [ab]	3.3%[a]
	% for-profit	14.2	17.6	16.4	16.2	17.1	
Austria	# hospital beds	67 853	63 674	63 248	64 008	64 825	-4.5%
	% for-profit	6.9	7.1	9.0	11.1	13.1	
Canada	# hospital beds	137 732	115 829	99 957	93 853	93 525 [ab]	-32.1%
	% for-profit	0	0	0	0	0.9	
Czech Rep.	# hospital beds	87 784	79 985	77 309	73 746	67 888	-22.7%
	% for-profit				13,7	17.7	
United States	# hospital beds	1 080 601	983 628	946 997	941 995	920 829 [a]	-14.8%
	% for-profit	12.3	13.1	13.8	15.1	16.5	
France	# hospital beds		484 279	455 175	416 710	413 206	-18.7%
	% for-profit		19.8	20.4	23.4	23.7	
Germany	# hospital beds	790 756	749 473	698 303	674 473	667 560	-15.6%
	% for-profit			29.7	30.0	29.8	
Greece	# hospital beds	52 227	51 500	52 511	54 012		3.4%[c]
	% for-profit	29.2	29.4	27.4	27.2		
Poland	# hospital beds			248 860	251 456	250 280	0.6%
	% for-profit			17.0	24.3		
Spain	# hospital beds	154 644	148 081	145 863	145 199	138 153	-10.7%
	% for-profit	19.5	18.0	19.7	18.2	18.8	
Sweden	# hospital beds	42 359	31 765	26 478	25 566	24 905	-41.8%
	% for-profit	0	<1	<1	<1		

a: based upon 2012

b: estimation

c: compared to 2010 instead of 2013

Source: (OECD Health Statistics 2015): June 2016

Evidence on whether private providers provide better quality care or improve access to services varies. US studies generally find that in acute care, for-profit hospitals charge higher prices while operating at the same or slightly lower costs, with little hard evidence of better quality of care (Schlesinger and Gray, 2006). European evidence is more diverse, especially when it comes to issues of access. With the exception of the Nordic countries, NHS health type systems often have a private parallel system for the better off (UK, Ireland, Italy, Spain, Greece). Another issue that also holds for most EU countries – probably with Germany as the major exception – is that for-profit providers treat less complex cases.

The evidence is rather different for long-term care, where private penetration is also much higher. US studies indicate that private for-profit nursing homes are more efficient and deliver equal quality of care compared to private nonprofit facilities. On the other hand staffing levels and job satisfaction were less and hospital referrals were more in for-profit nursing homes (Bos et al, 2016).

In Sweden, there has been a large increase of private providers within elder care during the last decade; both regarding nursing homes and within home health care. Quite opposite to what the government wished for, the market has consolidated with predominantly for-profit providers. Studies show that staff levels are lower among private providers but that they rate better on service aspects such as patient participation and documentation (Stolt et al 2011).

If we abstract from the huge varieties across the ownership literature, certain similarities can be discerned (Jeurissen, 2010). First, most private providers pay physicians more and nurses less, which is a matter of concern given the now extensive evidence of the importance of adequate numbers of well-motivated nurses for patient safety (Aiken et al, 2014). Second, private providers often employ more capital but operate with smaller more specialized facilities. International experience shows that safety net and tertiary care functions are overwhelmingly either public or nonprofit; and that the penetration of specialized for-profit facilities is much higher in urban versus rural areas. Third, in most countries the private for-profit sector is rather concentrated and operates at the national level. For-profit small and medium enterprise typically gets acquired in a consolidation process, although there also exists a market for small physician led facilities. Thus, fourth, growth often comes from mergers between for-profit companies or the privatization of public and private not-for-profit assets. In the German context public and non-profit hospitals have increased their efficiency after conversion to for-profit status (Tiemann and Schreyögg, 2012). For-profit providers seem more responsive towards incentives, both good and bad ones (Schwierz, 2011). Kankaanpää et al (2013) seem to confirm this hypothesis for Finnish occupational health providers; they conclude that for-profit unit prices declined once the competiveness of the catchment area increases.

Key reform issues and prerequisites

The plans for choice and competition in Finland are not fully decided yet, though there is increasing understanding within the government that the implementation should take place incrementally. For any model of choice to be successful, there are important pre-conditions which should be met and which are often cumbersome to implement.

Introducing freedom of choice

We suggest, below a basic typology of options for freedom of choice which will serve to provide some suggestions in the Finnish context. These options include:

i. Patient chooses the primary health and social care provider, public or private, out of those in a national register covering basic standards of quality and without any restrictions to market entry; the county then reimburses the provider retrospectively for the care provided;

ii. Patient chooses the provider which, in addition to the scenario above, will have to meet the conditions of a prospective contract set out by the county purchaser and which includes the form of reimbursement and some basic quality indicators, but without any restrictions to market entry;

iii. Patient chooses among a limited number of providers, which are under detailed contract by the county following a competitive selection against a series of quality criteria set out by the county.

Each model can be appropriate depending on context. The first model - the purest form of market choice - is likely to be highly inflationary as a result of supplier-induced demand. Its use may be limited to a very well defined, highly standardized, low volume, low cost set of services. The second model may be useful, for instance, to provide primary health and social care to relatively healthy population groups, who might choose among groups of practitioners working together to provide a well defined range of services, for a limited period of time and which would receive some form of adjusted per capita payment. One other form applicable here would be through vouchers given to patients to 'buy' a limited set or services or procedures such as 20 physiotherapy sessions. The third model could be also employed for basic primary and social care services, but would be also appropriate, for instance, to provide more complex services such as an integrated package of services to a diabetic patient which could then be reimbursed through a form of bundled payments.

One practical way forward for the reforms would therefore be to wait to introduce freedom of choice involving private providers until a later stage of the reform process once counties have developed their organizational and purchasing capacity sufficiently (See Chapter 9 on reform implementation). Concomitantly with the development of county structures, there could be some measures to encourage choice between municipal primary and social care centers. While choice is now possible, there are very few incentives, economic and otherwise, for those professionals and centers to attract new patients.

Considering the role of the private sector in the freedom of choice scheme

Historically in Finland in acute care, the private sector performs services that mostly target employees and include certain elective care procedures (e.g. fertility treatments, cataract surgery). Although the private sector struggled tremendously during the 1991-1994 recession, its scale and scope have gone up for quite a while now, especially in most recent years. In acute care it still consists of only few private hospitals, but in social- and occupational services as well as physician offices the private sector has a substantial stake. Although it is difficult to know how private providers would react to the reforms operationally, it is probable that existing larger enterprises will seek to acquire smaller providers.

In terms of which services may be most appropriate for choice and competition, evidence suggests that services with high levels of measurability and contestability gain more from freedom of choice in compari-

son to services that have low levels of measurability and contestability. One might consider this by setting the embarkation lines of FOC. This implies that any possible gains of freedom of choice come more to the fore in primary care and outpatient services as well as assisted living facilities and less in hospital settings.

While strong commissioning bodies and well-designed processes are crucial preconditions as described in Chapter 3, they are even more important once for-profit companies are involved in provision. Thus opening the market to for-profit providers is more logical with counties as purchasers in comparison to the current role of municipalities, given that counties should have greater leverage and capacity, though it must be done with great care. Commissioning and freedom of choice are easier when a well-defined and well-functioning market exists (EXPH, 2016).

Creating a level playing field amongst public and private providers

To allow providers to compete, public and private providers must operate on 'a level playing field', by which we mean they should be treated the same in terms of the way they are monitored, contracted and paid and in the complexity of patients that they care for. This may be challenging given the current linkages between county-owned provider organizations that compete under the freedom of choice scheme and the county itself, even with a purchaser provider split in place, as some counties may take anti-competitive steps to ensure that their own providers remain financially solvent. Independent surveillance capacity on the national level is needed as a watchdog on such practices.

Steps must also be taken to ensure that providers do not segment the market and offer services primarily to comparatively healthier populations. Creating a level playing field may necessitate that the private sector is somehow less well compensated or pays more taxes to counterbalance the potential for cream-skimming. International evidence suggests that very often for-profit providers target those patient groups where profit margins are high and turn away from services that are cross subsidized within public and non-profit institutions (for example education, training, severe psychiatric disorders and certain high cost treatments). Cream skimming may be reduced by putting some incentives in place to dissuade private providers from selecting only the healthiest patient groups, or by limiting the profitability of some services. It is also important to make sure providers meet nationally recognized quality standards before being allowed to offer services, and that information systems are in place that continuously monitor provider processes and quality of care. Additionally, with regards to the objective of improving equity, incentives will be needed to attract private providers to more rural areas with provider shortages, otherwise competition in these areas will be limited.

A public watchdog (competition authorities) is needed to assess fair competition. A competition authority already exists but probably needs time to build up expertise, such as criteria for relevant markets (geography, populations etc) and indicators for excessive market power (price setting etc.).

Meeting information needs to support choice and competition

Information is a fundamental requirement for choice and competition, to ensure that providers are delivering high quality care, and to act as a signal of quality for strategic purchasers, voters, and service users. Reports of provider quality are vital to strategic purchasing, and audit of purchaser and provider performance. A set of relevant quality indicators needs to be developed and enforced. Besides this, patients will be helped by standardized patient-reported experience measures (PREMs). Responsiveness surveys are being planned and should be integrated as a standard feature in the M&E framework.

Public reporting of provider quality is a general requirement and not only attached to the freedom of choice scheme. Existing information systems may form an adequate basis to support some degree of choice

(for example with respect to indicators such as waiting times or hospital readmission rates). However, in other domains (such as clinical quality, ambulatory care and long-term care) it may be necessary to introduce new indicators of quality to act as a basis for public reporting.

Without good quality information on quality, service users are in principle unable to exercise meaningful choice of treatment or provider. There is a great deal of international evidence on the impact of public reporting of provider quality (Rechel et al., 2016). In summary, it shows that few users make overt use of such information in making their choices. However, it does suggest that providers respond to such information, by seeking to improve their reported quality. Sometimes this improvement is secured by improving care standards, as intended. However, there is also ample evidence to suggest that providers may also seek to improve reported performance by 'cream-skimming' only those healthier patients likely to enjoy high quality outcomes, even if treatment could in principle yield health gains for more seriously sick patients. Such evidence does not invalidate the principle of public reporting of provider performance, but it does indicate that great care needs to be taken in adjusting those reports for the relative risk of the service user population.

5 COORDINATION AND INTEGRATION OF HEALTH AND SOCIAL SERVICES

Key Observations

- Coordination and integration of health and social services can lead to patient-centred care, increase quality and improve efficiency
- There are many preconditions to establishing service chains that integrate care
- Finland should focus on both horizontal and vertical integrated care models, building on its considerable existing experience and pilots
- Information systems must be carefully developed to facilitate providers to manage patients in integrated care models
- Care should be taken to ensure that integration of services is not disrupted by freedom of choice

Introduction

Currently, municipalities are responsible for both health and social care, however in many cases there remains limited coordination. Insufficient coordination and integration of health and care social services is a well-known problem in many countries today, especially for frail elderly, people with multiple chronic conditions, and people with substance abuse issues. These groups, who often need both social and health services, often fall through the cracks, missing out on needed services due to the lack of coordination between service providers, or get services at the wrong time. Thus, ensuring that integrated care models work properly is one of the most urgent tasks for many governments today. Problems with integration are also costly to both the individual and society, as they often lead to duplication of care, unnecessary treatments, and hospitalizations (Coleman 2003). With 10% of patients responsible for around 80% of costs in Finland there is clearly great scope for improvement regarding integration and coordination as this may improve patient care and efficiency.

While there seems to be no established definition of the concept of "integrated care," for the purpose of this report we consider integrated care to mean "a discrete set of techniques and organizational models designed to create connectivity, alignment and collaboration within and between the cure and care sectors at the funding, administrative and/or provider levels" (Kodner & Kyriacou 2000). This definition covers activities at vertical and horizontal levels, i.e., linking different levels of care such as primary, secondary and tertiary care or linking similar levels of care like primary and social care (Valentijn et al. 2013).

International trends and developments

How to attain vertical and horizontal integration is a question by no means isolated to the Finnish health care system or systems of its kind; this has been an ongoing and widespread policy concern in most Western countries (Bodenheimer 2008; Meads & Shaw 2010; Ahgren 2014; Rudkjøbing et al. 2012).

Initiatives at the macro/meso level: agreements and pooled funding

There is an extensive literature on integration on the organizational level, i.e. within the geographical units. A key finding of these studies is that integrated care models are often holistic in meeting the needs of the patients/users. Important implementation strategies include the use of multidisciplinary professional teams that work in a flexible way, have well-defined roles, and communicate effectively with each other. Pooled budgets, a single point of entry, as well as careful care planning are also factors that are seen as beneficial to collaboration and are a common trait of the models (Goodwin et al. 2013; Goodwin 2014; Curry & Ham 2010).

As in the Finnish reform proposal, a main policy instrument in integrating care services in the Nordic region has been agreements between stakeholders in the system – bilateral agreements between counties and vertical agreements between stakeholder associations and the national government. This instrument is often considered best where legislation or standardization of rules is not applicable (Rudkjøbing et al. 2014). In both Denmark and Sweden agreements have been used on both national and local levels to intensify efforts for certain patient groups for which services have been lacking. Patients suffering from chronic illnesses, the frail elderly, and patients with complex needs have been a particular focus. There have also been agreements on clinical pathways for certain diagnostic groups, e.g. for certain cancer treatments. Between regions level in the health care system, bilateral agreements have proven successful to integrate health care coordination in both Denmark and Sweden (Rudkjøbing 2014). In Finland, currently all hospital districts have developed care pathways to enhance mainly vertical integration in health care; these are based on evidence-based national clinical guidelines and mainly disease specific (see www.terveysportti.fi).

