CENTRALISING **HEALTH CARE ADMINISTRATION IN FINLAND** — AN INEVITABLE PATH?

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Summary: The discussion on the optimal degree of decentralisation and centralisation in the organisation of health systems is ongoing. Since the early 2000s, successive Finnish national governments have attempted to reform the health and social care system to increase the size of administrative units that organise services and to strengthen central steering. So far, developments have materialised mostly in the form of bottom-up solutions without being underpinned by a fundamental national level reform. However, the direction is towards more central steering, planning and organisation of services either through national reform or through bottom-up reforms implemented at local and regional level.

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The discussion on the optimal degree of decentralisation and centralisation in the organisation of health systems is ongoing. Many countries have implemented decentralising reforms and again re-centralised their health systems to improve the performance, governance and accountability of services. This is the case in Finland where the debate on the right form of governance and the balance between local governments, regional entities and the state has always been present. However, the discussion has intensified in recent years.

Finland has a health system with a highly decentralised administration, multiple funding sources, and three provision channels for statutory services in first-contact care: the municipal system; private services partly reimbursed by the national health insurance system; and occupational health care. The core health system is organised by the municipalities (i.e. 311 local authorities) which are responsible for financing primary and specialised care. The municipalities have the right to levy taxes. In addition, they get part of their funding through user fees and state transfers in the form of block grants.[1]

Since the early 2000s, successive Finnish national governments have attempted to reform the health and social care system to increase the size of administrative units that organise services and to strengthen central steering. So far, developments have materialised mostly in the form of bottom-up solutions without being underpinned by a fundamental national level reform.

However, the direction is towards more central steering, planning and organisation of services either through national reform or through bottom-up reforms implemented at local and regional level.

A series of failed reforms

Achieving greater administrative centralisation has been a long-term national level goal in the Finnish health system. There is broad consensus that the Finnish health system has inherent flaws, such as weak national stewardship and a large degree of fragmentation. The separate organisation of primary and specialised care and social services, particularly in the context of an ageing population, is seen as an obstacle to improving health system performance.

> pledged to continue centralisation of health care

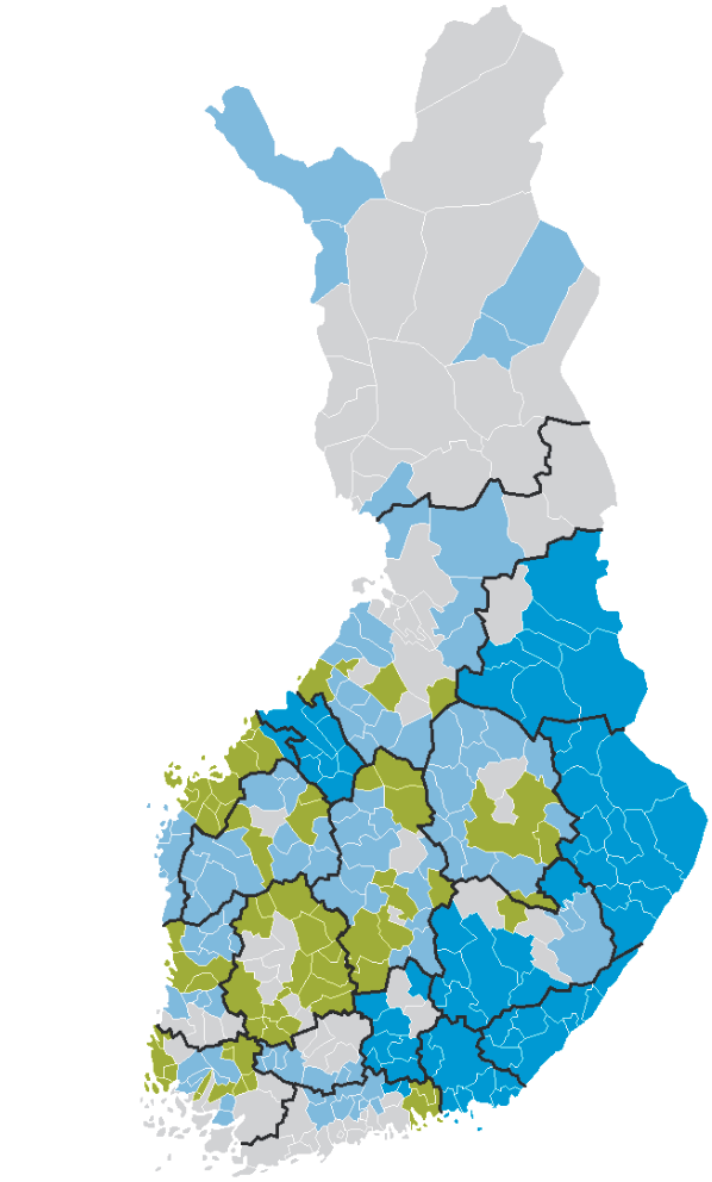
Over the past two decades, several governments, irrespective of political profiles, have attempted fundamental systemic reforms with three core aims: 1) centralisation of organisational structures; 2) improving access to primary care; and 3) integration of services (both horizontal and vertical). The implementation of these reforms on the national scale, however, has yet to succeed.

