Public responsibilities for health care services have been decentralised more in Finland than in any other country. In Finland, 415 municipalities, with a median of about 5,000 inhabitants, hold legislative responsibility for organising and funding health services for their residents. In addition to health services, municipalities are also responsible for organising social services and primary education. Municipalities have a significant degree of freedom to plan and organise these services as they see fit and state-level steering is quite weak. Municipal services are funded mainly by municipal income tax, state subsidies and user fees.

The municipal health care system provides the largest share of health care services in Finland (for example about 70% of outpatient physician visits, about 60% of outpatient dentist visits and about 95% of inpatient care periods). In addition to the municipal system, health care services are also delivered by occupational health care and private health care providers; these are partly reimbursed by the statutory National Health Insurance.

National legislation stipulates that every municipality must have a health centre that organises primary health care for its residents. In addition, every municipality must have a health centre that organises primary health services. Municipalities can either have their own health centre or they can jointly host a health centre with neighbouring municipalities. The survey recorded the number of vacancies on 30 May 2006. The ensuing data indicated that there were 4,113 unfilled posts. The greatest number of vacancies were for anaesthetists (398) and internists (312). These deficits in personnel may just be a foretaste of problems to come; migration rates continue to increase, with 1,167 doctors obtaining the necessary certification to pursue professional opportunities elsewhere in the EU in 2006, compared with 862 in 2005 and 461 in 2004.

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Restructuring municipalities and municipal health services in Finland

Lauri Vuorenkoski

Public responsibilities for health care services have been decentralised more in Finland than in any other country. In Finland, 415 municipalities, with a median of about 5,000 inhabitants, hold legislative responsibility for organising and funding health services for their residents. In addition to health services, municipalities are also responsible for organising social services and primary education. Municipalities have a significant degree of freedom to plan and organise these services as they see fit and state-level steering is quite weak. Municipal services are funded mainly by municipal income tax, state subsidies and user fees.

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(that is, a health centre maintained by a municipal federation). There are altogether 237 health centres in Finland, from which fifty-eight are joint health centre federations (2007, excluding the autonomous Åland islands). Legislation also divides the country into twenty hospital districts that are responsible for the organisation of municipal secondary health care services. Each municipality must be a member of one of the hospital districts. Hospital districts are financed and managed by the member municipalities. The catchment population of hospital districts varies from 65,000 to 1.4 million inhabitants.

Decentralisation has provided a good chance to ensure the accountability of health services to the local citizens. However, population movement from rural municipalities to cities, ageing of the population especially in rural areas (increasing demand of health services and a decreasing pool of health professionals), increasing problems in balancing public-sector finances and the increasing demands of new technology for resources and skills have made small municipalities more and more vulnerable when solely responsible for the organisation of health services.

“It is considered ... that the number of municipalities could be much lower and regional cooperation stronger”

In recent years concerns have grown that the problems with decentralisation of this magnitude outweigh the advantages. One of the most discussed future developments of the Finnish public sector health care system has been the creation of a more solid structural and financial basis for municipal services by creating larger units to take responsibility for the organisation of health services. Although the number of municipalities has already decreased in recent years (from 452 to 415 in 2000–2008), it is considered in the state administration that the number of municipalities could be much lower and regional cooperation stronger.

Numerous regional development projects have been conducted to both increase regional cooperation in primary health care provision and to integrate primary and secondary care services. One important example of such regional reform is the administrative experiment in the Kainuu region (North-East Finland) which started in 2005. The region covers nine municipalities and a total of 85,000 inhabitants. The experiment created a new regional self-regulating mid-level administrative body with its own regional council. The council is elected for a four-year term at the same time as the general municipal elections. The new administrative body has no right to levy taxes but it gets funding from member municipalities. It is responsible for organising several welfare services that were previously organised by the municipalities: upper secondary schools and vocational education, primary and secondary health services, and a large part of social services.

The two most recent reforms of this type have been carried out in the Itä-Savo and Päijät-Häme regions in 2007. Itä-Savo has a population base of 60,000 and Päijät-Häme 210,000. In both regions, the municipalities formed a new municipal federation to organise primary and secondary care and some social services. However, some municipalities in both regions still organise primary health care services on their own instead of giving organisational responsibility to the new municipal federation. The new organisations replaced hospital districts that organised only secondary medical services. Like hospital districts, the new municipal federations are governed and funded by member municipalities.

National project to restructure municipalities and municipal services

In May 2005, the government launched The Project to Restructure Municipalities and Services. The goal of the project was to create a sound structural and financial basis for the services that municipalities are currently responsible for, so that the required standard of quality, effectiveness, availability, efficiency, and technological advancement are secured.