Another example of integration on the macro/meso level is pooled funding and shared risk, creating economic incentives for coordination and collaboration. An example of a 'shared risk' model is the so-called Accountable Care Organizations (ACOs), developed in the U.S. after the Affordable Care Act (ACA). This model consists of networks of physicians, hospitals, home health agencies and skilled nursing homes that voluntarily come together and are held accountable for the quality and costs for all care delivered for a given population under a contractual arrangement with a commissioner (Shortell et al 2013). The Medicare funded ACOs are awarded a 'shared payment' based on the difference between a predetermined benchmark and their actual costs for a group of patients. These shared savings are then divided among the providers. Some studies on performance show cost savings relative to expected costs (Colla et al 2014, Epstein et al 2014, Nyweide et al 2015). Patient experience seems to have improved slightly, and process quality is unchanged or somewhat improved compared to non-ACO hospitals (Epstein et al. 2014, Nyweide et al 2015, McWilliams et al. 2014). Outcomes, in the form of readmission, have improved significantly over time in the ACOs. This positive result is primarily attributed to targeting at-risk patients better, and/or enhancing information sharing and general communication between hospitals and SNFs (Winblad et al. work in progress). Still, the evidence is far from conclusive, and more research, particularly on clinical outcomes at the individual level, is needed to establish the effects on health care spending and quality.

Initiatives on the inter-organizational level

There is an extensive literature on the main characteristics of integrated care models on the organizational level and what strategies have been used to promote integrated care that could also be of use in the Finnish case (Leutz 1999; Goodwin 2014). These models include population-focused strategies for certain patient groups, such as frail elderly, patients suffering from chronic illness or patients with both health care and social service needs. However, since the context differs greatly between countries, no single model can be applied universally (Curry & Ham 2010). Still, King's Fund in the UK has presented a report on similarities between models in seven countries that deliver integrated care for older people with complex needs. Its conclusions are similar to that of an earlier study of integrated care models in the UK. The report states that key aspects of a successful integrated model are (1) professionals being able to work together in a multidisciplinary setting, either through multiprofessional teams or provider networks, (2) personal contact with a named case manager or health care personnel, (3) holistic care assessment and care planning, and (4) a functional ICT-system (Goodwin 2014).

Multi-professional teams have proven particularly successful in the primary care setting, but also in hospital care (Epstein 2014), long term care (Hirdes & Kehyayan 2014) and mental health care (West et al. 2012). Integration through multi-professional teams combines responsibilities for commissioning services and promotes shared accountability, problem solving and decision-making to achieve optimal health and well-being in a defined population (Shortell et al. 1996; Ghorob & Bodenheimer 2015). Examples of multi-professional models in the primary care setting include both intra-organizational teams at health care centres, as well as inter-organizational teams in ambulatory, community-based services for certain patient groups. Integration of services in the primary care setting is of preeminent importance since the primary care facility is the default point of entry into the health care system as well as the base for continuous and comprehensive health service provision throughout the entire health care system (WHO 1978).

Case management has also been shown to be one of the most essential components of well-functioning integration on the inter-organizational level, where the case manager (or a care coordinator) functions as the hub for the numerous linkages in the complex health care system (Bodenheimer et al. 2002; Ghorob & Bodenheimer 2015). A case manager is responsible for linking all health care events and services, so that the patient receives adequate and appropriate care. Examples from Australia, The Netherlands and the United Kingdom show successful results in patient outcomes and patient satisfaction, especially in chronic disease management (Goodwin 2014). However, where case management is implemented, the role of the primary care physician needs to be addressed – will a single GP be responsible for patients, or will there be a separate functionary at the health care centers responsible for managing each patient's care chain?

As shown above, a wide range of implementation strategies – on macro and meso levels – are available to promote integrated care. Thus, we know quite a lot about the implementation strategies themselves, i.e., what has been done to create more integrated health care systems on the organizational level. However, many questions remain unanswered when it comes to the actual effects of integrated models on the individual level. In what way does the health situation of patients/users really improve if they take part in integrated models and what are the gains for society? A new review by the UK Parliament shows that costs have even increased in connection with some integration approaches. This may be explained by the identification of previously unmet needs (Parliamentary Office of Science and Technology 2016; Mason et al. 2014; Wilberforce et al. 2016). In the Finnish case it is therefore of uttermost importance to follow-up and monitor new integration initiatives in order to evaluate their effectiveness.

Key reform issues and prerequisites

While actual integration at the service level will remain a complex endeavor, there are important preconditions. Providers must be actively encouraged to work together; payment systems and financial incentives that foster cooperation among providers are powerful tools to do this (see section on purchasing and payment systems). Information technology that provides useful data to providers so that they can manage patient care as well as to the counties who will coordinate the integration is essential and will need to be developed (see section on information systems). No less important is to foster an understanding of different professional norms and behaviors. An important task for the Finnish authorities is to require multiprofessional training in the curriculum and during internships.

Establishing service chains

In the reform proposal the service chains (i.e. care paths) are set out as the most important tool to create integration. The counties will be responsible for identifying patient groups needing coordinated services as well as coordinating the service chains for those groups, for instance ensuring comprehensive clinical pathways for certain cancer patient groups, coordinating care for patients suffering from chronic illness or multimorbidity, as well as guiding frail patients or patients suffering from mental health problems. Even if this will be simplified by health and social care providers working together in the same organization (for the first time) an important concern is still to organize and facilitate the service chains in an effective manner, across sectors and including all relevant caregivers. There are a number of concerns to pay attention to in the Finnish case:

a. In the reform proposal, with more private providers, more attention should be paid to the formalization of contracts between the providers in the service chains. Roles and responsibilities for caregivers need to be defined and formalized in the contracts. Important issues to address are for example how flexible the collaboration will be and how and when new providers will be able to participate in the service chains/collaboration. Are there adequate incentives for all parts to contribute to a well-functioning service chain?

b. Targets for the integration initiatives, i.e. the service chains, need to be discussed and defined in a more explicit way than is done today, addressing the needs for the top consuming patient groups, e.g. the frail elderly or patients with chronic conditions. More precise goals are particularly important in order to evaluate outcomes, on individual as well as societal levels of the service chains.

c. Leadership of the integrated service chains needs to be defined. Who is in charge of the models/service chains and makes decisions regarding participation/regulation/implementation? For instance, will the county or local networks decide on eligibility criteria and what happens to those individuals that are excluded from the coordinated services.

d. Case management has shown to be an essential component of well-functioning integration models. Therefore, each person participating in a service chain in the counties ought to be assigned a case manager responsible for coordinating the different phases and contacts. Guidelines need to be established to decide what competence is required for this position (GP, nurse or social worker) and whether the person should be part of the service chain or a separate function.

e. Payment models are an essential component of successful integration. Integrated care often includes care trajectories where several actors are involved, both from primary care and social care. It needs to be clarified in the reform how much each provider will be paid and how revenues/savings are to be divided in bundled payment models. An alternative is to allocate the budget to the case managers who are then responsible for allocating resources. For some patient groups, such as mental health and other chronic diseases, the need for longevity of the care given and the open-endedness of the care chain may require the payment system to be set up differently than for patient groups with easier needs and diagnoses. Combining pooled funding, capitation and fee-for-services reimbursement is essential in incentivizing caregivers to coordinate care for groups such as these.

f. Accountability is particularly important in a model with several actors. How is the governance of the service chains supposed to take place and how is it accountable for the overall results/outcomes? Are staff responsible only for their separate parts or also for the whole service chain? Someone needs to be accountable, and who it is should be specified in the SOTE proposal.

Moving towards voluntary bilateral agreements

There are some crucial factors for the success of meeting bilateral agreements and implementing them. First, agreements need to be voluntary. This is both in regards to the agreement being initiated from the bottom-up, and for the follow-up mechanisms to work after implementation (Rudkjøbing et al. 2014). If the stakeholders do not consider the agreement to be in their best interest, it can potentially be regarded as an enforced standardization rather than an agreement. The current Finnish proposal emphasizes agreements on various levels. However, from reading the proposal it seems like the national government is having a veto function by demanding mandatory agreements if agreements are not established the local county level. This may lead to a situation where the agreements are perceived as involuntary in nature by the local actors, creating disincentives to follow them. To facilitate a situation where mandatory agreement are avoided the national government could establish support structures for successful collaboration on the local level.

Building on existing pilot programs

Innovating care for people with multiple chronic conditions in Europe (ICARE4EU) in co-operation with European Observatory on Health Systems and Policies has described and analyzed innovative approaches in multidisciplinary care for people with multiple chronic conditions currently in Europe. Based on care integration, financing mechanisms, patient-centredness and use of eHealth a Finnish integrated care practice, financed by MSAH, POTKU was select among eight of the 'high potential' programs.

Indeed, Finland has a considerable range and depth of experience with pilots. Given the context-specific nature of health and social care integration, Finnish regions that have had successful pilots should build on and scale up these programmes and be given the autonomy to do so. In this way a 'toolbox' for well-functioning strategies will be developed for other counties. It is also important to make sure that existing, well-functioning integration initiatives are not hindered by aspects of the reform. For example, if there is an introduction of a strict contracting model it could lead to a situation where successful initiatives, such as the South Karelia Social and Health Care District (Eksote) or the North Karelia Project on prevention (Korpela et al., 2012; Puska et al. 2009), do not function as they have previously. Similar pilot project have emerged

in Sweden, such as the TioHundra project in the northern Stockholm region. Here, a joint administration for health and social services was established, along with a joint health services council including both municipal and county officials. The project has been considered successful and is extended several times over a ten-year period. Joint decision-making across the different policy sectors, like in the TioHundra project, can potentially enhance care coordination for patients with chronic illness, multimorbid patients, and frail elderly in the Finnish case.

Additionally, most of the pilots have concerned horizontal integration among health and social services. Currently, several such projects are supported and financed by the Ministry of Health and Social Affairs in order to develop better practices. In these large scale projects within hospital districts or catchment areas case management tools, client plan and interprofessional cooperation are developed and piloted; academic research is linked or planned to be linked to some projects as well. These projects are effectively networked by THL and all outputs and outcomes are reported in Innokylä https://www.innokyla.fi/web/verkosto1803119 (only in Finnish). The projects are expected to produce tools and practices which can be used in all counties.

Nevertheless, as important in the Finnish case is the vertical integration between hospitals and primary care/social care, not least to facilitate cost savings connected to reducing admissions/readmissions, decreased length of stays and more efficient discharges from hospitals.

Creating information systems that support integration

The reform's aim of integration of social and health services will pose some specific challenges for the information system development. Developing information systems has been seen as a key element in health system reforms around the world; however in reality health information systems have been rarely developed as a systemic entity (AbouZahr & Boerma, 2005). This has been historically the case in Finland, mainly because the decentralized nature of the health system allowed the development of parallel information systems which were largely not interoperable (Vuorenkoski, Mladovsky, & Mossialos, 2008). The implementation of a new information structure in the Finnish system is a unique event, creating an opportunity to address some key obstacles in information sharing across the system – for personnel, for evaluation and research purposes, as well as for citizens and patients. In terms of integrating care services, the use and sharing of electronic health records (EHR) has been emphasized as a main function to increase efficiency and lessen the administrative burden for health care personnel (Chaudhry et al., 2006). Therefore, it is advisable that the reform proposal outlines a comprehensive information infrastructure that dissolves any current administrative boundaries between the health and social care sectors, ensuring accessibility and patient safety without threatening patients' integrity and rights.

Ensuring that choice does not jeopardize integration

There are significant risks that result from the freedom of choice and competition components of the reform that jeopardize the integration of care. By allowing patients to choose providers, it can be difficult to direct patients into cost-effective care pathways and to ensure coordination across providers who may be competing for business. In many respects, there is a risk that the aims of choice and competition can undermine that of integration and coordination if applied in the same areas. An alternative could be to remove the 3-10% high-risk patients (i.e. see bill, page 147) from the choice scheme in order to create more efficient service chains. A second alternative is to allocate the budget to the case-manager to organize services and allocate resources between the providers that the patient chooses.

6 PUBLIC HEALTH

Key Observations

- Finland is recognized as a leader in public health in Europe, with a strong record of achievement, and is looked to as an exemplar of what can be achieved.
- There are risks during any major organizational reform, including the loss of critical expertise, institutional memory, and networks.
- While recognizing the autonomy of the county authorities, there is a strong argument for developing guidance on the range of essential public health functions, drawing on Finnish and international good practice.
- Counties need a clearly defined public health mandate and capacity.

Introduction

The proposed health care reforms involve a number of changes that will impact on roles and responsibilities in relation to public health, even though this is not the main focus of the changes. Many public health functions currently reside at the level of the municipality, as part of its global responsibility for the population´s health and social care. Many of these functions will move to the new counties, including preventive care services, environmental health, and screening, as will at least some aspects of health reporting, including the existing Structural Social Reporting which seeks to document and map social problems but which is, at present, only undertaken in a small number of municipalities. Responsibility for well-being (i.e. Health in All Policies) will remain at the municipality level. Some specified tasks are undertaken by THL, as mandated by national legislation, such as infectious disease surveillance on the national level, availability of vaccines, and national registries. This will not change.