Due to the decentralised organisation of health and social care, as well as most other public services, it has been challenging to implement any major reforms without reducing the role of the municipalities. Such arrangements, together with the strong constitutional position of the municipalities, mean that finding a consensus on feasible policy solutions has proved very challenging and resulted in a series of failed reform attempts.

At first, in the early 2000s, the starting point was to reform the system through municipal mergers. While this only succeeded to some extent, the number of municipalities remains relatively large and the median population size remains small (see below). Subsequently, since 2010, the idea of transferring the responsibility for health care from the municipalities to regional entities has gradually started to gain ground.

The most recent reform attempt was introduced by the government in power from April 2015–March 2019. It envisaged

Figure 1: The organisation of primary health care and social services by region, 2019



Joint provision covering all or most of the region (62 municipalities, 16% of the population)

Joint provision covering some parts of the region (98 municipalities, 15% of the population)

Provision through host municipality model (61 municipalities, 21% of the population)

Provision organized by municipality itself (74 municipalities, 48% of the population)

Source: Local and Regional Government Finland, 2019; Municipal Boundaries © National Land Survey of Finland 2017; Map image © Association of Finnish Local and Regional Authorities/MS.

Table 1: Provision organised by the municipality itself: the number of municipalities and percentage of the total population covered

Population of municipality	Number of municipalities	% of total population
> 100,000	5	28%
50,000–100,000	4	4%
20,000–50,000	14	8%
< 20,000	51	8%

Source: Local and Regional Government Finland, 2019.

transferring all responsibilities for financing, organising and providing health care away from the municipalities, and could be seen as the most radical change to date. The plan was to create 18 administrative units (counties) with democratically elected councils, which would have been responsible for a wide range of tasks, including health and social care, emergency services, economic development, transport and the environment, as well as the current functions of the existing regional councils such as regional planning and development. The counties would have been financed entirely by the central government, i.e. they would not have the right to levy taxes. Municipalities in turn would have remained responsible for the promotion of health and well-being, and also for collecting municipal taxes but with a substantially lower tax rate.

Another component of the reform package was offering extensive choice and a competition model, which included the choice of a primary care provider and the freedom to establish practices for any qualified provider.

The bills on regional government and on choice and competition became the central pieces of the proposed reform package, but contained major challenges. Among these were the very tight budget constraints for financing of the counties, conflicts of the choice and competition model with the Finnish Constitution, and the process of integration of services within the planned system of multiple providers. Ultimately, it was the conflict with the provision of the Constitutional Law that, after several revision rounds with the Constitutional Law Committee, formally made the reform to fail in March 2019, resulting in the Government's resignation five weeks before the general elections in April 2019.[1]

However, the preceding intense preparation process seems to have set the stage for the next phase of the reform and the government in power since April 2019 has pledged to continue the centralisation of health care to 18 or more larger entities.