In the first phase, the project made three alternative proposals for reforming municipal services. The first alternative was to merge current municipalities so that each municipality would have a population base of at least 20,000 inhabitants. The second alternative was to integrate organisational responsibility of primary and secondary health care as well as certain social welfare services into new regional organisations with a population size of between 100,000 to 200,000 inhabitants (current municipalities would still be responsible for funding services). The third alternative was to introduce a new mid-level administration of twenty regions which would have organisational and funding responsibility to arrange most of the services (somewhat similar to the Landsting in Sweden). These regions would have their own representative elected councils and the power to levy tax and receive state subsidies.

“...mergers of municipalities can be a difficult process for local politicians, municipal employees and residents. However, the general view is that this is the right direction”

In January 2007, the Eduskunta (Finnish parliament) approved an act defining how to continue the process. The act states that organisational responsibility for primary health care and those social services closely related to health services should reside with organisations covering at least 20,000 inhabitants (currently only 23% of health centres have a population base of 20,000 or more). This would not necessarily require mergers of municipalities smaller than 20,000 inhabitants, but rather the forming of, for example, municipal federations where funding liability resides with individual municipalities. According to the act, the state will financially support mergers of municipalities. Additionally, the responsibility for the organisation and funding of forensic psychiatry examinations and examinations related to sexual abuse of children will be transferred to the state no later than 2009.

In autumn 2007, all the municipalities made detailed plans for the state administration on how these stated goals are to be achieved. However, the state administration was satisfied only with a minority of these plans. The majority of the municipalities were required to further specify their plans or have been summoned for negotiations with the state administration. Plans reveal that municipalities intend to form about seventy co-operative regions involving about three hundred municipalities. About half of these would work as joint-municipal federations. Another proposed model is that one municipality have the administrative responsibility of organising services and others have a
contract with that municipality related to the organisation of services for their residents (currently about twenty municipalities have arranged services according to this model). One identified problem with these proposals would be that social and health services could be dispersed to different regional organisations, which could hamper the seamless provision of services. Decisions on municipal mergers have already been made so that the number of municipalities will be reduced by sixty-two by January 2009. Additionally, in January 2008 there are another twelve ongoing merger processes involving twenty-nine municipalities.

The government will produce a report to the Eduskunta on the project’s progress in 2009. Municipalities are obliged to make final decisions on how they will implement the law prior to this date. The target for this process to be completed is 2012.

Conclusions
Municipal health services in Finland are undergoing major changes, with organisational responsibility for primary health services being transferred to larger organisations. However, it is difficult to estimate what the outcome of this process will be. The principle of municipal autonomy has a strong tradition in Finland. Municipalities value rather highly their independence to arrange basic services, so the reform will not be very easy. In particular, mergers of municipalities can be a difficult process for local politicians, municipal employees and residents. However, the general view is that this is the right direction in which to develop the organisation of health services in Finland.

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Observatory Venice Summer School

Hospital reengineering: New roles, tasks and structures

The European Observatory on Health Systems and Policies will hold its annual Summer School in collaboration with the Veneto Region of Italy from 3 to 8 August, 2008 on the island of San Servolo in Venice.

The theme of the summer school will focus on “Hospital reengineering: new roles, tasks and structures”. It will address how hospitals interact with the rest of the health and care systems and with the communities around them. The focus will be on the policy rather than management dimensions of boundaries to the outside world. The implications of relationships with other actors (including patient and consumer groups) will be addressed as well as the repercussions for the division of labour and internal organisation. It will help to understand and show how to support seamless links between services; and how to identify, plan for and manage hospitals’ place in health systems.

The summer school’s target groups are (i) senior to mid-level policy-makers and (ii) a limited number of junior professionals who are making careers in policy and management at a regional, national or European level. The intention is to raise key issues, share participants’ insights, develop a greater understanding of how evidence and context interact and build networks. The emphasis will be on participative approaches, complemented by some formal teaching (in English).

All participants should be in institutions with decision-making powers, whether government or non-governmental (for example, ministries, national health institutes, federal committees), relevant provider or payer associations (such as national insurance boards, hospitals or hospital federations, management boards, physicians’ chambers) or community stakeholder or consumer groups. Applications are welcome from all countries across the European Region.

The deadline for applications is 30 April 2008, earlier applications are encouraged. A selection process will follow and a limited number of bursaries will be available. The Summer School is accredited by the European Accreditation Council for Continuing Medical Education.

The programme will be tailored to the mix of participants and the course will be led by leading international experts and decision makers.

More information is available at www.observatorysummerschool.org
For specific questions regarding the Summer School please email summerschool2008@obs.euro.who.int