There is, however, a lack of detail on the proposed changes, which contrasts with the situation with respect to other aspects of the reforms. There are many issues that, as far as can be ascertained, have yet to be resolved. However, the Finnish situation is not unique, with public health often receiving relatively less attention during major health care reforms.

This section begins with an overview of major international trends in public health, setting out emerging views of how best to deliver key aspects. It then examines the proposed reforms, mapping them on to the WHO's list of essential public health operations and highlighting the challenges that may arise in each of them. It concludes with some broad recommendations.

International trends and developments

Finland has often been considered to be a leader in public health, with the North Karelia project a widely cited example. Finland has also been looked to by other countries on account of its success in areas such as cancer screening, where it has demonstrated the value of a well-organized, population-based system that outperforms many other countries. In a study undertaken by the European Observatory, which generated

scores to performance on a number of domains, Finland emerged fourth overall, only slightly behind Sweden, Norway and Iceland (Mackenbach, McKee 2013). Consequently, the challenge will be to identify areas where Finland can learn from experience elsewhere, ensuring that such lessons take full account of the Finnish context, and ensuring that, as has unfortunately been the case elsewhere, wide-ranging healthcare reforms do not undermine its historical achievements in public health.

Looking across Europe, it is clear that there is no definitive answer to the question of which level of government public health function should reside. In practice, this tends to follow from the administrative structure of the country concerned. Thus, in federal countries, many functions are undertaken at the subnational level, for example in the Länder in Germany, the Cantons in Switzerland, and the regions in Spain and Italy. In contrast, in more centralized countries, the same functions may be undertaken nationally, as in Ireland and Portugal, with the United Kingdom being an exception in having four subnational entities, with the largest, England, having no specific legislative body. Indeed, the peculiarities of the United Kingdom demonstrate clearly how the arrangements for developing and implementing public health policy often owe more to history than any rational decision-making process. In practice, the location of public health functions tends to follow, and fit around, administrative and legislative structures.

There is a growing recognition that a renewed emphasis on promotion of health and prevention of disease is essential if health systems are to be sustainable in the long term. Indeed, it can be argued that much of the need for health care reflects a failure to engage fully with prevention. This argument has been set out in many official reports, although perhaps the first to address the contribution of prevention to long term health system sustainability was the 2002 Wanless Report (Wanless, 2002) written for the Treasury in the United Kingdom. This argument has been extended in the documentation that forms the background to the European Union's health is wealth policy and to the World Health Organisation's Tallinn Charter (McKee, Figueras 2011) both of which also presented the now substantial body of evidence that better health promotes economic growth.

Although the term "public health" is widely used, it is interpreted very differently in different countries, in part because the concept, as expressed by different languages, brings with it specific historical legacies. Thus, in some countries, it is identified more with state medicine, whereby the authorities enforce regulations on, for example, food safety and environmental protection, whereas in others, it is associated more with social activism and empowerment of civil society. A key distinction is between public health measures that act at the individual level (mostly the duty of counties), such as health education, and those that act at the population level (both municipal and national responsibility), such as fiscal measures and legislation. Over recent decades there has been growing recognition that, while both may be needed, the latter are most effective. To complicate the situation further, in many countries a variety of concepts of public health coexist. Consequently, attempts to describe trends and developments in particular countries have been very challenging.

Beginning from first principles, it is clear that the locus for decision-making with regard to public health should be at the tier of government where it can be most effective. Thus, in areas such as alcohol, food, and tobacco policy, where the most effective measures involve taxation and product regulation, such as the implementation of standardized packaging for cigarettes, decision-making is most appropriate at the national level or, in the context of the European single market, at the European level. In contrast, some measures, such as restrictions on the number of sales outlets, both in terms of absolute numbers and opening hours, may more effectively be achieved at a subnational level. However, such decisions will often come within the remit of planning legislation, which is itself devolved. Other interventions, such as those involving health education, may more appropriately be implemented at municipal level, taking advantage

of links with the educational system. However, even here, there is an argument for creating partnerships across municipalities to pool expertise and develop appropriate materials.

Health protection is a key element of a comprehensive public health strategy, including environmental health, food safety, and communicable disease surveillance. Once again, the appropriate level of government at which to locate these functions will depend on broader considerations, including where the complimentary activities on which they depend can be found. However, in all cases, it will be important to ensure that there is a consistent national framework within which local activities can take place, and which can provide the specialized expertise that, inevitably, cannot be replicated at local level. For example, even in countries significantly larger than Finland, there will be a need for specialist advice on particular pathogens or chemical or radiological pollutants. While many tasks, such as inspection, can be undertaken at municipal or a county level, the crucial challenge is to ensure that the system includes strong and effective communication links with THL, the Finnish Institute of Occupational Health (TTL), and the Radiation and Nuclear Safety Authority (STUK).

The same principles apply to health promotion. Those elements that involve face-to-face contact with population are most likely to be effective if organized locally, involving trusted local institutions that have a good understanding of the populations that they are serving. However they are likely to rely upon specialist advice, for example in social marketing, to ensure that their messages are as effective as possible, and also to support them with evaluation.

The organization of population-based programmes that involve interaction with individuals is often best implemented in larger population units, mainly because of the need to concentrate specialized expertise in programme design and evaluation. Finland performs very well in both screening and immunization and it will be important to ensure that the structural reforms do not, in any way, undermine what has been achieved.

Concerns about weaknesses in the global public health system architecture has led to an intense debate on how best to organize public health functions at national level. The World Health Organization has identified 10 essential public health operations that it contends are essential for safeguarding and promoting population. These are listed in the table below and will form the basis for the subsequent discussion on the reform of public health in Finland.

Table 3. Essential Public Health Operations.

EPHO1	Surveillance of population health and wellbeing
EPHO2	Monitoring and response to health hazards and emergencies
EPHO3	Health protection including environmental occupational, food safety and others
EPHO4	Health Promotion including action addressing social determinants and health inequity
EPHO5	Disease prevention, including early detection of illness
EPHO6	Assuring governance for health and wellbeing
EPHO7	Assuring a sufficient and competent public health workforce
EPHO8	Assuring sustainable organizational structures and financing

EPHO9	Advocacy communication and social mobilization for health
EPH10	Advancing public health research to inform policy and practice

Key Reform Issues and Prerequisites

As noted above, the Finnish reforms envisage a transfer of a number of functions from the municipality to the county level, though the current proposals lack detail on how public health functions will change. Consequently, while other parts of this report have been able to explore very specific aspects of the changes, this is rather more difficult here. Instead, it may be more helpful to reflect on the diverse public health functions that should be undertaken and look at how they might be affected.

Before doing so, a brief digression is necessary. The term "wellbeing" features prominently in Finnish documents. Although increasingly widely used internationally, the meaning of this term requires clarification. Our discussions with Finnish colleagues suggested that, in the present context, it related primarily to the interface between health and employment, including active labor market programmes to get people back into work, but also some element or planning and urban design. This may be something that can be clarified by Finnish colleagues as it may simply be a matter of translation but, at present, it does seem somewhat unclear, which may be a problem given the emphasis placed on it in official documents.

We now consider how the new arrangements will impact on each of the Essential Public Health Operations listed above.

Surveillance of population health and wellbeing

Vital registration and related health statistics are recognized to be a very high quality in Finland. For example, the Finnish Cancer Registry is seen as an exemplar for other countries. At present, births and deaths are registered at the level of the municipality and transmitted centrally, where they are used to update the national population register and are analyzed by Statistics Finland which reports regularly on health-related trends and patterns.

Despite the availability of high-quality data, there have been concerns in the past that, while the larger municipalities are very capable of making use of the information, there is limited capacity in the smaller ones. The reforms offer an opportunity to create a critical mass in each of the new counties, but this will require sustained investment, based on a clear assessment of the information it will be required to fulfill their functions and the analysts needed to deliver this vision.

At present, proposals are somewhat unclear on how this will be done, simply stating that THL and the counties will have the responsibility to monitor the health and wellbeing of the population, but further details are not given. Of note, in general there is often a lack of clarity on roles and responsibilities across many other areas of the reforms as well.

Monitoring and response to health hazards and emergencies

Environmental health has been the responsibility of the municipalities. This includes ensuring the quality and hygiene of foodstuffs, assessing the health impacts of housing and public areas, noise abatement, the quality of drinking- and bathing-water, assessment of adverse environmental health effects and waste management. It is proposed that environmental health will become the responsibility of the counties but, again, precise details are not available at present.

Health protection including environmental occupational, food safety and others

Occupational health is very developed in Finland and, historically, many Finns receive much of their basic healthcare through occupational health services. There has been substantial growth in corporate provision of occupational health services, now covering 52% of enterprises and 58% of employees. The system is considered quite lucrative for providers, who are already consolidated to the point that very few small providers remain.

Problems in equity of access are largely explained by the parallel system of occupational health care, however the occupational health sector is not addressed under the current reforms. The Finnish Institute of Occupational Health has discussed the possibility that a large share of GP services would be shifted from occupational health services and the occupational health services would focus on preventive/health promotion activities and specialist consultation type support.

Health Promotion including addressing social determinants and health inequity

At present, municipalities have responsibility for increasing wellbeing, health and functional capacities of their residents, as well as building social inclusion and preventing marginalization. They do this through policies in the different sectors for which they have responsibility. These actions are designed to improve quality of life, increase employment and productivity, and limit the growth of expenditure of social welfare and health. Ultimate responsibility for these policies lies with mayor, with implementation carried out by the municipality's management group. This requires extensive cooperation within the municipal organization and with other municipal actors and players. To support the management group, a wellbeing team is sometimes created to facilitate implementation, with a coordinator for the promotion of wellbeing and health in the central administration of the municipality an important actor. In smaller municipalities, the coordinator may be shared by municipalities. The extent to which municipalities achieve these goals is seen as a key measure of their overall success. Clearly, it will be important that any changes do not diminish or impair their efforts.

It is envisaged that much individual level health promotion will remain with municipalities, with those elements of prevention that are embedded within health services becoming the responsibility of the new counties. The counties will have an important role in addressing social determinants of health and health inequity, in particular providing expert assistance to municipalities in promotion of health and wellbeing, prevention of substance use and preventive services. Additionally, counties will be required to compile a regional wellbeing review in collaboration with local municipalities. This will have to draw on a wide range of information, and especially that compiled by THL (Table 4)

This will clearly require close collaboration between counties and municipalities, within a clear framework setting out roles and responsibilities. There is no reason why this should not work but, once again, it will be important to achieve clarity on the precise arrangements to be adopted.

Table 4. Health information sources.

Topic	Website
TEAviisari benchmarking system	https://www.teaviisari.fi/teaviisari/en/index
Hyvinvointikompassi (Welfare Compass) indicator bank	http://www.hyvinvointikompassi.fi/en/web/hyvinvointikompassi/
Sotkanet indicator bank	https://www.sotkanet.fi/sotkanet/en/index
Indicators of health and inequalities	www.terveytemme.fi

Disease prevention, including early detection of illness

Municipalities have been responsible for immunization and screening, which includes both newborn screening and cancer screening in adults. In both cases, Finland is recognized as a leader within Europe. These services will be transferred to the counties as complete packages, simply relocating the administrative structures. It is, however, important to recognize that structural reforms typically lead to a temporary, but at times severe disruption of existing activities, often lasting 2-3 years. Given Finland's high level of achievement in these areas, it will be essential to guard against any deterioration, for example due to loss of key staff and institutional memory. This will require a carefully designed transition strategy. However, the reforms also offer an opportunity. Given the increasing technical complexity of screening, with new technologies, it is unrealistic to expect every county to have the requisite expertise. Consequently, there is a strong argument for using the reforms to establish a national function that is capable of keeping up to date with emerging evidence, synthesizing it, and disseminating it in the form of guidance to the counties. Such a function, ideally linked to the cancer registration system, can also make a valuable contribution to monitoring and evaluation, thereby maintaining Finland's excellent performance in this area.

The relationship with education services is complex. Ownership of the schools will remain at the municipality level, with the municipal authorities responsible for education within a national framework. This means that health education, as with other subjects, will be a municipality responsibility. School health services will, however, lie at the county level. Given the difficulties that have arisen elsewhere, it is important to pay particular attention to sexual health promotion and education, ensuring that messages are coherent at all levels, and ensuring strong administrative links. It should be noted that this is an area that has been problematic elsewhere when market-based reforms have been introduced, leading to fragmentation of services.

Assuring governance for health and wellbeing

The proposals state that municipalities will continue to have responsibility for the health and wellbeing of their populations, although this will also be the responsibility of the counties. Certain policies, such as fiscal and regulatory measures to tackle threats to health such as tobacco, alcohol, and poor diet, will inevitably lie at national level. Obviously there will need to be clarity on areas of responsibility. Some regulatory measures will move from municipalities to county level, such as planning approvals, but within national framework.

Assuring a sufficient and competent public health workforce

Counties will be responsible for ensuring that there is an effective public health workforce, acting within a national framework. Workforce planning is, intrinsically, extremely difficult. This is especially true in countries with sparsely populated rural areas, where it can be difficult to attract highly qualified professionals to those areas where the need is greatest. This is an area that will require careful attention, recognizing that, at present, there are significant geographical imbalances between the different parts of the country.