Small steps towards more centralisation

While the Finns are still waiting for a nation-wide reform, a lot has already happened in terms of centralisation during the past two decades. In the early 2000s, there were over 450 municipalities in the country. A slow process of centralisation has taken place since, and their number has been reduced to 311 municipalities (295 in mainland Finland) in December 2019. Despite a fall in the absolute number of municipalities by almost a third, the number of small municipalities is still high. In 2019, the average population size of the municipalities is about 18 000 inhabitants and, notably, the median size is 6 000 inhabitants.[2]

Municipalities can organise health care for their populations themselves or transfer this responsibility to another municipality or a joint municipal authority (**see Figure 1**). The organising function includes being responsible for defining and monitoring service volume and quality, assessing the needs of the population, ensuring equal distribution of services, deciding on the method of provision (e.g. service delivered by municipality, purchased or financed by a client voucher), and acting as public authority in decision-making. In the statutory health system, specialised medical care is provided by hospital districts. They are managed and funded by the municipalities and are responsible for organising and providing specialist medical services for the residents of member municipalities.

> comprehensive integration of primary and specialised health care as well as social services

Currently, 74 municipalities in mainland Finland (covering 48% of the population) organise services for their population themselves (**see Table 1**). In other words, the remaining 221 mainland municipalities have transferred the responsibility for organising services to another municipality or to a joint municipal authority. The median size of the municipalities that are organising the services themselves is around 7500 inhabitants with the smallest municipality having less than 1000 inhabitants and the largest over 600 000 inhabitants.[3]

During the past decade, regional joint organisations have also emerged. One such example is Eksote, which is a joint municipal authority of the South Karelia region (around 130 000 inhabitants). In addition to administrative consolidation, the joint authority has also aimed at comprehensive integration of primary and specialised health care as well as social services.[4] The services provided and organised by Eksote include, for instance, primary health care and specialised medical care, oral health care, mental health care and substance abuse services, diagnostic services, rehabilitation services, social services for adults, special services for disabled people, and services for older people.

In recent years, seven other areas have decided to implement similar arrangements. This indicates that in terms of organisation of services, the Finnish health and social care system has taken some important steps towards a more centralised administration as well as integrated service provision. However, according to the legislation, the municipalities are still responsible for financing of health and social care even if the organisational responsibility for services has been transferred to another municipality or a joint municipal authority.

At the level of specialised care, there also have been developments towards more centralised provision of services. This trend has been more pronounced since 2013, when a Decree on Emergency Care Services defined the overall principles of urgent care and its specialty level requirements.[5] This and subsequent legislation shifted both primary and specialist on-call services to jointly organised emergency care units, specified the requirements for key medical specialties, including the minimum acceptable total number of deliveries annually per hospital and the presence of certain specialists in hospitals with on-call units or performing any type of surgery. The aim of the Decree was originally to improve quality of care, but further amendments in 2014 set a specific national-level cost-saving target. Since 2015, the number of smaller somatic care hospitals has declined from 64 to 27.[6] Some of these facilities have been closed and some operate as satellite units of larger hospitals. In addition, psychiatric hospitals (previously located in separate facilities), were obligated to shift their on-call services and all in-patient care to the same premises as their somatic 24/7 care. Half of the 22 psychiatric institutions have since been closed, with a further six awaiting closure.

The process of centralisation in specialised care continues, with a further revision of the Health Care Act that was implemented in January 2017. The amendment centralised all 24/7 surgical services with on-call duties to 12 major hospitals (which will increase to 13 hospitals in 2020). In addition, in 2017 a Governmental Decree set volume-based requirements for key surgical procedures that will limit the number of hospitals able to perform these.

Difficulties in overall steering and in municipalities' abilities to organise adequate services

Even though there have been developments towards a more centralised system, the Finnish health system still remains decentralised and fragmented. The administrative structure makes the overall steering of the system difficult. The central Government's means for steering are based mainly on high-level regulation and soft guiding by recommendations and project funding aiming to develop different aspects of the services.

The municipalities continue to enjoy a high degree of autonomy. However, quite often their capacity to plan and evaluate performance of services and to make decisions on alternative models to organise services is limited. In specialised care, the smaller municipalities do not have enough power and expertise to impact the process of decision-making in their hospital district. A tangible example of challenges in health care governance and planning is well reflected in the stagnated resources in municipal health centres compared with increases in hospitals and occupational health care since 2000, which contrasts with overall Government policy, where the emphasis has been placed on the strengthening of primary care.