Assuring sustainable organizational structures and financing

It will be up to the counties to decide how they provide public health services from within their overall budgets. It may be helpful to develop national guidance, even if not on a statutory basis, to give some indication of the range of services that might be provided and the numbers of individuals and mix of skills required to deliver them. This is likely to include the ability to undertake assessments of need, design, implement and evaluate interventions, undertake disease surveillance, and mobilize action across a range of sectors. The move to counties offers some clear opportunities here but it also poses some threats. Just as at present, where there are widespread variations in the provision of public health functions among municipalities, it is likely that each county will place a different priority on these functions. Clearly, they will be acting within a national framework, including some areas where there are defined national and international responsibilities, such as environmental health, but there may also be considerable discretion as to what is or is not provided. While respecting the economy of the counties, it will be important to engage in a debate about the range of discretion that they will have in regard to measures to ensure population health.

Advocacy communication and social mobilization for health

NGOs have traditionally played an important role in health promotion. An example is the work of the Finnish Diabetic Association. These organizations obtain funding from three sources, competitive grants, the Finnish Slot Machine Association (*Raha-automaattiyhdistys*), a not-for-profit gambling organization that distributes its income to charitable causes, and municipalities. There is no reason to believe that the first two sources will change but it will be important to ensure clarity about continued funding from the municipalities.

Advancing public health research to inform policy and practice

Research relevant to public health, which encompasses the broader determinants of health, public health activities themselves, and actions within the health system that contribute to population health, will remain the responsibility of universities and THL. Given their responsibility for assessing public health needs and delivering policies, the new counties will be well placed to identify emerging issues requiring research. It will be important to establish a mechanism by which their views can be brought together and prioritized in ways that can influence the national research agenda.

At present, funding for certain activities undertaken by medical schools is channeled through the hospital districts using money distributed nationally. Experience elsewhere shown that funding of this sort is often poorly targeted, with distribution reflecting historical patterns. The reforms offer an opportunity to reassess how this funding is distributed, for example by linking it to specific objectives, including infra-

structure for research, such as Information Systems, and recruitment to clinical trials. The approach taken by the English National Institute for Health Research may offer some ideas for taking this forward.

It should lastly be noted that during 2013-17 THL has been subject to significant decreases in its basic funding (-35%). As a result, population and public health research is highly dependent on external funding and competitive grants from Academy of Finland and EU.

7 REINFORCING GOVERNANCE, REGULATION AND INFORMATION SYSTEMS

Key Observations

- Care must be taken to ensure the reforms are in line with constitutional requirements
- Although counties are expected to have significant autonomy, for many functions – including information systems, monitoring, and some aspects of purchasing –a strong governance role for authorities at a centralized level will be important
- The benefits of commercialization should be balanced against the benefits of trust in the current system
- A monitoring & evaluation strategy with pre-specified goals should be set up at an early stage
- Information systems will need to be in line with all aspects of the reform, supporting purchasing, choice, competition, integration and payment
- Interoperability of the IT system at the county level will be essential

Introduction

In this section we discuss governance, regulation and information systems, all of which play important roles in supporting and facilitating the reforms' success. Although there is no universally accepted definition of the concept of governance, the WHO considers 'leadership and governance' in the health sector as a fundamental building block of the health system, which it defines as "ensuring that strategic policy frameworks exist and are combined with effective oversight, coalition building, regulation, attention to system-design and accountability" (World Health Organization, 2007). Contemporary interest in health system governance can be traced back to the World Health Report 2000, which included an extensive discussion of the role of 'stewardship' in promoting improvements in health system performance.

The preceding sections have highlighted many challenges for governance raised by the reforms, particularly regarding the capacity of counties, as well as surveillance of the reformed system and regulation of the competitive markets. In addition to these challenges, the identification of information needs should also be seen as an urgent priority for almost all aspects of the reforms. Success in all areas will depend crucially on consistent implementation of compatible information systems and information platforms which collect and process data and make it available to all the actors across the country.

In this section we review a selection of challenges related to strengthening governance under the reforms. In particular, we devote significant attention to issues surrounding the development of information systems.

Strengthening governance

The reforms pose certain risks that require careful scrutiny from a governance perspective. Much of this relates to identifying entities accountable for various functions, as well as ensuring entities – whether they are counties, national level authorities or otherwise – have sufficient capacity to carry out their mandate.

Constitutional issues

A previous iteration of the reform was rejected (in February 2015) by the Parliamentary Constitutional Committee on the basis that that proposal, based on 5 areas organizing health and social care services, did not ensure the constitutional right of citizen involvement nor equal treatment of citizens. The current reform with 18 counties has been seen as a better model from the constitutional perspective as it would ensure better direct citizen voice; although the equal treatment of citizens within the current reform would still need to be fully assessed. At the center of the constitutional issues lies the administrative structure acknowledged in and set up by the Constitution. This structure is made of two levels – the municipal level and the central government level. In this sense the county structure comes "from the outside" of the constitutional provisions. This creates still some uncertainties on how much of the constitutional balance the county system is seen to be "disrupting" (e.g. by reducing role of the municipalities). Another dimension of the constitutional question relates to the delegation of public power for certain "administrative tasks" (there is no prescriptive list on what these tasks would be but decisions on child protection measures is a rather clear example of such a task). These task / actions can only be delegated to public actors, hence they should, in principle, not fall under any of the freedom of choice services. Grey zones around this question are however still large and there seems to be a rather wide variety of interpretation on the actual implication to the reform.

Strengthening the central level in the context of decentralization

There is a small and largely inconclusive literature on decentralization in health systems (Saltman, Bankauskaite and Vrangbaek, 2007). The general consensus is that there is a balance to be found between centralization (which can economize on managerial requirements, promote equity and secure economies of scale) and decentralization (which can offer greater sensitivity to local variations in needs and preferences, and promote experimentation).

With the reformed responsibilities, careful thought should be given to the respective roles of the municipalities, the counties, the catchment areas and the central government, and the relationships between them. As discussed in Chapter 3 (as well as in other chapters), many functions will be best provided at a central level (either through government action or voluntary collaboration amongst counties). They include:

- specification of information systems and protocols
- promulgation of 'best practice' clinical and service delivery guidelines
- organization of comparative 'benchmark' information and case studies on quality and efficiency;
- specification of the minimum levels of services;
- purchasing of some services, such as more specialized and complex treatments
- oversight of competition and the functioning of local provider markets
- intervention if lower tiers of government (such as counties) fail to fulfil their duties.

Some of these roles (such as clinical and service delivery guidelines) are already successfully undertaken at a national level in Finland (e.g. http://www.kaypahoito.fi/web/english/home), and it is important that these resources are maintained and strengthened further. Some national functions are necessary to maximize the benefits of decentralization by producing useful comparative information, some to avoid unnecessary duplication, and some to compensate for the limited managerial capacity that will be available in some counties. Moreover, particularly as freedom of choice and market competition play a role in the reforms, the capacity to supervise and regulate provider markets will be essential at a national level.

As discussed, responsibility for the integration of services will lie with the county. However, it is not clear from documents or discussions how that integration will be secured. Jurisdictions that already have nominally integrated health and care purchasers (such as Northern Ireland) have sometimes struggled to identify effective governance arrangements within the purchaser to assure integrated care. It is likely that individuals will require a nominated 'care coordinator' to provide integration, but it is not yet clear who is expected to fulfil that role. There is an important role for the national government in identifying and disseminating good practice in integrated care.

It is also important to develop mechanisms by which the national level can hold counties accountable for their performance. In most circumstances this should take a supportive form of comparative benchmarking and dissemination of good practice. In the case of a failure at a county, the legislation provides for national administration and eventually merger. Given the quite small populations covered by some counties, this consolidation may be inevitable and desirable particularly from the perspective of economies of scale, but the transition costs should not be underestimated.

There will furthermore be a need to assure good governance of the relationships between tiers of administration - for example between counties and municipalities for public health, and between counties and catchment areas for specialized services.

Ensuring commercialization does not jeopardize trust in the current system

Compared to other developed countries, Finland has not historically relied extensively on formal governance arrangements to control and enhance its health system performance. Instead, in common with other Nordic countries, it has relied to a large extent on 'trust' that providers, purchasers and patients will 'do the right thing' to ensure that - in general - the right services are delivered, with satisfactory levels of efficiency and a high level of clinical quality (Lyttkens et al., 2016). This reliance on trust has in general served Finland well. It means that the health system can in principle economize on formal mechanisms of specifying and checking performance levels, and at the same time allow innovation in service organization and delivery that more formal methods of governance may inhibit.

It is vitally important that the reformed system retains the beneficial elements of trust and autonomy that it has enjoyed hitherto. In particular, many formal aspects of governance impose significant running costs on the system that may be avoided if actors can be trusted. However, the reforms pose certain risks from a governance perspective. For example, the commercialization of some service may lead to different types of behavior on the part of some practitioners and provider organizations. Or some purchaser organizations may make procurement decisions that are - unwittingly or otherwise - affected by conflicts of interest. This issue is especially important in a system that has previously been lightly regulated, and so the actors involved may not be aware of the potential for adverse governance consequences.

Establishing a monitoring and evaluation strategy within a governance framework

One important aspect of 'meta-governance' should be considered: the monitoring and evaluation of the reforms themselves. A characteristic of most health system reforms is that their introduction is not properly monitored and their outcomes rarely evaluated. The WHO has developed a set of tools for monitoring and evaluation (M&E). Although intended for use in low- and middle-income settings, the principles of M&E are applicable to all health systems. The lack of attention to M&E in health system reforms can be considered a major policy failure worldwide. The reform exposes citizens to new methods of service organization and delivery, and involves reallocation of large sums of public finance. It is therefore incumbent on policymakers to incorporate the capacity for M&E into its reforms.

Smith et al (2010) propose a simple model of leadership and governance that comprises three fundamental relevant components: a priority setting function, under which objectives, standards and priorities are set *ex ante*; a performance monitoring function, which examines *ex post* whether expected criteria have been met; and an accountability function that seeks to correct poor performance. This model can be applied at any level of the health system: national policy; organizational management; clinical team; or individual practitioner. Many of the regulatory functions of health systems can be viewed within this model. In particular, this model works well when considering approaches to M&E; the questions one should ask are:

- have objectives, standards and priorities been adequately set, so that purchasers, providers and service users know what can be expected?
- are there adequate mechanisms for reporting against standards, and comparison between purchasers and service providers?
- are there adequate mechanisms for correcting unsatisfactory performance?

Setting priorities and standards is a key function in all health systems. Many criteria are set at the national level, first because it promotes equity of standards (such as access and quality) across the country, and second because it economizes on the need for local bodies to have to set their own standards. Examples include specification of national standards of services to which all citizens should be entitled, such as maximum waiting times. Given the ambition of severe constraints on expenditure growth, such national mechanisms will be essential to preserve equity and quality. The key requirement is to set the national requirements clearly but flexibly, so that they allow adequate local autonomy to innovate and test out new methods of service delivery.

The need for adequate performance reporting at all levels of the system is crucial. The specification and mandating of reporting requirements is usually a national governmental function, to assure standardization and economy of effort. However, that function is often delegated to an independent regulator. Note that there may also be an important role for clinical professional organizations to specify and disseminate performance criteria, as in the Swedish quality registers. Note also that provision of information will in general not be sufficient - there will also be a need for capacity at the national level to analyse and disseminate information in a form that is meaningful to all the prospective users of information.

The third aspect of this governance framework - securing accountability and change - is the least well-developed internationally. There are four broad approaches to accountability: central instructions; markets; elections; and professional control. None of these on its own appears to sufficient. Central intervention is likely to be needed when there are clear breaches of standards and unacceptable performance, but is unlikely to be the prime mechanism for continual improvement, as it is difficult to allow the necessary local autonomy. Markets may have some role to play in both strategic purchasing and individual choice, but markets in health and social car are replete with potential for failure, and there is considerable evidence that

they must be augmented with other control mechanisms. Elections may act as an important strategic consideration for county councils, and can promote local involvement, but they are unlikely to promote detailed improvement of services. Professional networks can be an important source of improvement, but depend heavily on the nature of clinical leadership.

Developing information systems

Need for information cuts across the whole spectrum of the reforms. This report has already discussed about the specific information needs regarding purchasing, choice and competition, integration and, above, on monitoring and evaluation. These information needs should not be responded to by ad hoc mechanisms and approaches but with the development of a comprehensive information system. Of course, Finland already has a very developed information system (at least on the health side, for social care the information system is maybe patchier), so the question is mainly about how to develop the current information system to make it fully attuned with the reform's information needs.

There is a general consensus that the information system needs still further development before it is fully in-line with what is needed from it in the reform context (although there are some divergences of point of views among the Finnish experts regarding the wideness of the gap between what exist and what is needed). Building the information system to support the reform is crucial, it will in many ways be the "lubricant" on which the reform will stand or fall. In other words, gaps in the information system will limit the possibilities of implementing the reform in an effective way.

The responsibility of developing the information system is shared among many actors – the providers, the municipalities (especially in the transition period), the counties, (in the future) the planned joint service center for IT, institutions mandated to collect data and who are custodians of databases and registries (e.g. THL and KELA), Ministry of Finance (as per its role in controlling large IT investments) and the MoHSA. These actors have already come together to discuss the information system development plans and there is the draft legislation has some anchoring points for the information system development, but, as the THL evaluation also underlines the practical implementation of the information system will depend on a yet to be defined process where the information system actors all have a clear role[4].

Defining and harmonizing key performance indicators

There is current ongoing work on defining and harmonizing the key performance indicators for the health (and social service) sector. These indicators should be in-line with the key assumptions and goals of the reform. For example, the stated goal of increased equity should be closely monitored both between and within counties (and between and within catchment areas). This should include indicators on utilization of services disaggregated by socio-economic stratifiers as well as geographic variables. Indicators providing information on people possibly forgoing health care because of financial and/or non-financial barriers will also be important in monitoring access to service.

Resource and process indicators will be important for monitoring availability of services and geographic dynamics of supply – for example the number of health or social service workers in a given area. Another set of indicators which could be included in the key indicators are those that can track any possible unintended consequences, such as the level and distribution of out-of-pocket expenditures.

[4] THL evaluation of the Draft Law of the Act on Organising Health and Social Services, THL, 2016

The yearly negotiations between MSHA and the counties (as per paragraphs 30 and 31 in the draft Law on Organizing health and social services) could be an opportunity to consolidate and apply these standard indicators at the county level. Having these indicators as key elements of the negotiations between MSHA and the counties will help to ensure effective information steering of counties from the central level.

One entry point for producing the necessary data should be the KANTA data base which already provides routine information from which for example disaggregated utilization data, disaggregated by patient background information, can be derived. The original core idea of KANTA services has been to ensure that patient records will be available through the central repository when the patient changes between providers. This is based on standardized message-based flow of data between KANTA and provider EPR-systems. However, to date the database only covers health services. The future integration of social service data in KANTA should fill this gap and provide a comprehensive source of data for both health and social services. But it is unsure how much of the social service data can be integrated in the KANTA system and how fast.

Survey data will still be important for example in studying responsiveness and health seeking behavior – both very important dimensions to take into account when monitoring the effects of freedom of choice. The current health sector surveys are mainly ad hoc based. A regular survey instrument that would follow the reform implementation and maturation be needed. This type of regular survey instrument is planned and will be executed by THL every 4 years resulting in data representative at the county level. A more frequent data collection is currently not possible without additional funding either from central government budget or joint funding by central and county budgets.

The counties will be the principle user of data on providers. Counties will need this data to fulfill their function of overall monitoring of the standards and quality of providers (as per paragraph 9 of the draft law on Counties), but they will also need more in-depth information as the purchasing decisions they will make are dependent on high quality information on costs, effectiveness and quality of care. The current draft legislation has the necessary provisions on mandatory data sharing by the providers. However, this will need to be translated into standard ways of collecting and extracting data from the providers in a form that will suit the needs of counties as organizers and purchasers.

Currently the patient cost data needed to accurately determine prices for services is not widely available; this leaves the possibility that counties will set prices that either overpay or underpay providers, both of which will have adverse consequences for the quality of care, the types of services provided and the supply of providers in the market (see Chapter 3 on payment systems). Setting the prices will almost inevitably go through cycles of trial and error, so it is crucial that counties have access to up to date data in order to respond adequately.

In order to ensure and incentivize data availability, quality and interoperability of the IT systems, it might be necessary to impose some minimum standards of data / IT systems before a provider is eligible for contracting. This might lead to some trade-offs in balancing market entry and the providers capacity to produce needed data. It has been voiced that some smaller operators will face financial problems because of IT investments required.

Making IT systems interoperable at county and provider levels

Information systems are likely to play a key role in securing effective integration. To secure effective integration, it will often be necessary to share patient records between providers, and with the purchaser. Interoperability is the technical underpinning of this information. Interoperability (in the health system context) has been defined as: "*the ability of health information systems to work together within and across*

organizational boundaries; [it] is the ability of different information technology systems and software applications to communicate, exchange data, and use the information that has been exchanged' (Healthcare Information and Management Systems Society). There has been a lot of recent work in Finland on interoperability especially on the level of patient health records through the KANTA software at the national level. KANTA services have the potential to fulfill some of the counties' (purchaser role) information needs. However, the roles and responsibilities on how KANTA-services and other centralized information services will be developed in the future is not fully clear yet.

Municipalities and hospital regions also have already IT system that can ensure this information exchange. The Helsinki and Uusimaa Hospital Region (HUS) is currently developing an IT system, Apotti, which aims at building a provider based interoperable system that also integrates health and social care (delivered in HUS facilities). It is not clear how systems such as Apotti are ready to accommodate the multiplicity of providers that may arise under freedom of choice. It is moreover likely that standards and protocols will have to be set at the national level, as providers will be reluctant to operate incompatible systems from one county to another.

Interoperability of the IT system will be crucial at the county level in order for the counties to fulfill their role of coordinators of health and social services. It will certainly be at the county level where the reality of the current situation of disparate and incompatible IT solutions will be mostly felt.

A basic requirement will be that provider systems communicate with a common IT system which is under the county's control (or under the control of a coalition of counties). Through this system counties can guide and monitor care paths as patients move from one provider to another. The IT interoperability at the county level will thus also serve the service integration for which data integration is a key prerequisite. Planning and monitoring the integrated care models is not possible without the integrated information on health and social service.

This county system can also serve as a mediator of information between the providers who will not necessarily come together spontaneously under one unified information system, especially as the reform will probably multiple the number of providers who all have their own systems. The counties role in ensuring continuity in information flow will is crucial as providers will be entering and exiting the market in a more fluid way than currently creating possible disruptions which will need to be dealt with by the counties.

Ensuring personal health data is secure for secondary use

A further consideration raised by patient information sharing is the need for data security and governance. A single serious breach of confidentiality could lead to major system disruption, for example if large numbers of people refuse to allow their data to be shared across providers. Policymakers need to be assured that information governance arrangements will be sufficiently robust under the reformed system.

The secondary use of personal health data is seen within the reform as an important big data initiative. This follows recent trends, especially in OECD countries, of using secondary data where the focus is on *"… the ability to monitor the same individuals over time, as they experience health care events, receive treatments, experience improvements or deteriorations in their health and live or die."* (OECD, 2013)

Secondary use of personal health data has shown its usefulness for example through the PERFECT project in monitoring the content, quality and cost-effectiveness of treatment episodes. While it is yet unclear on how the secondary use of personal health data will develop, it is easy to assume that it will yield information that can be used to improve health system performance.

At this point of development of the secondary data plan, what might need some focus are the data security aspects. Linking data and creating bigger pools of data comes with increased risks for large scale data

breaches that can endanger confidentiality and security of health data of a large amount of people (OECD, 2013).

The draft law on secondary use of data as published on the 15th of August is very comprehensive and seems to have all the different aspects of data confidentiality built in it (the draft law talks about encryption key, physical space, log keeping, organizing the etc.). However, the kind of data safety features that are designed in the law can be costly. It is necessary that the principles in the draft law are followed up with the necessary, sustained, and ring fenced financial resources, which do not fluctuate with budget changes of the institution which will be handling the data use authorizations and providing the IT platform through which the information will flow.

8 ACHIEVING THE REFORM OBJECTIVES

Key Observations

- Overall, the reforms are an ambitious effort to address concerns about inequalities in access to health and social care, effectiveness and sustainability of the public system
- Consolidating responsibility for purchasing and organizing at county level and focusing on integration and coordination of health and social care services have great potential for improving system performance, however investments in strategic purchasing are needed.
- Introducing some choice and competition could also spur innovation, although proper incentives and regulations must be in place to prevent unintended consequences such as cream-skimming
- Care must be taken to ensure that past achievements in public health are not compromised due to organizational changes
- Information on population needs, care pathways, costs, and provider quality are essential pre-requisites to enable all aspects of the reform, and the importance of information cannot be understated. That said, information technology is unlikely to lead to cost containment in the near term.
- The degree of cost containment sought by the reform may jeopardize the reform and damage access and quality of care

Assessment of the impact of the reform proposals

This section reviews the extent to which the reforms are likely to deliver on their broad objectives of improving equity, access and effectiveness, as well as achieving gains in efficiency and reducing costs. Drawing on the analysis above, we discuss some key observations, highlighting earlier findings the report in the context of the reform goals.

Consolidation of responsibility for organizing and purchasing to county level can improve leverage and reduce inequalities

Evidence suggests that municipalities have historically varied substantially in their capacity to organize services, given variation in their population size, demographics, and other factors. By consolidating responsibility to a county level, resources can be more equitably distributed, counties can better align the availability of services with need, and use their financial leverage to steer the efficient delivery of services.

Attention to strategic purchasing is therefore a key pre-requisite for the counties' success. The fundamentals of supporting strategic purchasing are discussed elsewhere in this report (see Chapter 3). Efforts should be directed towards conducting county level needs assessments so counties have a better sense of population needs and can consider how to allocate their resources in the first instance.

Competition may incentivize innovation but regulations must be in place to prevent cream-skimming and other unintended consequences

Freedom-of-choice for patients and clients is intended to better balance supplies and demands, more specifically to give care-users the formal option to vote-with-their-feet. The widely held expectation is that freedom of choice might attract (new) private providers to enter the market. However, this is still undecided and at this point in time it has not yet been decided which segments of the health sector will be opened up to choice. Experience elsewhere suggests that private providers are only likely to bid for contracts where there are few sunk costs and where the workload is as predictable as possible, in terms of both numbers and severity. Consequently, ambulatory care, elective services in secondary services, and nursing homes seems a natural choice, while creating additional capacity in high cost infrastructure such as university clinics risk substantial amounts of future sunk costs. Practical experience also suggests that they may demand major incentives to enter the market, including guaranteed patient flows, which if demand falls can undermine existing provision in public hospitals, and premiums on payments. One way to prevent cream-skimming is to ensure that costing is on a like for like basis, including traditional public sector activities such as training that are cross subsidized from profitable services.

In general, it is important to take into consideration that the attractiveness of the Finnish market will differ across counties and equal market penetration among the different ownership types cannot be guaranteed. Freedom of choice and competition will only improve access to care where providers are incentivized to participate in the market.

Integration of health and social care has potential to improve quality and efficiency, but there are important preconditions

The prominent role of social and health care integration in the reforms is a positive step for Finland, as better coordination can improve patient care and generate efficiency gains. With 10% of patients responsible for around 80% of costs there is clearly great scope for improvement. Better integrated health care and social services create conditions for a more patient-centered care in which the patient/user is in focus. Solutions better adapted to patient needs are more feasible in a model with less fragmentation and a coordinated care path. Cost savings can come about through reduction of unnecessary treatments, reduction of hospital admissions and readmissions, avoidance of duplication of services as well as shorter length of hospital stays, primarily due to better home care services and housing in the community – especially important for frail elderly patients. The county level offers a potentially good environment for care coordination, considering that the counties will be able to implement standards and guidelines throughout their entire organizations.

Nevertheless, there are many complexities (as there are around the world) to integrating health and social care services in practice. Country experiences demonstrate that coordinated activities do not necessarily take place even when health care and social services financing are integrated in the same regions, as regional entities may decide to split up the contracting into separate divisions, or use separate contracts and payment models. There are important preconditions for success. Providers must be actively encouraged to work together; payment systems and financial incentives that foster cooperation among providers are powerful tools to do this. Information technology that provides useful data to providers so that they can manage service pathways is essential and will need to be developed. Given the context-specific nature of health and social care integration, regions that have had successful pilots should build on these programmes and be given the autonomy to do so. There is also a need to start developing health and social care worker educa-

tion and training so that teaching and practicing the kind of skills needed in integrated care models are included in the curricula.

Fortunately, Finland has a considerable range and depth of experience with pilots that it can build on and scale up to achieve success in this area. However it is important to make sure that existing, well-functioning integration initiatives are not hindered by aspects of the reform. For example, if there is an introduction of a strict contracting model it could lead to a situation where successful initiatives such as the South Karelia Social and Health Care District (Eksote) does not function as it has previously.

There are also significant risks that result from the freedom of choice and market-based components of the reform. By allowing clients to choose providers, it can be difficult to direct patients into cost-effective care pathways and to ensure coordination across providers who may be competing for business. In many respects, there is a risk that the aims of choice and competition can undermine that of integration and coordination if applied in the same areas.

Lastly, a lot of the discussion has concerned horizontal integration among health and social services. As important in the Finnish case is the vertical integration between the hospital sector and primary care /social care, not least to facilitate cost savings connected to reducing admissions/readmissions, decreased length of stays and more efficient discharges from hospitals.

Care must be taken to ensure that past achievements in public health are not compromised due to organizational changes

As has been noted, Finland is recognized as a leader in public health in Europe. As the reforms proceed, two principles might usefully be considered. First, drawing on the now extensive evidence that any major organizational change risks compromising organizational effectiveness, due to the efforts that must be invested in the transition process and the risk of loss of institutional memory, care should be taken to ensure that past achievements are not compromised. Second, where possible, any opportunities presented by the reforms, such as the ability to concentrate expertise in larger territorial units, should be taken advantage of explicitly. In this respect, the development of comprehensive, integrated, and coordinated information systems will be a particular priority.

Drawing on experience elsewhere, there is a need to ensure clear lines of accountability for the many activities that contribute to population health. This is especially complex given how progress often depends on actions in many different sectors. Three challenges can be identified. First, it will be important to have complete clarity about the division of responsibility between the counties and municipalities. This is especially important where responsibilities transcend tiers of government, such as is the case in school health. Second, recognizing that public health at local level in Finland has benefited from strong links with the organization of health care delivery, it will be important to ensure that the move of the latter function to counties does not weaken the former. Third, it will be important to invest in the workforce required to deliver the new model of public health, and in particular those who are needed to provide a population health input into the purchasing and delivery of health care, including assessing health needs, developing appropriate packages of care, and evaluating effectiveness.