The capacity to deliver services that match population needs has also been weakened in the past decade. This has been driven by, for instance:

- the changing demography, namely population ageing, which is contributing to increased costs of health and social services;
- a decreasing birth rate and population growth;
- in-country migration, with working-age population concentrating in big cities and deteriorating local economies in many rural areas; and
- the rising costs of specialist health care.

For patients, this is reflected in long waiting times in primary care (up to several weeks for a non-urgent GP appointment in some health centres), but also in elective specialist care. The relatively high rates of (self-reported) unmet needs have been associated with long waiting times for the first appointment.[4] This is particularly the case for people outside of employment schemes, who do not have access to occupational health care.

The problems in access are intensified by an uneven distribution of resources across different regions in Finland. For example, the density of doctors is much greater in the capital region and in other big cities in comparison to more rural areas especially in eastern and northern Finland.[7]

How and when to undertake large-scale structural reform?

Because of the difficulties outlined above, there is relatively wide consensus among politicians and experts that the administration of the Finnish health system needs a large-scale structural reform. The recent steps towards a fundamental reform have laid the foundations, even though the actual reform failed. A notable development in the reform led by the government in power in 2015–19 was that the implementation process was initiated in 18 counties long before the legislation was even close to be passed. These county-level processes were financed from the central government budget. This means that in practice the reform preparations at local level were much more advanced in many counties than they were at the level of legislation. The financing was terminated after the government resignation, but some of the municipalities have decided to continue their preparation for county-level organisation.

It also seems that the current government (in power since April 2019) is following the steps taken by the previous government. In the government programme, it stated that "The health and social services reform will transfer the responsibility for organising health and social services to self-governing regions (counties) that are larger than municipalities. The responsibility for organising rescue services, too, will be transferred to the counties. There will

be altogether 18 autonomous counties. Separate legislation will be enacted on the functioning, finances and governance of the counties. Decision-making power in the regions will rest with directly elected councillors, and we will strengthen participation of county residents and reinforce user democracy." [8]

That is, in terms of administrative structure the plans of the current government are very similar to the reform that the previous government was pushing forward. However, the current government does not plan for the introduction of any choice and competition model – at least not to any large extent. In addition, the government is carrying out an expert investigation on the status of the capital region. The main reason for this is that Helsinki, the capital city of Finland with over 600 000 inhabitants, is opposing the regional model that would dismantle its power in the organisation of the services. The expert work should be ready by the end of 2019. It is possible that instead of being one county, the capital region would be organised into three to five counties of which Helsinki could be one.[9]

In conclusion, one can observe that while the fundamental reform is still waiting to be realised, the system has not been static and incremental development towards more centralised organisation of health care has taken place. Due to municipal mergers, the number of municipalities has decreased substantially. In addition to organising hospital care through hospital districts, the municipalities are increasingly organising health and social services in collaboration with each other and more recently, also through regional joint health and social care authorities. In hospital care, the centralisation of emergency services and certain medical tasks, such as deliveries and complex surgical treatments, have obliged hospital districts to collaborate. The process has also strengthened the mandate of university hospital districts to plan the coordination of hospital services in the areas for which they are responsible.

However, these changes have not substantially influenced the formal power of the central Government to steer the system. It remains to be seen whether the current government can succeed in delivering the structural reform, while at the same time there has been movement at the local level towards larger regions through joint municipal organisations in a county-wide manner. While the realisation of the national-level reform is still uncertain, the system is slowly moving towards more centralised organisation. Thus, the question is not whether there will be centralisation but rather when, how and to what extent.

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Finland: Health system review

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On the occasion of Finland's Presidency of the Council of the European Union in 2019, the European Observatory on Health Systems and Policies has released a new health system review (HiT) for Finland. Finland's health system has a highly decentralised administration, multiple funding sources, and three provision channels for statutory services in first-contact care. The core health system is organised by the municipalities which are responsible for financing primary and specialised care. The health system performs relatively well, as health services are fairly effective, but accessibility may be an issue due to long waiting times and relatively high levels of cost sharing. For over a decade, there has been broad agreement on the need to reform the Finnish health system, but reaching a feasible policy consensus has been challenging.