Given the risks of unintended consequences, it is strongly recommended that the new arrangements are tested, drawing on the now growing experience of scenario analysis and role play, as used in, for example, pandemic and emergency preparedness. This approach can easily be extended to other areas of public health. Thus, it will be helpful to evaluate how different scenarios play out, such as an outbreak of infectious disease, an episode of chemical contamination, or the pathway followed by a patient with complex problems, in the models proposed by the reforms.

Information technology is the lynchpin of the reforms but there is limited evidence that it will reduce expenditure growth

As highlighted throughout this report, good information on population needs, care pathways, patient costs and provider performance are essential to support all aspects of the reform. Nevertheless, information system development in context of the reform should be seen through the lens of digitalization, which has been embraced as an overarching government policy aiming at promoting and establishing public and private e-services and e-solutions. Globally digitalization in the health sector (possibly less in the social services sector) is seen as a way to "leap" over (physical) constraints by introducing new care models relying on information and communications technology (ICT) (OECD, 2015). In this sense, digitalization in the reform context is seen as a transformative element and a key enabler and driver of the reform aiming at increased efficiency, quality and accessibility.

ICT systems and solutions have long been seen as a key to better health system performance and cost savings. Kellermann and Jones note that in 2005 it was predicted that accelerating adoption of ICT technology could save the United States more than $81 billion annually. They further underline that "seven years later the empirical data on the technology's impact on health care efficiency and safety are mixed, and annual health care expenditures in the United States have grown by $800 billion." The authors attribute the disappointing results to several factors: "sluggish adoption of health IT systems, coupled with the choice of systems that are neither interoperable nor easy to use; and the failure of health care providers and institutions to reengineer care processes to reap the full benefits of health IT."

Evidence, from Estonia (the "most digitalized country in the world") also shows that the kind of savings envisaged from ICT have not materialized, at a system level, at least in the short to medium term. Estonia has in the last decade implemented a comprehensive eHealth plan. At the same time, between the year 2000 (before acceleration of eHealth) and 2015, current health expenditure increased from 5.2% of GDP to 6.3% of GDP, with government health expenditure increasing from 4.0 to 4.8% of GDP. While it is true that it is impossible to draw conclusions from the macro expenditure figures, it is still rather safe to say that the very comprehensive digitalization of the health system in Estonia has not produced any lasting paradigm shift that would be detectable from the health expenditure figures.

Taking into account the international evidence, Finland needs to keep a realistic view on how much digitalization can and cannot drive change and introduce cost savings at least at the system level and in the magnitude perhaps foreseen. As the THL evaluation noted, "the SOTE reform will necessarily require costly upgrade of IT systems and this transition would take around 10-15 years. With available material it is impossible to project if running the IT after the reforms would be less costly than before of the investment costs are factored in. "

The goal of reducing inequalities suggests reform of occupational health sector will eventually be necessary

Future efforts may be directed at reforming the occupational health sector. These services are perceived as more responsive and of comparatively higher quality. While occupational health seems to have been preserved in the reform plans, given that it is only available to relatively healthy workers, its continuation may compromise the objectives of expenditure control and in particular, equity. Indeed, inequalities in access are in large part due to the parallel system of occupational health care, perhaps even more so than the variability in capacity across municipalities. It could be argued that in order to create well-functioning integra-

tion for patients, the system should also include access to care providers connected to the occupational health system.

The resource allocation formula and planned budget caps may be too stringent for some counties

A resource allocation formula will fund counties according to population needs. While needs-based allocation can improve equity, international evidence shows that resource allocation formulas are imperfect tools for predicting costs; for risk pools of around 100,000 population they may only be accurate by +/- 2%. This means that it is inevitable that strictly following a resource allocation formula to set county budgets will lead to shortfalls in some areas.

Additionally, the resource allocation formula will impose a strict reduction in the rate of overall expenditure growth in an effort to achieve 3 billion euros in savings by 2029. Current forecasts indicate that this will substantially reduce the level of resources in some counties.

Counties in deficit may decide to cope with budget shortfalls by increasing user charges (if legally allowed) to shift the burden of paying for care to households, which will also serve as a barrier to access. They may also respond by delaying payments to suppliers or implicitly rationing care, further exacerbating access barriers and inequities. For public service utilities, counties by law will be the last-resort providers of liquidity and bear the costs of insolvency of these organizations, although given the continued commitment to universal coverage, the state would ultimately be the ultimate guarantor of access to care whatever ownership model was adopted.

In general, the total resource allocation to the health sector should also reflect some assessment of population health needs. Slowing the rate of expenditure growth is important to ensure sustainability of the system; however a more gradual approach to the resource allocation formula and budget caps than what is currently envisioned may be advisable if other policy objectives are not to be compromised. This may entail only gradual movements from current budgets to the targets implied by the resource allocation formula. Risk management strategies may be needed, such as additional funding from national level for high cost patients or more flexibility in year-to-year budgets than is currently envisioned.

Bending the cost curve is possible but the degree of savings sought by the reform will be challenging to achieve in the short or even medium-term

Efficiency gains can certainly be realized if providers adopt best practices. However the degree of monetary savings expected in the reforms – 3 billion euros by 2029 – will be difficult to achieve without major disruption to services and (possibly) reconsideration of the basket of services offered or the imposition of user charges. Although a bottom up assessment of savings done by analysts in Finland and presented to the expert panel finds around 3 billion euros can be saved if all facilities operate at or near that of best performers, it is unrealistic to expect this to occur in the short-term. Additionally, some efficiency gains could allow for money to be reallocated and spent elsewhere in the system to improve access to care and reduce waiting times, but will then not translate into commensurate monetary savings that reduce the rate of expenditure growth.

The reform experiences of other countries suggest it will take many years before any savings (either increasing efficiency or bending-the-curve) will materialize, as there are bound to be set-up costs and readjustment during the transition to the reformed system. For example, current resources and expertise in pur-

chasing and monitoring are limited and will need to be developed. It will be essential to allocate some additional, ring-fenced resources to build capacity early on in the reform.

9 REFORM IMPLEMENTATION

Key Observations

- Many aspects of the reform have the potential to reduce inequalities and improve efficiency, however the pace of implementation may be too optimistic and there is potential for misalignment in some areas (e.g. between integration and competition).
- Top priorities include establishing counties and building up their capacity to conduct strategic purchasing
- Use of framework legislation that sets general obligations and principles but leaves governing authorities some degree of flexibility in the future is advisable
- It will be essential to demonstrate early gains to maintain public support

Introduction

This report has reviewed key issues and prerequisites for reform success in five main areas:

i. Counties as organizers and purchasers of health and social care;

ii. Introduction of provider competition and freedom of choice;

iii. Integration of health and social care services within counties;

iv. Strengthening public health at the county level; and

v. Reinforcing governance, regulation and information systems.

Many of the issues and prerequisites highlighted relate to the process of implementation including approaches and support to managing change; steps, priorities and pace of implementation and aligning reform incentives and appropriate governance, information and regulatory mechanisms to enable implementation. This chapter will bring together some main observations for reform implementation that apply across several of the reform content areas.

Revising the pace of implementation

The reform plans include a helpful implementation timetable with approval of various legislations and implementation phases. The suggested timings, however, may be too optimistic in light of the complexity and the level of uncertainty of some of the reform strategies suggested and the capacity in terms of skills and information systems required. As noted in earlier sections above, some reform measures such as introducing freedom of choice, increasing provider competition or setting new payment systems involve a high degree of complexity. That is, in several instances, there is substantial uncertainty about their impact not

only in Finland but in other countries where they have been put in place. Moreover, many reform strategies such as those aimed at health and social care integration are highly context specific and will require experimentation such as in the form of pilots. In the same way, most require large technical capacity and skills and are particularly 'data hungry'. As repeatedly noted above, in spite of the major strengthening underway in IT systems it will take some time until the appropriate data on service quality, costs and performance is available. In the same way technical capacity and skills will have to be brought together and further developed.

The suggestion here is not to necessarily slow down the overall pace of the whole reform program, but rather tailor the timing, phasing and speed of implementation for each reform area in light of these concerns. This is in the first implementation stages of the reform, Finland should devote (often limited) organizational and political resources to priority strategies for which there is higher evidence certainty, impact potential; skills and capacity as well as consensus among stakeholders; and hence, overall, a higher probability of implementation success. The next two sections further build on these lessons to put forward some suggestions for managing the process of change and setting priorities for reform implementation.

Managing the reform process effectively

The approach and process of managing change is central to the success (or lack of success) of any reform program. We include here four sets of lessons that may be of particular relevance for Finland.

A first lesson in managing reform introduction relates with the needed alignment between reform strategies, which is a key determining factor of reform success elsewhere in other countries. Even when individual strategies are backed with strong evidence, they do sometimes generate conflict. This phenomenon can be observed in some of the proposed reforms, for instance, the focus on consumer choice may act against health care integration, or the county mandate for allocating resources and organizing services according to need may be at odds with the imperative to introduce provider competition and apply the 'money follows patient' principle; unless new reforms are cautiously design so they align with exiting systems or recent changes, and implementation is phased accordingly.

Second, there is a need to strike an appropriate balance between county autonomy and national level guidance. The highly devolved nature of decision-making in Finland can act as an obstacle to reform implementation, particularly if legislation is top down and highly normative without enough room for flexibility and adaptability to local circumstances. Or alternatively, the pressures for political and managerial decision making to remain at county level may act against the much needed implementation support and guidance from the central level.

Third, importantly there is a need for flexibility in adapting reform design and implementation to account for technical complexities and the level of uncertainty as well as for the capacity in terms of skills and information systems required. Similarly, as discussed, reform programs need to adapt flexibly to local circumstances and consider the potential for misalignment. In that regard, Finland may consider adopting framework legislation which sets out the main reform direction but allows bottom up innovation developments as well as more implementation flexibility.

Finally, for a reform plan to build momentum and gain broader stakeholder support there is need to demonstrate early successes. One very important condition for a successful reform – that is complex and far stretching - forms the need to show 'early gains' and capitalize on the 'low hanging fruit'. If what will inevitably be substantial numbers of skeptics can point to severe teething problems, the later phases of the reform may come under substantial threat. Such 'breeding of success by success' needs to be assessed

against strategies that point into other directions, such as start on a small scale and take time to build up knowledge and expertise.

Setting implementation priorities

This section draws on the above observations to suggest a series of practical priorities for reform implementation. In the first place, this means that Finnish policy makers may need to start the reform process by giving the highest priority and devote the main share of the resources to the establishment of the new county organization structures for which there is significant consensus among stakeholders as well as a large degree of technical certainty. Moreover, these new county functions form the basis to enable the introduction of the further reforms including strategic purchasing, contracting, provider competition, freedom of choice, new payment systems, integration of care and public health. Therefore the main priority should be to put in place a series of prerequisites for the new county financing, purchasing and organization functions to work, chiefly:

- building purchasing capacity and skills, including the swift and effective integration of staff from municipal administrations;
- stepping up the implementation of new information systems;
- establishing a health and social needs assessment function; and
- putting in place the new governance arrangements including needed regulation, guidance and support between central agencies and the new counties.

These are fundamental preconditions which need to be fully in place before considering the implementation of other strategies. Hence, regardless of the particular models for consumer choice, market competition or provider payment to be eventually selected, a fully functioning county purchasing organization needs to be in place.

These priorities have a number of implications for the introduction and prioritization of other reform strategies. These have already been addressed in previous chapters and they will be only outlined here.

In the first phase of the reform, the bulk of current service provision arrangements including organization and payment may need to be transferred and maintained as they are until the purchasing function is put in place. In particular, it may be helpful to start progressively with soft but transparent contracting approaches and simple easy to understand payment systems grounded on negotiation and agreements between purchasers and providers. However, there must be sufficient flexibility for those counties with larger capacity to begin with more complex approaches as long as there are national standards for contracts and payment systems towards which counties will all eventually converge. This does not preclude the flexibility to adapt these mechanisms to county specific circumstances such as including additional incentives for geographical dispersed areas or particular priority services.

With regard to competition and freedom of choice, as suggested in chapter 4, current plans for progressive implementation of freedom of choice and introduction of competition for those less complex and patients and easily defined services are in the right direction. This is, as long as the payment is in line with the actual costs of providing those services and there will not be incentives for cream skimming in future once the large bulk of patients and services are included in the competition and freedom of choice scheme. In the same way, also as noted in chapter 5, the implementation of new integrated care models should be in the first instance grounded on existing innovative models in selected counties, which could then be scaled up to the entire country.

10 CONCLUSIONS

The international expert panel's review of the health and social care reform package finds that the proposals have great potential to reduce inequalities and improve efficiency. The aim of the review was primarily to assess, or better predict the expected impact of the proposals and identify risks and prerequisites to ensure that this potential is fully realized and reforms are implemented successfully. As noted, the approach taken by the expert panel to arrive at its conclusions has a number of limitations that need bearing in mind when assessing the findings.

Study limitations

Three sets of limitations are considered here. First, the scope of, and time devoted to the review – the report focused on a subset of reform areas deemed of key priority by the panelists, and for a limited time period including two country visits, meetings with a limited selection of key stakeholders and assessment of some key documentation. Second, the assessment is based on predicted rather than actual measured impact. The conclusions draw on expert opinions, drawing from prior experiences in other countries as well as academic research. Indeed, many if not all reform effects are context-specific and so there is no guarantee that what has occurred in other countries will transpire in Finland.

Finally, at the time of writing this report many details of the reforms are not yet decided – these could have important, unanticipated spillover effects throughout the system. Likewise, although every effort has been made to identify unintended effects of the reforms, with such comprehensive plans in place, it is not possible to ascertain how all aspects of the reform will impact on each other. Many – if not all – aspects of the reforms are intertwined and depend on each other for success; for example, the capabilities of the counties to act as strategic purchasers is reliant on the existence of provider and patient data that will be collected by new information systems. Freedom of choice is also dependent on available and accessible provider data. Other aspects of the reform may hinder each other's success if not dealt with carefully – in the case of freedom of choice and care integration they have the potential to be diametrically in opposition to each other if not dealt with carefully.

It is therefore imperative to underline that the risks highlighted in the report may not arise. However, it is important that adequate scrutiny is given to these and other potential risks. This is especially important given that the system has previously been lightly monitored and regulated, and so the actors involved may not be aware of the potential for adverse consequences.

Summary of key findings

Among all the proposed reforms, the consolidation in responsibility for organizing and purchasing of health and social services from the municipality to the county level is seen as top priority. It can create strong preconditions to improve equity and efficiency of care delivery, as well as to improve care coordination. To realize these gains, it is essential that strategic purchasing capabilities are developed; doing so will require investments in information systems, so that data needed on costs and provider performance are readily available. At present, data and skill gaps limit the counties' ability to elaborate the very complex contracting methods and procedures other countries put in place when they introduce a purchasing provider split – often at a high administrative cost. Finding the balance between county autonomy and central level steer-

ing will be critical; for effective purchasing and payment systems the national level will need to play a strong role providing contracting guidance, information support and regulation.

Plans to allow freedom of choice and provider competition – although not yet fully decided – also have the potential to increase the supply and quality of health and social care providers. However choice and competition must be implemented with some caution and incrementally, particularly as existing evidence internationally and in Finland are inconclusive in terms of impact. Also some approaches to freedom of choice under consideration may jeopardize the concomitant plans to integrate health and social care. Hence the recent support for adopting a more gradual pace to implementation of choice is a positive development. Finland also currently relies extensively on trust in order to economize on governance efforts. Care should be taken to ensure that the commercialization of services does not jeopardize the beneficial consequences of trust inherent in the current system. Choice and competition may deliver improvements in efficiency and spur innovation, however there must be strong incentives to discourage cream-skimming, as well as incentives for providers to offer services in underserved markets.

The explicit goal in the proposal to integrate health and social care within counties is also a positive step to improve care quality for vulnerable patient groups such as frail elderly, chronically ill and drug abusers. In order to promote care coordination and integration, it is important to create the right incentives for the collaborating actors, such as information systems that enable coordination, fair payment systems, and voluntary bilateral agreements. There are also a lot of excellent pilots in Finland that could be scaled up to further stimulate integration.

The responsibility for public health services and health and well lbeing will also move from municipalities to counties although the health and wellbeing function will for the most part remain at municipality level. Overall this shift has the potential to further improve the public health function. However care must be taken to ensure that organizational change does not disrupt the historical successes Finland has had in public health.

Key preconditions for the reform's success include the development of good governance mechanisms – some of which are described above, such as the balance between central and local autonomy and the maintenance of trust in the system – and importantly the development of good and transparent information systems collecting data on quality and performance. Consistent, interoperable information systems will be needed to assure good performance at the system level, organizational level, clinical level and patient level. The rapid development of such systems, especially for the counties which will need to use this information for effective purchasing, is a prerequisite for the success of the reforms, and there is a clear role at the national level to facilitate progress. A clear strategy to monitor, evaluate and review the reforms is also essential, and should be initiated at an early stage.

Finally, plans to slow the rate of expenditure growth - with an objective of 3 billion euros saved by 2029 - to address the so-called 'sustainability gap' are very ambitious and carry some risks of jeopardizing some of the potential benefits of the reforms. While there is a clear potential for efficiency gains in the system, the degree of investment needed to support the reforms – as well as the intended objective to reduce inequalities – make it challenging to achieve such a high level of savings in the short-term without compromising other objectives of the reforms. Given the risks of unintended consequences, the implementation of reform would be best managed step-by-step, assessing the impacts and ensuring a flexible approach to reduce the rate of expenditure growth if needed. Early efforts should concentrate primarily on some of the least contestable aspects of the reform, such as strengthening county capacity, investing in information systems, and supporting integration of care for high cost high need clients.

REFERENCES

AbouZahr, C., & Boerma, T. (2005). Health information systems: the foundations of public health. Bulletin of the World Health Organization, 83 (8) .

Ahgren, B., 2014. The path to integrated healthcare: Various Scandinavian strategies. International Journal of Care Coordination, 17(1–2), pp.52–58.

Aiken LH, Sloane DM, Bruyneel L, Van den Heede K, Griffiths P, Busse R, et al. Nurse staffing and education and hospital mortality in nine European countries: a retrospective observational study. Lancet. 2014; 383(9931): 1824-30.

Ashton T, Cumming J, McLean J. (2004) Contracting health services in a public health system: the New Zealand experience. Health Policy;69:21–31. doi: 10.1016/j.healthpol.2003.11.004.

Ashton T. (2005) Recent developments in the funding and organisation of the New Zealand health system Australia and New Zealand Health Policy 2:9

Bank of Finland (2015) Bank of Finland Bulletin <http://www.bofbulletin.fi/en/2015/5/pace-of-debt-growth-disquieting/>

Bodenheimer, T., 2008. Coordinating Care — A Perilous Journey through the Health Care System. New England Journal of Medicine, 358(10), pp.1064–1071.

Bodenheimer, T., Wagner, E. & Grumbach, K., 2002. Improving primary care for patients with chronic illness: the chronic care model, Part 2. Journal of the American Medical Association, 288(15), pp.1909–1914.

Bojke C, Goddard (2010) M. Foundation trusts: a retrospective review. Centre for Health Economics research paper 58..

Bos A, Bosselie P and M Trappenburg, Financial performance, employee well-being, and client well-being in for-profit andf not-for-profit nursing homes: a systematic review, Health Care Management Review, 2016 ahead of print.

Chaudhry, B. W. (2006). Systematic Review: Impact of Health Information Technology on Quality, Efficiency, and Costs of Medical Care. Annals of Internal Medicine, 144(10) , 742-52e.

Coleman, E.A., 2003. Falling through the cracks: Challenges and opportunities for improving transitional care for persons with continuous complex care needs. Journal of the American Geriatrics Society, 51(4), pp.549–555.

Colla, C.H. et al., 2014. First national survey of ACOs finds that physicians are playing strong leadership and ownership roles. Health Affairs, 33(6), pp.964–971.

Curry, N. & Ham, C., 2010. Clinical and service integration The route to improved outcomes. The Kings Fund, pp.1–64.

Epstein, A.M. et al., 2014. Analysis of early accountable care organizations defines patient, structural, cost, and quality-of-care characteristics. Health Affairs, 33(1), pp.95–102.

Epstein, N.E., 2014. Multidisciplinary in-hospital teams improve patient outcomes: A review. Surgical Neurology International, 5(8), p.295.

Eurobarometer (2007) Health and long-term care in the European Union (283). < http://ec.europa.eu/public_opinion/archives/ebs/ebs_283_en.pdf>

Eurostat (2016). EU-SILC database.

Expert Panel on Effective Ways of Investing in Health (EXPH), Best practices and potential pitfalls in public health sector commissioning from private providers, European Union, 2016.

Ghorob, A. & Bodenheimer, T., 2015. Building teams in primary care: A practical guide. Families, Sysems and Health, 33(3), pp.182–192.

Goodwin, N. et al., 2013. Co-ordinated care for people with complex chronic conditions: Key lessons and markers for success. The Kings Fund, p.44.

Goodwin, N., 2014. Providing integrated care for older people with complex needs Lessons from seven international case studies. , pp.1–28.

Healthcare Information and Management Systems Society http://www.himss.org/library/interoperability-standards/what-is

Hirdes, J.P. & Kehyayan, V., 2014. Long-term care for the elderly in Canada: progress towards an integrated system. In V. Mor, ed. Regulating Long-Term Care Quality – An International Comparison. Cambridge: Cambridge University Press, pp. 324–356.

ICARE4EU. http://www.icare4eu.org/index.php.

Isaksson D, Blomqvist P, Winblad U (2016) Free establishment of primary health care providers: effects on geographical equity. BMC Health Serv Res. 2016 Jan 23;16:28.

Jeurissen PPT, For-profit hospitals. A comparative and longitudinal study of the for-profit hospital sector in four Western countries, Dissertation, Erasmus University Rotterdam.

Kankaanpää E, I Linnosmaa and H Valtonen, Market competition, ownership, payment systems and the performance of health care providers – a panel study among Finnish occupational health services providers, Health Economics, Policy and Law(8)4:477-510.

Kellermann and Jones (2013) What It Will Take To Achieve The As-Yet-Unfulfilled Promises Of Health Information Technology. Health Aff January 2013 vol. 32 no. 1 63-68

Kodner, D.L. & Kyriacou, C.K., 2000. Fully integrated care for frail elderly: two American models. International journal of integrated care, 1(November), p.e08.

Korpela J, Elfvengren K, Kaarna T, et al. (2012) Collaboration process for integrated social and health care strategy implementation. International Journal of Integrated Care. Vol 12, 18 May 2012.

Leskelä, R.-L., V. Komssi, A. Sandström, S. Pikkujämsä, A. Haverinen, S.-L. Olli and K. Ylitalo-Katajisto (2013), 'Heavy users of social and health care services in the city of Oulu', Finnish Medical Journal, 68(48): 3163–3169.

Leutz, W.N., 1999. Five laws for integrating medical and social services: lessons from the United States and the United Kingdom. The Milbank quarterly, 77(1), pp.77–110, iv–v.

Lyttkens, C. H., T. Christiansen, U. Häkkinen, O. Kaarboe, M. Sutton and A. Welander (2016). "The core of the Nordic health care system is not empty." 2016 4(1).

Mackenbach J, McKee M. Successes and failures of health policy in Europe: Four decades of divergent trends and converging challenges: Four decades of divergent trends and converging challenges. Buckingham: McGraw-Hill Education (UK); 2013.

Mason, A., Goddard, M. & Weatherly, H., 2014. Financial Mechanisms for Integrating Funds for Health and Social Care: An Evidence Review,

McKee M, Figueras J. Health Systems, Health, Wealth And Societal Well-Being: Assessing The Case For Investing In Health Systems: Assessing the case for investing in health systems. Buckingham: McGraw-Hill Education (UK); 2011.

McWilliams, J.M. et al., 2014. Changes in Patients' Experiences in Medicare Accountable Care Organizations. New England Journal of Medicine, 371(18), pp.1715–1724.

Meads, G. & Shaw, S., 2010. Integrated primary care in an integrated Europe. Primary Health Care Research & Development, 11(2), p.105.

Nyweide, D.J. et al., 2015. Association of Pioneer Accountable Care Organizations vs traditional Medicare fee for service with spending, utilization, and patient experience. JAMA - Journal of the American Medical Association, 313(21), pp.2152–2161.

OECD. (2013). STRENGTHENING HEALTH INFORMATION INFRASTRUCTURE FOR HEALTH CARE QUALITY GOVERNANCE. Paris: OECD.

OECD. (2015). The evolution of health care in a data-rich environment. In Data Driven Innovation: Big Data for Growth and Well-Being (pp. 331-). Paris: OECD.

OECD (2016), Better Ways to Pay for Health Care, OECD Publishing, Paris. DOI: http://dx.doi.org/10.1787/9789264258211-en

OECD (2016). Health database.

Parliamentary Office of Science and Technology, 2016. Integrating health and social care services, London.

Personal communication. August 2016 and email conversation with Liina-Kaisa Tynkkynen, Institute for Advanced Social Research, Tampere.

Propper, C. and G. Leckie (2011). Increasing Competition Between Providers in Health Care Markets: The Economic Evidence. The Oxford Handbook of Health Economics. S. Glied and P. Smith. New York, Oxford University Press: 602-623.

Puska, P.; Vartiainen, E. (2009). Community-based intervention studies in high-income countries. In: Oxford textbook of public health, Volume 2: the methods of public health 2009, Editors Detels, R.; Beaglehole, R.; Lansing, M. A.; Gulliford, M.No.Ed.5 pp.557-566 ref.41

Rechel, B., M. McKee, M. Haas, et al (2016). "Public reporting on quality, waiting times and patient experience in 11 high-income countries." Health Policy 120(4): 377-383.

Riksrevisionen, 2014. Överenskommelser mellan regeringen och SKL inom hälso- och sjukvården t att – frivilligt att delta men svårt att tacka nej,

Rudkjøbing, A. et al., 2012. Integrated care: a Danish perspective. Bmj, 345(2012), pp.1–5.

Rudkjøbing, A. et al., 2014. Health care agreements as a tool for coordinating health and social services. International journal of integrated care, 14(December), p.e036.

Rudkjøbing, A., 2014. Towards coordinated care – Governance in a fragmented healthcare system. University of Copenhagen.

Saltman, R., V. Bankauskaite and K. Vrangbaek, Eds. (2007). Decentralization in Health Care: Strategies and Outcomes. Maidenhead, Open University Press.

Schlesinger and Gray, How Nonprofits Matter in American Medicine, And What To Do About It? Health Affairs 2006(25)4:287-303.

Schwierz C, Expansion in markets with decreasing demand-for-profits in the German hospital industry, 2011(20)6:675-687.

Shortell, S.M. et al., 1996. Remaking health care in America. Hosp Health Netw., 70(6), p.43–4, 46, 48.

Siciliani, L., Moran, V., Borowitz, M (2014) Measuring and comparing health care waiting times in OECD countries. Health Policy. Volume 118, Issue 3, December 2014, Pages 292–303.

Siverbo, S, 2004. “The purchaser-provider split in principle and practice. Experiences from Sweden.” Financial Accountability & Management, 20(4): 401-420.

Stolt R, Blomqvist P, Winblad U. Privatization of social services: quality differences in Swedish elderly care. Soc Sci Med. 2011 Feb;72(4):560-7.

Takian A, A. Rashidian, and L. Doshmangir (2015) The experience of purchaser–provider split in the implementation of family physician and rural health insurance in Iran: an institutional approach. Health Policy and Planning. 0:1261–1271 doi:10.1093/heapol/czu135

Tiemann O and J Scheyögg, Changes in hospital efficiency after privatization, Health Care Management Science 2012(15)6:310-326.

Tynkkynen L, I Keskimäki, J Lehto (2013) Purchaser–provider splits in health care—The case of Finland Health Policy 111 (3), 221-225

Tynkkynen, L., Chydenius, M. & Saloranta, A., 2016. Expanding choice of primary care in Finland : much debate but little change so far ☪. Health policy, 120(3), pp.227–234.

Valentijn, P.P. et al., 2013. Understanding integrated care: a comprehensive conceptual framework based on the integrative functions of primary care. International Journal of Integrated Care, 13(March), p.e010.

Vuorenkoski, L., Mladovsky, P., & Mossialos, E. (2008). Finland: Health system review. Health Systems in Transition; 10(4) , 1–168.

Wanless D. Securing our future health: Taking a long-term view. London: HM Treasury; 2002.

West, M. et al., 2012. Effectiveness of Multi- Professional Team Working (MPTW) in Mental Health Care. , pp.1–199.

WHO, 1978. Declaration of Alma-Ata, International Conference on Primary Health Care, Alma-Ata, USSR, 6-12 September 1978.

WHO (2007). Everybody's Business: strengthening health systems to improve health outcomes. WHO's framework for action. Geneva, World Health Organization

Wiens V, Kyngas H, Polkki T. A descriptive qualitative study of adolescent girls' well-being in Northern Finland. International journal of circumpolar health. 2014;73:24792.

Wilberforce, M. et al., 2016. Is integrated care associated with service costs and admission rates to institutional settings? An observational study of community mental health teams for older people in England. International Journal of Geriatric Psychiatry.

Winblad, U. et al., Do Accountable Care Organizations Reduce Re-hospitalizations from Skilled Nursing Facilities? Work in progress.

APPENDIX 1

THE FINNISH SOCIAL AND HEALTH SERVICES REFORM 2016-19
INTERNATIONAL REVIEW PANEL
Terms of reference

1. Objectives of the evaluation

The purpose of the international review of the planned Finnish social and health services reform is to provide an evidence-informed expert opinion / assessment on the expected impact of the new reform measures contained in the recent Government legislation of April 2016. The report resulting from this exercise should be made available before the Government´s bill is finalized and submitted to Parliament in late 2016. This review constitutes the first phase of a more comprehensive reform monitoring and evaluation program that will take place over the next years and along the implementation of the health and social services reforms.

The review has four overall aims

- To assess the expected impact of reform proposals by analyzing the strategies for reform and drawing on experience with similar reforms elsewhere in relevant countries.
- To determine health system and social services prerequisites in a range of system domains such as of governance, incentives or information systems; to enable effective reform implementation.
- To provide recommendations (if and whenever required) to adjust reform proposals in light of the results of the analysis.
- To preliminary assess the evaluation framework in place to monitor and evaluate the reforms in the short and mid-term[5].

Central questions to include in the review are:

- pros and cons of the networking governance model (regional autonomy (n=18) combined with enforced legal and financial guidance by the state);
- prerequisites and effects of the comprehensive social and health services service integration based on multiple providers (public, private, third sector);
- impact of the reform on the provision and access to health promotion and prevention services;
- effects on the health and social care expenditure trends and, in particular, the extent to which the reforms will succeed in containing costs;
- pros, cons and impact on the Finnish model of opening the service market to multiple providers and provider competition;
- impact of the health (and at least to some degree social) services customer choice model; and
- effects on service access and implications on the socioeconomic, health and social wellbeing inequalities;

[5] As noted this review will be followed in a second phase by the development and implementation of a comprehensive monitoring and evaluation framework of the reforms. The international panel review team or may continue to support Finnish Ministry of Social Affairs and Health to establish such evaluation mechanism.

2. Methodological approach and expected outputs

The review will be based on the following phases / activities:

I. MSAH in cooperation with the THL and the Ministry of Finance to prepare a full description of the reform proposals and provide key reform documents to the review panel.

II. Review panel to carry out a preliminary analysis of the documentation.

III. Review panel to participate in a first workshop in Finland organized by the MSAH - scheduled for the first week of July 2016. The aim of the workshop is to present and learn about the reform proposals, discuss pros and cons as well as implementation issues with experts and key stakeholders in the country. The workshop will provide panel reviewers with a more in depth understanding of reform contents and issues as well as with the opportunity to address questions to national experts and collect additional information.

IV. Review panel to prepare an interim report with a preliminary assessment based on the documentation analysis, the workshop and the analysis of relevant reform experience elsewhere in other countries. MSAH to furnish panelists with additional information and documentation as required.

V. Review team to present a preliminary draft report in a second workshop in Finland. The aim is to gauge initial reactions, obtain additional information, clarify any remaining reviewer's questions and, overall, strengthen the validity and quality of the assessment.

VI. Review team to prepare a final report[6] with the main results and recommendations of the review. MSAH to assist by collecting and providing feed-back and review comments.

3. Composition of the international review panel

The review team will be composed by a group of 6-8 renown international health and social policy experts bringing know-how in a range domains including macroeconomics; health economics and finance; health and social services governance, organization and management; and political economy of reform. In addition, they will possess some understanding of the Finnish health system as well that of other Nordic countries.

Panel members will be drawn from the following expert groups:

- Senior staff from international organizations / bodies in particular from WHO, OECD and the Commonwealth fund.
- Experts from (and on) Nordic countries working in the analysis and/or implementation of reforms in the health (and particularly) social sector.
- Experts with analytical and reform implementation experience from countries (e.g. UK, Netherlands) that have undergone (or are undergoing) reforms in areas relevant to this review such as introducing new models of public / private provision, market competition mechanisms, integration between the social and health sectors or consumer choice of providers.
- Senior staff from the Observatory to coordinate the expert panel and provide its secretariat.

The panel members will devote to this review about 8 to 10 days in total over the period of this exercise i.e. 4 months from June to September. The time will be split between country missions, two of about 2 days

[6] The completed report may need to be presented at a final face to face event.

each to participate in workshops; and 4-6 days of desk work reading documents, analyzing materials and writing the report.

4. Preliminary timetable

The indicative timetable is as follows:

Action	**Indicative timeline**
1. Mandate accepted and panelists nominated	Early June 2016
2. Agreement signed with OBS and panel members	Mid June 2016
3. First visit to Finland, presentation of the main features of the re-form, workshop with key experts including Ministeries (MSAH and Finance).	First week of July 2016
4. Second visit to Finland and interim report	Early Sept 2016
5. Feedback, supplementary information	Late Sept 2016
6. Final report	Mid October 2016

APPENDIX 2

July 2016 expert panel country visit #1

Name	**Affiliation**
July 6th, 10.15-11.45 Session 1	
Tuomas Pöysti	MSAH (Ministry of Social Affairs and Health)
Liisa-Maria Voipio-Pulkki	MSAH
Ilmo Keskimäki	THL
Päivi Voutilainen	MSAH
July 6th, 12.00-13.15 Session 2	
Pekka Järvinen	MSAH
Liisa-Maria Voipio-Pulkki	MSAH
Taru Koivisto	MSAH
Päivi Voutilainen	MSAH
Taina Mäntyranta	MSAH
Riku Elovainio	OECD
Kati Hokkanen	MSAH
July 6th, 14.30-15.45 Session 3a	
Pekka Järvinen, Liisa-Maria Voipio-Pulkki, Taru Koivisto, Päivi Voutilainen, Taina Mäntyranta	
Maritta Korhonen	MSAH
Sinikka Salo	MSAH
Kati Hokkanen	MSAH
July 6th, 14.30-15.45 Session 3b	
Ermo Haavisto	Satakunta hospital district
Markku Mäkijärvi	Helsinki and Uusimaa hospital district
Juha Tuominen	Terveystalo
Kari Varkila	Pihlajalinna Group (large private healthcare company)
July 6th, 16.00-17.00 Session 4a	
Markus Sovala	MF (Ministry of Finance)
Eeva Mäenpää	MF
Noora Heinonen	MF
July 6th, 16.00-17.00 Session 4b	
Kati Myllymäki	South Savo social and health region
Göran Honga	Vaasa Hospital district
Risto Mäkinen	City of Helsinki

Jukka Mattila	Lappi Hospital district
July 6th, 16.00-17.00 Session 4c	
Markku Pekurinen	THL (National Institute for Health and Welfare)
Ilmo Keskimäki	THL
Eeva Reissell	THL
Anu Muuri	THL
July 7th , 10.00-11.00 Session 6 a	
Taru Koivisto	MSAH
Kristiina Mukala	MSAH
Elina Palola	MSAH
July 7th , 10.00-11.00 Session 6b	
Taru Kuosmanen	City of Tampere

September 2016 expert panel country visit #2

Name	**Affiliation**
Sept 5th, dinner	
Tuomas Pöysti	MSAH (Ministry of Social Affairs and Health)
Liisa-Maria Voipio-Pulkki	MSAH
Annakaisa Iivari	MSAH
Outi Antila	MSAI
Sinikka Salo	MSAH
Taina Mäntyranta	MSAH
Session 2 a	
Riikka-Leena Leskelä,	NHG
Paulus Torkki	NHG
Raija Volk	MSAH
Antti Väisänen	MSAH
Markku Pekurinen	THL (National Institute for Health and Welfare)
Pirjo Pietilä-Kainulainen	MSAH
Session 2 b	
Jouko Narikka	MF (ministry of Finances)
Tuulia Hakola-Uusitalo	MF
Tanja Rantanen	MF
Noora Heinonen	MF
Marja Paavonen	MF

Teppo Heikkilä	MSAH
Timo Seppälä	THL
Päivi Sillanaukee	MSAH
Session 3a	
Pekka Kahri	THL
Hannu Hämäläinen	MSAH
Maritta Korhonen	MSAH
Jari Porrasmaa	MSAH
Heikki Onnela	Apotti project
Session 3 b	
Piia Rekilä	Ministry of Economic Affairs and Employment
Martti Virtanen	Finnish Competition and Consumer Authority
Pia Maria Jonsson	THL
Kati Hokkanen	MSAH
Session 3c	
Pekka Järvinen	MSAH
Noora Heinonen	
Ilmo Keskimäki	THL
Session 4 plenary	
Martti Hetemäki	MF
Liisa-Maria Voipio-Pulkki	MSAH
Noora Heinonen	MF
Session 5 a	
Taru Koivisto	MSAH
Pekka Jousilahti	THL
Tapani Valkonen	THL
Session 6b	
Kirsi Varhila	MSAH

October 10, 2016 – Presentation of international expert panel preliminary findings

Eskola	Juhani	Director General	THL
Hakola	Tuulia	Ministerial adviser	MF
Heinonen	Noora	Ministerial adviser	MF
Hämäläinen	Päivi		THL
Junnila	Maijaliisa		MSAH
Koivisto	Taru	Director Dept for Promotion of Welfare and Health	MSAH
Kuopila	Antti		Association of Finnish Local and Regional Authorities.
Laakso	Teija		Fimea (Finnish

			Medicines Agency)
Larjomaa	Eeva	Director, Information and Communication Unit	MSAH
Mattila	Jukka	Ministerial adviser	MF
Moisio	Antti	Ministerial Counsellor	Finnish Council of Regulatory Impact Analysis
Mäntyranta	Taina	Medical Counsellor	MSAH
Narikka	Jouko	Budget Councellor	MF
Niemelä	Katariina	Secretary	MSAH
Niemi	Veli-Mikko	Director General, Dept for Promotion of Welfare and Health	MSAH
Parjanne	Marja-Liisa	Director	MSAH
Partanen	Marja-Liisa	Director General	Valvira (National Supervisory Authority of Welfare and Health
Pekurinen	Markku	Director, Department of Health and Social Care Systems,	THL
Pietilä-Kainulainen	Pirjo	Ministerial adviser	MSAH
Pöysti	Tuomas	Under-Secretary of State, Project leader of the reform	MSAH
Rantalainen	Jenni	Secretary	MSAH
Saario	Minna	Project manager	MSAH
Salo	Sinikka	Leader of change in social and health care reform	MSAH
Salo	Päivi	Ministerial Counsellor	MSAH
Suomaa	Leo	Director General, Department for Occupational Safety and Health	MSAH
Whellams	Anne	Consultant	F-Innova Associates Oy
Virtanen	Martti	Research Director	Finnish Competition and Consumer Authority
Voipio-Pulkki	Liisa-Maria	Director of health care group	MSAH
Volk	Raija	Director of Planning and Development Group.	MSAH
Yrjö-Koskinen	Jaakko	Medical Counsellor	MSAH
Hokkanen	Kati	Senior Officer	MSAH
Torvinen	Anniina	University trainee	MSAH